

**ASSESSMENT AND TREATMENT OF ANXIETY IN
PRIMARY SCHOOL CHILDREN**

by

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PROMOTER: Professor L. J. Jacobs

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(ii)

I declare that Assessment and Treatment of Anxiety in Primary School Children is my own work and that all the sources I have used or quoted from have been indicated and acknowledged by means of complete references.

I wish to acknowledge my gratitude for being awarded a Doctor's Exhibition by the University Council.



D. M. SHAND

November 1994

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This study is dedicated to the memory of my late parents,
Dick and May Apthorp.

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The Researcher

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PRIMARY SCHOOL CHILDREN**

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DEGREE: DOCTOR OF EDUCATION

DEPARTMENT: PSYCHOLOGY OF EDUCATION

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SUMMARY

Anxiety, in excess, has been found to have a crippling and often debilitating effect on both adults and children. It can affect all aspects of their lives and can lead to psychiatric disorders. This study was initiated by the researcher's observation that more children of all ages, referred to her private practice, were suffering from high levels of anxiety than in previous years.

A literature study was conducted into the phenomenon, anxiety, in order to establish:

- * the different types of anxiety;
- * the different theories of anxiety;
- * the development of anxiety in young children;

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- * the effect anxiety has on primary school children generally and specifically on their emotional, sexual, social, cognitive and moral development;
- * the symptom formation and psychosomatic illness caused by anxiety;
- * the disorders of childhood and adolescence caused by anxiety; and
- * the means of assessing and treating anxiety in primary school children.

The researcher then assembled a battery of standardised tests to assess anxiety in primary school children and devised a therapy, namely Hypno-play therapy, to treat anxiety in primary school children.

An idiographic study was then conducted on six primary school children, identified as suffering from high levels of anxiety. These children were assessed on the battery of tests, designed specifically to analyse their different types of anxiety, namely state and trait; general and test; free-floating and manifest; overt and covert and normal and neurotic. These results were then interpreted holistically, viewing the child within his life-world and attempting to make meaning of his anxiety within this context. Three of these children were then given Hypno-play therapy on a regular basis for 8-12 sessions and were thereafter reassessed on two questionnaires, to ascertain whether their anxiety levels had been reduced by the therapy. Other aspects, such as causes and symptoms of anxiety, were also reviewed.

Findings in the empirical investigation appear to confirm that anxiety can be identified in primary school children by means of a psychometric assessment, consisting of a variety of tests and can be treated successfully by Hypno-play therapy.

'Life is not without sorrow, pain and anxiety - but it
is also not without joy, comfort and tranquillity'.

M K Shapiro, 1988

May the anxious children of this world be helped to find the balance.

[Throughout the thesis, the convention of writing **he** to denote both sexes, has been used to avoid clumsiness and the constant repetition of both **he** and **she**].

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CHAPTER ONE

INTRODUCTORY ORIENTATION, PROBLEM ANALYSIS, CONCEPT DEFINITION AND AIM

1.1 INTRODUCTION

All children demonstrate signs of emotional distress at some time or another and every child has some occasion to manifest a special need [Lidz 1983:164]. However, emotional stability in the child is considered vital to his development in later years as a balanced, productive and happy person:

According to Schaefer and Millman [1981:X] the difference between normal and abnormal behaviour in the child is one of degree. The more misbehaviour the child exhibits, the less age-appropriate the behaviour, the longer the duration of the problem and the more resistant the child has been to efforts to help him, the more likely it is that professional assistance is required to resolve the problem. However, they further state that apart from the severity, persistence and resistance to change, there are certain other signs to look for which indicate that a child is experiencing serious psychological difficulties, one of which is prolonged, constant anxiety, apprehension or fear which is not proportionate to reality.

Anxiety is seen as a state or emotion that can cause emotional instability if it hampers the development of the child. It has far-reaching effects at a physical, psychological, social and scholastic level.

According to Hersov [1987:368-369] it is generally accepted that anxiety plays an important role in essentially all emotional disorders in children. Rutter [1970] and Wolff [1971] both report that it is also accepted that anxiety plays a part in many of the behaviour disorders of childhood and adolescence.

Suinn [1975:215] refers to anxiety as the 'cornerstone of all psychopathology'. He maintains that the most important symptoms of mental illness are 'manoeuvres to cope with anxiety in an attempt to discharge its intolerable pressure'. He also states that the symptoms can be an indication that the personality has been completely overwhelmed by the force of anxiety.

1.2 AWARENESS OF PROBLEM

When a child has been identified by his parents, the school or his doctor as having 'abnormal behaviour' in some form, he is usually referred to a psychologist for assessment and treatment. In order to arrive at the level of general functioning in the child and, in particular, the emotional stability of the child, various tests and other exploratory media are administered to the child in the form of an assessment. From this assessment, the level of anxiety in the child is often indirectly measured.

In her assessment of children, this researcher has become aware of the presence of high levels of anxiety in many children, irrespective of the problems identified and the symptoms presented by the child. Children with both emotional and behavioural problems have high levels of overt and/or covert anxiety present. These high levels of anxiety present themselves in many ways, i.e.:

- * in the drawings of children;
- * in other projective tests such as the Children's Apperception Test, the Thematic Apperception Test and the Incomplete Sentences Blank;
- * in questionnaires such the Children's Personality Questionnaire;
- * in clinical interviews with the child, highlighting eating, sleeping and

behavioural patterns;

- * in the clinical observations of the child by the psychologist; and
- * in the clinical history obtained from the child's parents revealing sleeping and eating difficulties, excessive bedwetting, sleepwalking, night terrors, repetitive nightmares, excessive fears and many psychosomatic complaints such as headaches, stomachaches, certain forms of asthma as well as in the obsessive-compulsive, phobic and nervous behaviour of the child.

According to Matthews and Odom [1989:153], there appears to exist a negative relationship between anxiety and self-esteem which would have far-reaching effects on the child's emotional and social development. According to Berlin [1979:41], when anxiety consistently interferes with the child's capacity to experience satisfaction and pleasure, it demands clinical investigation.

1.3 EXPLORATION OF PROBLEM

It is apparent from the literature that excessive anxiety can be viewed as having a very negative effect on both adults and children. Hambly [1991:7] maintains that a recent survey in Britain indicated that thirteen people out of every hundred [13%] experience anxiety-related symptoms to a degree that affects their everyday lives significantly.

According to Shaefer and Millman [1981:74-75], the Joint Commission on Mental Health of Children found, in 1973, that 10% of all American children suffered from feelings of fearfulness and anxiety that seriously interfered with their functioning.

In Africa, it is reported by Acuda [1993:54], that 10 - 24% of children under 15 years suffer from mental health problems, which vary in severity from mild adjustment disorders to severe conditions such as psychosis. According to recent research in Kenya and Zimbabwe, Acuda states that the commonest disorders are of the psychoneurotic type, which would include the anxiety-related ones, followed, in descending order of frequency, by depression, conduct disorder and childhood psychosis.

A recent South African survey [St Leger 1994:1], states that a higher proportion of black pupils (30%) are suffering from anxiety and 'abnormal' as opposed to 'positive' stress. Symptoms are reported as tiredness and irritability, sleeping disorders and neck- and backache. The sample consisted of 368 matric pupils from four high schools in greater Johannesburg [Northern Suburbs, Lenasia, Bosmont and Soweto]. It was further stated that in 'normal' South African society, only 6% [as compared to the 30% mentioned previously] of the population, falls into the category of suffering from 'anxiety and abnormal stress'. In the United States, the figure is quoted as low as 1.5 - 3%. Although there are obviously many abnormal factors contributing to this high anxiety and stress level in black matric pupils, it highlights the necessity of finding a suitable battery of tests to assess the anxiety, and a therapy that could assist these children in dealing with their anxiety and stress.

According to Schaefer and Millman [1981:75], anxiety interferes with the child's ability to function effectively. They maintain that anxious children:

- * are often easily frightened;
- * appear to look for things to worry about;
- * feel ill at ease, apprehensive and overtly anxious about everyday situations;

- * are often less popular, less creative and less flexible than other children;
- * are more suggestive, indecisive, cautious and rigid than others;
- * have low self-concepts;
- * are more dependent on adults; and
- * have difficulty expressing their anger openly.

Suinn [1975:217-218] concentrates on the negative effects of high anxiety on cognitive functioning. He states that anxiety:

- * is a hindrance to the learning of complex tasks;
- * lowers the performance on timed intelligence tests;
- * lowers the capacity to discriminate among similar objects;
- * reduces the number of responses which lead to response stereotype;
- * interferes with communication; and
- * provokes primitivisation of behaviour to the point of temporary loss of rationality in problem-solving.

Although there are underlying reasons for high anxiety levels in certain children, the symptoms of the anxiety are often presented as the problem. These symptoms, which are often overt behaviours, e.g. poor academic performance, enuresis, stuttering, etc., are brought to the attention of the professional psychologist. The

child will then usually be emotionally and intellectually assessed by the psychologist in order to obtain more information about the problem.

There are few tests, especially in South Africa, that focus on measuring the concept, anxiety, in the child and to this researcher's knowledge, no therapy designed specifically for treating anxiety in children. It is the researcher's view that high levels of anxiety, as well as its underlying causes and its symptoms, need investigation and finally treatment.

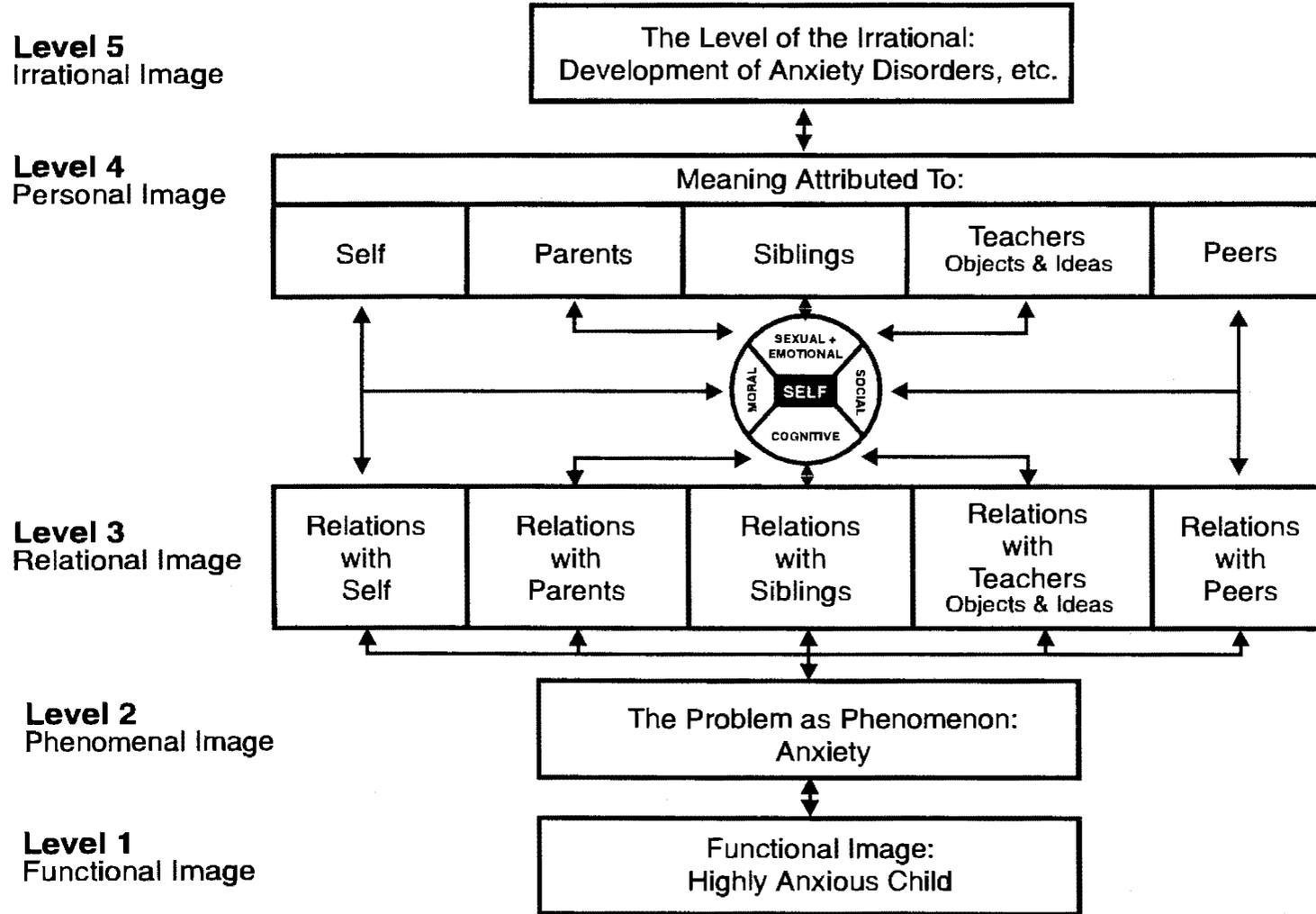
It would appear that most international research has focused on normative studies of anxiety in its many varied forms, i.e. state vs trait anxiety, general vs test anxiety and manifest vs free-floating anxiety. Very little research appears to be available from an idiographic perspective where the anxiety and its symptoms are viewed, assessed and treated as part of the child and his life-world. In fact, Erickson [Mills & Crowley 1986:44] states emphatically that the present symptoms need to be accepted and incorporated into the treatment strategy of the child. For this reason it is believed to be important to assess individual children by means of an idiographic model which will enable the researcher to view the child and his anxiety, holistically, within his life-world.

1.3.1 Model Used for Exploration of Problem

A model developed by Jacobs and Vrey [Shand 1990:79-81] and designed for idiographic diagnosis and research will be modified and used for the purpose of this study. It involves five different levels of viewing the child; each one concentrating on a different image of the child. The modified model is illustrated by the following diagram [Figure 1.1].

FIGURE 1.1

IDIOPGRAPHIC RESEARCH & DIAGNOSTIC MODEL



The various levels can be explained as follows [Shand 1990]:

1.3.1.1 Level 1: Functional image

This refers to the presenting problem of the child. As far as this research is concerned, the image will refer to the child who is experiencing difficulty with anxiety, i.e. the highly anxious child. Tentative hypotheses will be formulated regarding the nature of the anxiety.

1.3.1.2 Level 2: Phenomenal image

In this image the presenting problem is analysed with the assistance of the hypotheses formulated in Level 1. Information is then gathered so that possible causes of the anxiety can be identified. The child's family background is included under this image, as well as his birth and school history, to give as comprehensive a history as possible.

Certain tests to measure his levels of anxiety will be conducted as well as a qualitative analysis of his behaviour during testing. Projective media, interviews and questionnaires will also be used to investigate the child in his world. Interpretation of test results and projective material will enable the attainment of the third level, the relational image.

1.3.1.3 Level 3: Relational image

In this image all the relevant relationships of the pupil are investigated. For the purpose of this research, this image will deal with the child's relationships with the self, parents, siblings, teachers, objects, ideas, and peers. According to the results obtained from Level 2, the quality of the child's relationships can be examined and problem areas can be further investigated.

1.3.1.4 Level 4: Personal image

For the purpose of this study the child's self has been divided into four 'parts' in order to understand the different components of his self. These relate to the different perspectives of the child's development and refer to the following areas;

- * emotional/sexual;
- * social;
- * cognitive; and
- * moral.

It is felt that to understand the complex phenomenon of anxiety and the effects it has on the development of the child, it is essential to view the child holistically but from as many different perspectives as possible. This personal image is the integration of the child's perceptions of his relationships. Of importance is how his perception of these relationships may contribute to his level of anxiety or vice versa. As this involves the child's understanding of the problem from his personal and unique point of view, an attempt will be made, through the assessment and treatment of the child, to verify the hypotheses formed and the information gleaned from the psychometric tests and projective media, in order to allow the child better insight into himself.

1.3.1.5 Level 5: Irrational image

Should a child be unable to attribute rational meaning all of the time he may display pathological behaviour at certain times. Such behaviour may present in the form of severe symptom formation, resulting in psychosomatic disease or in the anxiety disorders such as overanxious disorder, separation anxiety disorder and avoidant disorder. [These will be discussed in a future chapter.] These

pathological behaviours would need to be treated by a clinical or counselling psychologist or one who has had experience in handling such children.

1.3.2 Assessment of Anxiety

In researching the availability of psychometric measures to assess the levels of anxiety in children, several aspects and difficulties were encountered, namely:

- * anxiety is viewed as a multidimensional phenomenon and the self-evaluating questionnaires and inventories appear to assess only one type of anxiety at a time;
- * the tests all appear to come from overseas, mainly the United States of America and Britain and none which is suitable for the primary school child is standardised for the South African population;
- * certain personality tests offer the calculation of second-order factors such as anxiety, but there appears to be much controversy as to whether these are acceptable as measurements of the phenomenon, anxiety;
- * intelligence tests such as the Wechsler Intelligence Scale for Children [Revised], are used and certain sub-tests such as Arithmetic, Digit Span and Coding, are analysed to ascertain the child's levels of anxiety;
- * projective media such as drawings, incomplete sentences and certain Thematic Apperception test cards, also offer valuable information on aspects of emotional difficulties and highlight levels of anxiety; and
- * structured and semi-structured interviews are widely used by psychiatrists and psychologists in obtaining valuable information from both the children and their parents, and certain of the questions focus directly on the fears

and anxieties of the children and how they may affect their eating, sleeping and elimination patterns, as well as their overall development intellectually, emotionally and socially.

The following are some of the tests encountered in a preliminary search:

* **Questionnaires and Inventories**

- State-Trait Anxiety Inventory for Children;
- The Children's Form of the Manifest Anxiety Scale;
- The Revised Children's Manifest Anxiety Scale;
- IPAT Anxiety Scale;
- General & Test Anxiety Scales for Children;
- Children's Personality Questionnaire; and
- Test Anxiety Questionnaire.

* **Interviews**

* **Projective Media**

- Drawings;
- Incomplete Sentences Blank; and
- Thematic Apperception Test.

Although deductions can be made from the Children's Personality Questionnaire

[CPQ] with regard to the level of the child's anxiety, Owen and Taljaard [1989:368] warn that the research conducted on the CPQ is insufficient for the calculation of second-order factors, such as anxiety.

Certain of the psychometric measures of anxiety will be more fully explored in Chapter Four.

1.3.3 Treatment of Anxiety

It would appear that very often the symptoms of the anxiety are treated in the child [i.e. stuttering, enuresis and lack of academic achievement], without the causes of anxiety being attended to.

Play therapy is often the medium used to treat the primary school child who displays emotional, behavioural and social difficulties. However, play therapy is an extremely broad concept and covers all forms of psychotherapy done with children and includes all the various schools of thought in psychology today.

It is felt that children with high levels of anxiety may need or can greatly benefit from a more directed form of therapy to deal with the anxiety as well as the underlying causes and the symptoms. It is proposed that during the play therapy sessions, certain of the aspects of the child's anxiety, its root causes, as well as its symptoms, can be treated.

1.4 FORMULATION OF PROBLEM

It would appear from the literature that high levels of anxiety in children can be viewed as destructive, debilitating and often crippling and can affect their cognitive, emotional, social and physical development negatively. It can also lead to psychopathology in the child and/or in the adult.

It seems imperative that parents, teachers, psychologists and researchers become more aware of the presence of anxiety in children and of its negative effects on their development, generally, as well as the underlying causes of the anxiety so that both the causes and the anxiety, along with its symptoms, can be treated.

A need has been identified therefore, to investigate the anxiety levels of the child and to create a therapy to treat the anxiety professionally, in the form of psychotherapy. It also appears important to understand the causes of the anxiety so that the emotional needs of the child are better met, the environmental stresses can be modified, reduced or regulated and the child can be taught coping skills to maintain an optimal level of anxiety. If a better understanding can be obtained of the phenomenon, anxiety, as well as the ability to assess it accurately and treat it successfully, then psychologists and indirectly teachers and parents, may be better equipped to render more support and assistance to the highly anxious child and thus prevent further psychopathology from developing in him, while encouraging him to reach his full potential intellectually, emotionally and socially.

1.5 STATEMENT OF RESEARCH PROBLEM

The research problem is defined as follows:

Question 1:

- * How can we best assess anxiety in primary school children?

Question 2:

- * How can this anxiety be treated successfully?

1.6 AIM OF RESEARCH

A distinction is made between the specific and general aims of this research.

1.6.1 Specific Aim

The specific aim of this research is to investigate anxiety in primary school children in order to understand how best it can be measured by means of a psychometric assessment and how it can be treated successfully by the psychologist.

This will take the form of :

- 1.6.1.1 a selection of inventories, questionnaires, interviews and projective media that can be used with primary school children to assess anxiety; and
- 1.6.1.2 the development of a therapy namely, Hypno-play therapy, for the treatment of anxiety in primary school children.

1.6.2 General Aim

The ultimate aim of this investigation is to come to a deeper understanding of the phenomenon, anxiety, in primary school children in order to:

- * assist the children emotionally, intellectually and socially;
- * prevent psychopathology from developing in the children;
- * contribute towards a frame of reference for those adults who have a pedagogic responsibility towards primary school children, i.e. psychologists, teachers, principals and parents; and
- * make a contribution to fellow colleagues of a model for assessing and a therapy for treating highly anxious children.

1.7 DEFINITION OF CONCEPTS

1.7.1 Anxiety

According to Sarason and Sarason [1980:161] anxiety is usually defined as a 'diffuse, vague, very unpleasant feeling of fear and apprehension'.

Suinn [1975:215] largely agrees with this definition but refers to it as 'an unpleasant emotional state cued off by the presence of a threat and associated with subjective feelings of tension and apprehension'.

In the theoretical and research literature the terms anxiety, fear, nervousness and tension, seem to be employed interchangeably. Those theorists, from a Psycho-analytic persuasion, prefer to reserve the term, anxiety, for fear that is experienced in the absence of external danger; most Learning theorists, on the other hand, apply the term, anxiety, to fear that is learned in the presence of a specific harmless stimulus [Davison & Neale 1978:112-113].

For the purpose of this study anxiety will refer to both of these concepts, which are viewed as two sides of the same coin. The different types of anxiety will be fully explored in Chapter Two.

1.7.2 The Primary School Child

Regulations, promulgated by the Minister of Education under the National Education Policy Act [Act 39 of 1967], resulted in the South African child's school career being divided into four phases [Kokot 1988:12]:

- * Junior Primary Phase [Grades i, ii and Std. 1] ± 6 - 8 years of age;
- * Senior Primary Phase [Std. 2, 3 and 4] ± 9 - 11 years of age;

- * Junior Secondary Phase [Std. 5, 6 and 7] \pm 12 - 14 years of age;
and
- * Senior Secondary Phase [Std. 8, 9 and 10] \pm 15 - 17 years of age.

For the purpose of this study, the primary school child will be defined as any school child between Grade 1 and Std. 5 [six to twelve years of age]. This is due to the fact that although the Std. 5 pupil is considered to have reached the Junior Secondary Phase, he is usually still accommodated in the primary school and for practical reasons, will be considered a primary school child.

1.7.3 Assessment

According to Jackson and Messick [1978:X], the term, assessment, highlights a wider approach to the appraisal of human differences than the term, measurement, especially as it was used in the past. However, they believe that measurement methodology has become an integral part of psychological science and that the same general principles hold, for both psychological measurement in its formal sense and for the field clinical evaluation procedures usually implied by the term, assessment. 'An assessment procedure is a way of gaining information about a person', according to Pervin [1970:71]. It usually involves the systematic observation of behaviour under specified conditions and in relation to specific stimuli.

According to Plenk and Hinchey [1985:128], 'total assessment must include standardized testing, behavioral observations and ratings, developmental history and play interviews'.

Assessment is used in this study to evaluate the phenomenon, anxiety, in children by means of structured and non-structured tests, clinical interviews, behavioural observations, questionnaires and inventories as well as from the developmental

history of the child.

1.7.4 Treatment

Psychotherapy, according to Suinn [1975:519-520], is a method of treatment which involves 'a corrective experience accomplished through the interaction between a professional therapist and one or more patients'. The aim of treatment is to restore the person to a more effective and satisfying state of adjustment than before.

The treatment of a child would usually be through the medium of play as he does not yet have the verbal facilities for most forms of psychotherapy. For the purpose of this study, treatment will focus on play therapy in the form of Hypno-play therapy, which may be viewed as a combination of play and hypnotherapy.

1.8 METHOD OF RESEARCH

1.8.1 Literature Study

A literature study will be conducted in order to:

- * investigate the phenomenon, anxiety, generally;
- * explore different types of anxiety and the relationship between anxiety and fear, phobias, depression and stress;
- * explore the various theories of anxiety, such as the Psychoanalytic, Psychodynamic, Learning and Existential theories;
- * explore the effects of anxiety on the general development of the child and

in particular, the primary school child;

- * explore the psychosomatic symptoms in the child which are caused by anxiety as well as the anxiety disorders that develop in the highly anxious child;
- * establish a method of assessing anxiety in the child by means of nomothetic tests as well as idiographic measures, using questionnaires, inventories, interviews and projective media; and
- * create a therapy for the treatment of anxiety in the primary school child by exploring the various theories of play therapy and hypnotherapy.

1.8.2 Empirical Study

Hypotheses, arising from the literature study, will be tested by means of an empirical investigation.

1.9 RESEARCH PROGRAMME

The research is planned as follows:

- * Chapter One gives an exposition of the problem. It serves as an introductory orientation as to how the researcher became aware of, explored, formulated and finally stated the research problem. Concepts relevant to the field of study have been defined and the aims of the investigation have been stated.
- * Chapter Two investigates the phenomenon, anxiety and explores the various types of anxiety as well as the theories of anxiety.

- * Chapter Three describes the development and effects of anxiety on children in general, and in particular, on primary school children.
- * Chapter Four explores methods of assessing anxiety in primary school children.
- * Chapter Five investigates the various methods of treating anxiety in primary school children.
- * Chapter Six describes the experimental design of the investigation.
- * Chapter Seven records the empirical investigation of the assessment of six anxious primary school children.
- * Chapter Eight records the empirical investigation of the treatment of one highly anxious child in detail and compares the treatment of two other highly anxious children with it.
- * Chapter Nine offers the conclusions, recommendations and implications that can be drawn from the findings of this investigation.

CHAPTER TWO

AN ANALYSIS OF THE PHENOMENON ANXIETY, DIFFERENT TYPES OF ANXIETY AND VARIOUS THEORIES OF ANXIETY

2.1 INTRODUCTION

Anxiety plays an important role in the study of the psychology of normal people [Davison & Neale 1978:112]. According to these authors, most people experience some measure of anxiety at least weekly. However, these brief periods of anxiety are not in any way comparable in intensity and duration, nor are they as debilitating as those suffered by the highly anxious person.

As Suinn [cf. 1.1] has pointed out, abnormal amounts of anxiety appear to be the 'cornerstone of all psychopathology'. He [Suinn 1975:215] maintains that it signals danger to 'one's security, to one's psychological safety, to one's self-esteem, to one's sense of well-being'. He associates it with conflict and states that it is accompanied by physiological processes.

For Freud [Spielberger 1972a:5] anxiety was not only a central problem in neurosis but 'understanding anxiety was also essential to the development of a comprehensive theory of human behaviour'.

2.2 ANXIETY AS A PHENOMENON

In the twentieth century, anxiety, according to Spielberger [1972a:5], has 'emerged as a central problem and a predominant theme of modern life'. However, according to him, a basic shortcoming in current theory and research on anxiety, is that the researchers represent a wide range of different theoretical orientations and employ a wide range of research methods. For this reason, it is extremely difficult to define anxiety generally.

However, the term, anxiety, is most commonly used, according to Spielberger [1972a:24], to 'denote a palpable but transitory emotional state or condition characterised by feelings of tension and apprehension and heightened autonomic nervous system activity'.

As mentioned in Chapter One [cf. 1.7.1] the terms, anxiety and fear, are often used interchangeably, depending on the theoretical context in which they are used. Psychoanalytic theory prefers to use the term, anxiety, for fear that is experienced in the absence of external danger while Learning theory tends to apply the term, anxiety, to fear that is learned in the presence of specific, harmless stimuli, according to Davison and Neale [1978:112-113].

Most researchers [Spielberger 1972a; Suinn 1975] view anxiety as often being diffuse and not specifically related to any situation. It is seen as persisting over much longer periods and can become attached to new triggering cues. Fear, on the other hand, usually dissipates after the feared object has been removed or withdrawn. However, Kaplan and Sadock [1989:960] believe that this theoretical distinction cannot always be strictly maintained as in the case of phobic symptoms.

Fear and anxiety may both be present in varying proportions at any given time and in any given situation and the relationship between anxiety and fear will therefore be examined in more detail further on in this chapter.

Freud [1936], May [1950], Rutter and Hersov [1987], Sarason and Sarason [1980] and Spielberger [1972a & b], all appear to agree, to some extent, that anxiety:

* is a vague unpleasant, emotional or affective state;

- * is a state of diffuse arousal, an emotional response system;
- * involves several dimensions, i.e. subjective, cognitive, behavioural and physiological;
- * is cued off by the presence of a threat or perception of a threat or unresolved fear;
- * acts as a warning signal to the individual;
- * is associated with a varying number of subjective feelings, i.e. fear, dread, guilt, tension, apprehension, uncertainty and helplessness; and
- * is accompanied by physiological changes involving the sympathetic and parasympathetic nervous systems which include pupillary dilation, palmar perspiration, increased or rapid heart rate, rapid respiration, tremors, restlessness, fainting, dizziness, loss of appetite, diarrhoea, sleeplessness and urinary frequency.

The above definition of anxiety refers to normal or state anxiety which is a transitory experience and varies in intensity and fluctuates over time. However, trait anxiety [Spielberger 1972a:39], is used to describe a basic personality trait of the individual. An excess of this anxiety in the person may then be seen as abnormal or pathological. This aspect of anxiety will be fully explored under the heading of Different Types of Anxiety [cf. 2.2.1].

2.2.1 Different Types of Anxiety

2.2.1.1 State and trait anxiety

The concept of states refers to behaviours that are reversible and that change in their level more rapidly than behaviours associated with traits. Cattell and Scheier [Pervin 1970:416] maintain that there are two different forms of anxiety; state and trait anxiety, and that trait anxiety is not just temporary state anxiety held permanently high. They maintain that the individual will show some fluctuations in his behaviour that do not represent changes in the trait structure and that may be the result of changes in the physiological functioning of the organism.

Kaplan and Sadock [1989:573] maintain that the term, anxiety, has been used in reference to an emotional state, a response syndrome, as well as to specific psychiatric disorders. They propose that a 'disagreeable emotional state that signals anticipated or impending threat, has affective features as well as autonomic, visceral, perceptual, cognitive and motor manifestations'. They further propose that the emotion of anxiety is associated with 'automatic hyper-arousal and attentive hyper-vigilance in which internal and external environments are monitored intensively for information relevant to the sense of threat'. For them, anxiety occurs when threat is not well defined.

Researchers such as Cattell and Scheier [1961], Pervin [1970], Spielberger [1972 a&b] and Suinn [1975], emphasise the transitory nature of state anxiety [A-State]. They refer to it as a transitory or temporary unpleasant state, reaction or episode that varies in intensity and fluctuates over time. It is cued off by the presence of a threat or a situation perceived by the individual as personally threatening.

It is associated with subjective feelings of tension, apprehension and is accompanied by physiological changes in the body involving the sympathetic and parasympathetic nervous systems. It includes increased heart rate and respiration, palmar perspiration, pupillary dilation, etc..

It refers to the reaction of a typically non-anxious person and does not persist beyond the provoking situation. It is therefore considered normal and appropriate to the situation. It is distinguished from anxiety-proneness or trait anxiety [A-Trait] by nature of 'individual differences in the frequency that anxiety states are manifested over time' [Spielberger 1972a:10].

Individuals differ considerably in their proneness to anxiety and trait anxiety refers to anxiety that is used to characterise or describe the basic personality of an individual. It therefore refers to a 'lifelong pattern of anxiety as a temperament feature' [Kaplan & Sadock 1989:573].

According to Pervin [1970], Spielberger [1972] and Suinn [1975], trait anxiety remains fairly stable across situations. It therefore characterises the person who operates generally at a high anxiety level and who reacts as 'jittery', 'skittish', 'hypersensitive to stimuli' and who is 'psycho-physiologically more reactive than others' [Kaplan & Sadock 1989:573].

According to Blankstein [1976:781] and Hodges and Felling [1970:333], the above model of trait anxiety emphasises only unidimensional trait anxiety. They propose an alternative model which emphasises the interaction between situational and personality factors and is viewed as tridimensional in that there are three types of trait anxiety elicited according to the type of situation involved.

The three dimensions are:

- * interpersonal anxiety - which is elicited by interpersonal or ego-threatening situations;
- * physical danger trait anxiety - which is elicited by situations involving physical danger; and
- * ambiguous threat anxiety - which is elicited by novel or unfamiliar situations.

Cattell [1959:464] views anxiety as multidimensional. Trait Anxiety is seen as a second-order personality factor. According to him, the second-order personality factors such as anxiety and extraversion, found in adults, also exist in children. There are certain differences, however, e.g. the anxiety factor in children is less concerned with internal conflict associated with defects of personality integration and more with situational threat than in adults.

He views the following personality factors as making up the second-order factor of anxiety:

- Factor -C [ego weakness];
- Factor +O [guilt proneness];
- Factor -H [high automatic susceptibility to threat];
- Factor +Q3 [poor self-sentiment]; and
- Factor +Q4 [high ergic tension].

Subsequent research involving the S-R Inventory of General Trait Anxiousness devised by Endler and Okada [1975:319], indicates that the unidimensional trait anxiety measured by the State-Trait Anxiety Inventory [STAIC], correlated most highly with the interpersonal trait anxiety on the general trait measures, as

opposed to the other specific anxiety measures.

The effect of state-trait anxiety on cognitive functioning was explored by Hodges and Spielberger [1969:430-434]. In their research they found that state anxiety was more important than trait anxiety in predicting significant decrements in the Digit Span sub-test of the WISC.R. They therefore concluded that state anxiety differences were responsible for decrements on memory and learning tasks. However, they viewed anxiety as a unidimensional trait. Endler and Okada, as mentioned above, propose that trait anxiety is multidimensional, which suggests that individuals not only vary in their proneness to experience anxiety states, but also in the number and type of situations that are likely to produce state reactions.

Finch, Anderson and Kendall [1976] researched the hypotheses that if trait anxiety was unidimensional and did not affect the child's performance on the Digit Span sub-test, as Hodges and Spielberger proposed, the three anxiety factors of the Children's Manifest Anxiety Scale [CMAS] namely:

- * worry and over-sensitivity;
- * anxiety: physiological; and
- * anxiety: concentration;

would not be related to Digit Span performance, as they are derived from a trait anxiety measure. However, if the trait anxiety was multidimensional as proposed by Endler and Okada, it would predict that individuals with high scores on the Anxiety: Concentration factor would perform more poorly than those with low scores.

In their research, with 38 emotionally disturbed children, they [Finch *et al.* 1976:874] found that their results supported the multidimensionality of trait

anxiety [at least with emotionally-disturbed children]. The highly anxious children, as defined by the CMAS, differed significantly from the low-anxious children in the ability to concentrate on the Digit Span sub-test but not on the other two components of the test.

2.2.1.2 General and test anxiety

General anxiety refers to anxiety that the person is likely to experience in his everyday life, i.e. worries and fears pertaining to everyday things. Test anxiety however, refers specifically to anxiety aroused by test or evaluation situations.

The influence of anxiety on performance has a great deal of significance for educational practice as well as psychological theory. According to Center [1981:101], various researchers have developed different theories in an attempt to explain the effects of anxiety on performance. The majority of these theories is based on the S-R Learning Theory and on Psychoanalysis [Ruebush 1963:466-474].

Sarason *et al.* [Center 1981:101-102] conceptualise anxiety as a general, dispositioned, unidimensional trait with cue rather than drive properties. They do not differentiate between anxiety and fear and take the test or evaluative classroom situation as an example of a stressful event. They hypothesise that anxiety develops within the family circle where the child's behaviour is subject to constant parental evaluation. They propose that if parents are particularly negative in their evaluation of the child or have unrealistically high expectations, they will evoke angry feelings in the child that he is not able to express because of his dependency on them for approval, love, support and care. The child's fear that his parents will withdraw their love and support while he is so dependent on them generates primal anxiety in the child. This anxiety, which is aroused in him through feelings of negative self-esteem, develops into specific test anxiety evoked by any situation which is perceived as a threat to his self-esteem and in which his

dependency needs cannot be gratified [Sarason, Davidson, Lighthall, Waite & Ruebush 1960: 230-233]. This theory maintains that because of the stimulus similarities between parent and teacher, the school situations arouse test anxiety in the child [Sarason *et al.* 1960:276]. They propose that the test anxiety has a debilitating effect on performance because it arouses task-irrelevant responses.

In the test or evaluation situation the teacher will give no cues to correct performance and the test anxious child will respond more to learnt irrelevant cues of inadequacy and fear of failure, than to the relevant cues of the task [Center 1981:102].

Beidel and Turner [1988:275] have found that test anxious children reported more fears and general worries than their non-test anxious peers. The test anxious children experienced more negative cognitions and subjective distress when taking a test. Fear of negative evaluation was also not limited to an actual test, but applied to social evaluative tasks as well. Surprisingly, 60% of the test-anxious sample of Beidel and Turner met the DSM III criteria for an anxiety disorder indicating that test anxiety appears to be linked to the other forms of anxiety.

Beidel and Turner [1988:276] mention that anxiety over test performance has been related to low self-esteem, dependency and passivity. They also maintain that it could serve as an etiological factor in the development of school phobia. There appears to be increasing evidence therefore, that test anxiety is not a phenomenon on its own and is not a highly circumscribed condition, but may serve as 'an indicator of the existence of more pervasive anxiety states'.

Walter, Denzler and Sarason [1971:320-332] report that in two research studies conducted by them on high school students, they found differences between test anxiety and its effects on performance. In the first study, the results agreed with previous evidence that test anxiety is more consistently related to test performance than are more general anxiety indices. Test anxiety was significantly and

negatively related to intellectual test performance and not significantly related to grade point averages. However, in the second study, none of the measures of anxiety was significantly related to the grades or the intellectual test performance of the boys, as it was in the case of the girls. The researchers hypothesise that the difference in socio-economic level of the children in Study 1 and 2 differed considerably, with the first group coming from a higher socio-economic group than the second. However, they do not fully explain why the boys of this study should have been less affected by the test anxiety than the girls. They suggest that the relationship of test anxiety to social class factors, to the sex of the subjects and to general and specific ability factors, should be further and more systematically explored.

Sarason, Davidson, Lighthall and Waite [1958] developed two anxiety scales for measuring test anxiety [Test Anxiety Scale for Children (TASC)] and general anxiety [General Anxiety Scale for Children (GASC)].

2.2.1.3 Overt and covert anxiety

Overt anxiety implies that the anxiety in the person can be openly measured without any hidden aspects. This would indicate that the anxiety is at a more conscious level in the individual. Cattell's IPAT Anxiety Scale differentiates between overt and covert anxiety. The overt anxiety score is obtained from 20 direct, symptomatic items which serve, firstly, as a report of actual symptoms and, secondly, as an indication of the person's awareness of his problem and, thirdly, in special circumstances, as a clue to the attempted distortion or exaggeration of symptoms.

Covert anxiety is anxiety that is disguised, hidden and often not available to the person's conscious mind. Cattell's IPAT Anxiety Scale [Bendig 1960:159-163] has 20 items with disguised cryptic statements which yield a measure of the person's covert anxiety without the person being aware of the diagnostic meaning

of the items.

2.2.1.4 Free-floating and manifest anxiety

According to Kaplan and Sadock [1989:573] free-floating anxiety is 'a condition of persistently anxious mood in which the cause of the emotion is unknown and large numbers of diverse thoughts and events all seem to trigger and compound the anxiety'. This results in common psychiatric symptoms in an effort to control and reduce this anxiety. Manifest anxiety, on the other hand, refers to the symptoms of anxiety that the person is aware of and admits to. In Psychoanalytic terms, it is assumed that this anxiety is a 'symptom of a deeper repressed conflict' [Reber 1985:416].

The Personality Scale of Manifest Anxiety was developed by Taylor [1953:285-286] in 1951. According to her, performance in a number of experimental situations is related to the level of anxiety as revealed on a test of manifest anxiety; the variation in drive level of the individual is related to the level of internal anxiety or emotionality and the intensity of this anxiety, and can be tested by a pen and paper test consisting of items describing what have been called overt or manifest symptoms of this state, i.e.:

- * I cannot keep my mind on one thing;
- * I worry over money and business; and
- * I have a great deal of stomach trouble.

2.2.1.5 Normal and neurotic anxiety

Suinn [1975:215-217] states that under normal conditions, anxiety can be viewed as a 'helpful ally, rather than a fearful foe'. He mentions that it serves:

- * as an early warning system;
- * to protect the individual by dulling his general awareness and heightening his sensitivity to the warning cues;
- * to stimulate learning;
- * to encourage optimum performance;
- * to prepare the person to cope with challenges; and
- * to make the person more perceptive of his environment and therefore more able to adapt to it.

According to Giordano [1987:535] what characterises the healthy personality is his ability to recognise and regulate anxiety. Giordano maintains further that the person's inability to cope with anxiety rather than the anxiety itself, is what is so destructive to the individual.

However, according to Crosby [1976:237], there is a need to distinguish between normal anxiety and neurotic anxiety and fear. He states that normal anxiety, referred to as real or objective anxiety by Freud, is a reaction to an external danger and as such, it is a natural, normal and useful function.

He maintains that in contrast to normal anxiety, neurotic anxiety is a reaction that:

- * is disproportionate to the objective threat or danger;
- * involves repression and/or other mechanisms of intra-psyche conflict;

- * requires neurotic defence mechanisms for its management; and
- * although it involves conscious awareness, it cannot be confronted constructively on the level of consciousness and cannot be easily relieved, even if the threat is removed.

2.3 RELATIONSHIP BETWEEN ANXIETY AND

2.3.1 Fear

Researchers such as Crosby [1976], Kaplan and Sadock [1989] and Suinn [1975], report that fear is an emotional state that exists when the source of threat is precise and well-known. It is usually directed at a specific object, situation or danger and in this way it differs from anxiety in that it is a reaction to a real danger of an identifiable object which threatens the individual with possible injury or death. The fear reactions usually dissipate upon the withdrawal from or the disappearance of the feared object. Suinn [1975:216] states that fear 'mobilises efforts appropriate to coping with the feared object such as preparations to fight, flight, reassurance or re-evaluation of the situation'.

On the other hand, anxiety, according to the above researchers, is often diffuse and not directly related to any situation. It persists over a much longer period and can become attached to new triggering cues. It is Suinn's belief that 'severe anxiety is usually disruptive and excites a wide variety of behaviours, including irrelevant, disorganised and inappropriate responses' [Suinn 1975:216].

Kaplan and Sadock [1989:960] state that the Psychoanalytic view of anxiety is that it is the person's 'response to a danger that threatens from within, in the form of a forbidden instinctual drive that is about to escape from the individual's control'. However, they believe that this theoretical distinction cannot always be strictly maintained. They point out that with phobic symptoms, the patient

experiences the threatening situation as being external, although there may be nothing dangerous about it in reality. At the same time, an external situation that is genuinely dangerous, may arouse instinctual drives that produce internally derived anxiety.

Crosby [1976:237] agrees with Kaplan and Sadock and recognises that fear can be both rational where it is proportional to the real danger and irrational, as in phobias, where the object or situation is feared but without good reason.

Dollard and Miller [Fischer 1970:67] theorise that when the source of fear becomes obscured through certain events and processes, it becomes anxiety and emerges only under certain conditions of neurotic conflict. Epstein [Spielberger 1972b:12] concurs with Dollard and Miller and states that anxiety is regarded as 'a state of unresolved fear'.

Fear and anxiety may be present in varying proportions in any given situation and it seems, therefore, more beneficial to ascertain the causes of the emotion rather than to attempt to distinguish between these two emotions.

2.3.2 Phobias

In the phobic disorders, anxiety is a central component which is no longer free-floating or unexpected, as in a panic disorder, but it is attached to specific objects, certain situations and sometimes even activities.

Rutter and Hersov [1987:371] define phobic states as 'emotional disorders in which there is an abnormally intense dread of certain objects or specific situations that normally do not have that effect'. It must therefore be distinguished from the normal psycho-physiological reaction of fear to a genuine threat. Healthy and adaptive fears change in the process of normal development; they become diminished in intensity and disappear at different stages of the

child's life.

According to Miller, Barrett and Hampe [1974:90], both fears and phobias involve similar behavioural expressions, subjective feelings and accompanying physiological change, but in phobias, the responses are 'excessive, persistent and unadaptive'. Rutter and Hersov [1987] add that there is a strong need in the individual to flee or avoid the phobic object or situation and Reber [1985:543] states that the fear is based on 'irrational and not sound judgement'.

Kaplan and Sadock [1989:953] mention that the predominant feature of a phobia is 'a persistent avoidance behaviour, secondary to irrational fears of a specific object, activity or situation'. They further elaborate that these fears are unreasonable and unwarranted and are not in proportion to the real danger, or lack thereof, of the object, activity or situation feared. The sufferer is also aware that his reactions are irrational.

2.3.3 Depression

Depression is generally defined as a mood state characterised by a sense of inadequacy, a feeling of despondency, a decrease in activity or reactivity, pessimism and sadness [Reber 1985:188]. In psychiatry, Kaplan and Sadock [1989:896-897] explain that depression is used to signify an abnormal mood, similar to sadness, unhappiness and misery of everyday experiences.

The depressed person is often not able to experience pleasure in any form or with any experience. These authors state that anxiety is the 'third most common symptom of a depressive illness and is experienced as a state of continual apprehension'. The depressed person often feels tense and unable to relax. Accompanying this, is a difficulty in concentration and a lack of attention. Often, the person will complain of forgetfulness and irritability. Outbursts of ill temper and frustration frequently occur. The psychological aspects of anxiety

in the depressed person are usually accompanied by somatic symptoms which mostly indicate overactivity of the sympathetic nervous system, i.e. rapid and missed heartbeats, dryness of mouth, indigestion, wind, colic, diarrhoea, sweatiness, headaches and giddiness [Kaplan & Sadock 1989:898]. However, anxiety can also appear to be absent in the depressed person.

Ollendick and Yule [1990:126] stress that additional efforts have recently been focused on determining the correlates of anxiety and depression in children, using the Children's Depression Inventory [CDI]. High scores, according to Doerfler, Felner, Rowlinson, Raley and Evans have been associated with heightened levels of anxiety [Ollendick & Yule 1990:126]. According to their own research, Ollendick and Yule [1990:126-128] found that depression and anxiety were highly related to both samples of 663 eight to ten-year-old children. They also mention that children who reported high levels of depression, also reported high levels of manifest anxiety and high levels of social evaluative fear.

Last, Strauss and Francis [1987] report on the comorbidity of anxiety and depressive disorders and state that a relatively large percentage of children with a primary diagnosis of one of the three major childhood anxiety disorders that they assessed, also carried a secondary diagnosis of major depression.

2.3.4 Stress

According to Rutter and Hersov [1987:154], stress is very difficult to define, due to the 'multiplicity of meanings' assigned to it; firstly, in terms of its stimulus properties, secondly in its response parameters and thirdly, in the blending of the two through interaction.

Kagan [Rutter & Hersov 1987:154] mentions that the stimulus side is represented by some event or class of events which, in turn, is accompanied by internal bodily changes that have undesirable emotional components such as

anxiety, fear, sadness, hopelessness and guilt. A relationship is, therefore, implied between the individual and his environment. The event [or class of events] becomes the stressor if it produces, in the person exposed to it, an awareness of potential harm or threat [which is accompanied by physiological changes, increased heart rate, respiration, etc.] that can, but need not be, potentially damaging.

Selye [Honig 1986:51] stresses the stimulus properties and defines stress as 'a stimulus event of sufficient severity to produce disequilibrium in the homeostatic physiological systems'. At the same time, Selye acknowledges its response properties and states that 'stress is the nonspecific response of the body to any demand'. He maintains that stress is caused by the way stress or stress agents are perceived, interpreted or appraised in each individual case. Selye [1979:59] relates a story of two young boys raised by an alcoholic father, who were interviewed later in life by a psychologist. One was a teetotaler, the other a hopeless drunk and on being asked why each developed as he did, each gave the answer, 'What else would you expect when you have a father like mine'.

Lazarus and Folkman [1984:21] also emphasise its response qualities and state that the experience of stress is personal and subjective, depending on how the individual appraises the events in his life as a result of different learning histories, personality styles and coping abilities. It is therefore evident that different individuals will cope differently with a similar unpleasant event because they will appraise it differently. It may be seen as a threat to be avoided or tolerated or as a challenge to be overcome. The essential characteristic of stress then, is change in one's life situation requiring adaptation and adjustment [Martin 1988:136].

Sarason and Sarason [1980:131] conclude by stating that 'although stress is a highly personal response, a number of situations almost always lead to stress for the majority of individuals'. They list accidents, natural disasters, war, death,

concentration camps and physical illness as stress-arousing situations for all people.

2.4 DIFFERENT THEORIES OF ANXIETY

2.4.1 Introduction

'The importance of anxiety as a fundamental human emotion is widely recognised by behavioral and medical scientists, many of whom regard anxiety as a basic condition of human existence' [Spielberger 1972a:X1].

Theories of anxiety have increased over the years, possibly due to an increased concern about the stresses in life, especially modern day society. Research into anxiety, fear and stress has accelerated. However, there is still very little consensus with regards to the conceptual meaning of anxiety as well as the causes of it and there is no real agreement, as yet, as to how it should be measured. Nevertheless, considerable progress has been made in the past decades and there have been attempts by different theorists such as Spielberger, Cattell, Mandler, Sarason, Beck, Levitt and others [Spielberger 1972a], to share their knowledge on anxiety for the advancement of science.

According to Kaplan and Sadock [1989:960], anxiety is 'a complex issue'. They maintain that in anxiety, 'people's mental and bodily functions find a meeting place unparalleled in other aspects of human life'. They maintain that any discussion on the aetiology of anxiety must, therefore, deal with both psychological and physiological processes. They highlight the controversy that exists as to which comes first:

- * the conscious experience of the affect; or

- * the bodily changes associated with it.

They conclude that the human organism reacts to stimuli with a variety of responses, some of which are best described in psychological language and some in the vocabulary of physiology.

Many theories of anxiety exist at present; a few main ones are:

- * Psychoanalytic and Psychodynamic theory;
- * Learning theory; and
- * Existential theory.

For the purpose of this study, a relatively brief summary of each theory will be attempted and the interrelationship of the various theories will be explored, as it is the researcher's view that all of them offer valuable insight into the multifaceted and complex issue of anxiety.

2.4.2 Psychoanalytic Perspective

2.4.2.1 Sigmund Freud's theory

According to Davison and Neale [1978], Kaplan and Sadock [1989], Pervin [1970], Reber [1985] and Wicks-Nelson and Israel [1984], anxiety as seen from a Psychoanalytic perspective, is a vague unpleasant emotional state with qualities of apprehension, dread, distress and uneasiness. It is seen to act as a signal that psychic danger would result were an unconscious wish to be realised or acted upon. It is, therefore, the danger signal to the ego that some unacceptable impulse is seeking to gain consciousness.

According to Kaplan and Sadock [1989:961], Freud's experience with phobic symptoms led him to concede the importance of anxiety as a psychological force. However, possibly due to his training as a neurologist, his initial explanation of

its genesis was expressed mainly in physical concepts. As his first theory emerged and became more complex, he began to see anxiety as a result of repression and as a psychological reaction of the ego to dangers that threaten it from without and within.

Later, after moving away from his earlier model of psyche, which portrayed the human mind as being divided between conscious and unconscious processes, each with characteristic modes of thinking, Freud moved to a structured model in which the psychic apparatus consisted of three psychological agencies:

- * the ego,
- * the superego, and
- * the id,

each with its own specific function.

In this model, anxiety was seen by Freud as the ego's reaction to instinctual forces arising from the id, which if uncontrolled could be dangerous to the self; either because of their inherently disruptive potential or because of retaliating punishment arising from the superego or the external world, if they were acted upon.

In Freud's second theory, anxiety became a psychological force in its own right rather than merely an ego affect [Freud 1936:22]. As a signal of danger, anxiety was viewed as being a central moving force in all of the workings of the psychic apparatus; its primary function being to motivate the ego to use repression and other defence mechanisms to control the underlying drives and affects. Anxiety was seen now as the cause of repression rather than the result of it.

According to Sarason and Sarason [1980:54], Freud's definition of anxiety, as a response to perceived danger or stress, distinguished between two types of anxiety-provoking situations:

- * anxiety caused by excessive stimulation that the organism does not have the capacity to handle; and
- * anxiety caused by psychic energy accumulated due to inhibitions and taboos that prevent it from being expressed.

In the first situation, Davison and Neale [1978:118] mention that the birth process is seen as the prototypic anxiety situation for which the infant is flooded with excitation over which he can exert no control. This is further explored by Pervin [1970:231] who maintains that the Psychoanalytic theory of anxiety states that at some point the organism experiences a trauma or incident of considerable harm or injury and that anxiety represents a repetition of the earlier traumatic experience, but in miniature form. Anxiety, in the present, is then related to an earlier danger. Because the earlier trauma is often not available to consciousness, the anxiety has a free-floating quality which has the effect of the person feeling apprehensive nearly all of the time in the absence of reasonable danger.

The second situation would refer to the source of anxiety residing in the superego and the individual experiences guilt and self-condemnation as a result. The anxiety is referred to as moral anxiety and is examined in more detail in the following section [cf. 2.4.2.1.1.].

2.4.2.1.1 Psychoanalytic types of anxiety

According to Spielberger [1972a:23], Freud differentiated between three types of anxiety; normal anxiety, neurotic anxiety and moral anxiety, according to its

source. The sources of anxiety may reside in:

- (a) reality, in which case the anxiety would be termed **normal**;
- (b) the id, with the anxiety being termed **neurotic**; or
- (c) the superego, with the anxiety being termed **moral**.

(a) Normal Anxiety

Freud, Goldstein and Horney [Crosby 1976:237] agree that rational fear or normal anxiety is a reaction to a specific danger. Therefore, for Freud, normal anxiety or objective anxiety did not in itself constitute a pathological problem because:

- * it is not disproportionate to the objective threat;
- * it does not involve a repression or other mechanism of intra-psychic conflict; and/or
- * it does not require neurotic defence mechanisms for its management.

It can be confronted constructively on the level of conscious awareness and can be relieved if the objective situation is altered or changed in any way. An example of normal anxiety could be the feelings of apprehension experienced before a candidate's final examinations. According to Sarason and Sarason [1980:55], normal anxiety often arises in anticipation of danger rather than after a dangerous situation occurs. It serves, therefore, as a protective function by signalling the approach of danger and warning the individual to prepare to defend himself.

(b) Neurotic Anxiety

Where the id is the source of anxiety, the individual feels threatened with feelings of being overwhelmed by his impulses. Crosby [1976:237] states that neurotic anxiety is often termed **subjective anxiety**. It is a reaction to a threat which is 'disproportionate to the objective danger'. It involves repression and disassociation and other forms of 'intra-psychic conflict'. He maintains further that it is managed through various forms of retrenchment of activity and awareness such as inhibitions, the development of symptoms and varied neurotic defence mechanisms.

According to Davison and Neale [1978:119], neurotic anxiety is the fear of the disastrous consequences that are expected to follow if a previously punished id impulse is allowed to express itself. In this sense, it is based on reality or normal anxiety. The individual has to associate an instinctual demand with an external danger, before he learns to fear his instincts and he has to link it to being punished for them. Where impulsive behaviour causes the person to get into trouble, as it usually does, he learns how dangerous his instincts are. For Freudians, the essence of neurotic anxiety appears to be repression. The core of the neurotic anxiety lies at the person's lack of awareness of the conflict. Davison and Neale explain further that Freud believed that the unconscious mind does not distinguish between fact and fantasy. Therefore, the perceptions of the person are important and his **reality** is the only one that counts for him. What constitutes a real danger in his unconscious mind may not necessarily constitute a rational danger for others. The stimuli triggering the expressions of neurotic anxiety are internal and stem from previously punished id impulses. According to Davison and Neale [1978:119-120], neurotic anxiety can be expressed in several ways, i.e. free-floating anxiety, phobias and panic reactions.

(i) Free-floating anxiety

The person experiences feelings of apprehension and fear, much of the time, in the absence of reasonable danger. He becomes afraid of his own id and its power to release unacceptable impulses and wishes.

(ii) Phobias

These take the form of intense irrational fear and the avoidance of specific objects and situations such as open spaces, lifts, dogs, etc.. The feared objects and situations are hypothesised to be symbolic representations of the object or situation chosen earlier for gratification of the id impulse. The choice, and therefore the impulse as well, is subsequently punished and results in the whole conflict being repressed. According to Hall [1964:65], 'behind every neurotic fear there is a primitive wish of the id for the object of which one is afraid'.

(iii) Panic reactions

Neurotic anxiety may become manifested as a panic reaction, which can be described as a sudden, inexplicable outburst of severe and prolonged fear.

(c) Moral Anxiety

According to Pervin [1970:231], 'where the superego is the source of anxiety, the individual experiences guilt and self condemnation'. It is the ego's fear of punishment that the superego imposes for failure to adhere to standards of moral conduct, that overwhelms the controls of the ego and causes a panic or traumatic state [Davison & Neale 1978:118-119].

Anxiety therefore alerts the individual to the presence of intense unconscious conflict or an unacceptable wish. If this anxiety cannot be managed by direct action, the ego initiates unconscious defences such as defence mechanisms to

ward off the awareness of the conflict.

2.4.2.1.2 Synthesis of Anxiety from a Psychoanalytic Perspective

Anxiety is seen to develop out of a conflict between the push of the id instincts for expression and the ego's appraisal of external dangers or between the id instincts and the threat of punishment by the superego. According to Crosby [1976:238], Freud viewed the ego as 'the real focus of anxiety'. The ego perceives the situation as dangerous and anxiety ensures the repression of the dangerous impulses by the employment of defence mechanisms.

The discomfort experienced by the anxious ego can be reduced by several manoeuvres:

- * object anxiety, which is rooted in reality, can often be dealt with by removing or avoiding, in a rational way, the danger of the external world; and/or
- * neurotic, and sometimes moral anxiety, may be handled through an unconscious distortion of reality by means of defence mechanisms.

(a) Defence Mechanisms

A defence mechanism is referred to by Suinn [1975:229] as a 'security mechanism'. It is the behaviour the individual adopts in order to cope with threats to the personality. It can also be defined as a strategy which is unconsciously utilised and serves to protect the ego from anxiety [Reber 1985:179].

For the purpose of this study only a few of the most important defence mechanisms will be explored.

(i) Repression

Repression is seen as a defence mechanism that is directed both at external as well as internal dangers. It is directed at fear-arousing events in the person's environment as well as internal wishes, impulses and emotions which cry out for gratification but arouse guilt [Sarason & Sarason 1980:55]. It represses the anxiety-laden thoughts and compulsive impulses from the person's conscious mind and thereby reduces anxiety. According to Suinn [1975:219], once repression occurs, the information is essentially irretrievable and the person must function without the advantage of the knowledge of the repressed material. In this way, there is a falsification or denial of reality of which the individual is totally unaware and the repression can, therefore, be seen as an obstacle to the adjustment of the person even though it reduces the anxiety level.

Projection is a form of repression where the characteristics or impulses of a person are repressed and then projected or externalised onto another person or object in an attempt to distance the person from them [Sarason & Sarason 1980:56].

(ii) Denial

Denial of reality is often seen when the individual attempts to avoid having to recognise the magnitude of the threat. Sarason and Sarason [1980:56] define it as 'the refusal to acknowledge the anxiety-arousing aspects of the environment'. The denial may relate to the emotions associated with an event or idea or to the event or idea itself. According to Suinn [1975:220], denial is one of the few defence mechanisms that functions at both conscious and semiconscious levels. This indicates that there is a certain awareness of the reality but a need to avoid having to deal with it. He states further that denial can take the form of fantasy such as daydreaming, wishful thinking and identifying with others as a means of escape.

(iii) Regression

This mechanism involves the return to an older established pattern of behaviour which usually involves a reversion in time [Suinn 1975:224]. Sarason and Sarason [1980:56] describe it as 'going back to earlier ways of behaving that were characteristic of a previous development level'. Fixation involves clinging to a fixed mode of behaviour and in this way, is an ally of regression. When fixation occurs during the years of growth, the development of the child is arrested and it prevents him from achieving a higher level of maturity and adjustment. According to Suinn [1975:225], the child will often return to an earlier point of fixation in his development when he regresses.

2.4.3 Variations of Psychoanalytic, Psychodynamic and Social Perspectives

2.4.3.1 Carl Gustav Jung

Jung maintains that anxiety is the individual's reaction to the invasion of his conscious mind by irrational forces and images from his collective unconscious [Crosby 1976:238-239]. According to May [Crosby 1976:238], Jung believes in the autonomy of the unconscious mind. He suggests that people are afraid of becoming conscious of themselves; that they prefer to observe factors external to their consciousness. He maintains that they fear 'the dominance of the collective unconscious' which is the 'residue of the functions of our animal ancestry and the archaic human functions which exist on sub-rational levels in the human personality'. Jung [1969:14-15] relates his theory of anxiety to the 'fear of the unknown perils of the soul'.

2.4.3.2 Otto Rank

According to May [1950:128], Otto Rank was largely influenced by his famous studies of birth trauma when he wrote about anxiety. For him, the life history of a human being is an endless series of experiences of separation; each one presenting the possibility of greater autonomy for the individual. Birth is not only the first, but also the most dramatic experience of separation, according to Rank and is followed by weaning, starting school, leaving home, marriage and finally, death. For Rank [Crosby 1976:239], it is these separations which cause anxiety. Crosby mentions further that 'primal anxiety' is made up of what Rank [1936:175] termed as 'life fear' and 'death fear'; life fear being the fear of having to live as an isolated person, while death fear relates to the regression of losing the sense of being an individual and becoming dependent on others again. These two fears, at opposite ends of the continuum, form a deep conflict for the individual. When these two forms of anxiety can be balanced, Rank maintains that we have mental health. When they are not in balance, neurotic anxiety develops [Crosby 1976:239].

2.4.3.3 Alfred Adler

Adler emphasised that feelings of inferiority are the root cause of anxiety [Crosby 1976:238]. In this respect, he departed from Freud's theory and his entire theory became more social and cultural and, in a sense, more interpersonal. Hall and Lindsey [1970:125] concur with Crosby and explain that for Adler 'the person is embedded in a social context from the first day of life'. They suggest, further, that the person is continually involved in a network of interpersonal relationships which shape his personality and provide concrete outlets for his striving for superiority. Crosby [1976:238] concludes that, according to Adler, the goal of the individual, who suffers from feelings of inferiority, is to gain security by achieving superiority. A way of doing this is to employ 'anxiety and neurotic compensating endeavours' to gain superiority

over others. Anxiety is, thus, used as a means of controlling others and giving the self feelings of 'power and security'. These patterns are usually formed early in childhood when the child learns to depend excessively on those close to him.

2.4.3.4 Karin Horney

Horney's treatment of anxiety is extensive and thorough, according to Crosby [1976:239]. For her, a severe conflict lies at the root of anxiety. On the one hand, there is a need in the individual for parental affection and love, and on the other hand, is the fear of losing that love [Horney 1937:63-66]. The fear of the loss of love causes suppression of all feelings of hostility that the individual would otherwise express against his parents. Anxiety results, which in turn causes repression. Horney maintains that the main factor in neurosis is conflict. She views the chief conflict as the child's need for parental love and the need to express hostility. Hostility cannot be expressed because of the fear of losing the parents' love and this causes severe anxiety in the child, which can only be dealt with by means of repression.

Horney [May 1950:140-141] states that 'neurotic anxiety and helplessness are not the results of a realistic view of inadequacy of power, but arise out of an inner conflict between dependency and hostility; and what is felt as the source of danger is primarily the anticipated hostility of others'. Horney refers to this anxiety as **basic anxiety** in the sense that it is the basis of neurosis and it develops in early life, out of disturbed relationships between the child and his parents or significant individuals in his environment. Horney [1937:63-78] states that 'hostile impulses of various kinds form the main source from which neurotic anxiety springs'. She maintains that if the hostility is repressed, the person does not know that he is hostile. Horney differs from Freud in that she does not view sexuality as a specific source of anxiety, but rather that the repressed, hostile impulses of the individual cause the anxiety.

Basic anxiety varies only in extent and intensity, according to Horney. She differentiates between neurotic and normal anxiety and describes basic anxiety as having a normal corollary which refers to the anxiety the individual feels about his creator. These are the feelings of helplessness all individuals feel towards forces more powerful than themselves, such as catastrophes, political events and accidents. This anxiety, according to Horney [1937:94-95], does not, however, imply hostility towards these powers.

For Horney, neurotic anxiety implies that:

- * the very essence or core of the individual's personality is endangered;
- * the danger perceived by the individual is some type of threat, usually involving a loss of love, acceptance or approval; and
- * the accompanying feelings of helplessness result from the individual being caught between his perceived need and his hostility towards those upon whom he is dependent.

According to Horney [Crosby 1976:241], it is the neurotic individual's security, which rests on the functioning of his neurotic trends, which is endangered rather than his ego, as believed by Freud. Crosby concludes that Horney's contribution to an anxiety theory clearly demonstrates that 'anxiety is essentially caused by internalised conflict'. Although Freud demonstrated conflict between the id, ego and superego, Horney has demonstrated that it is the neurotic defence mechanisms and safety devices that protect the person from anxiety and anxiety attacks. Only when these neurotic mechanisms break down or are threatened in some way does the anxiety arise. However, the anxiety can be transformed into symptoms which can negatively affect the person.

2.4.3.5 Harry Sullivan

Sullivan [Crosby 1976:241] emphasises the concept of interpersonal relationships as being 'the essential core of personality development' and sees anxiety as the 'result of disturbances in these relationships'. He maintains that infancy is characterised by complete dependence on the significant adult, usually the mother or mother-substitute. A self-system develops and with it, the individual picks up a 'new piece of equipment' which Sullivan calls anxiety [Crosby 1976 :241].

According to Crosby [1976:241-242], Sullivan maintains that the 'self dynamism' [self-system] which may be viewed as the individual's mechanism of adjustment, is his manner of behaving in order to fulfil his drives and motives and to protect himself against stress and discomfort. This self dynamism is therefore built out of the experience of approbation and disapproved of rewards and punishments [Sullivan 1953:19-20]. In this way, anxiety becomes an emotional signal that warns the individual of the danger of overstepping the boundaries or limits set by his caretakers. Feelings of unworthiness, inferiority and self-depreciation are internalised by the individual, into his self dynamism and later personality traits will be consistent with this self dynamism and will be subject to anxiety whenever he transgresses its internalised mode of behaviour. In some cases, part of the individual's personality may become partially or totally dissociated from the self and work powerfully towards defeating the self whenever possible [Crosby 1976:242].

2.4.4 Learning Theory Perspective

2.4.4.1 Introduction

Learning theory, in its simplest form, is the study of the circumstances under which a response and a cue stimulus become connected. After learning has been completed, response and cue are bound together in such a way that the appearance of the cue evokes the response [Hall & Lindsey 1970:423].

In Learning theory, the distinction between fear and anxiety is a difficult issue. Some theorists use the term interchangeably. However, Spielberger [1972a:12] quotes Epstein as distinguishing between them in terms of whether or not the arousal evoked by the threatening circumstances is channelled into appropriate purposive action. Fear is viewed as an avoidance motive in which a high level of arousal is directed into flight. Anxiety is regarded as a 'state of unresolved fear' [cf. 2.3.1] in which the arousal that occurs, following the perception of the threat, persists and becomes diffused because the individual is unable to direct it into purposive behaviour. Indecision, conflict and external restraint contribute to the 'evocation of anxiety reactions' by producing 'cognitive incongruity and response unavailability'.

According to Rutter and Hersov [1987:370], anxiety is a hypothetical construct that mediates the escape and avoidance responses which is based on the S-R theory of learning. They mention that the unpleasant qualities of anxiety encourage the individual to avoid the anxiety-provoking situation, thereby reducing the anxiety.

Ross [1974:204-205] suggests that there are certain experiences that elicit anxiety in the individual and these would be associated with the sensation of pain. An aversive stimulus would ordinarily elicit behaviour that would result in the termination of such stimulation and this escape behaviour probably has a large innate, genetic component in an attempt to preserve the species. Ross maintains that avoidance behaviour results in anxiety taking the place of the 'aversive object, which being avoided, is no longer an effective aversive stimulus'. Anxiety mediates the avoidance behaviour and maintains it by furnishing the reinforcing consequence. Ross describes anxiety as a process that gives rise to observable phenomena that infer that anxiety is present. Observable physiological changes include heart and respiratory rate, alterations in skin conduction, restlessness, tremors and jumpiness. These are accompanied by subjective feelings of apprehension, worry, fear and a sense of impending

danger. The threatening situation or event cannot always be specifically described by the person. According to Ross [1974:205], 'anxiety has physiological, motor and cognitive components but the identification of anxiety does not demand the demonstration of all three components in every case'.

2.4.4.2 Dollard and Miller

According to Fischer [1970:65], Dollard and Miller base their theory of anxiety on Hall's theory of Learning. They maintain that all behaviours [responses] are understood as being 'drive impelled' and that all learning [habit acquisition] is held to be the 'function of reinforcement'. Any stimulus is capable of arousing the organism and functioning as a drive. However, certain classes of stimuli are said to form a base for most human motivation. These classes largely represent the innate and primary drives of hunger, sex and pain [Dollard & Miller 1966:30].

According to Reber [1985:43] the word, anxiety, is used to connote a secondary conditioned drive which functions to motivate avoidance response. Thus an avoidance response is assumed to be reinforced by a reduction in anxiety. Agreeing with this definition, Dollard and Miller [1966:31] believe that a secondary class of drives has resulted from the conditions of our social existence and is an elaboration of the primary ones. Fischer [1970:67] mentions fear as an extremely important secondary or learned drive. Dollard and Miller [1966:63] differentiate between fear and anxiety and state that when the 'source of fear is vague or obscured by repression, it is often referred to as anxiety'. Anxiety is conceived as emerging only under certain conditions of neurotic conflict. The role of fear and anxiety in neurosis is seen as central to Dollard and Miller's theory of psychopathology [Fischer 1970:67]. In its capacity as a drive, fear serves as a prime motivating factor in conflict, symptom formation and repression. It is viewed as the prime causal factor in the genesis of neurosis.

Dollard and Miller [1966:127] believe that an 'intense emotional conflict is the necessary basis for neurotic behaviour'. Furthermore, the conflict must be unconscious and created in childhood. The type of conflict that appears most frequently and is the most closely linked to neurosis, is the approach-avoidance conflict [Dollard & Miller 1966:352-366]. In this conflict, the individual has strong tendencies to approach and avoid the same goal. For instance, the person seems unable to go forward far enough to reach his goal or to go far enough away to forget it. Dollard and Miller [1966:357] quote Mrs A. who was continually sexually attracted to men other than her husband. However, she was unable to achieve her goal of successful adjustment in her marriage and therefore did not want to, or could not, leave her husband.

Fischer [1970:67-70] explains that the outcome of a neurotic unconscious conflict is the development of symptoms in which anxiety plays a central role. It is therefore possible that Mrs A. could develop a phobia, for instance, of travelling in a car. This would unconsciously protect her from leaving home. Fischer mentions unlearned and learned symptoms; the former being heart palpitations etc., that tend to accompany chronic anxiety. If these serve to diminish the fear drive, usually through eliciting sympathy and comfort from significant others, there is no real need for further fear-impelled responses.

However, learned responses are formed when some maladaptive response reduces the drive level and is therefore, reinforced. Fear is seen as the drive that can most motivate the learning of symptoms because 'it is so strong, can easily be attached to new cues and is the motivation that produces the inhibiting responses in most conflicts' [Dollard & Miller 1966:190]. The symptoms that it can produce range from phobias, compulsions, hallucinations, delusions, psychosomatic symptoms and many more.

2.4.4.3 Joseph Wolpe

Wolpe [Spielberger 1966:179-183] maintains that neurotic responses result from certain kinds of experiences and are therefore, in a sense learned by simple conditioning. He views anxiety as central to most neuroses and states that conditioning and deconditioning of neurotic anxiety can occur. He believes that the 'commonest human neurotic-response constellation is anxiety' and defines it as a 'sympathetic pattern of autonomic response' [Spielberger 1966:182]. He suggests that the origin of the neurosis is almost always related to a single experience or recurrent occasions of high anxiety or to a chronic anxiety-evoking state of affairs. He sees the neurotic anxiety-response as 'unadaptive' in that it 'does not promote the satisfaction of the needs of the organism' [Spielberger 1966:183]. In fact, he views it as obstructing satisfaction and of being an unpleasant experience for the individual. However, unlike many other unadaptive habits, neurotic anxiety 'is not extinguished by its repeated evocation',

According to Wolpe, these neurotic anxiety-response habits can be eliminated by counter-conditioning, if the anxiety-evoking stimuli are presented to the organism at the same time as a response that can inhibit anxiety in the organism. Wolpe first introduced the term 'systematic desensitization' to describe the method of deconditioning neurotic anxiety. It is based on the concept of reciprocal inhibition where certain reactions to stimuli can be extinguished [Emery 1969:268; Kaplan & Sadock 1989:263].

Emery [1969:267-268] maintains that the extinction of the unpleasant emotional reactions occurs because the usual anxiety responses cannot take place when the client is experiencing more pleasant stimuli, like the deep relaxation of hypnotic trance. As Emery points out, it is impossible to be relaxed and to feel anxious at the same time. Therefore the anxiety is systematically reduced. This is done in the following way; it includes listing the anxiety-evoking stimuli in a hierarchy and placing the most disturbing one on top. The person is then deeply relaxed

or encouraged to go into a trance, if hypnosis is used, and encouraged to think about and imagine the least anxiety-evoking stimulus first, while remaining deeply relaxed. Sometimes the person is exposed, *in vivo*, to the actual stimuli, if the imagery is not effective for the person. The list is then systematically worked through. The procedure is repeated until the stimuli no longer evoke any anxiety in the person and at such time, the anxiety-provoking stimuli can be said to have become extinct.

2.4.4.4 Cognitive behavioural perspective

According to Kaplan and Sadock [1989:965] Behaviour theorists have recently become increasingly interested in cognitive approaches to conceptualising and treating anxiety disorders. These approaches suggest that faulty, distorted or counterproductive thinking patterns accompany or precede maladaptive behaviour and emotional disorders. One model surmises that anxiety-disordered patients tend to overestimate the degree of danger and probability of harm in a given situation and underestimate their abilities to cope with perceived threats to their psychological and physical well-being. Panic-disordered patients often have thoughts of loss of control and fear of death, that follow physiological symptoms that are not easily accounted for, such as heart palpitations and light-headedness which are then followed by panic attacks. Patients with generalised anxiety disorders are viewed by this perspective [Kaplan & Sadock 1989:965], as holding 'distorted, disabling thoughts' which threaten their physical and social well-being.

2.4.5 Existential Perspective

2.4.5.1 Erich Fromm

Fromm [Crosby 1976:242] views the individual's character as developing from the influence of his society and his culture and the history of these. For him the

individual must experience a **second birth** in which he is freed from the significant others, usually his parents, in his life. Fromm sees it as being freed from the 'incestuous ties of blood and clan'. For Fromm, man's biggest and most important struggle is facing the insecurity of being autonomous. He claims that Western man appears to prefer the 'security of enslavement to the insecurity of freedom' [Crosby 1976:242].

Fromm [1941:134-206] talks of the **burden of freedom** from which the individual often attempts to escape by being exploitive, hoarding, marketing or receptive. This results in him becoming secure by means of authoritarian domination, possession and control of things, being valued by the dictates of the market place or by submissive dependency. Fromm states that until man gives birth to himself, he will not be able to face the insecurities of the truly productive and self-fulfilling person. For him the 'kernel of every neurosis, as well as of normal development, is the struggle for freedom and independence' [Fromm 1941:178]. He maintains that many normal people have given up this struggle by giving up their individual selves and are thus well-adapted and considered to be normal. Many neurotic people on the other hand, have not given up fighting against complete submission but, at the same time, remain dependent on others. Neurosis is therefore an attempt, although an unsuccessful one, to solve conflict between the basic dependency and the quest for freedom [Fromm 1941:179]. Parental authority and the way children cope with it are revealed by Fromm [1941:153-158] as being the crucial problems of neurosis.

2.4.5.2 Rollo May

May [1950:191] states that the nature of anxiety is understood when the question is asked as to what is 'threatened in the experience which produces the anxiety'. For him, like Horney [Crosby 1976:241], it is the core or existence of the personality of the individual that is threatened. May [Crosby 1976:243] states further that 'anxiety is the apprehension cued off by a threat to some value which

the individual holds essential to his existence as a personality'. The occasions of anxiety, as well as the values on which they depend, will vary with different people but what remains constant is that the threat is towards a value that the individual holds vital to his existence and consequently to his security as a personality.

May [1950:190-193] distinguishes between fear and anxiety. He maintains that the individual experiences various fears on the basis of the security pattern he has developed for himself but, in anxiety, it is the security pattern itself that is threatened.

2.4.5.3 Victor Frankl

Frankl [1992] maintains that the source of much anxiety, both normal and neurotic, results from the individual's perceived lack of meaning and purpose in human life. In contrast to Freud [cf. 2.4.2.1.], Frankl believes that neuroses do not emerge from conflicts between drives and instincts but from conflicts between various values, moral conflicts and spiritual problems. Frankl [Crosby 1976:243] emphasises the 'importance of phenomena such as meaning, purpose and value in the inner thought-feeling' of the person. Although Frankl does not appear to search for the cause of anxiety, he demonstrates clearly that the basic life conflicts can be moral and spiritual and of an aesthetic and metaphysical nature. He sees the **essence of being** as vital to understanding the individual in totality.

2.4.5.4 Abraham Maslow

Maslow, according to Crosby [1976:243], views **neurotic anxiety** as resulting from a 'fixation in the safety needs'. Growth and safety are polar opposites and Maslow defines the process of growth as a 'never-ending series of free choice situations which confront the individual at each point throughout his life'. He must choose between the 'delights of safety and growth, dependence and

independence, regression and progression, immaturity and maturity'. Both safety and growth have anxieties and delights and the individual will only grow forwards when the delights of growth and the anxieties of safety are greater than the anxieties of growth and the delights of safety [Crosby 1976:143]. 'Safety needs are prepotent over growth needs', according to Maslow [1962:47]. Therefore, 'only a child who feels safe, dares to grow forwards healthily'. Maslow further believes that only if the child is not crippled with fear and feels safe enough to dare, will he be able to express himself spontaneously.

For Maslow [1962:54] the individual would only tend to regress or fixate 'under the impact of danger, threat, failure, frustration and stress'. 'Rigid defences and safety measures cut off the possibilities of growth' [Crosby 1976:243]. In this way, 'neurosis is self-perpetuating', according to Maslow [1962:52]. Maslow embraces the conflict theory developed by Horney [cf. 2.4.3.4] but sees the fundamental conflict as the need for safety versus the need for genuine freedom and selfhood. He maintains that the individual becomes neurotic when he searches for or defends a pseudoself or a self-system [Crosby 1976:243].

2.4.5.5 Paul Tillich

Tillich [Crosby 1976:244] is unique in his contribution to the study of anxiety as he involves three disciplines in his theory: philosophy, psychology and theology.

He mentions three types of anxiety:

- * the anxiety of fate and death;
- * the anxiety of emptiness and meaninglessness; and
- * the anxiety of guilt and condemnation.

Tillich [Crosby 1976:244] describes neurotic anxiety as the way of avoiding non-being by avoiding being. He maintains that 'anxiety is the awareness of unresolved conflicts between structured elements of the personality'. For him, the neurotic individual affirms the self in his neurosis and this self becomes a reduced one. Because of the neurotic individual's greater sensitivity to non-being and consequently his great levels of anxiety, he settles down to a fixed, though limited and unrealistic self-affirmation. He finds himself in a conflict with reality and he is hurt by reality penetrating his defences as well as the imaginary world he creates for himself.

Tillich [Crosby 1976:244] states that the neurotic individual's 'limited and fixed self-affirmation both preserves him from an intolerable impact of anxiety and destroys him by turning him against reality and reality against him and by producing another intolerable attack of anxiety'. For Tillich, the only way to deal with anxiety is for the individual to confront his own 'being' and to resolve the conflicts between the elements of his personality.

2.4.6 Synthesis

The concept of anxiety has gained widespread acceptance in the various analytical approaches to psychological illness [Kaplan & Sadock 1989:964-965]. The analytical classification of anxiety gives system and order to a great deal of clinical observation:

- * it defines a relationship between past and present in the individual; and
- * it suggests a hierarchy of levels of clinical anxiety and attempts to link the degree of pathology to the phase of development in the individual. Generally, the earlier the phase from which it stems the more serious the diagnostic and prognostic impact, although this does not always hold true.

Sigmund Freud saw anxiety as a process in which the mental apparatus as a whole and the ego in particular, are overwhelmed or threatened by quantities of unmastered excitation and he set about explaining the sources, meanings and original situations of this excitation.

According to Kaplan and Sadock [1989:965], differences in opinion about the nature of anxiety arise in many instances from differences in emphasis or from focusing on one kind of anxiety to the relative exclusion of others.

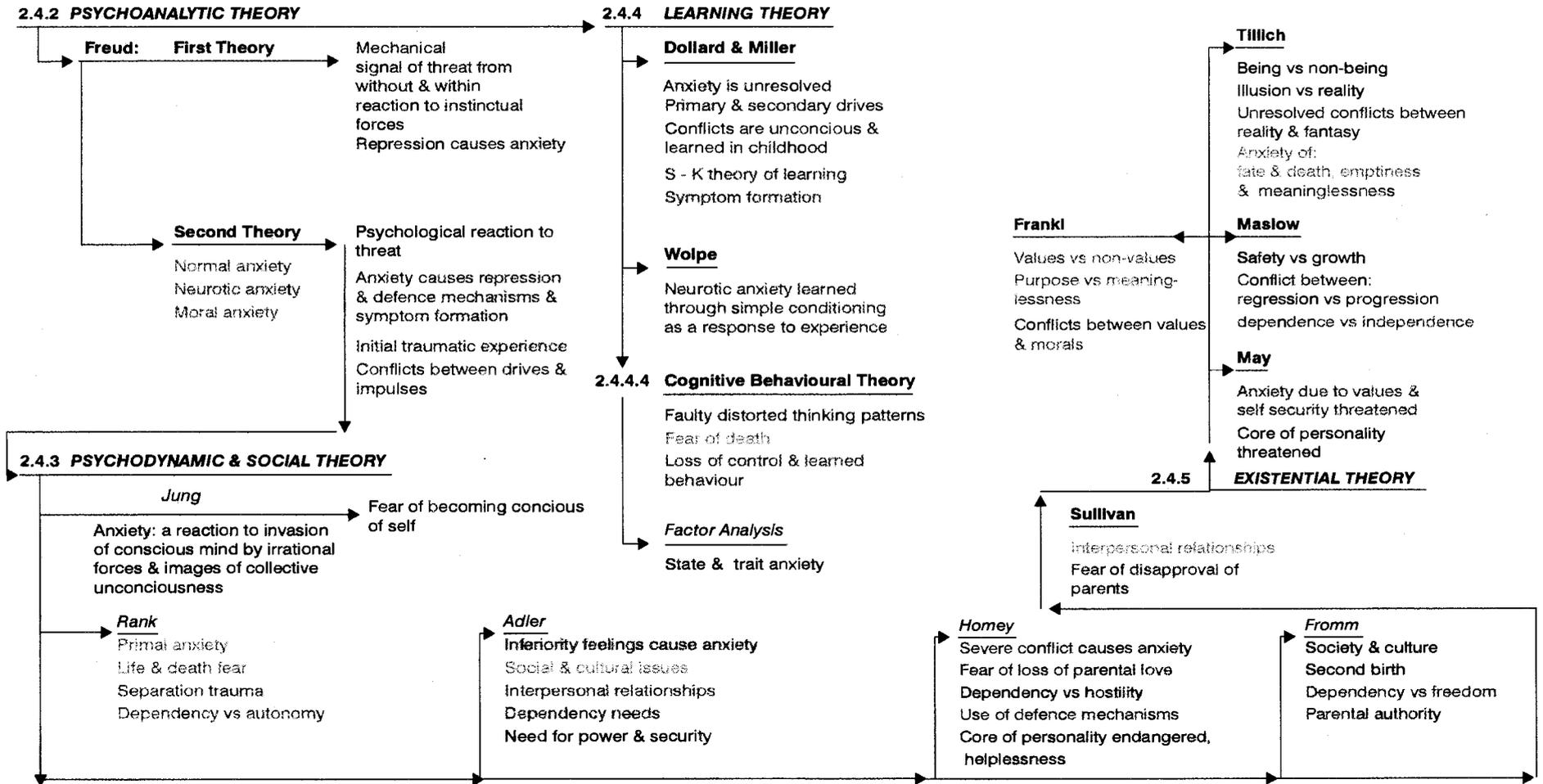
These differences have resulted in :

- * Otto Rank tracing back the genesis of all anxiety to the processes involved in the trauma of birth;
- * Sullivan conceived anxiety, according to Fischer [1970:144-146], as being fundamentally a tensional phenomenon emerging primarily in an interpersonal context and pervaded with social meaning; [Kaplan and Sadock (1989:965) highlight Sullivan's emphasis on the early relationships between mother and child and the role the mother's anxiety plays in her baby's future level of anxiety];
- * Learning theorists defined anxiety as a subtype of fear; the fear being understood as a learned drive that is a disruption in the organism's homeostasis and is ultimately related to the occurrence of painful stimulation [Fischer 1970:152-154]; [From the basis of Learning theory, factor analysis developed and, within it, distinctions were made between state and trait anxiety. Many different measures of anxiety developed in an attempt to objectively measure the phenomenon, anxiety (Spielberger 1972a &b)]; and
- * Existential theorists mostly viewed anxiety as being central to the human condition; [they point to the fear of **non-being** and some deny that it is

related to conflict or to past experiences (Kaplan & Sadock 1989:965); Reber [1985:43] elaborates on anxiety accompanying the awareness of meaninglessness, incompleteness and the chaotic nature of our present world; Fischer (1970:155-160) reports that Existential theorists understand anxiety as an affective disposition that expresses the individual's relatedness to a world that has lost its meaning and anxiety, from this perspective, is also linked to man's reluctance to accept the inevitability of his own death].

It has become evident from Chapter Two that although there are differences between the various theories on anxiety, there are also similarities. Figure 2.1 attempts to relate the common elements of the theories to one another.

FIGURE 2.1
INTERRELATIONSHIP OF ANXIETY THEORY



It is also proposed that a theory, containing the most important components of each of the theories mentioned, could be formulated. Crosby [1976:244-245] describes his view of an eclectic theory below [cf. 2.4.7].

2.4.7 An Eclectic Theory

According to Crosby [1976:244-245] the essential components of an Eclectic theory would include :

2.4.7.1 Intra-psycho conflict

An intra-psycho conflict, where one part of the personality is opposing or oppressing another part, is essential in understanding a theory of anxiety. Repression and/or dissociation are the results of anxiety and serve to reduce conscious awareness of the conflict.

2.4.7.2 Early environmental experiences

Early environmental experiences, especially involving the mother or mother-substitute, are crucial for understanding how the conflict came about. Feelings of hostility result from the parent-child confrontations. Fear of parental disapproval and punishment, combined with an even greater fear of the loss of parental love, puts the child in a double-bind situation.

2.4.7.3 Concept of loss or separation

The concept of loss or separation includes the fear of the loss of a specific person or a value or security system. When the established defence mechanisms and safety devices are threatened, the individual experiences anxiety.

2.4.7.4 Socio-economic and cultural issues

Socio-economic, cultural, political and authoritarian patterns with a historical frame of reference are also important. The individual must be viewed within his own community. Conflicts may be universal, but the nature of the conflict will depend heavily on the culture from which the individual comes.

2.4.7.5 Learned behaviour

The dynamics of Learning theory is important in the understanding of anxiety. The situations giving rise to the original conflicts, together with the patterns of response and reaction, have to be learned on a very deep and profound level or they would not be so difficult to unlearn in later life. The process of internalising is essential in understanding the development of personality, anxiety and neurosis.

2.4.7.6 Loss of meaning in human existence

The Existentialists have made a valuable contribution in demonstrating that the meaning of the individual's existence or lack thereof is always a companion, if not a causative factor, to mental health versus neurotic anxiety. The nature of being, non-being, purpose, meaning, values and goals within the setting of a specific culture, are crucial issues which directly affect the individual's sense of identity and security.

2.5 CONCLUSION

Anxiety is seen to be a complex, multidimensional phenomenon that affects every human being to some extent or another. In manageable amounts, anxiety is positive, as it motivates certain forms of behaviour. However, abnormal amounts

of anxiety are crippling and debilitating to the person's normal functioning. It is seen as the 'cornerstone of all psychopathology' [cf. 2.1].

The different types of anxiety relate closely to the different theories of anxiety, i.e.:

- * Psychoanalytic, Psychodynamic and Social theories
types of anxiety: normal, neurotic, moral and free-floating;
- * Learning theory
types of anxiety: fear, state and trait, general and test, overt and covert, free-floating and manifest; and
- * Existential theory
types of anxiety: fear and neurotic.

Anxiety is also closely related to other phenomena, such as:

- * fear;
- * phobias;
- * depression; and
- * stress.

The effects that the above-mentioned have on anxiety, and vice versa, have to be taken into account when understanding the phenomenon, anxiety.

This chapter is concluded with a suggestion from Crosby [1976:244] that an **Eclectic theory** of anxiety can incorporate the main components of all the various theories of anxiety. For the purpose of this study, this Eclectic approach will be adopted; firstly, in viewing the development of anxiety in the different stages of development of the child [Chapter Three] and secondly, in researching suitable assessment measures [Chapter Four] and thirdly, in researching effective treatment therapies for anxious primary school children [Chapter Five].

CHAPTER THREE

THE EFFECTS OF ANXIETY ON PRIMARY SCHOOL CHILDREN

3.1 INTRODUCTION

Empirical educational theory stresses the importance of viewing the child holistically in order to obtain a more comprehensive image of aspects affecting the child's development. It has, therefore, been decided to include five well-known theorists on child development; each one focusing on a different aspect of development in order to establish a framework which will provide the necessary structures within which anxiety can be examined.

Freud's psychosexual stages, Erikson's psychosocial and Sullivan's social needs stages, Piaget's cognitive stages and Kohlberg's moral judgement stages of development will be briefly explored in an effort to create a structure within which the effects of anxiety on children can be examined.

3.2 STAGES OF DEVELOPMENT OF THE CHILD

3.2.1 Freud's Psychosexual Stages

The Psychoanalytic perspective of anxiety relies on a stage theory of development in the child. As the child develops, the focus of psychic energy passes from one bodily zone to another [Wicks-Nelson & Israel 1984:55]. This process leads the child through stages of psychosexual development in a fixed pattern. Each stage is named after the bodily zone that is the primary source of gratification for that particular period. Each stage is involved in a developmental crisis which the child has to resolve if he is to move onto the next stage. If he is unable to do so, he becomes psychologically 'fixated' at that particular stage. The causes of fixation can be two-fold:

- * he may not be able to meet the demands of the environment while satisfying his own needs and may become psychologically frustrated; or
- * his needs may be so well met that he is unwilling to leave that particular stage and his behaviours associated with the stage continue inappropriately.

It is therefore, evident that utter frustration or overindulgence can fixate a child at a particular stage which will adversely affect his development at all subsequent stages. A brief summary of the various stages that pertain to this study follows.

3.2.1.1 Oral stage [0 - 1½ yrs]

Freud assumed that the infant was born with biological instincts that demanded satisfaction. Therefore the infant's need of food, warmth and the reduction of pain and frustration represented a striving for sensory pleasure. This striving or psychic energy Freud named libido [Mussen, Conger & Kagan 1990:154].

At this stage, according to Freud [Kaplan & Sadock 1989:58], the infant's main pleasure is derived from being fed. The oral area is a particularly sensitive one in the infant and he seems to gain not only intense pleasure from sucking but also uses this activity to explore and satisfy himself.

Between 2 - 6 months of age, the infant begins to be aware that need satisfaction cannot be provided by the self but comes from outside the self and this signals the beginning of the symbiotic phase [Kaplan & Sadock 1989:364]. At this time, the infant behaves and functions as though the mother and himself are 'an omnipotent system and essentially a dual unity within a common boundary'. From time to time these boundaries are differentiated when the infant is in a state of **affect hunger** but disappear when his needs are once again satisfied. Gradually, the infant forms more stable images of the mother's breasts, face and hands and

slowly object constancy develops. When the infant is being fed and cared for, his attention, which is derived from the libido, is slowly focused, more and more, on the primary caretaker, [usually the mother], who provides the gratification. Wicks-Nelson and Israel [1984:55] stress the infant's dependency on the mother or mother substitute at this stage.

They also distinguish between:

- * the oral-passive stage, which is associated with sucking and gratification; and
- * the oral-aggressive stage which develops simultaneously with the infant's first teeth and the development of biting.

At such time, according to Wicks-Nelson and Israel [1984:55], the infant also realises that the mother's breast or feeding bottle is not always readily available and, therefore, the feelings of frustration rather than satisfaction may arise. At such times the infant may seek satisfaction by acts of aggression such as biting. They maintain further that the final and crucial conflict of the oral and dependency themes lie in the weaning of the child and difficulties, in this regard, can cause fixation of this stage.

3.2.1.2 Anal stage [1½ - 3 yrs]

In the anal stage, the child's libidinal energies are primarily centred on the function of elimination. The child has begun to gain control of his bladder and bowels and his attempts to do so constitute sources of both interest and exploration for him [Rutter & Hersov 1987:58-59]. The retention and expulsion of faeces are the major sources of stimulation and pleasure during this period and toilet training is the major task for resolving the conflicts at this stage.

Wicks-Nelson and Israel [1984:56] state that according to Psychoanalytic theory, if the parental demands are met with little difficulty, the basis for self-control is established. Difficulties at this stage may cause the child to 'act out' and defecate when and where he pleases in an aggressive and hostile way or 'hold back' and refuse to defecate in a passive-aggressive manner. In each instance, the fight for control or dependence vs independence between child and parent seems evident.

Reber [1985:31] distinguishes between two distinct aspects of the anal stage:

- * anal expulsiveness in which pleasure is derived from the passing of faeces; and
- * anal retentiveness in which pleasure is associated with the withholding of faeces.

According to Psychoanalytic theory, fixation at this stage can result in personality differences in adult life.

3.2.1.3 Phallic stage [3 - 6 yrs]

During this stage the genitals become the focus of pleasure through masturbation, and the inspection of and curiosity about the sexual organs [Wicks-Nelson & Israel 1984:56]. According to Kaplan and Sadock [1989:364], this stage signifies that the child has reached object constancy and is able to differentiate between different objects or people. He is also able to maintain meaningful relationships whether or not his needs are satisfied. Ambivalent feelings towards a particular object [person] can be tolerated and the person can be valued for qualities that he possesses beyond the child's need-gratifying functions.

Wicks-Nelson and Israel [1984:56] mention further that the conflict, at this stage

for the boy, is called the Oedipus complex and it describes the boy's unconscious desire to possess his mother and eliminate his father-competitor. The boy's fear that his father will retaliate is known as castration anxiety. The parallel process for the girl is known as the Electra complex and her penis envy arises from her awareness of lacking a penis and she blames her mother for her deficiency. Her resentment and anger towards her mother make her fearful of losing her mother's love. For a boy to resolve his conflict during this stage, he must abandon his desire to possess his mother and must identify with his father by introjecting the attitudes and values of his father. By doing this, his superego is formed and his masculine identity begins to establish. A girl has to give up her wish for a penis and identify with her mother if she is to resolve this conflict, thereby accepting the feminine role.

Wicks-Nelson and Israel [1984:56-57] maintain that resolution of these two conflicts are central to both sex role identification and moral development in the child. Freud, according to them, also suggested that the basic personality structure is laid down by the end of the phallic stage.

3.2.1.4 Latency stage [6 - 12 yrs]

According to Freudian theory [Wicks-Nelson & Israel 1984:56], a period of relative sexual stability and inactivity in the child precedes the phallic stage. According to Reber [1985:392] sexual interest at this stage is presumed to be sublimated. Wicks-Nelson and Israel [1984:56-57] agree that sexual and aggressive impulses in the child are subdued and only revived in the following genital stage in adolescence.

However, Rutter and Hersov [1987:59] propose that research findings have shown that these views are incorrect. Although children tend to play almost exclusively with those of their own sex and there may be a greater concealment of sexual

interests during middle childhood, they maintain that research has demonstrated that overt sexual activities and interests are common and widespread. Masturbation increases gradually in frequency and heterosexual interests and concepts develop systematically. This aspect will be more fully explored further on in this chapter, under the developmental stages of the primary school child.

3.2.2 Social Development Stages

3.2.2.1 Erikson's psychosocial stages

Erikson was not included in Chapter Two as he appears not to have focused on the phenomenon, anxiety, to the same extent as other theorists like Freud [cf. 2.4.2.1], Horney [cf. 2.4.3.4] and Sullivan [cf. 2.4.3.5]. However, he has made a considerable contribution to psychology through his research into the psychosocial functioning of the child and, for this reason, it is felt that it is imperative that his theory be included in this chapter. Erikson supports Freud's assumption that early mother-child relationships are important for the infant's development but, according to Mussen *et al.* [1990:156], he emphasises the 'psychological consequences of being cared for in an affectionate, consistent, reliable and gentle manner' and moves away from the more biological aspects of feeding and toileting which were emphasised by Freud.

Erikson [1977:226] describes the growth and crisis of the human being in terms of a series of alternative basic attitudes. Erikson maintains that these attitudes 'pervade surface and depth consciousness and the unconscious'. He views them as ways of experiencing and behaving, as well as inner states that can be determined by test and analysis. He proposes that the most critical developmental event, during the first stage of the child's development, is the establishment of a sense of trust in another person. If this does not develop the infant will not progress satisfactorily to the next stage. In this manner, he retains the 'essence

of the Freudian idea of fixation' as quoted by Mussen *et al.* [1990:156]. According to Erikson, the unfolding of personality takes place in certain psychosocial stages which he refers to as the 'Eight Ages of Man' [Erikson 1977:222]. Those relevant to this study are discussed briefly, as follows:

3.2.2.1.1 Stage I: Basic trust vs mistrust

According to Erikson [1977:222] the first signs of social trust in the infant are the ease with which he feeds, the depth at which he sleeps and the relaxation of his bowels. This stage usually extends through the infant's first year of life and the dimension that emerges, during this period, involves basic trust at the one end of the continuum and mistrust at the other.

Kaplan and Sadock [1989:399] explain that this trust depends on the **consistency** and **sameness** that the infant experiences from his primary caretaker. In this way, the degree to which the infant comes to trust the world, other people and himself, depends to a considerable extent, upon the quality of his care initially.

Elkind [1981:352-354] maintains that the infant, whose needs are met when they arise, develops a sense of the world as a safe and caring place and of people as trustworthy and dependable. However, when the care is inconsistent, inadequate and rejecting, the infant develops an attitude of mistrust, fear and suspicion of his world in general and people in particular, which will influence his personality development. During the second six months of the infant's life [Erikson 1977:223; Kaplan & Sadock 1989:399] his relationship with his **world** is tested. Due to his frustration and pain at teething, he looks for relief in biting and being comforted. He is also driven to move from **getting** to **taking**. Erikson views teething as a prototype for future masochistic tendencies if the infant learns mistrust instead of trust. Weaning is also considered an important milestone for the infant, as it is in Freudian theory, in that if the child's basic trust is strong he

will be able to be weaned and still maintain a hopeful and favourable attitude towards his world.

Erikson [1977:224] sums up this stage by stating that the amount of trust the infant derives does not depend so much on 'absolute qualities of love or demonstration of love, but rather on the quality of the maternal relationship'.

3.2.2.1.2 Stage II: Autonomy vs shame and doubt

This stage spans the second and third years of the child's life. Autonomy in the child emerges as his motor and mental abilities develop. These include learning to walk and talk, feeding himself and controlling his bladder and bowels [Kaplan & Sadock 1989:400].

Erikson [1977:226-227] mentions that the child's new-found muscular maturation 'sets the stage for experimentation with two simultaneous sets of social modalities; holding on and letting go'. If the child's needs, which are to do what he is capable of doing, at his own pace and in his own time, are recognised by his parents, he will develop a sense of autonomy; a sense that he is able to control his muscles, his body, his impulses and himself within his environment. Erikson believes that outer control from his parents, at this stage, must be firmly reassuring and supportive; 'as his environment encourages him to stand on his own feet, it must protect him against meaningless and arbitrary experiences of shame and of early doubt' [Erikson 1977:266].

According to Kaplan and Sadock [1989:400], shame occurs when the child becomes overtly self-conscious through exposure to his negative qualities and behaviour, etc. Toilet training must never become a contest of will between the mother and the child. The mother must understand the child's need both to oppose and to submit. If she is unable to allow the child this freedom, a state of

inactivation may take place, creating a sense of 'defeat with deep feelings of shame and doubt' [Kaplan & Sadock 1989:406].

Erikson views the child's will to be himself, as being the rudiment of ego strength at this stage [Erikson 1964:186]. It is, therefore, at this stage that the ratio of love and hate, cooperation and wilfulness, freedom of self-expression and its suppression is so important. In Erikson's words 'from a sense of self-control without loss of self-esteem comes a lasting sense of goodwill and pride; from a sense of loss of self-control and a foreign over-control, comes a lasting propensity of doubt and shame [Erikson 1977:228].

3.2.2.1.3 Stage III: Initiative vs guilt

The child passes through this stage at approximately 3 - 5 or 6 years of age. He is usually fully in control of his body and can initiate motor activities at both a gross and fine motor level. Erikson [1977:229] describes this stage as when 'the child suddenly seems to grow together both in his person and in his body'. He further describes the child as 'more relaxed, loving, brighter in judgement and in free possession of a surplus of energy' which permits him to forget failures quickly and to approach tasks that seem desirable with undiminished and more accurate direction. According to Kaplan and Sadock [1989:406], children of both sexes explore time, space and fantasy with new vigour. The awakening sexual interests need to be carefully handled by parents to retain ego tension and avoid guilt. The child's conscience begins to govern his initiative and purpose becomes the rudiment of the ego-strength.

Erikson [Elkind 1981:353] believes that whether the child leaves this stage with his sense of initiative outbalancing his sense of guilt, will depend largely on how his parents respond to his self-initiated activities, his fantasy, his sexual curiosities and his outbursts of rage against his siblings. Erikson [1977:230] emphasises the

child's development of a conscience and states that 'infantile sexuality and incest taboo, castration complex and superego all reunite here to bring about that specifically human crisis during which the child must turn from an exclusive pregenital attachment to his parents to the slow process of becoming a parent, a carrier of tradition'. If the child does not resolve this stage's crisis and passes through to the next stage, he may develop a sense of guilt that will persist through the rest of his life.

3.2.2.1.4 Stage IV: Industry vs inferiority

This is the stage at which the child, aged 6 years, first enters formal schooling and it lasts until the child is \pm 12 years of age. Erikson [1977:232] maintains that the child has to 'forget his past hopes and wishes, while his exuberant imagination is tamed and harnessed to the laws of impersonal things'.

According to Kaplan and Sadock [1989:406] the danger of this stage is that the 'new feeling of industrious learning will be destroyed by a feeling of inferiority' if learning is not a creative endeavour.

Elkind [1981:352-254] mentions the child's ability to use deductive reasoning and to play and learn by rules. The child is concerned with how things are made, how they work and what they do. Erikson [1977:233] sees this as a period of adjustment in the child. He begins to understand that 'there is no workable future within the womb of his family' and this frees him to apply himself to skills and tasks outside of the family. He develops a sense of industry. He is able to learn from those around him and the fundamentals of technology develop in the child.

Erikson [1977:233] concludes that the child's danger at this stage 'lies in a sense of inadequacy and inferiority'. If he despairs of his ability to be industrious and loses hope of his own abilities and is criticised about them at home or at school,

he may very well begin to feel inferior. Constant failures, no matter what the reason, will also reinforce a sense of inferiority.

According to Elkind [1981:352-254], this is the first stage at which the child's ability to resolve the crisis does not depend solely on his parents but involves the actions of other adults, e.g. teachers, as well. Erikson therefore views the primary school child as being occupied with his relationship with the world of skills and with those who teach and share these new skills with him such as his parents, his teachers and his peers.

Table 3.1 illustrates Erikson's stages of development, up to the stage of adolescence. It demonstrates the psychosocial crises the child has to face, as well as the key relationship/s within each crisis. The psychosocial modality of each stage is also included [Kokot 1988:62].

TABLE 3.1

ERIKSON'S STAGES OF DEVELOPMENT

	Psychosocial Crisis	Key Relationship/s	Psychosocial Modalities
I	Trust vs Mistrust	Maternal Person	To get To give in return
II	Autonomy vs Shame & Doubt	Parental Persons	To hold (on) To let (go)
III	Initiative vs Guilt	Basic Family	To make To "make like"
IV	Industry vs Inferiority	"Neighbourhood" School	To make things (= completing)
V	Identity vs Identity Diffusion	Peer Groups & Outgroups	To be oneself (or not to be) To share being oneself

3.2.2.2 Sullivan's social needs stages

Sullivan emphasises the importance of interpersonal relationships and mutual adjustment rather than intra-psychic balance. Furthermore, he views anxiety as the 'result of disturbances in these relationships' [cf. 2.4.3.5]. It seems important that his theory of psychosocial development be included with Erikson's, as it differs in focus to Erikson. While Erikson emphasises attitudes, Sullivan focuses on social needs. He lists these as tenderness, companionship, acceptance, interpersonal intimacy and sexual contact. Underlying these needs are biologically rooted tensions which serve as the motivational forces towards seeking interpersonal contact which can satisfy these needs.

Burhmester and Furman [1986:41-42] quote these tensions as taking the form of negative emotions such as anxiety, fear, loneliness, boredom and ostracism. They also maintain that Sullivan defined his developmental stages into psychosocial events rather than according to chronological age. However, neo-Sullivans have attempted to place these stages in a chronological time-frame and therefore the age ranges, in Table 3.2, should be viewed as only approximate.

The beginning of each stage is marked by an emerging social need that is added to the hierarchy of desired interpersonal situations. Each new need is added to the existing ones, rather than replacing them and this is represented by the step organisation of the cumulative nature of emerging social needs in Table 3.2 [Kokot 1988:62]. For the purpose of this study, only the first four stages will be explored.

Table 3.2 also includes the key relationships that are most important for the fulfilment of the child's needs during each developmental period. It can therefore be seen that a new emerging need motivates for the formation of a new type of relationship, e.g. in the juvenile stage, the need for acceptance promotes the formation of close peer relationships.

TABLE 3.2

MODEL OF EMERGING SOCIAL NEEDS AND KEY RELATIONSHIPS

EMERGING SOCIAL NEEDS AND KEY RELATIONSHIPS				STAGE V SEXUALITY Opposite-sex partner	
			STAGE IV INTIMACY Same-sex friend	Opposite-sex friend/ romance Same-sex friend	
			STAGE III ACCEPTANCE Peer Society	Heterosexual Crowd Friendship Gang	
		STAGE II COMPANIONSHIP Parents	Peers Parents	Same-sex friend Parents	Opposite-sex friend / romance Same-sex friend
	STAGE I TENDERNESS Mother Parents	Parents	Parents	Same-sex friend Parents	Opposite-sex friend / romance Same-sex friend Parents
INFANCY (0 - 2 yrs)	CHILDHOOD (2 - 6 yrs)	JUVENILE STAGE (6 - 9 yrs)	PRE - ADOLESCENCE (9 - 12 yrs)	EARLY ADOLESCENCE (12- 16 yrs)	

3.2.2.2.1 Stage I: Tenderness

According to Sullivan's theory, the infancy stage [approx. 0 - 2 years] revolves around the need for tenderness from the parental figures [but which is usually fulfilled by the mother]. This involves a need for protective care 'delicately adjusted to the immediate situation' [Kokot 1988:55]. This continues through life as the need for nurturance and support, especially at times when the child feels helpless and distressed. Sullivan's view is that anxiety in the mother can lead the child to associate interpersonal tenderness with feelings of insecurity.

3.2.2.2.2 Stage II: Companionship

During the childhood stage, the need for adult participation, in the form of companionship, evolves. The child needs a significant adult, usually the mother or father, to participate in his play and to show him interest and involvement. This need also continues through life as a desire for shared companionship.

3.2.2.2.3 Stage III: Acceptance

Following on from Stage II, companionship with other children becomes increasingly important in the juvenile stage, when the child enters formal schooling. The child becomes increasingly aware of differences between himself and his peers in appearance, competency abilities, social skills, family backgrounds, etc.. The child uses these differences as a measure of desirability as a companion or playmate. Along with this process of peer evaluation, is the need for acceptance by his peers. This need is accompanied by a fear of being excluded and ostracised. According to Sullivan, the child's feelings of self-worth are increasingly influenced by his peer society at this time. If he is excluded from the peer group, developmental arrest may take place, which affects the child's self-esteem for life and deprives him of

experiences which are necessary for the development of skills to interact successfully with his peers.

3.2.2.2.4 Stage IV: Intimacy

Sullivan views this stage of pre-adolescence as an important turning point in development. The child's new need is for intimate exchange and for close relationships or **chumship** which Sullivan views as vitally important. This is seen as a new kind of relationship. It is less self-centred than the interaction of the previous juvenile stage and allows for more mutual satisfaction for both children [Kokot 1988:58].

Piaget [Kokot 1988:57-58] also views the pre-adolescent stage as allowing the child friendships that are vital to the development of later intimate interactions, such as marital and parenting relationships. Sullivan [Kokot 1988:58] stresses the natural therapeutic effect that this type of relationship can have on developmental arrests resulting from earlier, less positive relationships with parents and peers. The failure to form a relationship of this kind results in feelings of loneliness and isolation.

3.2.3 Piaget's Cognitive Stages

Piaget, according to Rutter and Hersov [1987:198], considers thought and emotions to develop simultaneously and his view is that 'affectivity constitutes the energetics of behaviour patterns whose structures correspond to cognitive functions'. For this reason it seems important to explore the development of the cognitive stages in the child if he is to be assisted emotionally.

Piaget views the child as a biological organism in that he adapts to his environment by actively organising and interpreting experiences through the higher mental functions. Through the process of assimilation [taking in] and accommodation [modifying these schemes] the child develops his perceptions

of his world. Both maturation and experience are considered necessary for cognitive development of which the following assumptions are made by Piaget [Wicks-Nelson & Israel 1984:26]:

- * the periods of development occur in an invariant order;
- * no period can be skipped;
- * each period is more complex than the preceding one and represents a transformation of what previously existed; and
- * each period is based on the preceding one and prepares for the succeeding one.

Piaget [Rutter & Hersov 1987:191] found through his research that children think very differently to adults and, in this way, they experience a reality of a world that is qualitatively different from the reality known to adults. Again, for this reason it is very important to fully understand the implications of their cognitive development in order to assist them emotionally.

Piaget divides the course of development into four distinct stages:

- * sensorimotor stage [0 - 2 years];
- * preoperational stage [2 - 7 years];
- * concrete operational stage [7 - 11 years]; and
- * formal operational stage [11+ years].

For the purpose of this study, the first three stages will be briefly explored. [The following sources were used as references: Kaplan & Sadock 1989:400-

402; Mussen *et al.* 1990:125-129; Rutter & Hersov 1987:191-201; and Wicks-Nelson & Israel 1984:26.]

3.2.3.1 Sensorimotor stage [0 - 2 years]

The infant begins to construct his reality with sensory and reflexive motor abilities with which he is born. He learns to know his environment through sensorimotor interactions. These become more and more refined, coordinated and integrated with age and experience until such time that the child learns to control them fully. In this way, he moves from automatic gross responses to refined actions that serve some good goal-directed purpose. His **intelligence**, therefore rests mainly on his actions and movements coordinated under schemata or patterns of behaviour. He has no mental representation to begin with and therefore no conscious memory.

His awareness is constrained to the **here and now**. He finally achieves object permanence by the age of two years and at such time he realises that, although an object has disappeared from his view, it still exists. The beginnings of reversibility of action develop where the child perceives that by reversing an order of certain actions, the original state can be restored, e.g. rolling over and finding himself on his back once more. This allows for the development of reversibility of thought at a later stage.

3.2.3.2 Pre-operational stage [2 - 7 years]

At this stage, there is a shift in the child's cognitive abilities in that the emphasis moves away from the sensorimotor to the internal manipulation of symbols and the child can now deal with very basic and simple problems. Language development becomes a focal point. He is now able to construct stable, internalised representations that transcend the immediate present and he is equipped for verbal communication, gestures, drawing and symbolic play. The child understands everything exclusively from his own perspective

and may therefore be said to be egocentric or self-centred; the reason being that he assimilates his own immediate action and therefore represents reality according to its momentary, figurative qualities. His thinking consists of an illogical and magical element and he still demonstrates non-reversible thinking with the absence of conservation [understanding the relationship between shape and mass]. He can believe that inanimate objects are alive and have feelings and intentions and, in that way, his toys are very much alive in his world. He also believes that the punishment of all bad deeds is inevitable.

3.2.3.3 Concrete operational stage [7 - 11 years]

At this stage the child demonstrates the emergence of logical thinking such as cause and effect. The concept of reversibility is available to him and he is able to sequence and serialise. He understands part-whole relationships and can classify objects both concretely and abstractly. He develops conservation of number, length, weight and volume. At this stage, the child comes to have a far better understanding of relationships among environmental events and can coordinate manifold points of view and can accept another person's point of view. He becomes less egocentric. It is therefore evident that the child's ability to appreciate someone else's point of view, rests on the psychological functions that underlie his comprehension of concepts like conservation, according to Piaget.

In summary, Piaget believes that:

with each successive level of development and corresponding structure of mind, the child transcends one reality by constructing another. In the course of this progress, logical principles are abstracted from the coordination of actions [Rutter & Hersov 1987:196].

3.2.4 Kohlberg's Moral Development Stages

Like Piaget [cf. 3.2.3], Kohlberg believes that moral development depends on

advances in the cognitive development of the child. Kohlberg has based his stage theory of moral development on the assumption that each stage represents hierarchically more complex and abstract levels of reasoning. Children are assumed to pass through the stages in a fixed order. Only after the reasoning of an earlier stage has been mastered, can the child move to the next stage of development. Kohlberg also accepts that an individual's level of development may not reach the final stages. It would appear that only very few people, such as trained philosophers, reach Stage 6, according to Woolfolk and McCune-Nicolich [1984:106].

Kohlberg divided moral development into three levels:

- * preconventional: judgement is based solely on the individual's own needs and perceptions;
- * conventional: the expectations of laws and society are taken into account; and
- * post-conventional: judgements are based on principles that go beyond specific laws.

Each level was further divided into two stages. For the purpose of this study, only the first three stages of moral development will be examined. Mussen *et al.* [1990:447-457], Wicks-Nelson and Israel [1984:262-263] and Woolfolk and McCune-Nicolich [1984:103-105] have been used as references.

3.2.4.1 Level 1: Preconventional level

3.2.4.1.1 Stage I: Punishment and obedience

At this level, children judge right and wrong primarily by the consequences of the actions. The child at this stage acts egocentrically. He does not

consider the interests of others nor does he recognise if they are different to his. He cannot relate to two points of view. He tends to view actions for their physical consequences rather than psychological ones. For example, if he breaks a precious ornament he may view it **wrong** because mummy is cross, but will not fully appreciate its possible sentimental or financial value. Goodness and badness are judged in terms of their physical consequences. At Stage I, right and wrong are judged in terms of obeying rules in order to avoid being punished.

3.2.4.1.2 Stage II: Instrumental relativism

At this stage, the child begins to take others into consideration and a sense of reciprocity develops. Doing what is fair constitutes an equal exchange. The child's moral orientation is still primarily individualistic, egocentric and concrete but the rights of others can co-exist along with the rights of the individual. He is able to strike up agreements and make deals that are to his advantage. He will follow rules only when it is to someone's immediate interest. He may not see the necessity of keeping clothes neatly packed or hung up. He will act to meet his own interests whenever possible but allow others to do the same. His moral values reside in the instrumental gratification of his needs and are directed by the concrete exchange of favours.

3.2.4.2 Level 2: Conventional Level

3.2.4.2.1 Stage III: Interpersonal concordance

At this level, the focus is on interpersonal relationships and social values and these begin to take precedence over individual interests. At Stage III, the child may initially emphasise 'being a good person in your own eyes as well as those of others'. This implies having worthy motives and showing concern about others.

Conformity of behaviour, following the behaviour of the majority, is important. The intention behind an action acquires great importance. The child seeks approval by being good. He will respect and attempt to follow **Golden Rules**. Mutual relationship such as trust, loyalty, respect and gratitude become important to the child at this stage. He is able to put himself in the other person's shoes and understand his perspective even if it is different to his. His moral value is defined in terms of social conformity, mutual interpersonal expectations and interdependent relationships. However, he does not yet consider a more generalised system perspective of the society as a whole.

3.3 SYNTHESIS OF THE STAGES OF DEVELOPMENT

An attempt has been made to view the normal development of the child holistically and from different perspectives, namely sexual, social, cognitive and moral. Certain theorists who have contributed significantly to the theory of child development, have been included in this chapter. It is evident from the previous research that anxiety negatively affects all aspects of development in the child. It is therefore important that we understand how the child should develop optimally, in order to assess the child accurately and treat his anxiety successfully.

It would appear that the highly anxious child may have difficulty passing successfully through Freud's psychosexual stages and it is highly likely that he may fixate at certain stages. It is also postulated that the highly anxious child would experience more feelings of mistrust, shame and doubt, guilt and inferiority than the less anxious child. He may have unmet needs of tenderness, companionship, acceptance and intimacy as well. It would seem realistic to suggest that he would doubt his own intellectual abilities and therefore not accept that he may have successfully reached Piaget's cognitive

stage, appropriate to his age and intellectual ability. High levels of anxiety would affect the child's moral development negatively as his feelings of guilt, shame, insecurity and inferiority may preclude him from dealing with moral issues and feeling assertive enough to develop healthy and well-adjusted morals and values. The development of a healthy conscience would therefore be affected.

The correlation of Freud's psychosexual stages, Erikson's psychosocial stages, Piaget's cognitive stages and Kohlberg's moral stages of development has been attempted in Table 3.3, to assist the reader in seeing the child's development holistically. Sullivan's social needs have been excluded as they were dealt with fairly conclusively earlier in the chapter [cf. 3.2.2.2].

It is interesting to note how these four theorists' ideas and beliefs compliment one another, even to the extent of the chronological ages for the various stages. If we are to view the child as an integrated whole, it seems imperative to understand the development of the child, from all of these perspectives.

TABLE 3.3

CORRELATION OF FREUD'S PSYCHOSEXUAL, ERIKSON'S PSYCHOSOCIAL, PIAGET'S COGNITIVE AND KOHLBERG'S MORAL STAGES OF DEVELOPMENT

APPROXIMATE AGES IN YEARS	FREUD'S PSYCHOSEXUAL STAGES	ERIKSON'S PSYCHOSOCIAL STAGES	PIAGET'S COGNITIVE STAGES	KOHLBERG'S MORAL STAGES
INFANT 0 - 1 YRS	Oral Developmental Crisis: Weaning	Basic Trust vs Mistrust (Oral-sensory) Crisis: Hope "I am what I hope I have and give"	Sensorimotor Stage (0 - 2 Yrs) "I only know an object to the extent that I can act upon it"	Level I: Preconventional Stage 1 Punishment and obedience
TODDLER 1 - 3 YRS	Anal Developmental Crisis: Toilet Training	Autonomy vs Shame and Doubt (muscular-anal) Crisis: Will "I am what I can will freely"	Pre-operational Stage (2 - 7 yrs) "I understand the world through my own experiences"	"I must not do wrong because I may get caught"
PRE-SCHOOL CHILD 3 - 6 YRS	Phallic Developmental Crisis: Desire to possess parent of opposite sex - fear of retaliation from same-sex parent	Initiative vs Guilt (Locomotor-genital) Crisis: Purpose "I am what I can imagine I will be"		Stage 2 Instrumental Relativism (need for fairness) "I must not do wrong because it is wrong"
PRIMARY SCHOOL CHILD 6 - 12 YRS	Latency Developmental Crisis: None	Industry vs Inferiority (Latency) Crisis: Competence "I am what I can learn to make work"	Concrete Operational Stage (7 - 11 Yrs) "I can think logically and see others' points of view"	Level II: Conventional Stage 3 Interpersonal Concordance "I want to be good so others will approve of me"
ADOLESCENT > 12 Years	Genital	Identify vs Isolation	Formal Operational Stage (12 + yrs)	Stage 4 Law & Order

3.4 EFFECTS OF ANXIETY ON THE DEVELOPMENT OF YOUNG CHILDREN

3.4.1 Introduction

From Chapter Two, it has become apparent that most theories on anxiety maintain that the roots of anxiety lie in childhood [cf. 2.4.2; 2.4.3; 2.4.4 and 2.4.5]. According to Freudian theory, children's psychological disorders develop from one or two sources. The child may be experiencing difficulty resolving the psychosexual conflict of a particular stage or may be fixated at an earlier stage of development. In either case, anxiety is seen as central to the symptoms that develop. Kaplan and Sadock [1989:963] mention that anxiety can be found throughout all the phases of early childhood and is manifested in different characteristics as the child develops. Psychodynamic theorists such as Horney [cf. 2.4.3.4], Sullivan [cf. 2.4.3.5] and Erikson [cf. 3.2.2] maintain that anxiety develops out of disturbed relationships in the child's early life.

Learning theorists such as Dollard and Miller [cf. 2.4.4.2], Wolpe [cf. 2.4.4.3] and Cognitive Behaviour theorists [cf. 2.4.4.4] believe that the child learns to associate certain stimuli with possible pain and danger to his physical well-being and in this way learns to feel anxious or fearful. Dollard and Miller [Hall & Lindsey 1970:440] identify four areas in the child's development that are particularly likely to produce conflict and emotional disturbances, depending on how they are handled. They list them as:

- * the feeding situation in infancy;
- * toilet or cleanliness training;
- * early sex training; and

- * the training for control of anger and aggression.

Existential theorists such as Maslow [cf. 2.4.5.4] believe that if certain needs in the child are not met, these needs become fixated and anxiety results. The Existential belief [cf. 2.4.5] that the source of anxiety has to do with the perceived lack of meaning and purpose in human life, indicates that the development of a healthy self-concept, conscience and value system are imperative to the child if he is to be able to deal with his feelings of anxiety effectively.

3.4.2 The Developmental Stages of Early Childhood

3.4.2.1 Foetus [0 - 9 months]

Kaplan and Sadock [1989:964] state that modern investigators of early childhood development generally agree that infants are unable to experience anxiety per se before the age of 3 - 4 months.

However, Greenacre [Brody & Axelrod 1970:6] has posed the question as to whether a predisposition to anxiety may stem from constitutional factors such as the intensity of reflex stimulations that are experienced in the foetal and perinatal periods of the infant's development and organised at birth shortly afterwards.

Mussen *et al.* [1990:77] venture further back into the development of the foetus and state that despite there being no direct connection between the mother's and the foetus' nervous systems, the mother's emotional state during pregnancy can influence the foetal reactions and development. They explain that emotions such as rage, fear and anxiety bring about changes in the mother's autonomic nervous system which, in turn, liberate certain chemicals such as acetylcholine and epinephrine into the bloodstream and these affect the foetus. Hormonal changes, due to the secretion of endocrine glands, take

place and with the changes in the composition of the mother's blood new substances are transmitted through the placenta which produce changes in the foetus' circulatory system.

The research of David; Joffe; Sameroff; Zax and Sontag [Mussen *et al.* 1990:77] has concluded that prolonged maternal emotional stress during pregnancy may have lasting consequences for the child. Low birth weights, prematurity, hyperactivity, instability, eating difficulties, excessive bowel movements, colic, sleep disturbances, excessive crying and the excessive need to be held are all possibly consequences to prolonged emotional stress to the foetus via the mother.

3.4.2.2 Infant [0 - 1 year]

According to certain theorists such as Brody and Axelrod [1970]; Freud [1936], Smith and Danielsson [1982], the infant responds to painful, traumatic situations such as hunger and painful bodily sensations by means of diffuse, somatic, autonomic and motor discharge and these are accompanied by an undifferentiated experience of displeasure which develops into anxiety as the ego develops.

Freud [1936:141] explained that the anxiety experienced in the process of birth becomes the prototype of anxiety experienced later on as an affective [emotional] state. He refers to the birth anxiety as **primal anxiety** and describes it as 'involuntary, automatic and economically justified in a traumatic situation'. This anxiety is also referred to as **id manifestations** [Smith & Danielsson 1982:2] or **id, impulse or traumatic anxiety** [Kaplan & Sadock 1989:963-964].

Kaplan and Sadock [1989:964] describe traumatic anxiety as a response to an actually present, overwhelming, dangerous and traumatic situation. Id or

impulse anxiety is seen as related to the primitive, diffuse discomfort of the infant when he feels overwhelmed by needs and stimuli that he cannot control.

Smith and Danielsson [1982:2] refer to the somatic discharge phenomena of anxiety as id manifestations and view these as a reaction to a traumatic situation.

Brody and Axelrod [1970:9] maintain that as the infant perceives some **dystonic** condition in his own body, perceiving at the same time his own immediate, involuntary response to it, the ego is born and begins to serve a primary function in the infant. Anxiety is one of the main emotions with which the ego develops.

Therefore, it is only when the infant begins to develop a primitive ego structure that he begins to experience anxiety as a qualitatively distinct affect that signals the threat of a potentially traumatic situation [Kaplan & Sadock 1989:964].

Smith and Danielsson [1982:2] agree with this and define anxiety as 'a reaction to danger, present or anticipated'. Brody and Axelrod [1970:5] confirm that anxiety proper can only be experienced at a certain point of ego organisation. They state that Freud clarified, in his second theory of anxiety, that it has a physiological phase in excitations occurring within the birth process. Later on, in infancy, these physiological responses are processed into serving to alert the infant to danger, essentially that of being alone and helpless.

3.4.2.2.1 Development of a protective shield

Brody and Axelrod [1970:42] mention Freud's theory which states that as a result of ceaseless impact of external stimuli upon the infant [organism], a protective shield is gradually formed. This shield is described as a 'permanent and unchangeable crust through which to receive external stimuli in small

quantities by means of sensory organs and through which to be protected at the same time from too great an impact of external stimuli'.

Benjamin [Brody & Axelrod 1970:47] sees the protective shield as both biologically given and as a product of development. At birth, according to Benjamin, there is a passive barrier due to the lack of functioning connections. At the age of 3 - 4 weeks, the infant shows a marked increase of sensitivity to external and internal stimuli, which can be corroborated by electroencephalograph [EEG] changes. An active barrier develops at \pm 8 - 10 weeks and matures rapidly. Benjamin regards the period between 3 - 4 weeks and 8 - 10 weeks as one of heightened vulnerability when the infant is in special need of maternal protection against stimuli. He hypothesises that maternal failure to manage this need might contribute to a heightened predisposition to anxiety. Brody and Axelrod's [1970] research confirms this hypothesis.

3.4.2.2 Anxiety preparedness and development of signal anxiety

Brody and Axelrod [1970:56] postulate that **anxiety preparedness** develops in the infant as an adaptive reaction to the penetration of anxiety through the protective shield. In this way, the infant learns to turn away from or blunt the stimuli that are threatening to him and as a result of these threats, anxiety, in anticipation of them, arises. This is the beginning of signal anxiety.

Brody and Axelrod [1970:54] believe that if this signal anxiety is turned outward, it is an undifferentiated cry for the mother. However, if it is turned inwards, it is a 'silent summoning of a proto-typical defence'. In other words, if the infant is usually comforted by the mother, he will learn to cry out. However, if he learns that the mother is often unavailable, he will learn to stifle his cry and withdraw. Brody and Axelrod postulate further that a process of anxiety development takes place in which the stages of the development of the protective shield and the preparedness for anxiety lead

through physiological paths to an emerging ego functioning and the emotion of anxiety.

According to Kaplan and Sadock [1989:964], the infant becomes better able to manage himself, his needs and his environment as his cognitive and executive ego functions are strengthened and organised into a structure of growing complexity. Anxiety at this time becomes more differentiated, more affective and less somatic and in this way signal anxiety evolves from traumatic anxiety. The acute traumatic anxiety discussed previously tends to disappear but is never eradicated. It remains a potential response to overwhelming environmental disasters for which the individual is unprepared. Prolonged traumatic anxiety will emerge, in its genetically earlier somatic and undifferentiated form, at such times.

3.4.2.2.3 Relationship with mother or mother-substitute

Freud considered the infant to be a biological organism who required that his physical and psychological needs be met [cf. 3.2.1]. In this sense, Freud saw the mother or caregiver as an important person in the child's life. The successful resolution of developmental crises that the child passes through at each stage of his psychosexual development, such as weaning and toilet training, depends to a large extent on the manner in which the mother or caregiver interacts with the child.

Erikson supports Freud's theory that early mother-child relationships are important [cf. 3.2.2] but emphasises the quality of the relationship more than the physical aspects of feeding and toileting.

Sullivan [Crosby 1976:241] emphasises the concept of interpersonal relationships as being the essential core of personality development and considers anxiety to be the result of disturbances in these relationships.

The infant, according to Sullivan [Kokot 1988:54-55], discovers his powerlessness and due to disappointments of the early post-womb experiences, he begins to develop actions, thoughts and foresight to protect himself from the insecurity and helplessness of the situation.

In infancy, the baby is completely dependent on his mother or mother-substitute for all his needs. A self-system or self-dynamism [cf. 2.4.3.5] develops and with this need for self-preservation comes anxiety. Kaplan and Sadock [1989:964] refer to this as signal anxiety [cf. 3.4.2.2.2] and define it as an ego affect that alerts the infant to anticipate the threat of a traumatic situation. It is, in effect, a response to cognitive processes such as the perception of indications of potential danger and the memory of past experiences of psychic trauma.

Brody and Axelrod [1970:87] maintain that at about six months of age, the infant discriminates between his mother and other persons. Kaplan and Sadock [1989:964] confirm that as the infant's cognitive capacities for perception and memory develop, he begins to recognise his mother as a distinct person. His ego develops as a result of repeated interactions between himself and his environment and he gradually learns that his needs, e.g. hunger, are usually gratified by his mother or surrogate-mother. His perceptions of her and ultimately his internal memory images of her [imprints] enable the infant to postpone an immediate discharge of id anxiety in response to the early sensation of hunger as he anticipates that his mother will be there to attend to his needs. However, his perceptions of his mother's absence becomes itself a signal of the potential approach to a traumatic situation if she is not available to him. According to Brody and Axelrod [1970:87], the threat of **object loss** or loss of his mother arises.

Freud [1936:102] explained that the object loss is the danger appertaining to the state of dependence in early childhood. He clarified that the psychic mother-object replaces for the child the biological foetal situation. During

intrauterine life, the mother and child are one and only after birth does the mother become an object on which to depend. He postulated, further, that **spoiling** which may be interpreted as overindulging young children by meeting all of their needs all of the time, has the undesirable result that the danger of object loss [the object being the protection against all situations of helplessness] is overemphasised in comparison with all other dangers. It therefore encourages the child to be over-dependent both at a motor and a psychic level and to fear the loss more.

According to Freud [1936:155], when the infant experiences anxiety he also experiences pain. He is not yet able to distinguish temporary absence from permanent loss; when he fails to see his mother on a given occasion he behaves as though he is never going to see her again. The initial cause of anxiety which the ego itself introduces is therefore loss of perception of the object which becomes equated with loss of the object.

According to Brody and Axelrod's [1970:87-88] view of the development of anxiety, a 'failure to maximise the infant's cathexis of the mother and so of the external world attaching to her presence and behaviour', by the time the infant reaches the last months of his first year, would mean that the threat of object loss would be heightened. During the last six months of the infant's first year a process of differentiation takes place between infant and mother. This will be encouraged by a 'preparedness for anxiety' through the infant experiencing pleasure and displeasure in optimal amounts and to optimal degrees by his needs being met at a satisfying level.

Provence and Lipton [Brody & Axelrod 1970:98] found that adequate physical care but inadequate emotional and social stimulation of infants were found to result in their failure to develop adequately and this affected their cognitive and social development.

Brody and Axelrod [1970:9] conclude that many researchers accept the view that serious consequences, positive and negative, follow from the quality and quantity of the mother-infant interaction. They state further that it is well documented, in psychological theory, that the temporary or permanent disappearance [of a certain length of time] of the mother in the second half of the infant's first year, affects him very negatively and can result in depression [Brody & Axelrod 1970:98].

Separation anxiety is defined by Reber [1985:687] as 'the hypothesised anxiety on the part of the infant or child concerning possible loss of the mother object'. Stranger anxiety, according to Gittelman [1986:37-38], refers to the infant's avoidance of strangers and a turning towards his mother for protection and reassurance.

3.4.2.2.4 Separation and stranger anxiety

As the infant develops a focused attachment relationship with the mother or mother-substitute, he begins to avoid strangers and seeks comfort and protection from his mother. He will also show distress at being separated from his mother and this is related to his fear of object loss. Gittelman [1986:38] emphasises that the term 'separation anxiety' refers to the child's protest at the mother's departure, distress caused by her absence and anxiety about her anticipated absence. The form this distress takes, e.g. crying, fear, withdrawing, etc. and the duration and intensity of the reactions will vary with:

- * the infant's age;
- * the quality of the mother-infant relationship;
- * the nature of the situation; and

- * previous experiences with anxiety.

Brody and Axelrod [1970:232] add to this list with:

- * the infant's immediate physical and emotional state;
- * whether he sees her leave or whether he finds out after she has gone;
- * the frequency and duration of her usual absence;
- * the frequency with which other family members come and go from the home;
- * the person with whom he is left; and
- * the capacity he has to occupy himself in the mother's presence and when alone.

Gittelman [1986:38] believes that the quality of the early experiences the infant or child has with the mother or mother-substitute, her availability and ability to protect the child from danger and excessive distress, sets the stage for later close relationships and influences the degree of trust and confidence the child can place in his future interpersonal relationships. Infants who have experienced responsive and available mothering develop a sense of security and trust. Gittelman [1986:42] found in his research that mothers who explained their departure to the infants were more in tune with the infant's developmental needs and their infants were more secure in the knowledge that maternal departure would be followed by return. They have learnt that when the mother leaves she will return and that their signals of distress and discomfort will be acknowledged and responded to. Secure infants and children are less likely to become upset by typical, brief separations than are

insecure infants and children who have experienced a relationship with a mother who is:

- * unavailable;
- * rejecting; and
- * unresponsive.

These infants and children will be prone to more intense upset at separation from their mothers and will experience chronic anxiety about where they are and if or when they will return. These mothers will have failed to serve as adequate protectors or sources of comfort for their offspring.

3.4.2.3 Toddler [1 - 3 years]

During the second year of life, the child progresses from the status of an infant who is responsive to stimuli but basically dependent on others for the satisfaction of most of his needs, to that of a child with some measure of independence [Mussen, Conger & Kagan 1969:242]. It is during this time that the child's psychosocial world changes dramatically and his relationship with his mother or mother-substitute continues to be of major significance in the child's life.

3.4.2.3.1 Relationship with mother or mother-substitute

According to Psychoanalytic theory, separation anxiety can exist in the preoedipal child of two to three years of age [Kaplan & Sadock 1989:963]. It appears to develop as a fear of the loss of his mother and is related to his fear of not having his physical needs met. In essence, this is a survival fear. However, it develops into a fear of the loss of his parent's love and the fear of rejection and abandonment which will mean that his emotional needs will

be left unmet.

Freud [1936:156] maintained that as the child grows older he learns, from experience, not to fear the loss of an object, e.g. his mother, so much as she will usually return. This relates to Piaget's object permanence [cf. 3.2.3.1]. However, the child now learns that the object [mother] may have become angry with the child and now loss of love, on the part of the object [mother] becomes a very threatening prospect and the reason for anxiety.

3.4.2.3.2 Relationship with parents

Horney [May 1950:141] states that 'anxiety develops in early life out of a disturbed relationship between the child and the significant individuals in his personal environment, normally his parents'. Horney maintains that the severe conflict at the root of anxiety is the need for parental affection and love and the fear of losing that love. The child so fears the loss of his parents' love that he suppresses and withholds all of his feelings of hostility against his parents. This, in turn, causes anxiety which causes repression. The conflict is therefore between dependency and hostility, and the source of danger felt by the child is really the anticipated hostility of others [May 1950:140].

Sullivan [1953] postulates that as the child develops, the significant adults, usually his parents, use their disapproval and dissatisfaction of his performance as a means of educating and socialising him. The child gradually comes to perceive, according to Sullivan [1953:19-20], the disappointing statements of his parents and coupled with the restrictions and prohibitions that they place on him he becomes aware of a 'peculiar colouring of discomfort' that Sullivan refers to as anxiety. He maintains that the self-dynamism is built up out of his experience of approbation and disapproval or reward and punishment. Anxiety becomes a warning signal as to when he is in danger of overstepping the boundaries of his parents' instructions.

Sullivan maintains that feelings of unworthiness, inferiority and self-deprecation are all internalised into the self-dynamism.

Crosby [1976:242] believes that later personality traits will be consistent with the child's self-dynamism and that the individual will feel anxious every time he transgresses his internalised mode of being. It would seem that in this way trait anxiety [cf. 2.2.1.1] could develop. This leads to part of the individual's personality becoming totally or partially dissociated from the self and working very powerfully to defeat the self at every opportunity.

3.4.2.3.3 Anxiety as a learnt response

According to Learning theorists such as Mussen *et al.* [1969:135-138] the arousal of anxiety may be learnt. They maintain that the child learns the unpleasant quality of many classes of events and hence, there are many varied causes of anxiety. They mention the following:

- * Anxiety over potential physical harm: This anxiety results from the child's associating certain stimuli with possible pain and danger to his physical wellbeing, e.g. high places, dangerous animals, fire and deep water. The child may have experienced the pain characteristics of these events or may have been told that these situations lead to pain and physical harm. It may also be learned through modelling where the child learns to become afraid of large dogs because his mother becomes hysterical whenever she sees one. Once the connection between the sight of a dog and anxiety has been learnt, the child will attempt to avoid dogs in the future. He may also generalise this reaction in terms of all objects he has labelled **dog** or animal and thereby may become fearful of big and small dogs and even other furry animals such as cats, rabbits, etc..

- * Anxiety over loss of love, which stems from the child anticipating that his source of affection, nurturance and acceptance will be withdrawn or lost.
- * Anxiety over the inability to master his environment: When the child feels unable to handle or master the problems and stresses of the environment, feelings of inferiority arise which are directly related to anxiety.
- * Anxiety over a deviation from cultural expectations: Every culture has an unwritten list of valued traits, beliefs and motives that it expects its members to possess. When the child perceives a great discrepancy between his own skills, traits and temperamental qualities and those he feels he should possess, anxiety is generated. An issue arises between the self-concept and the ideal self and anxiety is related to the degree to which the child perceives himself as deviating from his own or his culture's ideal standards. The source of the anxiety is centred in the sex-role development in the child and in the development of self-esteem [Mussen *et al.* 1969:138]. Toilet training in this stage of development can be cited as an example of cultural standards being imposed on the child.

3.4.2.3.4 Development of the self, conscience and value system

Existential theorists such as Maslow [Crosby 1976:243-244] support Horney's conflict theory and see the need for safety vs the need for genuine freedom and selfhood. Maslow maintains that if certain needs in the child are not met, fixation of these needs will arise and rigid defences will cut off the possibilities of growth.

Anxiety is seen as part of the defence of the 'pseudo-self'. Maslow [1962:52] maintains that the individual is 'neurotic to the extent that he is selfless'. In this sense, the child's needs and the healthy development of his self with its component of a conscience and value system is vital to his emergence as a free, self-actualising human being. Although the older child may have a better developed conscience, the 2 - 3 year old is in the process of learning right from wrong.

3.4.2.4 Pre-school child [3 - 6 years]

According to Mussen *et al.* [1969:324], these are critical years for personality development because 'many characteristics of paramount importance are established or modified' during this time. They mention sexual curiosity, independence and dependence, aggression, achievement motivation or mastery, sex-typing and conscience. It is their belief that some of the traits that become stable and enduring early in life, are predictive of future behaviour and they give, as an example, a socially anxious five-year-old who is very likely to become a shy adolescent.

Mussen *et al.* [1969:352] believe that the pre-school years are a critical period for the development of anxiety as the young child is exposed to many sources of anxiety and has to learn to deal with them. He also has to learn to express his aggressive, sexual and dependent feelings and this may cause him to become anxious. The possible loss or dilution of parental love when a sibling is born is something many pre-schoolers have to deal with. He may also become apprehensive about real or imagined rejection by his parents or peers.

3.4.2.4.1 Separation anxiety in the pre-school child

From a Psychoanalytic perspective, Kaplan and Sadock [1989:963] mention that separation anxiety often gives way to the nightmares and fears of injury

in the oedipal child, due to fantasies of castration relating to developing sexual impulses. Reber [1985:108] defines castration anxiety as real or imagined threats to one's sexual functions and adds that the threats are seen as symbolic and not physical.

3.4.2.4.2 Relationship with parents

According to Mussen *et al.* [1969:138], guilt is a special anxiety that appears in the three- to four-year-olds and is elicited through a fear of the loss of parental love. It is characterised by feelings of self-derogation and unworthiness. Mussen *et al.* [1969:352-354] maintain that the antecedents of anxiety are overly severe punishment and restrictions, parental efforts to impose standards of behaviour that are too high for the child to achieve, harsh negative evaluations of the child's behaviour and achievements and inconsistencies in the parental treatment of the child together with frequent and intense mood changes and reactions to the child. They state further that the child's anxieties are the 'result of a complex interaction between the parental threat of negative evaluation of the child's performance and the child's conflicting feelings of aggression towards his parents and his need to be dependent on them.

Sarason *et al.* [1960:232] view the anxious child's greatest difficulty as that of being evaluated by over-demanding parents, especially mothers. They maintain that when the child cannot fulfil the mother's demands, his failures 'result in experiencing negative evaluations and the development of a derogatory self-image'.

Mussen *et al.* [1969:354] describe the pervasive effects of anxiety on the pre-school child as negatively affecting social and cognitive functioning. They maintain that 'over time anxiety scores become increasingly and negatively related to indices of intellectual and academic performance'.

3.4.3 Synthesis of the Effects of Anxiety on Young Children

It has become evident from the literature that anxiety is a normal, healthy **warning system** in every child's development and if his emotional, sexual, social, cognitive and moral needs are met, he will, usually, be able to deal with normal anxiety and stress from his environment.

Anxiety can negatively affect the foetus if the mother is experiencing emotional trauma and prolonged periods of anxiety. Research has proved that it can cause low birth weight, prematurity, hyperactivity, instability, eating difficulties, excessive bowel movements, colic, sleep disturbances, excessive crying and the continual need to be held.

The birth process is normally seen as the first traumatic event for the child. It therefore forms the prototype of future anxiety in the child after the age of 3 - 4 months. Initially, the diffuse, somatic, autonomic and motor discharge in the infant is seen as displeasure or distress [cf. 3.4.2.2]. As the ego develops, traumatic anxiety develops as a response to the threat of potentially harmful situations to the infant. A protective shield develops to protect him, to a certain extent, against anxiety and he learns to turn away from or to blunt threatening stimuli. In this way, signal anxiety develops and he may cry out to his mother if he has learnt to rely and depend on her, or he may turn inwards and become withdrawn if he perceives that his physical needs may not be met. According to Brody and Axelrod [1970:25], the infant who has experienced unusual stress and anxiety with 'hypercathesis of pain, sensory discomfort or sensory confusion' may have less energy to explore his world and develop optimally.

However, if the infant is given sufficient care and protection by his mother or mother-substitute, he will be able to manage his environment and cope with his anxiety. Object loss, separation anxiety and stranger anxiety are all stages through which the child must pass and which are anxiety-provoking for

him. His fear behind these is his fear that his physical needs may not be met if he were to lose his caregiver.

Later on he learns to fear rejection and abandonment and a conflict arises between his need for parental love and affection and his need to express his anger and hostility towards his parents, especially with regard to their need to socialise him; e.g. weaning, toilet training, etc..

As he passes into the pre-school stage, feelings of unworthiness, inferiority, self-doubt and guilt may create excessive and pervasive feelings of anxiety. Trait anxiety, which implies that anxiety has become a characteristic of the child's personality, can develop at such time, as it is a critical time for personality development and development of serious pathology through symptom formation.

To summarise, a degree of tension is obviously necessary to motivate an infant's or child's behaviour and an infant or child who has experienced optimal degrees of tension will discharge this tension economically and pleurably through activity. He will have the right amount of energy at his disposal for the exploration of his world and for the 'attainment of gratification from his alertness, and for the development of his curiosities' [Brody & Axelrod 1970:25].

According to Gittelman [1986:47], most infants and children who experience sensitive and responsive caretaking, learn to separate from their mothers and meet the new developmental challenges of 'environmental mastery, pre-school entry and the establishment of peer relationships'. Most infants and children can also cope with separation experiences which are more traumatic, such as hospitalisation or a mother's return to work, although they are likely to experience some transient distress which usually has no long-term effect.

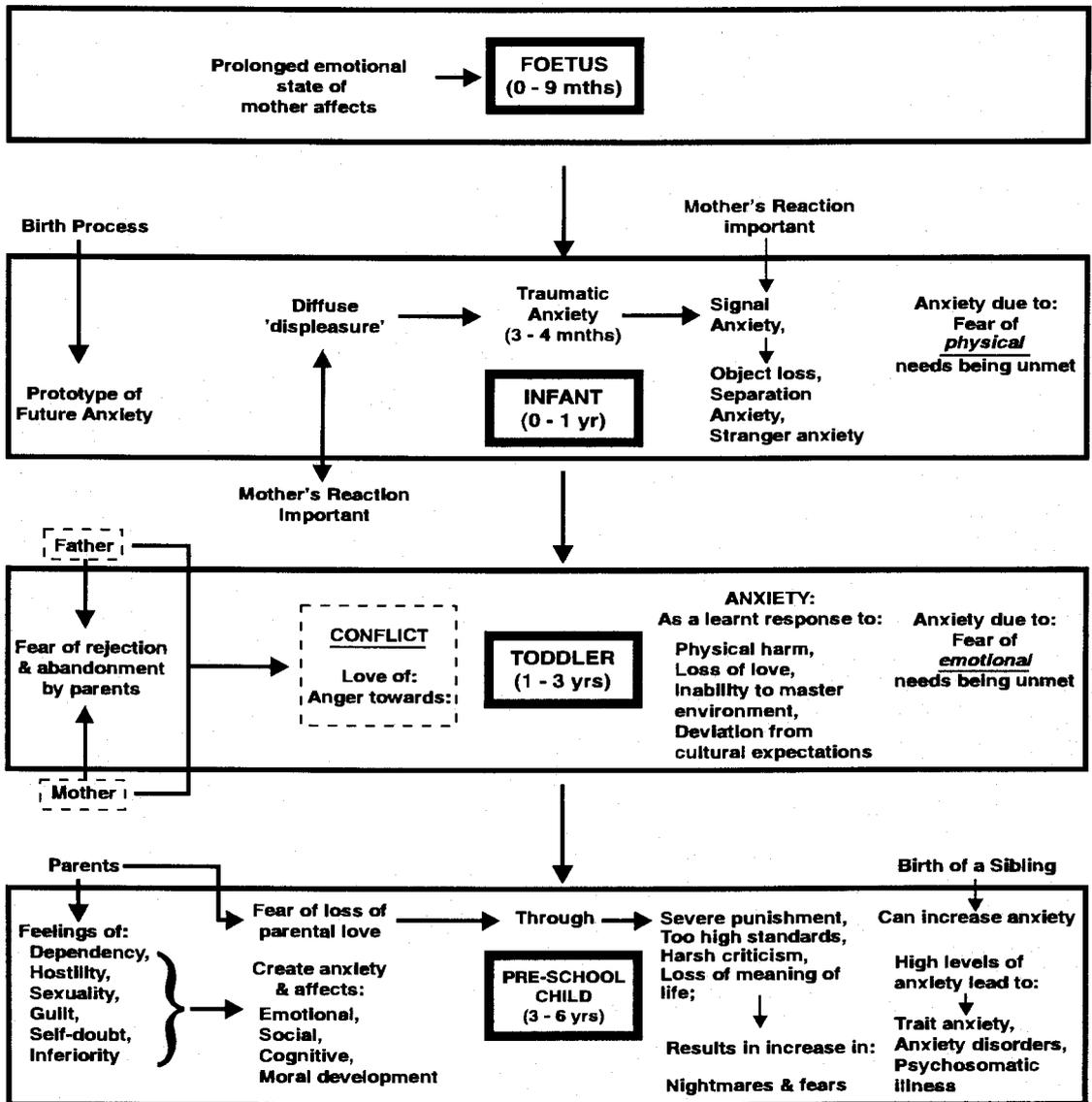
However, if the child's needs are not adequately met, he will be unable to deal with anxiety and stress from his environment. He may, therefore, not develop emotionally, sexually, socially, cognitively and morally in accordance with his chronological age and symptom formation in many different forms, may become evident.

Figure 3.1 attempts to briefly sketch the development of anxiety, through the various stages of development, namely:

- * the foetus;
- * the infant;
- * the toddler; and
- * the pre-school child.

FIGURE 3.1

THE DEVELOPMENT OF ANXIETY IN THE CHILD UP TO 6 YEARS OF AGE



3.5 EFFECTS OF ANXIETY ON PRIMARY SCHOOL CHILDREN [6 - 12 years]

3.5.1 Introduction

The primary school child has been defined in Chapter One [cf. 1.7.2] as 'any school child between Grade i and Std. 5' [six to twelve years of age]. In order to understand the primary school child more fully it has been decided to view the child from four different perspectives within this stage of development [cf. 1.3.1.4]. They are:

- * sexual and emotional;
- * social;
- * cognitive; and
- * moral.

According to Psychoanalytic theory [Wicks-Nelson & Israel 1984:56], the six-year-old child entering primary school, is also entering Freud's latency stage of psychosexual development, in which his sexual and aggressive impulses are subdued.

Erikson maintains that the child at this age needs to enjoy a sense of industry and mastery over his environment, so as not to feel inferior to his family members and peers. Socially, the child is gradually increasing his circle of interpersonal relationships and along with his peers, his relationships with teachers and other authority figures become important. Erikson [1959:87] stresses the role of teachers and parents during the primary school stage. He writes, 'Good parents, healthy parents, relaxed parents feel a need to make children trust their teachers and therefore to have teachers who can be

trusted'. He believes that good teachers are directly responsible for the development and maintenance of a sense of industry in children and that the children are able to positively identify with those 'who know things and know how to do things'.

Sullivan [Pervin 1970:246] emphasises that these are critical years in which the individual must develop social skills and cognitive abilities and during which he must undo all earlier disturbances in the growth process.

Piaget places children of approximately this age in the concrete operational stage of cognitive development and states that the process of logical thinking is now developing [cf. 3.2.3.3]. The child is therefore able to conserve numbers and measurement and has learnt to sequence, serialise and classify. He has become less egocentric and can appreciate another person's point of view.

The primary school child's moral development is at around Level II: Stage III [interpersonal concordance]. This implies that the child is able to focus on those around him with regard to his relationships and social values. He needs to be a 'good' person demonstrating worthy motives and concern for others. A high level of conformity of behaviour is evident and the opinion of his peers is important to him. He is able to step into another's shoes and observe his point of view.

3.5.2 Psychosexual and Emotional Development

3.5.2.1 Freud's psychosexual stages of latency

[Freud (1966) and Wicks-Nelson & Israel (1984) have been used as references]

The primary school years, according to Freud, are considered to be a period of relative stability for the child. His sexual and aggressive impulses are

subdued. Freud maintained that the basic personality structure is laid down by the end of the phallic stage and the psychological disorders discussed at the end of this chapter [cf. 3.7] are therefore believed to be created by the time the child reaches the latency stage. However, Freudian theory maintains that a child may be experiencing difficulty resolving the psychosexual conflict of a certain stage of development, or that he may be fixated at an earlier stage and anxiety is seen as central to his symptom formation [Wicks-Nelson & Israel 1984:56-57].

3.5.2.2 Anna Freud's contribution

Anna Freud placed less stress on the psychosexual stages of development and emphasised development in the child as continuous. The concept of developmental lines emerges from her theory and the sequence from the complete dependence of the newborn infant to the self-reliance of the young adult, emphasises her view that the child's reactions to situations will change as development occurs. The reaction at any one time will depend on the degree of progress along this line of dependence through to self-reliance. Therefore, what is appropriate at one age may be inappropriate at another and vice versa [Freud 1966:62-91].

3.5.2.3 Dependency, separation anxiety and school phobia

When the primary school child suffers from school phobia or separation anxiety, Wicks-Nelson and Israel [1984:149] report that the basic notion is the existence of a mutual and excessive dependency between mother and child. Strong attachment on the child's part leads to fear that something terrible will happen to the mother or himself. The child's insistence at remaining at home or getting upset at being separated from the mother satisfies both the mother's and child's needs and anxieties.

The Diagnostic and Statistical Manual for Psychiatric Disorders [DSM III] provides for a diagnosis of school refusal under the category of separation anxiety disorder [American Psychiatric Association 1980:34-35]. Reber [1985:687] defines this disorder as an 'excessive and inappropriate anxiety on separation from the primary attachment figure or from the home environment'. Unrealistic worries about harmful things happening to the attachment figure while away, persistent fears of being lost, kidnapped or even killed if separated from the mother, plague the child.

School phobic children, according to Mussen *et al.* [1969:521], often over-value themselves and overestimate their own power and achievements and then try to hold onto their own unrealistic self-images. When this is threatened in the school situation, by competition from their peers or realistic appraisal of their work by the teacher, they suffer anxiety and retreat to another situation where they can maintain their narcissistic self-images. This retreat may well include establishing an overdependency on the mother.

The Psychoanalytic view suggests that mothers of school-phobic children often have 'poorly resolved dependency relationships with their own mothers and can therefore closely identify with the child' [Wicks-Nelson & Israel 1984:149]. They appear overprotective, indulge the child's every need and have unresolved neurotic conflicts concerning aggression. These conflicts interfere with their management of their children and make discipline difficult.

The child suffering from separation anxiety, often has aggressive wishes towards the parent that cannot be expressed for fear of abandonment. The child defends against these wishes by regressing to an earlier dependency stage and projects his anger onto the outside world and his school environment, in particular. The father's role in the life of a school-phobic child is often a negative one. He has not been able to counteract the mother's overprotectiveness and may feel helpless and excluded by their close

and mutually dependent relationship.

3.5.2.4 Fear, hostility and anxiety

According to Horney [1937:86-88], fear in the child may be aroused directly by the threats, prohibitions and punishment of the parents, as well as outbursts of temper or violent scenes by the parents and witnessed by the child. It may also be aroused by indirect intimidation such as warning the child about all the evils that may befall it, e.g. great dangers of life such as accidents, strangers, climbing trees, etc. The more apprehensive the child is made to feel, the less he will be able to show or even feel hostility and the more passive and anxious he will become. Horney also mentions that when genuine affection is absent there is often a great deal of emphasis, especially verbally, about how much the parents love the child and how much they would give up and sacrifice for him. Such a child will cling to this substitute for love and will be fearful of being rebellious lest he lose the **reward** for being docile and passive.

According to Horney [1937:88-89], if the parents of a child offer him only negatives about himself and his performance, especially during his primary school years, the child will be inclined to develop not only a reaction of hatred towards them but a distrustful and spiteful attitude towards everyone around him. The more he projects his anxiety onto the outside world the more he will believe and become convinced that the world is a dangerous and frightening place. Such a child feels helpless to deal with his negative feelings and cannot allow his interactions with others to be positive and fulfilling and he then becomes oversensitive to criticism and teasing. He develops an 'all-pervading feeling of being lonely and helpless in a hostile world' [Horney 1937:89].

For Horney [1937:88-89], a basic anxiety is inseparably interwoven with a basic hostility that arises through faulty interpersonal relationships with the

significant figures in the child's life. Furthermore, Horney believes that infantile anxiety is a necessary factor for the development of later neurosis. Horney [1937:96] maintains that basic anxiety in the child has certain implications for his attitude towards himself and others. It often implies that the child will feel emotionally alone and isolated, which is especially hard for the child to bear, considering that it concurs with a feeling of intensive weakness of the self. This implies a weakening of the foundations within the child of his levels of self-confidence and it bears with it the germ for a potential conflict between the desire to be dependent and rely on others and the impossibility to do so because of a 'deep distrust of and a hostility towards those in authority'. This results in the child spending the greatest part of his energies trying to gain reassurance from those around him and not being free to explore and develop.

3.5.2.5 Dependency vs autonomy

As explained earlier in Chapter Three [cf. 3.2.2], Erikson maintains that the child between 6 - 12 years enters the psychosocial developmental age of industry vs inferiority. According to Mussen *et al.* [1969:515], the child whose efforts at mastery behaviour have been consistently met with criticism and/or ridicule for his ineptness and inadequacy, will usually develop anxiety and uncertainty in the face of new and challenging situations. He will begin to feel inferior and will be inclined to withdraw and avoid new challenges. The child will be unable to become autonomous and independent if he is subjected to emotional criticism, a series of injustices and/or rejections. Mussen *et al.* state further that, if the child has only known harsh and inconsistent discipline and has not developed strong internal controls through his conscience, he is likely to emerge as an 'angry, rebellious, unmanageable child who lacks the ability to conform comfortably to social patterns expected of his age-group.

According to Mussen *et al.* [1969:515-516] the child with parents who are overprotective, perfectionistic, overly meticulous and compulsive and who inhibit any evidence of spontaneous emotion in the child, will emerge as anxious, overly critical of himself and lacking in spontaneity and self-confidence. He will also exhibit strong tendencies towards being over-controlled, orderly and possibly obsessive-compulsive in personality.

3.5.3 Psychosocial Development

It is evident from the previous section that the child's parents have a great deal of influence over him as he develops and therefore, the child's emotional development cannot be examined in isolation. The relationship between parent and child needs to be studied simultaneously and therefore much of the early social development of the child has already been examined throughout Chapter Three.

It is common knowledge that as the child enters his primary school years, his horizons widen dramatically and he is subjected to an ever-widening series of influences such as peers, teachers, learning, sport, social activities, etc.. However, despite this, Mussen *et al.* [1969:482] maintain that the relationship he has with his parents remain the most significant environmental factor that will determine what kind of person he becomes. According to them, it also determines to a large extent how anxious he is. Sullivan [Burhmester & Furman 1986:41-42] maintains that the parents are always important in meeting the child's needs for tenderness, no matter what age he is. His other social needs at this stage, include companionship and intimacy [cf. Table 3.2].

3.5.3.1 Relationship with parents

At primary school level, the child needs to become increasingly more independent of his parents even though he needs a warm, loving and

supportive relationship with them. This is a time for 'letting go' of dependency needs.

According to Horney [1937:85], there are great individual differences in the degree to which children remain dependent on their parents. She maintains that much depends on what the parents attempt to achieve in the education of their children.

- * Some parents can encourage the child to become strong, courageous, independent and capable of meeting challenges.
- * Others have a tendency to shelter the child, encourage obedience at all costs and keep him ignorant of life in general. They appear to have a need to keep him dependent on them for their own needs. The more helpless the child is made to feel by the parents, the more he will suppress his anger and opposition. Horney [1937:86] quotes that his underlying feeling is, 'I have to repress my hostility because I need you'.

It is the belief of Mussen *et al.* [1969:482] that if the child's parents provide good role models, are warm, loving, accepting, consistent and flexible in managing the child's behaviour, and do not control or dominate the child to the extent that they thwart the child's development, the child will be able to deal with psychological difficulties if he does encounter them. Therefore, if parents are well-adjusted and mature people themselves, they are more likely to 'react with sensitivity and nurturance to their children's signals and needs than immature maladjusted parents' [Mussen *et al.* 1990:478].

If the child's basic needs are not met by the parents, he may well encounter psychological and psychosomatic problems which are severe, chronic and refractory to treatment [Mussen *et al.* 1969:515].

3.5.3.2 Relationship with siblings

According to Lamb [1982:6] siblings play an important part in the socialisation of the child. They help to:

- * set and maintain standards;
- * provide models to emulate and for sex typing;
- * advise;
- * serve as confidants; and
- * support in times of emotional stress.

Mussen *et al.* [1990:495] maintain that the child learns patterns of loyalty, helpfulness and protection from his siblings as well as conflict, domination and competition.

However, it does depend on the birth order of the child. First-born children who have no older siblings tend to be more strongly motivated towards achievement, more outgoing, more dependent on others for support, more adult-orientated and conforming to authority, more conscientious but more prone to guilt feelings, more cooperative, responsible, helpful and less aggressive than the children who follow. However, this has to do with the lack of influence of an older sibling as well as the high expectations of most parents of their first-born.

At primary school level the older boy sibling is often viewed as powerful and bossy while the older girl sibling is more likely to care for the younger siblings, even mothering them. This results in the majority of second-born children developing a strong attachment to their older siblings. Sibling

interaction has proved to be quite stable over time. Therefore, children who were friendly to the new baby sibling remain friendly three to four years later. Those who had difficulty accepting the new baby are more aggressive towards him in later years [Mussen *et al.* 1990:498].

3.5.3.3 Relationship with peers

Peers begin to play an increasingly more important role in the life of the primary school child. After engaging in more parallel, associative and cooperative activities between the ages of 2 and 5 years, the emerging primary school child, more predominantly after \pm Std.2, makes a shift from family focus to peer focus [Wicks-Nelson & Israel 1984:34].

At such time the child:

- * identifies more strongly with his peers;
- * prefers to associate more often with his peers; and
- * considers peer values and norms to be increasingly more important.

Wicks-Nelson and Israel [1984:34] explore further the many positives that peers provide for one another. They maintain that peers:

- * serve as a sense of emotional security and support;
- * provide information about normative standards in many situations;
- * serve as a standard against which accomplishments and failures can be judged;

- * serve as models and reinforcers of each other's behaviour;
- * teach each other many types of skills informally and formally;
- * allow for the rehearsal of role play;
- * socialise each other; and
- * protect each other from the forcefulness and control of adults.

3.5.3.4 Relationship with teachers

The primary school child spends more time with a particular teacher [class teacher], especially in the first 3 - 4 years of school, than at any other stage of his life. This would make him very vulnerable to the effects of this relationship.

According to Kokot [1988:77], Goodlad *et al.* found that positive teacher behaviour was strongest in the primary school years. This included behaviour such as praise, guidance, reassurance and encouragement.

Vrey [1979:117] found that early studies demonstrate that the child's performance at school can be related to his perception of the teacher's evaluation of him.

According to Glidewell, Kantor, Smith and Stinger [1966], the primary school teacher:

- * serves as a role-model for his pupils ;

- * serves as a focus of interpersonal exchange by influencing the climate of the classroom;
- * affects the status of relationships among the children; and
- * influences individual behaviours, moral orientations and intellectual performance levels.

It is therefore evident that the support and nurturance of the teacher, as well as the parents, are of utmost importance to the emotional stability of the primary school child.

3.5.4 Cognitive Development

According to Piaget's theory of cognitive development, the primary school child is at the concrete operational stage which indicates a measure of logical thinking and reasoning which the child has been able to abstract from his environment. He understands relationships between things better and can accept others' points of view. He is less egocentric, which enables him to interact better with the significant others in his environment.

Personality theorists consider anxiety to be an important factor in producing a discrepancy between performance and potential [Nijhawan 1972:3]. Because anxiety is accompanied by tension and rigidity and affects the thought processes, the child is prevented from taking the initiative and attempting new and challenging tasks.

3.5.4.1 Effects of anxiety on cognitive performance

According to Sarason *et al.* [1960:74] many studies report evidence of a negative relationship between anxiety and achievement in the school situation.

The achievement area most susceptible to the interference of anxiety, according to the researchers, seems to be arithmetic computation. Sarason *et al.* [1960:66] has reason to hypothesise that when the test-anxious child has to function independently in a problem-solving situation, his performance will be adversely affected.

According to Mussen *et al.* [1969:474], the degree of anxiety associated with intellectual mastery is important. The two conditions under which anxiety is the most likely to occur are when, firstly, expectancy of success or failure is moderate and, secondly, when motivation is high, but expectancy is low. In the first instance, the child's uncertainty as to how he will perform, increases anxiety. In the second instance, the child values competence on a certain intellectual task but expects failure and this would, therefore, generate anxiety as there is a discrepancy between a valued goal and the hope of obtaining the goal.

Odiar [Sarason *et al.* 1960:72] in an attempt to compare the theories of Freud and Piaget, stresses the control role which anxiety plays in the inception and continuation of certain types of thinking such as 'infantile thinking' which refers to Piaget's preoperational stage and the belief that inanimate objects are alive and have feelings and intentions [cf. 3.2.3.2]. Anxiety causes the more logical thought processes to revert to their original preoperation stage by exerting a dissociative action on consciousness. Often dangerous situations are enhanced and exaggerated by prelogical thinking which, in turn, increases the anxiety.

3.5.4.1.1 Test anxiety

Reber [1985:766] defines test anxiety quite literally as anxiety about taking a test. According to him, test scores can be depressed by high levels of this anxiety. It should be noted, however, that the anxiety has more to do with

the results the child will obtain on the test than the actual sitting of the test.

Klein and Last [1989:42-43] describe test anxiety as a specific fear that can render children miserable and incapacitated. The primary school child is therefore, especially vulnerable, considering Erikson's theory that he is in the stage of industry vs inferiority [cf. 3.2.2.1.4] and that his performance and mastery skills are especially important to him. [It must be remembered that test anxiety refers to a fear of being **evaluated** generally, even if a test or examination is not written [cf. 2.2.1.2].

Beidel and Turner [1988:275-286], who have conducted one of the few clinical studies of childhood test anxiety, have found that when they compared 25 test-anxious children to 25 controls on scales and interview measures, one quarter of the test-anxious children received an anxiety disorder diagnosis while none of the controls did. The two most frequent diagnoses were of overanxious disorder and social phobia. This suggests that test anxiety may only be one symptom of an anxiety disorder that affects many aspects of a child's development.

3.5.5 Moral Development

According to Kohlberg's moral development stages [cf. 3.2.4], the primary school child should be at Level 2: Stage III: interpersonal concordance [cf. 3.2.4.2.1]. This indicates that the child has become far less egocentric and is now able to focus on his relationships with those around him and to perceive their needs and interests to a larger extent.

Kohlberg bases his theory on the ability in the child to reach a certain level of abstract reasoning. Therefore, if the child does not reach that level cognitively or regresses for any reason, he will be unable to reach Kohlberg's stage III. His moral values, at this stage, are defined largely according to social conformity, mutual interpersonal expectations and interdependent

relativeness. He has a need to be accepted [Sullivan, cf. 3.2.2.2.3] and this encourages him to want to have worthy motives and to show concern for others. He has a need to be good and to demonstrate his goodness. He aspires to relationships in which there is trust, loyalty, respect and gratitude and is prepared to conform socially and become intimately involved with the significant people in his life. Because he can see different points of view and understands the consequences of his actions better, he is prone to more guilt feelings about his wrong-doings.

According to Mussen *et al.* [1990:103], parents play a major role in the child's moral development. If parents explain the harmful consequences of the child's misbehaviour for other people when disciplining him, and if the parents are loving and supportive all of the time, the child is more likely to adopt their moral standards than if parents discipline by means of threats and harsh punishment.

Sarason *et al.* [1960:33] maintain that as the child enters the psychosexual stage of latency [cf. 3.2.1.4] he depersonalises and internalises the parental institutions. From a Psychoanalytic perspective, the development of the superego is seen to be very important during this stage of development. The child appears less concerned about the dangers of castration, but more concerned about **superego** or **moral anxiety**. This anxiety is the anxious reaction of ego when it feels threatened by the possibility of the superego becoming angry with it, punishing it or ceasing to love it [cf. 2.4.2.1.1]. It continues to develop from the pre-school stage and intensifies at this stage of the child's development, if the child experiences frequent guilt for wrong actions, the expectation of being found out and being critically and harshly punished.

Kaplan and Sadock [1989:963] point out the connection between moral anxiety and the child's inability to control or channel his impulses creatively and positively. Feelings of dependency, hostility and fear all threaten to

overwhelm the child if they are extreme and this makes the child anxious that his ego will not be able to cope with the integration of these impulses and feelings. It also has to do with the child's feelings that he is unable to live up to his parents standards and values for him. His **superego, conscience or parent** [in Transactional Analytic terms], is, in essence, an introjection of his parents' moral values and standards for him. Therefore, if these are unrealistically high, he will experience guilt and self-condemnation in the form of moral anxiety [cf. 2.4.2.1.1] when he is unable to live up to them. This results in a state of panic or traumatic anxiety and the presence of intense unconscious conflict is evident. The child may not be able to manage the anxiety by direct action, in which case the ego initiates unconscious defences to ward off the conflict.

Existential theorists [cf. 2.4.5] maintain that the source of anxiety, both normal and neurotic, has to do with the perceived lack of meaning and purpose in human life, i.e. non-values and non-living. Anxiety would, therefore, increase if the child does not find meaning in his world as his self-concept and conscience emerge at a stage when superego anxiety is possible.

3.5.6 Synthesis of the Effects of Anxiety on Primary School Children

An attempt has been made to view the primary school child holistically but at the same time to analyse different aspects of his self and investigate what effect anxiety has on them. The self has been divided into four different components, namely:

- * psychosexual and emotional;
- * psychosocial;
- * cognitive; and

* moral.

* **Psychosexual and emotional development**

The primary school child is in the latency stage of psychosexual development and Freud [cf. 3.2.1.4] believed that the child's sexual and aggressive impulses were normally subdued at such time. It is therefore hypothesised that the child who is experiencing high levels of anxiety at this stage, has fixated at, or regressed to an earlier stage of development.

- Relationships with self, parents, siblings, peers, teachers, objects and ideas

Emotional difficulties of the highly anxious child appear to be excessive feelings of dependency, hostility and fear because of his relationships with others which, in turn, lead to a low or unrealistic self-concept and this, in turn, would negatively affect the child in all his interpersonal relationships, i.e. with himself, parents, siblings, peers, teachers, objects and ideas.

Emotional difficulties, separation anxiety and school phobia at this stage of the child's development, are usually the result of excessive dependency of the child on the mother or the home and/or an unrealistic self-image due to defence mechanisms, such as denial and repression. Where the child's real self and ideal self differ drastically from one another, the child feels he is unable to meet the demands and challenges of his environment. Sometimes the mother's own unresolved dependency needs affect the child negatively. Often high levels of hostility cannot be expressed due to a fear of abandonment by the parents. Excessive threats, harsh punishment and severe criticism of the child increase his levels of anxiety and encourage the child to feel even more insecure, lonely and helpless than before.

* **Psychosocial Development**

According to Erikson and Sullivan [cf. 3.2.2], the child now has to master the crisis of industry versus inferiority and has an additional social need for acceptance and intimacy. He believes that he is 'what he can make work' [cf. Table 3.3].

- Relationship with self

It is evident that the highly anxious child does not develop a sense of mastery or industry, despite possible abilities in this area and that he, in fact, develops a sense of inferiority.

- Relationships with parents, siblings, peers and teachers

His sense of inferiority is usually linked to the harsh criticism or ridicule he has experienced from his parents, siblings, peers and teachers over his formative years. He will react in certain ways which often increase this negative feedback to him and so the circle continues. He becomes unable to face up to new challenges and is thereby prevented from becoming independent and autonomous. He, therefore, remains excessively dependent on his parents, which increases his feelings of hostility and fear [explored under psychosexual and emotional development], critical of himself and lacking in spontaneity and self-confidence. This may even lead to obsessive-compulsive personality traits developing in the child.

The highly anxious child will often not have his social need for tenderness, companionship and intimacy met by the significant people in his life, due to certain factors. This would then increase his anxiety, his sense of loneliness and isolation. He will then not be able to gain a sense of security and support from his peers. He will often be unable to respond positively to authority and his teachers, due to his high levels of hostility and anxiety and

will often project his anger onto his school.

* **Cognitive Development**

The primary school child is at the concrete operational stage of cognitive development according to Piaget [cf. 3.2.3.3], which indicates that his logical thinking ability is now developing. Odier [Sarason *et al.* 1960:72] reports that his research into Freud's and Piaget's theories, leads him to believe that anxiety causes the more logical processes to revert back to earlier stages of development, by the process of dissociation.

- Relationship with self and objects and ideas

It is therefore evident that anxiety negatively affects the cognitive development of the child [cf. 3.5.4.1]. The tension and rigidity accompanying the anxiety, affect the thought processes and prevent the child from taking the initiative and facing new challenges. This then has a negative effect on his school performance and in particular, his arithmetic computation.

Anxiety is most likely to occur in the child:

- * when he is unsure of how he will perform; highlighting feelings of insecurity, uncertainty and helplessness; or
- * when his motivation is high and his expectancy is low; highlighting feelings of inferiority, fear and lack of confidence.

Test anxiety refers to a specific fear of being evaluated and the highly anxious child who has not mastered the initiative vs inferiority crisis, will tend to feel uncertain and insecure about being evaluated. It is now believed

that test anxiety is not an isolated form of anxiety, but integrated with and part of the multi-dimensional phenomenon of anxiety.

- Relationship with teachers, peers, parents and siblings

It is evident that the child who feels inferior and insecure about his cognitive abilities, and who lacks confidence in himself, will not be able to relate positively to those around him. In this manner, his interaction with his teachers, peers, parents and siblings, will all be negatively affected.

* **Moral Development**

The primary school child is usually at Level II: Stage III, interpersonal concordance, according to Kohlberg [cf. 3.2.4.2.1], indicating that he should be able to focus on those people around him with regard to his relationships and social values. He has the ability to be working with and caring about others and has a strong moral need to conform and to do the 'right' thing. He is free to conform if he so desires.

- Relationship with self

Psychosexually [cf. 2.4.2.1.1] he is at the stage where excessive moral anxiety may develop if the ego becomes overly threatened by the possibility of the superego punishing it or ceasing to love it. This happens if the child has been subjected to harsh criticism, ridicule and rejection by significant others and has incorporated unrealistic and excessively high moral standards for himself to attain. The feelings of guilt are then intensified and tend to plague the child.

- Relationship with objects and ideas

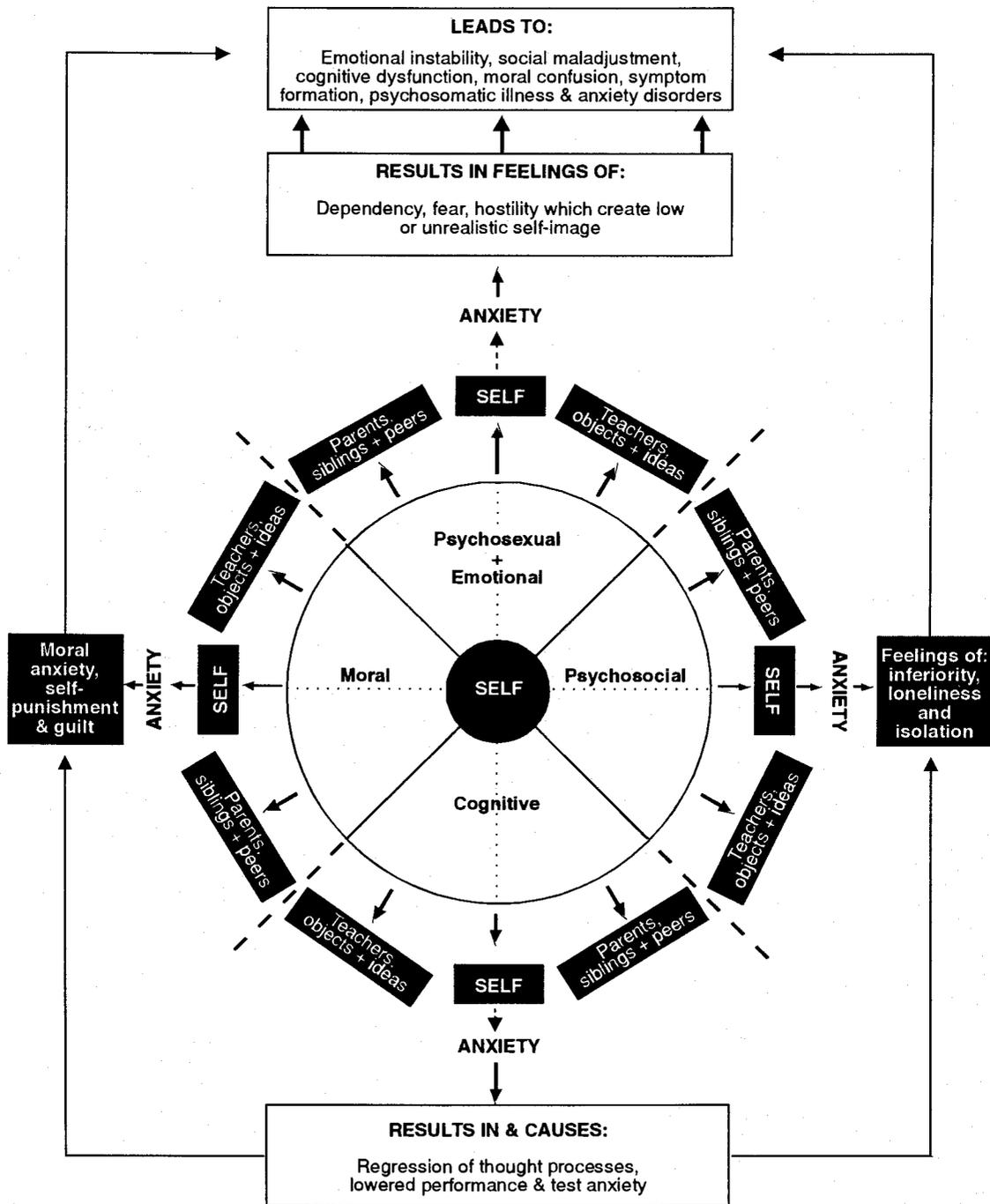
Existential theorists maintain that the source of anxiety has to do with perceived lack of meaning and purpose in life. Therefore, if the child does not find meaning in his world because of feelings of inadequacy, dependency, hostility, etc., his levels of anxiety will increase and he will tend to be overly critical of himself and punish himself harshly.

- Relationships with parents, siblings, peers and teachers

Parents who have explained the consequences of the child's behaviour to him and who have been loving and supportive throughout his development, will encourage their offspring to adopt their moral standards without difficulty. However, parents who have been harsh, threatening and punishing, will encourage their children to adopt this approach to themselves as their consciences develop. The parent's moral standards become introjected into the child's superego and he will then experience severe moral anxiety unnecessarily which in turn, will negatively affect his relationship with his parents, siblings, peers and teachers.

[Figure 3.2 will attempt to summarise, in diagrammatic form, the different components of the child's self, his relationships with significant others and the effect anxiety has on and is affected by these relationships.]

FIGURE 3.2
THE DEVELOPMENT OF THE PRIMARY SCHOOL CHILD
WITH REGARDS HIS RELATIONSHIPS
AND DEVELOPMENT OF ANXIETY



3.6 SYMPTOM FORMATION IN PRIMARY SCHOOL CHILDREN AND THE DEVELOPMENT OF PSYCHOSOMATIC ILLNESS

3.6.1 Introduction

The term, symptom formation, is initially a Psychoanalytic one, according to Reber [1985:753], and refers to a complex process through which neurotic symptoms are assumed to develop. It implies that substitute objects are found for unacceptable id impulses. It permits some psychic satisfaction and the release of tension while the behaviour associated with it persists and is manifested as a neurotic symptom.

According to Hypnoanalysis, explored in Chapter Five [cf. 5.3.4.2], habits develop in the person which affect his ways of thinking, feeling and behaving and forms the aetiology of clinical symptom formation. The **clinical symptoms** are in essence a **protective barrier or wall of protection** [Ritzman 1990:153] for the person and assist him in surviving. These symptoms can take any form at all and can manifest themselves in inhibited behaviour which is related to the anxiety-prone child, or acting-out behaviour such as behavioural problems, hyperactivity, etc., or they can take the form of somatic complaints such as headaches, asthma, etc.. Often a system or individual organ is unconsciously chosen as the seat of the somatic complaint.

A psychosomatic illness is therefore a general label which refers to any illness or disorder with somatic [bodily] manifestations that is assumed to have at least a partial cognitive and emotional aetiology, i.e. they are, to some degree, psychological [Reber 1985:597].

Kaplan and Sadock [1989:388] explain psychosomatic disorders as 'those characterised by functional and sometimes anatomical alterations'. They state that the DSM III-R lists them vaguely as 'psychological factors affecting

physical conditions'. However, there seems to be much disagreement among theorists with regard to psychosomatic illness. Alexander [1950:51-52] states that, theoretically, all diseases are psychosomatic in that 'emotional factors influence all body processes through nervous and humoral pathways'. This belief is more in keeping with psychosomatic medicine today as approached from a holistic view, than the specificity theories which assumed that psychological factors played a central causal role in certain diseases only.

Kaplan and Sadock [1989:1161-1164] concur with this belief and state that 'the human organism is indivisibly psychosomatic'. According to them, both the body and mind need to be seen as aspects of one unified organism and not separate parts. For them, all diseases, as well as their causes, are psychosomatic and somatic illnesses often follow very stressful life situations, conflicts and emotional distress. The effect of illness on the psyche also has to be taken into consideration.

3.6.2 Psychosomatic Illness in Primary School Children

Mussen *et al.* [1969:524] state that psychological problems in the school-age child may also 'be reflected in psycho-physiological [psychosomatic] symptoms of one sort or another'. This can be understood from a Psychoanalytic view in terms of the symptoms being affect equivalents or symbols representing blocked emotions.

When the child is unable to express himself through speech and/or behaviour, for whatever reason, his emotions are expressed along somatic pathways which result in structural or functional alteration in an organ or organ system. Therefore anxiety, anger and sexual impulses may be expressed via the intestinal, respiratory or circulatory systems [Kaplan & Sadock 1989:388].

According to Spielberger [1972a:13], there is an interaction of cognition and anxiety in the development of the psychosomatic symptoms in the child or

adult. If the cues associated with the anxiety reaction [which may be cognitive or physiological], are interpreted as danger signs themselves, then more anxiety is evoked and a spiral effect is created. Spielberger states further, that the 'psychosomatic symptoms develop when an anxiety-prone individual, who is disposed to excessive reactions in one or more physiological symptoms, is continually exposed, over a long period of time, to situations he interprets as threatening'.

3.6.2.1 Cultural factors

Horney, Halliday and Mead [Kaplan & Sadock 1989:1159] emphasise the influence of culture in the development of psychosomatic illness. It is their belief that cultural influences which affect the mother, also affect the child at all stages of development.

Murphy [Deutch 1953:173] believes that psychosomatic conditions must be seen as symbols and treated in terms of intra-ego and interpersonal relationships, at all levels. Gerard [1953:95] highlights the importance of deficient gratification in the mother-child relationship for the psychophysiological fixation on an infantile level and for the choice of somatic dysfunction.

In Gerard's study of 38 children, all under the age of twelve years and presenting with psychosomatic symptoms, all the mothers lacked **mature motherliness**. He describes these mothers as narcissistic, disinterested in the child, except as a self-enhancing asset. The mothers all resented the amount of care that the children needed and seldom gained pleasure from the mother-child relationship [Gerard 1953:88].

3.6.2.2 Other factors

Alexander [1950:52] believes that there are many factors in the aetiology of

disease and as his belief is that all diseases are psychosomatic to an extent, he maintains that all the following factors should be considered:

- * hereditary constitution;
- * birth injuries;
- * organic disease in infancy;
- * nature of the infant care, e.g. weaning, toileting and sleeping patterns;
- * accidental, physical and/or emotional traumatic experiences in infancy and childhood;
- * the emotional climate of the family; and
- * specific personality traits of the parents and siblings.

3.6.3 Synthesis

Psychosomatic illness is such a broad concept that it could be the focus of a research project on its own. For this reason, it has been examined only briefly. However, it is important to understand that all forms of pathology have symptoms and **choosing** the physical aspects in which to develop the symptoms, is only one of many choices open to the individual. Anxiety, however, has a physiological component, as mentioned in Chapter Two [cf. 2.2] and, therefore, the effect it has on the body is also of considerable importance, but out of the scope of this research project.

3.7 CHILDHOOD DISORDERS RELATED TO ANXIETY

3.7.1 Introduction

Reber [1985:118] states that 'childhood disorders refer to the full, formal, psychiatric diagnostic category; disorders first evident in infancy, childhood or adolescence'. He explains that the term, **disorder**, refers to a psychiatric syndrome as categorised by the DSM III. He also mentions that it is slowly replacing the term, **neurosis**, used previously by psychiatrists and psychologists [Reber 1985:206].

According to Wicks-Nelson and Israel [1984:139] childhood disorders can be grouped into two broad categories:

- * externalising disorders; and
- * internalising disorders.

The anxiety-related disorders are referred to as internalising disorders and include phobias, obsessive-compulsive anxiety, neurosis and depression.

They state further that this cluster of behaviours is an internalising, over-controlled or anxiety-withdrawal dimension or syndrome.

Characteristics associated with this syndrome are:

- * anxious, fearful, tense;
- * shy, timid, bashful;
- * withdrawn, reticent, seclusive, secretive;

- * depressed, sad, disturbed;
- * hypersensitive, easily hurt, embarrassed;
- * self-conscious, inferior, worthless, friendless; and
- * easily flustered, aloof, cries frequently.

According to Last *et al.* [1987:726] anxiety disorders in children have suffered from a 'relative paucity of empirical research', although much has been written about them for decades. Recently, however, researchers have started to pay increased attention to childhood anxiety disorders. They define the three main DSM III anxiety disorders that usually appear during childhood and adolescence as the:

- * overanxious disorder;
- * separation anxiety disorder; and
- * avoidant disorder.

However, they mention other anxiety disorders that may be applied to youngsters as well as to adults [Last *et al.* 1987:726]:

- * phobic disorder;
- * panic disorder;
- * obsessive-compulsive disorder; and
- * post-traumatic stress disorder.

For the purpose of this research only the three main anxiety disorders will be briefly discussed in an attempt to highlight to what extent anxiety can affect the functioning of the child.

3.7.1.1 Overanxious disorder

According to Kaplan and Sadock [1989:1849], a child suffering from an overanxious disorder has an 'abundance of more generalised worrying and tension, without having a specific object, situation or person onto whom the worry, fear and apprehension are centred'.

3.7.1.1.1 Diagnostic criteria

[American Psychiatric Association (DSM III) 1980:37]

The diagnostic criteria require that the predominant disturbance is generalised and that persistent anxiety or worry is manifested by at least four of the following:

- * unrealistic worry about future events;
- * preoccupation with the appropriateness of the child's behaviour in the past;
- * Over-concern about competence in a variety of areas, e.g. academic, athletic, social, etc. ;
- * excessive need for reassurance about a variety of worries;
- * somatic complaints such as headaches or stomachaches, for which no physical basis can be established;

- * marked self-consciousness or susceptibility to embarrassment or humiliation; and/or
- * marked feeling of tension or inability to relax.

The child must be troubled by unrealistic and excessive worry regarding at least four of the above, for a period of at least six months, for a diagnosis to be made.

3.7.1.1.2 Clinical description

Such children are excessively concerned with their competence and performance and often exhibit nervous habits such as nailbiting, sleep disturbances, bedwetting and physical complaints such as stomachaches and headaches.

Barrios and Hartman [1988:198] also stress the frequent somatic complaints of the child and, in addition, report on the child's persistent and pervasive anxiety expressed by a combination of preoccupation with past, present and future events, repeated requests for reassurance, marked self-consciousness and feelings of tension.

3.7.1.1.3 Prevalence

According to the DSM III [Wicks-Nelson & Israel 1984:150], the overanxious disorder is apparently common. They report that evidence suggests that the disorder occurs in 2 - 3% of the population. It is most common among small families, is found in higher socio-economic groups and affects the first-born more often. It is also reported that it occurs in families where there is unusual concern about the level of performance reached. The onset is usually described as gradual and diagnosis in the child before the age of three is not recommended.

Kaplan and Sadock [1989:1849] confirm some of Wicks-Nelson and Israel's findings and state that it occurs in 2% of the rural areas but seems to be twice as prevalent in the impoverished urban areas [which conflicts with the findings of Wicks-Nelson and Israel, that it occurs more frequently in the higher socio-economic groups]. They also report that first-born and only children have the highest incidence of this disorder. They further report that more girls appear to suffer from the symptoms. However, it would appear that more boys are actually treated for the symptoms than girls. It would seem that the families in which the children develop overanxious disorders, display many other anxiety disorders such as phobias, separation anxiety disorder, panic disorder and generalised anxiety disorder. The incidence of depression is often much higher in such families and there is less indication of a genetic component to the depression.

3.7.1.1.4 Aetiology

Freudian theorists postulate that there is an unconscious conflict within the child that causes the over-anxiety [Kaplan & Sadock 1989:1849]. However, they mention that some cases originate in depressive settings and that they are relieved when the depression is treated. Other cases show more uncertainty as to the origin and cause.

3.7.1.1.5 Prognosis and treatment

Kaplan and Sadock [1989:1849] stress that children suffering from this disorder respond excellently to individual psychotherapy. Some cases, they maintain, abate spontaneously without treatment due to the fact that the older child may not perpetuate the overanxious disorder to the same degree that the younger child does. However, some untreated cases become chronic and may continue into adulthood and therefore treatment is recommended. They propose that the treatment be multi-modal, including individual therapy as well as family therapy, relaxation training, social skills training, peer group

therapy as well as in some instances, drug therapy.

3.7.1.1.6 Symptom formation

Klein and Last [1989:35] mention that the overanxious disorder has to do with anxiety pertaining to social behaviour. Children suffering from this disorder tend to have excessive and/or unrealistic concerns about competence, tend to be perfectionistic and want to do well academically, socially and in sport. The somatic complaints that accompany this disorder occur spontaneously and are not linked to a particular situation as in separation anxiety disorder. The symptoms often take the form of headaches, stomachaches, back pains and a general lack of feeling of wellbeing.

Generalised tension and an inability to relax are further symptoms of this disorder. Tension can be expressed as nervous habits such as nailbiting, foot tapping, hair pulling or fidgeting. Many children with this disorder exhibit specific social phobias, e.g. fear of public speaking, in addition to their other overanxious symptomatology.

Children who show symptoms of overanxious disorder may also exhibit school reluctance or refusal in an attempt to avoid confronting their anxiety within the school environment.

3.7.1.2 Separation anxiety disorder

The hallmark of separation anxiety disorder is excessive anxiety concerning separation from major attachment figures such as parents, home and other familiar surroundings [Klein & Last 1989:29].

3.7.1.2.1 Diagnostic criteria

[American Psychiatric Association (DSM III) 1980:34]

The diagnostic criteria require that the excessive anxiety be manifested in at least three of the following:

- * unrealistic worry about possible harm befalling major attachment figures or fear that they will leave and not return;
- * unrealistic worry that an untoward calamity will separate the child from a major attachment figure, e.g. he will be lost, kidnapped, killed or be a victim of an accident;
- * persistent reluctance or refusal to go to school in order to stay with a major attachment figure or at home;
- * persistent reluctance or refusal to go to sleep without being next to a major attachment figure or to go to sleep away from home;
- * persistent avoidance of being alone in the home and emotional upset if unable to follow the major attachment figure around the home;
- * repeated nightmares involving a theme of separation as in disaster, death, kidnapping, etc.;
- * complaints of physical symptoms on school days, e.g. headaches, stomachaches, nausea and vomiting;
- * signs of excessive distress upon separation or when anticipating separation from major attachment figure, e.g. temper tantrums, crying and pleading; and/or

- * social withdrawal, apathy, sadness or difficulty in concentrating on work or play when not with a major attachment figure.

The duration of the disturbance must be of at least two weeks. It must not be due to a pervasive developmental disorder, schizophrenia or any other psychotic disorder. If the person is 18 years old or older, it must not meet the criteria for acrophobia.

3.7.1.2.2 Clinical description

According to Kaplan and Sadock [1989:1847-1848], the child who is suffering from a separation anxiety disorder often carries an oppressive, hostile, dependent aura along with fear and trembling. He cannot trust easily, is suspicious, doubting, enraged, vindictive and needs to enslave the parent to some degree. They state further that separation anxiety [cf. 3.4.2.2.4] is a developmental stage found universally in children between the ages of 9 months and 3 years and should be viewed as a normal sequence that helps the attachment process between the child and his parents. However, after the age of \pm 4 years the child should have developed the resources both emotionally and cognitively, to reduce his dependency on having to be physically near the significant attachment figures.

Kaplan and Sadock [1989:1848] maintain that in actual clinical cases they have been involved in, it is very rare that separation anxiety disorder is a pure culture of separation anxiety. Usually, it is mixed with other fears in addition to the fear of separating from the key attachment figures in the child's life. Coexistent depression is reported to be present in more than half of the subjects studied in certain research projects. An overanxious disorder is often present in addition to the separation anxiety disorder. There is also evidence of panic disorder and phobic avoidance such as school phobia [cf. 3.5.2.3] being closely related to separation anxiety disorder.

3.7.1.2.3 Prevalence

According to Kaplan and Sadock [1989:1847], separation anxiety disorder has a lower than 2% prevalence in the general population. However, it accounts for \pm 5% of cases seen at most child psychiatry clinics in the United States of America. There appears to be no difference between the sexes, and boys and girls are fairly evenly represented by this disorder. The most common age is 11 years when the child is usually in Std. 4 in the primary school.

3.7.1.2.4 Aetiology

Many theorists have postulated on the causes of separation anxiety disorder although the aetiology, at this stage, is still unknown. Kaplan and Sadock [1989:1847-1848] mention Otto Rank's [cf. 2.4.3.2] hypothesis that the fear of leaving the key attachment figure and the need and longing to fuse with him or her is a recurring issue for many people and is not confined to one specific stage of development.

Freudian theorists [Kaplan & Sadock 1989:1848] believe that normal separation anxiety [cf. 3.4.2.2.4] is seen in many children between the ages of 1 - 3 years but can become constellated through fixation and regression and can then develop into a separation anxiety disorder.

The possibility that there is a biological predisposition to suffer from separation anxiety disorder, which may be inherited, is offered by Kaplan and Sadock [1989:1848] as well as many other researchers of this disorder.

3.7.1.2.5 Prognosis and treatment

The prognosis for separation anxiety disorder is reported by Kaplan and Sadock [1989:1849] to be good, especially if the parents are empathic and flexible. They warn, however, that cases must be treated immediately and

timeously as untreated cases can become chronic, with fears spreading and physical symptoms embraced and elaborated with somatoform and other disorders. The treatment plan is usually multi-modal and it involves the child, his parents, teachers and peers. Family counselling and therapy is recommended for the child to achieve a more wholesome adjustment. The child will usually benefit from individual psychotherapy, according to Kaplan and Sadock [1989:1849]. Drug therapy may also be used, such as an anti-depressant like Tofranil.

3.7.1.2.6 School phobia or refusal

According to Wicks-Nelson and Israel [1984:148-149], school phobia refers to an extreme reluctance to go to school. Severe anxiety and the development of symptoms such as stomachaches, dizziness and nausea encourage the parents to react to the child and allow him to stay home. It affects children of all ages and levels of intelligence. It appears to affect slightly more girls than boys and occurs in the higher socio-economic groups. It appears to be the result of a mutual and excessive dependency between mother and child and/or a learnt response due to some association of school with an existing intense fear of losing the mother. The most common conceptualisation of school phobia attributes to the problem of separation anxiety and for this reason, the DSM III provides for the diagnosis of school refusal under the category of separation anxiety disorder.

3.7.1.3 Avoidant disorder

3.7.1.3.1 Diagnostic criteria

[American Psychiatric Association (DSM III) 1980:36]

The diagnostic criteria require that the child:

- * demonstrates persistent and excessive shrinking from contact with

strangers;

- * desires affection and acceptance from family members and has warm satisfying relationships with familiar figures;
- * shows avoidant behaviour sufficiently severe to interfere with social functioning in peer relationships;
- * is aged, at least, 2½ years and if 18 years or older, does not meet the criteria for avoidant personality disorder; and
- * has experienced the disturbance for at least six months.

3.7.1.3.2 Clinical description

According to Klein and Last [1989:37], in avoidant disorder the child is excessively fearful about being around unfamiliar people. He will be warm and loving with his family and people he knows well, but is extremely reluctant to enter situations where there is someone whom he does not know. He does not warm to strangers even after a considerable length of time.

This disorder, as described by Klein and Last [1989:37], can also be apparent from the child's verbal and physical behaviour during a clinical interview. He may refuse to speak, hide away and appear very reticent. He will often have few or no friends as he is usually unable to interact socially. According to Wicks-Nelson and Israel [1984:153] the avoidant child is inhibited by anxiety from making friends but is able to enjoy peer relationships once they are established. He will often be unassertive and lacking in confidence. Usually, the child with an avoidant disorder will have an additional concurrent anxiety such as an overanxious disorder.

3.7.1.3.3 Prevalence

According to Kaplan and Sadock [1989:1851], it would appear that this disorder is fairly uncommon, although they stress that this may be the result of it not being diagnosed as often as the other two anxiety disorders. However, Wicks-Nelson and Israel [1984:153] report that information concerning the prevalence of withdrawn-isolated behaviour is not readily available and is difficult to interpret because of definitional problems. They quote the studies of Hops and Greenwood and report that 5 - 28% of pre-schoolers have been designated as **isolates** and 1 - 3% of primary graders designated as **withdrawn**.

3.7.1.3.4 Aetiology

Very little has been established on the aetiology of avoidant disorder, according to Kaplan and Sadock [1989:1851]. However, they state that the child who has been victimised by abuse and neglect, can develop this disorder. Children from enmeshed families also appear to be at risk for this disorder.

3.7.1.3.5 Prognosis and treatment

There is a favourable prognosis for children suffering from this disorder if they receive fairly intensive, individual psychotherapy once or twice a week for six to eight months. Family therapy is also recommended to assist the child emotionally. If treated, the child usually will not develop phobias or an adult avoidant personality disorder. However, Kaplan and Sadock [1989:1851-1852] maintain further that many adult-centred psychologists mention that nearly all their clients report that they experienced symptoms of an avoidant disorder in childhood.

The treatment recommended above can also include psychoanalysis, child guidance as well as drug therapy, although the extensive use of drugs has not yet been investigated.

3.7.2 Summary of the Anxiety Disorders

It has become evident that if the child's levels of anxiety become too high, his whole functioning is affected. In the extreme cases [$\pm 2 - 3\%$ of the population], anxiety disorders develop. These include:

- * overanxious disorder;
- * separation anxiety disorder; and
- * avoidant disorder.

Other disorders related to anxiety, include phobic disorder, panic disorder, obsessive-compulsive disorder and post-traumatic stress disorder. However, these have not been included in this thesis.

Table 3.4 summarises the first three anxiety disorders mentioned, in an attempt to highlight the most important aspects of the disorders and to be able to compare them with one another.

It therefore becomes evident that anxiety in the child should be assessed and treated as early as possible in the development of the child. In this way, it may be possible to prevent the disorders from developing.

TABLE 3.4

SUMMARY OF ANXIETY DISORDERS OF CHILDHOOD AND ADOLESCENCE

	OVERANXIOUS DISORDER	SEPARATION ANXIETY DISORDER	AVOIDANT DISORDER
TYPES OF ANXIETY	Excessive or unrealistic worry about multiple situations & events	Separation from major attachment figures (parents) and home	Excessive fearfulness & avoidance of social interactions with unfamiliar persons
FEARS	Not being competent	Separation	Being negatively evaluated
DIAGNOSTIC CRITERIA & DURATION OF ONSET	Children demonstrate at least 4 of 7 diagnostic criteria for period of 6 months or longer	Children demonstrate at least 3 of 9 diagnostic criteria for a minimum of 2 months	Children demonstrate all the diagnostic criteria for a period of at least 6 months
AGE OF ONSET	Any Age	3 Years	2 1/2 Years
PSYCHIATRIC DISORDERS THAT CORRELATE	Major Depression (35%) Simple Phobia (27%)	Major Depression (32%) Attention Deficit & Hyperactive Disorder (23%) Oppositional Disorder (23%)	Overanxious Disorder (64%) Separation Anxiety (36%) Major Depression (35%)
PSYCHOSOMATIC SYMPTOMS	Headaches Stomachaches Back pains Feelings of non-wellbeing	Abdominal pains Palpitations Headaches Dizziness Nausea	N/A
CHIEF SOURCE OF REFERRAL	Child or parents	Parents: often due to school refusal	Staff members at school
PROBLEMS ENCOUNTERED AT SCHOOL	Test Anxiety, Self-consciousness: To present to class Dressing in the gym Eating in front of others	Learning problems due to absenteeism Loss of contact with peers	Poor peer relationships Shyness & self-consciousness to present to class
TREATMENT	Individual therapy Family therapy Relaxation training Peer group therapy Learning coping skills	Solving immediate crisis often to do with school refusal Individual therapy Family therapy	Individual therapy Family therapy

3.8 CONCLUSION

The specific aim of this study, as stated in Chapter One [cf. 1.6.1], is to investigate methods of assessing and treating anxiety in the primary school child. In order to do this, the development of anxiety through the different developmental stages of the child's life, must be examined. This has been attempted in Chapter Three.

At this point, it may be concluded that:

- * the child's development can be divided into different components, i.e. psychosexual and emotional, psychosocial, cognitive and moral;
- * anxiety affects the child at each stage of development;
- * the effects of anxiety differ, depending on the stage of development that the child is in;
- * the child has certain emotional needs that have to be met by significant others, otherwise high levels of anxiety develop;
- * the relationships in the child's life, especially with the mother or mother-substitute, have a direct effect on the development of anxiety; and
- * anxiety in the child can lead to emotional instability, social maladjustment, cognitive dysfunction, moral confusion, symptom formation, psychosomatic illness and anxiety disorders.

Chapter Four will therefore investigate the various means of assessing anxiety in its different forms, in the primary school child, with the aim of identifying the highly anxious children, so that they may be recommended for therapy.

CHAPTER FOUR

THE ASSESSMENT OF ANXIETY IN PRIMARY SCHOOL CHILDREN

4.1 INTRODUCTION

According to Werry and Aman [1980:165] anxiety features prominently in the reasons for which children are seen by mental health professionals. However, to define this anxiety appears to be a difficult task. Werry and Aman [1980:167] classify anxiety in children as:

- * an isolated symptom [fear] or situational anxiety;
- * a psychopathological trait; or
- * a disorder.

The difference between a trait and a disorder appears to be one of degree. They state 'it has been customary to convert these traits to disorders by an arbitrary clinical judgment [sic] or statistical-normative cut-off point of severity' [Werry & Aman 1980:168].

They warn that the measurement of anxiety in children will be dictated to by the particular concept held by the researcher of that anxiety. Furthermore, the measurement thereof rests largely on teacher- and parent-derived estimates, typically through the use of symptom checklists and some self-report instruments.

Much has been written on the various types of anxiety [cf. 2.2.1] and many

tests have been devised to measure specific types of anxiety, such as state, trait, test and manifest anxiety and it would seem that the focus has been on normative studies of these types of anxiety. Very little appears to have been researched from an idiographic perspective of viewing the child as a whole and his anxieties, and their significance, as part of his life-world.

4.1.1 Important Criteria in the Measurement of Anxiety

In order to measure a phenomenon accurately, certain criteria have to be met. Hoghughi [1980:25-26] mentions that the two most important criteria are reliability and validity.

4.1.1.1 Reliability

Reliability refers to the measures' dependability, stability and consistency. It presupposes that the test would measure the same phenomenon each time it was used, in a variety of different settings and over a period of time.

4.1.1.2 Validity

Validity is the most central and complex criteria of the two and it reflects the extent to which the measure **measures** what it claims it can measure. The validity of any test or measure can be viewed in terms of its content, its ability to predict certain outcomes and the degree to which it fits into an established and acceptable theory.

4.2 DIFFERENT MEASURES OF ANXIETY IN CHILDREN

[The following sources were used in researching the different measures: Lee & Piersel 1987:1299-1304; Werry 1986:73-100; Werry & Aman 1980:171.]

There are many different measures of anxiety in children. These are divided roughly into three categories and are considered to be of varying importance, depending on the theoretical perspective of the researcher or clinician.

The three categories are:

- * the measurement of physiological symptoms of anxiety which can lead to psychosomatic illness;
- * the observation of motoric and behavioural manifestations of anxiety; and
- * the measurement of subjective symptoms of all forms of anxiety by means of psychometric tests and projective media.

According to Werry [1986:76], anxiety symptoms can be 'subjective and verbalised, focused or non-focused, psychophysiological, cognitive or behavioural'. However, as anxiety is a normal emotional reaction [cf. 2.1] in many instances, the psychophysiological significance of its symptoms depends on many factors, such as its severity and disabling effect, persistence, age appropriateness, associated symptomatology and peer or family group norms.

Werry [1986:93-94] maintains that the physiological measures include cardiovascular, pupillary, respiratory, musculo-skeletal, electroencephalogram, endocrine and palmar sweat gland measurement.

Behavioural measures, such as the behavioural interview, general purpose codes and anxiety codes, have begun to be explored since 1986, according to Werry [1986:93]. He maintains that their great advantages centre on 'high reliability, relevance to treatment and potential as research measures'. However, they have a number of problems associated with their use, such as

that they tend to be cumbersome, time consuming, expensive and generate consumer resistance. They can be viewed as intrusive and therefore create reactivity or distortion of the naturalness of the behaviour and do not render as many data as rating scales do.

For the purpose of this study, the first two categories of physiological measures and behaviour measures will not be explored due to the extensiveness of the subject matter.

4.2.1 Measurement of Subjective Symptoms of Anxiety

4.2.1.1 Types of Anxiety

The various types of anxiety that will be dealt with, under this section, include:

- 4.2.1.1.1 state and trait anxiety;
- 4.2.1.1.2 general and test anxiety;
- 4.2.1.1.3 overt and covert anxiety;
- 4.2.1.1.4 free-floating and manifest anxiety; and
- 4.2.1.1.5 normal and neurotic anxiety.

4.2.1.2 Psychometric tests and projective media

The psychometric tests and projective media for assessing anxiety in children can be divided into the following categories, namely:

- * **questionnaires and inventories;**
- * **interviews; and**
- * **projective media such as drawings, stories and completing sentences.**

4.2.1.3 Assessing the types of anxiety by means of psychometric tests and projective media

Anxiety is often described as a diffuse, vague and very unpleasant feeling of fear and apprehension [Sarason & Sarason 1980:161]. Anxiety, fear, nervousness and tension are also often used interchangeably. Therefore, in an attempt to assess the broad concept of anxiety, the different types of anxiety, which were discussed in Chapter Two [cf. 2.2.1], have been identified in the search for more precision and conciseness. However, it is this researcher's view that, at all times, anxiety should be viewed as one phenomenon and that different types of anxiety assist us in examining under what forms and conditions the anxiety is exposed and observed. [This is explained diagrammatically by Figure 4.1 further on in the text]. State anxiety [A] refers to a reaction to a specific situation. Furthermore, state anxiety can be viewed as having a transitory nature and varying in intensity as well as fluctuating over time. Trait anxiety [F] becomes characteristic of the child's basic personality and remains fairly constant over time and situation.

General anxiety [B] refers to the worries and fears the child has with regard to his everyday life. Test anxiety [G] describes the child's anxieties and fears at being evaluated with regard to his performance and abilities.

Overt anxiety [C] can be described as anxiety that the child is aware of at a conscious level and that can be measured without any hidden aspects. Covert anxiety [H] is hidden and disguised and is not readily available to the child's conscious mind.

Free-floating anxiety [D] indicates that the cause of the anxiety is unknown to the child and is at an unconscious level only. Manifest anxiety [I] is at a conscious level, with the child being fully aware of his anxiety-related symptoms.

Normal anxiety [E] can be seen as a reaction to real, external danger, while neurotic anxiety [J] can be viewed as a disproportionate reaction to a threat or danger that may be real or imagined.

If one is to view anxiety as one phenomenon, with the different types of anxiety as part of that phenomenon, then the following diagram [Figure 4.1] may be of assistance in understanding which types of anxiety are assessed by the various measures of anxiety.

FIGURE 4.1

THE DIFFERENT TYPES AND MEASURES OF ANXIETY IN CHILDREN



4.2.1.1 Questionnaires & Inventories	4.2.1.2 Interviews	4.2.1.3 Projective Media
<ul style="list-style-type: none"> ● STAIC - A + F + E + J ● CMAS + RCMAS - C + F + I ● GASC + TASC - B + G 	<p>Structured</p> <ul style="list-style-type: none"> ● DICA - all <p>Semi-Structured</p> <ul style="list-style-type: none"> ● CAEF - all ● CPI - all 	<p>Drawings</p> <ul style="list-style-type: none"> ● DAP - all ● KFD - all ● Incomplete Sentences ● Blank - all ● TAT - all

4.2.1.3.1 Questionnaires and inventories

(a) State-Trait Anxiety Inventory for Children [STAIC]

[The following sources were used to research this test: Biaggio 1985; Buros 1974; Dorr 1981; Endler 1978; Hedl & Papay 1982; Mitchell 1983; Papay, Costello Hedl & Spielberger 1975; Papay & Spielberger 1986.]

This inventory was initially designed by Charles D Spielberger in collaboration with C. Drew Edwards, Robert E. Lushene, Joseph Montuori and Denna Pletzek, as a research tool for investigating anxiety in elementary school children. It consists of two self-report scales for measuring state anxiety [A-state] and trait anxiety [A-trait]. The former can be used as an index of drive level or actual levels of A-state caused by stressful situations, while the latter measures the anxiety-proneness in children and is also a screening test for detecting neurotic tendencies in primary school children. The title of the test is 'How I Feel Questionnaire'.

The manual provides separate norms for each school standard and for both A-state and A-trait. Anxiety percentile ranks and normalised standard scores are provided. The alpha-reliability internal consistency coefficients for A-state are 0,82 for boys and 0,87 for girls. The coefficients for A-trait are 0,78 and 0,81 respectively. Test-retest reliability coefficients for A-trait are 0,65 for boys and 0,71 for girls, while the coefficients for A-state are much lower, at 0,31 and 0,47 respectively. The authors explain these low scores as an index of the transitory nature of anxiety states. According to Endler [1978:1098], the test-retest reliability is poor, while the internal consistency of the STAIC scales is fairly good. Certain limitations of this inventory are highlighted by Endler and these are:

- * the predictive validity which could be improved;

- * the fact that both A-state and A-trait are multidimensional and yet the scales are treated as unidimensional; and
- * the lack of investigation into the correlations between the two states such as sex and age difference.

However, despite the limitations, Endler [1978:1098] describes this scale as 'probably the best scale available for assessing anxiety in children as it has a good theoretical basis, adequate norms, adequate reliability and moderate validity'.

(b) The Children's Form of the Manifest Anxiety Scale [CMAS]

[The following sources were used to research this test: Castaneda, McCandless & Palermo 1956; Hagborg 1991; Richmond & Miller 1984; Werry 1986.]

This scale was developed by Castaneda, McCandless and Palermo in 1956, from Tayer's adult scale of manifest anxiety. It was designed to be used with fourth, fifth and sixth grade children [Stds. 2 - 4].

A total of 42 items were selected and modified from an original 60, plus 11 additional items [L Scale] were designed to provide an index of the child's tendency to falsify his responses to the anxiety items. One-week retest reliabilities averaged at $\pm 0,90$ for the anxiety scale and at $\pm 0,70$ for the L Scale. Intercorrelations between the anxiety scale and the L Scale clustered around the zero value. Girls were found to score significantly higher than boys on both scales. Significant differences on the L Scale were found to be associated with the child's grade.

The CMAS discriminates between normal and various clinical populations but is insensitive to stress. Norms exist but vary according to locality. Factor

analysis has revealed two to three similar factors, namely:

- * overanxiousness;
- * physiological anxiety; and
- * cognitive anxiety [inattentiveness, preoccupation, etc.].

The last two factors are sometimes combined as one factor by certain studies. According to Hagborg [1991:423] the psychometric characteristics of the CMAS have been criticised by Flanagan, Peters and Convoy, despite its widespread use. Therefore a revised test became necessary.

(c) The Revised Children's Manifest Anxiety Scale [RCMAS]

[The following sources were used to research this test: Gresham 1989; Hagborg 1991; King, Guillone & Ollendick 1990; Mattison, Bagnato & Brubaker 1988; Reynolds 1980; Reynolds & Richmond 1978; Stewart 1989.]

The Revised Children's Manifest Anxiety Scale was developed by Cecil K. Reynolds and Bert O. Richmond in 1978, from a need to improve the psychometric standards of the children's form of the manifest anxiety scale, as it was believed that:

- * this test did not poll enough areas of anxiety in children;
- * that the vocabulary was too difficult for the primary grade children, slow learners and mentally retarded children;
- * that only 12 of the 42 items met the criteria of good test items; and
- * that the test could not be used across a spectrum of ages.

The major purpose of the Revised Children's Manifest Anxiety Scale [RCMAS] was to:

- * investigate the possibility of shortening the administration time if at all possible;
- * increase the clarity of the items;
- * lower the reading age; and
- * to improve the test item criteria.

The RCMAS is a 37-item self-report instrument entitled 'What I think and feel' and designed to measure the level and degree of anxiety in children and adolescents. It can be used with pupils between the ages of 6 - 19 years who have a third grade reading level. It offers a total anxiety score, a lie score as well as three factor-analytically devised scales in which anxiety manifests itself as:

- * physiological anxiety; somatic problems etc;
- * worry/oversensitivity; worrying and rumination; and
- * social concerns/concentration; attentional and interpersonal difficulties.

The RCMAS has been standardized on a large sample [over 4 700 school-aged children]. The Total Anxiety score is reliable enough across most ages to permit reliable interpretations. The internal consistency coefficients range from 0,56 to 0,80 across the 11 age groups for its three factors. However, Gresham [1989:695] warns that these sub-scales should not be interpreted

because of large errors of measurement contained in the scores. The internal consistency coefficients for the Total Anxiety score are consistently above the 0,80 for all age groups.

The validity of the RCMAS is based on its 0,85 correlation between Total Anxiety and the Trait Scale of the State-Trait Anxiety Inventory for Children, supposedly supporting its validity as a measure of chronic anxiety. However, Gresham [1989:697] warns that the validity data for the RCMAS are sparse and that the test authors have made errors in the factor analysis of the instrument.

The Lie Scale has adequate estimates of internal consistency reliabilities [0.77 across the age groups]. The concurrent validity is supported by its correlation with the Marlowe-Crowne Social Desirability Scale and serves therefore as a measure of other and self-deception. Reynolds [1980:775] reports that the results of his study provide considerable support for the construct validity of the RCMAS as a measure of chronic manifest anxiety, independent of state or situational anxiety. He states further that the magnitude of the correlation between the RCMAS and the STAIC trait scale suggests that the two scales may be used as alternate form measures.

According to Mattison *et al.* [1988:147] the RCMAS can be successfully used as one part of an empirical multimethod assessment for the most accurate identification of children with anxiety disorders. The worry/oversensitivity factor significantly distinguished the anxiety group from the group of other disorders. Within the anxiety group, this same factor showed the highest mean T-score and was most commonly the highest T-score in the RCMAS factor profile.

King *et al.* [1990:70] found that the RCMAS possessed adequate reliability with Australian children and adolescents, which is important for the psycho-

metric properties of this scale, as it appears to be suitable for international use rather than only with American children, for whom the test was designed.

In summary, Stewart [1989:697] states that the RCMAS 'is a carefully constructed revision of the original CMAS with psychometric properties that support its usefulness as a measure of the trait of anxiety with children of school age'.

(d) IPAT Anxiety Scale

[The following sources have been used to research this test: Bendig 1960; Cattell, Scheier & Madge 1968; Owen & Taljaard 1989.]

This scale was developed by Cattell to measure **total** anxiety [Bendig 1960:159]. It consists of 40 objective trichotomously scored items; the first 20 items are disguised **cryptic** statements that have high loadings on the anxiety factor and yield a measure of covert anxiety, while the last 20 items are more obviously overt symptomatic statements; responses which are summed for an overt anxiety score. The sum of the covert and overt scores gives the total anxiety measure and the difference between these two scores is intended to give a measure of the degree to which the person is, or is not, conscious of his anxiety.

Owen and Taljaard [1989:373] describe the aim of the test as providing a speedy evaluation [\pm 10 mins] of the 'manifested level of anxiety, regardless of current conditions or immediate situation'. This, by implication, means that it tests trait anxiety without being affected by state anxiety.

The IPAT Anxiety Scale has been designed to assess five personality factor traits from research with the 16 PF Test. These five factors represent the most important components of the second-order anxiety factors; namely:

- * Factor - C [ego weakness];
- * Factor +O [guilt proneness];
- * Factor - Q3 [lack of self-sentiment]; and
- * Factor +Q4 [frustration and tension],

Factor - H [shyness] is not included in the IPAT Anxiety Scale as it is felt to play a less important role than the other five factors in the anxiety syndrome among the American population [Owen & Taljaard 1989:373].

The reliability of the IPAT Scales was calculated with the test-retest and split-half methods, as well as with the Kuder-Richardson Formula 20. Reliability coefficients for the whole scale vary between 0,76 and 0,88 and can be regarded as satisfactory.

Construct validity is reported to be 0,80 for Afrikaans-speaking pupils and 0,76 for English-speaking pupils.

The IPAT Anxiety Scale has been standardized by Cattell *et al.* [1968] for the South African population, but is only suitable for pupils 15 years and older.

Table 4.1 illustrates the factors and how they relate to the questions of the IPAT Anxiety Scale.

TABLE 4.1

TABLE TO ILLUSTRATE FACTORS & RELATED QUESTIONS OF THE
IPAT ANXIETY SCALE

Item numbers as they appear in the test

- Q3	1, 2, 3, 4	21, 22, 23, 24
- C	5, 6, 7	25, 26, 27
+ L	8, 9	28, 29
+ O	10, 11, 12, 13, 14, 15	30, 31, 32, 33, 34, 35
+ Q4	16, 17, 18, 19, 20	36, 37, 38, 39, 40
	(unconscious or covert symptoms)	(conscious or overt symptoms)
	UNCONSCIOUS ANXIETY	SYMPTOMATIC ANXIETY

(e) **General and Test Anxiety Scales for Children [GASC and TASC]**

[The following sources have been used to research this test: Center 1981; Cox & Leaper 1959; King, Ollendick & Guillone 1991; Sarason *et al.* 1958.]

This test was designed by Sarason and his associates who conceptualised anxiety as having a general pre-dispositional unidimensional trait [cf. 2.2.1.3]. No distinction was made between anxiety and fear. There are 45 items on the GASC which sample the worries and fears which children are likely to experience in their everyday lives. The 30 items on the TASC are designed to elicit attitudes towards and reactions to all kinds of school test situations and are a shortened form of the initial Test Anxiety Scale of 43 items.

Reliability figures for the GASC and TASC are quoted as ranging from 0,94 to 0,98 for uncorrected split-half reliability and from 0,54 to 0,57 on test-retest reliability.

Baynk and Proger [1971] state that the TASC was originally designed as a unidimensional measure but that subsequent research has indicated that it is in fact, multidimensional. This observation has been highlighted by Beidel and Turner [1988:276] as well.

4.2.1.3.2 Interviews

Structured and semi-structured child interviews have been found to yield a high degree of agreement between different interviews [Hill 1987:249-263].

Rutter and Graham [1968:576] report that even a short psychiatric interview with a child was found to be a reasonably sensitive diagnostic instrument. However, in reviewing the research, they found that more reliable and valid

judgements were obtained as to whether the child exhibited any psychiatric disorders than individual ratings on specific aspects of behaviour, such as depression or anxiety. In addition, psychologists and psychiatrists can distinguish between the presence or absence of emotional/psychiatric difficulties on the basis of a clinical interview with a child [Cox, Holbrook & Rutter 1981; Kestenbaum & Bird 1978; Rutter & Graham 1968].

According to Cox, Rutter and Holbrook [1988:64-72] children are interviewed for a number of reasons. These include the making of a psychiatric diagnosis, such as anxiety, depression or an attention deficit disorder. Children are often interviewed personally rather than obtaining information from their parents, because parents often underestimate how unhappy, anxious or distressed a child is and therefore cannot accurately assess the child's emotional difficulty.

According to Hoehn-Saric, Maisami and Wiegand [1987:543] the interview is very important in uncovering anxiety in children. They maintain that the self-rating measures fail to distinguish clinically identified anxiety entities. They believe that the ability of children to complete self-rating scales meaningfully is limited, as they lack self-awareness but also tend to externalise their distress, to deny symptoms that are perceived as signs of weakness and to present a facade of bravado. They maintain that the assessment of anxiety is valid only if this underlying feeling of distress can be elicited. However, Rutter and Graham [1968:576] warn that individual ratings on specific aspects of behaviour proved to be less reliable than the overall psychiatric diagnosis. Anxiety appeared to be easier to rate reliably than depression and both were found to be reasonably efficient in the differentiation of the child with a psychiatric disorder. It was found that certain influences involved in the diagnostic process, in relation to an assessment of anxiety, were more reliable than others. Fidgetiness, tension

and tremulousness were less effective indications of anxiety than tearfulness, an anxious expression and a preoccupation with anxiety topics during the interview. Their research demonstrated the following behaviours as indicative of a high level of anxiety:

- preoccupation with anxiety topics;
- preoccupation with depressive topics;
- anxious expression;
- sad expression;
- poor attention span or persistence;
- depressed or sad mood;
- lack of smiling;
- muscular tension;
- tearfulness;
- tremulousness; and
- startle.

Orvaschel [1985:737-745] maintains that the following psychiatric interviews are well designed and valuable in assessing behaviours that provide diagnoses according to the DSM III [American Psychiatric Association 1980]. They are:

- * **Children's Assessment Schedule [CAS];**
- * **Diagnostic Interview for Children and Adolescents [DICA];**
- * **Diagnostic Interview for Children [DIC];**
- * **Interview Schedule for Children [ISC]; and**
- * **Kiddie SADS [K-SADS].**

For the purpose of this study, the interviews will be divided into two groups, namely structured and semi-structured interviews. The Diagnostic Interview for Children and Adolescents [DICA] will be discussed under structured interviews and the Children's Anxiety Evaluation Form [CAEF] and the Children's Psychiatric Interview [CPI] will be discussed under semi-structured interviews.

(a) Structured interviews

According to Lewis [1989:1726] structured interviews for children have been devised to improve the reliability and validity of information and observation regarding psychiatric diagnosis. Structured interviews have the advantage of focusing on important areas in the child, ensuring that all important aspects are covered, rather than leaving them to chance, in the hope that they will be spontaneously dealt with. They are, however, more or less rigid in structure and sometimes the conclusions that are drawn, do not correspond to the complexity of the clinical diagnosis. The clustering of items around symptoms may also limit their use as far as rapport is concerned, as the negative behaviour in the child tends to be highlighted much of the time. The lack of normative data is another drawback, according to Lewis [1989:1726].

Edelbrock, Costello, Dulcan, Conover and Kala [1986:181], in their study of 299 disturbed children between the ages of 6 - 18, used structured interviews with both the children and the parents. They found low to moderate levels of agreement regarding the presence of and severity of child psychiatric symptoms. Agreement between the children and parents was higher on behaviour and conduct problems than on anxiety, fears, obsessions-compulsions, psychotic symptoms and affective disturbances. Of interest is the fact that children, rather than parents, reported more affective and neurotic symptoms. Also of note is that there was more discrepancy between the younger children's information and that of their parents than in the older ones.

Parent-child agreement increased sharply with age.

Sylvester, Hyde and Reichler [1987:668] report that from their research it became evident that the use of the structured interview can assist in distinguishing between normal and pathological children but that, as the need for diagnostic specificity increases, parent and parent-child concordances decrease markedly. They suggest the use of multiple measures to establish better reliability and validity.

(i) The Diagnostic Interview for Children and Adolescents [DICA]

The Diagnostic Interview for Children and Adolescents [DICA] can be considered a structured interview. It tends to be a lengthy interview containing 207 items which Lewis [1989:1726] feels may exhaust the child.

It was developed by Herjanie and Welner in 1981 [Orvaschel 1985:738] and modelled after the Diagnostic Interview Schedule. It can be administered by clinicians or trained interviewers and requires little clinical judgement on the part of the interviewer. It can be used with children between the ages of 6-17 years while its parallel, the DICA-P, is administered to the parents concerning the child. It takes approximately 60 - 90 minutes to administer to each individual. According to Orvaschel [1985:741], test-retest reliability has been quite high and validity data awaits more extensive testing.

Silverman [1991:111] reports on a revised version of the DICA [DICA-R] which was developed in 1987. She states that it differs from the DICA in several ways and these have been listed below.

- * It allows for the diagnosis of DSM-III-R disorders.

- * It consists of four interviews instead of only two, as it divides children into two groups, namely 6 - 12 years and 13 - 17 years. This allows for more age-appropriateness of wording and examples in the interview.
- * It is also organised diagnostically and covers all the childhood anxiety disorders, e.g. separation anxiety disorder [SAD], overanxious disorder [OAD], avoidant disorder [AVD], as well as all the adult anxiety disorders, with the exception of the generalised anxiety disorder [GAD] and social phobia.

Silverman [1991:112] reports that reliability studies on the DICA-R are currently in progress.

(b) Semi-structured interviews

The semi-structured interview is less rigid and directive than the structured one and allows for more flexibility and open-ended questions which would assist the child in opening up and volunteering information about himself.

Graham and Rutter [1968:581-591] found that, in their research using an open-ended interview with 268 parents, the results of the preliminary use of the interview suggested high reliability of the overall judgement of psychiatric abnormality. Reliability of rating individual symptoms was also high where strict behavioural criteria could be met. However, where inferences had to be drawn or where relationships were being judged, less satisfactory reliability was obtained.

Hoehn-Saric *et al.* [1987:541] in their preliminary work with a self-rating instrument, found many contradictions of symptoms on the same rating scale, and ratings were often inconsistent with the clinical impressions. They stress that clinically-anxious children often deny relevant symptoms, while others

may exaggerate their symptoms. In order to obtain clinically meaningful assessments of anxiety, they developed the Children's Anxiety Evaluation Form [CAEF] which was based on the history of the child as well as a semi-structured interview with him.

(i) The Children's Anxiety Evaluation Form [CAEF]

The CAEF uses three modes of information-gathering, namely clinical history, symptoms and signs.

The semi-structured nature of the interview, according to Hoehn-Saric *et al.* [1987:543], allows a trained examiner the flexibility to establish a comfortable, relaxed relationship with the child to allow him to disclose symptoms that would not have been elicited in either a structured interview or on a self-rating instrument.

At the same time, the CAEF provides a framework that covers all relevant signs and symptoms of anxiety. The incorporation of checklists and clinical ratings into the form, provides more precise readings of symptoms and improves interrater reliability. The Pearson's correlation coefficients on interrater reliability were 0.81 on the total score, 0.73 on Part I, 0.86 on Part II and 0.87 on Part III.

This form was correlated with the Revised Children's Manifest Anxiety Scale [RCMAS] and the State-Trait Inventory for Children [STAIC], and the Pearson's correlation coefficients were calculated between the three anxiety measures. The CAEF correlated significantly with the RCMAS and the Trait Scale of the STAIC, but not with the State Scale of this test.

(ii) The Child Psychiatric Interview [CPI]

It is reported that the CPI is intended as a guide for interviewing children and should not be viewed as all inclusive. It appears to have been developed in South Africa by Holford and Smith [1992:38-40] from the work of Hoghughi, Hill, Robin and Rutter and, therefore, should not be confused with Feighner's Children's Psychiatric Interview, constructed in 1969 [Orvaschel 1985:738].

Aspects of this interview that focus specifically on anxiety in the child, have been extracted and they are listed below.

*** Introduction and Interviewing**

This involves:

- escorting the child to the office or playroom, etc.;
- reassuring him that the confidentiality of the sessions will be respected under normal circumstances;
- discussing the reason for his referral; and
- allowing him to draw, construct or play with specific toys set out for the interview in order to relax and reassure him.

*** General Questions**

These include general topics and conversations about recent events and activities, i.e.:

- where he lives and with whom, etc.;

- which television programmes he enjoys;
- his hobbies and interests and the sports that he enjoys;
- his ambitions, hopes and aspirations;
- the three wishes he would make;
- the companions he would take to an island, the moon, the dentist, and the shop, etc.; and
- free drawing by allowing the child to draw whatever he chooses and to relate a story about his drawing afterwards.

* **Structured and Specific Questions**

Questions about:

- school: how he is getting along, his favourite subjects, how he likes his teacher, any homework difficulties, anxieties he may experience around taking tests and examinations or performing in class individually;
- peers: his special friends, being teased or bullied at school, anxieties about or pressures from his peers, feelings of loneliness;
- appetite: whether he likes eating, any variations in eating patterns, weight loss or gain;
- sleep, dreams and nightmares: how he copes with going to bed at night, falling asleep and getting up in the mornings, whether he experiences nightmares and whether these are recurring ones, whether he seeks

comfort in his parents bedroom and whether his parents tend to comfort him more often during these times, variations in sleeping patterns;

- worries: the things which tend to worry him, nice or nasty thoughts interfering with his falling asleep at night or with his concentration in the classroom, being burdened by nice or nasty thoughts he can't get rid of, what his biggest worry is;
- fears: what his fears are, what he has been scared of in the past, what scares him in the present, fears he may have about his family being hurt or losing a member of his family;
- depression: whether he cries often, feels unhappy much of the time, feels sad for no reason; and
- anger: the things that make him angry, how he reacts when angry, fights that he may get involved in with peers, whether they are verbal or physical, fights he may have with siblings, whether they are real or friendly ones, the frequency with which they may occur, the things that help him to get over his anger.

* **Mental Status Examination**

Other factors to be taken into account are:

- general appearance;
- interview reaction: eye contact, preoccupation with anxiety, spontaneous remarks, rapport with interviewer;

- cognition: level of general intelligence, attention span, distractibility, impulsivity;
- motor reaction: level of activity [hyper- or hypo-], fidgetiness, muscle tension, coordination, tics, involuntary movements;
- affect: anxious, withdrawn, tearful, sad, depressed, sullen, angry, hostile, oppositional;
- speech: level of comprehension, use of language, stammering or stuttering, lisps, indistinct expression, aphasia; and
- thought content: impairment of thought, inappropriateness in behaviour or speech, repetition of words or phrases, drifting off the topic, delusions and hallucinations, mood swings, bizarre behaviour.

4.2.1.3.3 Projective media

Projective tests are non-standardised tests because of the very nature of the tests. They have been defined by Woolfolk and McCure-Nicolich [Shand 1990:83-84] as 'an indirect method for obtaining a diagnosis of personality organisation by interpreting an individual's response to relatively ambiguous stimuli'. These tests are, therefore, based on the assumption that the subject will project his own needs, attitudes or fears onto his responses to the various media. This, therefore, allows him to project onto another object or person in order to make it safe enough for him to respond with conscious and unconscious emotional material. Projection can be referred to as a defence mechanism and can serve to avoid the experience of guilt or anxiety. Projection media are therefore measures that can aid the researcher in investigating the person's personality, his anxieties and his conflicts.

For the purpose of this study, the following projection media will be examined, namely Drawings [Draw-A-Person and Kinetic Family Drawing]; Incomplete Sentences Blank and Thematic/Children's Apperception Tests.

(a) Drawings

It was Aristotle's belief that the soul never thought without an image [Di Leo 1973]. The child's images are reflected in his drawings and, therefore, reflect his thoughts and feelings. Children's drawings are universally accepted as being a simple and direct form of communication. They are a means through which the child may project or explore the meanings he has assigned to others, as well as to himself [Koppitz 1968:74-81, Machover 1978:35-36].

Piaget and Inhelder [Di Leo 1973: Foreword] are quoted as stating that 'drawing consists in externalizing a previously internalized mental image'.

Koppitz [1968:3] hypothesises that human figure drawings 'reflect primarily the child's level of development and his interpersonal relationships; that is, his attitudes towards himself and towards significant others in his life'. She also maintains that these drawings reveal a child's attitude towards life's stresses and strains, his strong fears and his anxieties, which may be conscious or unconscious.

Hammer [1954:41] believes that the drawing medium, especially of familiar concepts such as the person, 'has been found to enhance the projection of the subject's deepest fantasies, wishes, conflicts and fears on both conscious and unconscious levels'. He maintains that, 'the unconscious is laid bare, especially in the language of graphic symbols ...' and that 'the subject often brings to the surface what he dare not or cannot say in words'.

Handler and Reyher [1964:261-264] warn that the effects of stress must be taken into account when the child is asked to draw a person. Their research reveals that externally-induced anxiety increases manifestations of anxiety in figure drawings. These anxieties they divide into two groups, namely:

- * the laboratory or test-room stress situation; and
- * anxiety-producing intra-psychic processes activated by drawing the human figure.

The first mentioned would correlate closely with overt, state, test and/or normal anxiety, while the second would refer to covert, trait, general and/or neurotic anxiety. They suggest that it may be important to ask the child to draw the person at the beginning and end of the session and to observe possible differences in the child's drawings. They believe that the clinician's focus should be on the nature of the control or management of anxiety and not on the anxiety *per se*. They found that when the person was under stress while drawing the human figure, the following anxiety indices were often not present:

- * shading;
- * erasure;
- * upper left placement on page;
- * reinforcement; and
- * lines emphasised.

However, stress tended to increase the frequency with which the following indices were found:

- * increase and decrease of size;
- * light and heavy lines;
- * increase of line pressure;
- * lines discontinued and absent;
- * omissions;
- * distortion;
- * detail loss; and
- * hand and body simplification.

The indices that were not affected by stress are:

- * head size;
- * head and body ratio; and
- * transparencies.

The reliability and validity of projective tests is especially hard to assess. However, Albee and Hamlin [1949:389-392], in their investigation of the reliability and validity of judgements of adjustment inferred from drawings, found that their results confirmed that psychologists can make 'reliable

judgements of global adjustment' from drawings of a man and a woman. They state that the reliability coefficients obtained were sufficiently high to warrant rejection of the null hypothesis.

Certain critics, such as Swensen [1965], have reviewed the literature on the research findings derived from empirical investigations of the validity and reliability of figure drawing tests. Their findings have cast some doubts on the value of these tests but they also strongly report that additional research is needed, using more effective methodological procedures. Hammer [1965:659] scrutinised Swensen's report to determine the justifiability of some of his conclusions and found that certain of Swensen's research reasoning contained popular fallacies, i.e. that when certain groups of subjects are compared with other groups of subjects, extremes in each group tend to cancel each other out and this yields a more benign mean for the group and thus tends to obscure and cancel out noteworthy occurrences.

However, statistically quantifiable procedures for coding graphic and structured characteristics of figure drawings have begun to appear in the literature and will help toward better objectivity in the future.

(i) Draw-A-Person [DAP]

Machover [1978:35] states that 'the human figure drawn by an individual, who is directed to draw a person, relates intimately to the impulses, anxieties, conflicts and compensations characteristic of that individual'. In some sense, the figure drawn is the person and the paper corresponds to the environment.

Di Leo [1973:20] warns that this may not always be true. He states that 'while it is a fact that the vast majority of children will draw a person of their own sex, it is also true that the human figure they draw spontaneously is an adult and not a child'.

Jolles [1952:113-118], in his study of approximately 2560 drawings of humans, done by children ranging between the ages of 5 - 12 years, also found that children do tend to draw persons of their own sex first. However, certain interesting variations were noted. There was a tendency for 11 or 12 year-old females to draw more figures of the opposite sex first, than the younger girls and the males. Furthermore, girls generally tended to draw more human figures of the opposite sex than boys did. It was also found that the 5, 6 and 7 year-old males were more likely to draw a person of the opposite sex first, possibly representing their mothers, than the older group of boys. There was also evidence that the sex of the drawn person tended more strongly to represent the sex-role identified with by the subject.

Di Leo [1973:20] concurs with this finding and states that while the vast majority of latency children draw their own sex first, a reversal of this tendency may indicate a 'failure to adopt a sex-role in conformity with their biological sex'. However, he believes strongly that when a child is well-adjusted and free from anxiety, his intellect is free, his behaviour is exteriorised and he is able to forget himself and express in drawing, a concept of humankind rather than just the self. The self is, in fact, included and absorbed, but not dominant. The less well-adjusted a child is, the more inclined he is to worry and think about himself. The child who is tormented by anxiety cannot forget the self and cannot involve himself thoroughly with the world of persons and things. Di Leo [1973:213], therefore, concludes that the well-adjusted child is less likely to focus on himself than the anxiety-ridden child.

Research into the human drawings of children has revealed that one aspect of the projective technique of House, Tree and Person [H-T-P] designed by John N. Buck in 1948, is, in essence, so similar to the Draw-A-Person test that the research on this test has been included in this chapter. This aspect is the 'Person' drawing of the H-T-P.

Drawings can also be analysed in terms of the levels of anxiety that the child projects onto his drawings. Of the many indices of anxiety that have been identified by the following writers, Machover, Buck, Caligar, Witkin *et al.* and Goldworth [Handler & Reyher 1964:261], the following signs on the DAP have been selected as indicating the possibility of the presence of high anxiety, as they appear to be supported by many researchers in this field. However, Koppitz [1968:55] warns that the total drawing and the combinations of various signs and indicators should always be considered and should be analysed on the basis of the child's age, maturation, emotional status, social and cultural background and then evaluated with other available test data.

Anxiety indices, that can be found in drawings, are listed below.

* **Excessive erasing or rubbing out** indicates anxiety. The area that is erased also draws attention to a possible anxiety, conflict or concern about that area [Odgon 1967:50].

* **Excessive, irrelevant detailing** is frequently a function of anxiety [Hammer 1954:47].

* **A lack of detail** tends to indicate anxiety [Handler & Reyher 1964:261].

* **Shading** is one of the most common indices of anxiety [Koppitz 1968:57]. Koppitz [1968:57] reports that according to all experts, shading is 'a manifestation of anxiety and the degree of shading shown is thought to be related to the intensity of the anxiety within the child. While shading in the drawings of young children can be normal, beyond the age of 8 for girls and 9 for boys, shading becomes clinically significant. Koppitz [1966b:314] found in her study of 76 pairs of public school children, matched for age and sex, that the emotionally unstable children shaded the body and limbs of their human figure drawing more frequently than the head, neck or face. Hammer

[1954:48] maintains that excessive shading in any area of the human drawing indicates anxiety in the area thus treated. 'The more profuse, extensive, dark and diffuse the shading, the more extreme is the anxiety reaction depicted' according to him. He also mentions that non-excessive, moderate and easily applied shading can reflect tact and sensitivity in the child rather than anxiety. Goldstein and Faterson [1969:456] confirm the findings of Hammer [1954], Koppitz [1966b, 1968] and Machover [1978], but mention that in their study the validity of the clinical use of the amount of shading in the DAP, as an index of anxiety, was only relevant when the self-sex drawing was used. Machover [1978:103] mentions that the meaning of the child's shading, while denoting anxiety, may relate to a general insecurity in an adult world rather than individual pathology. Shading can also be an indication of aggression and conflict but anxiety will also be present. Machover [1978:98-99, 145] makes mention of anxious aggression. Covert or furtive anxiety is indicated, according to Machover [1978:114] by the shading of the genital areas and the rationalised shading of the male swimming trunks or shorts. Anxiety in this respect reflects on sex identification issues and body-image. The shading of the legs is regarded as anxiety about size and physical growth. Shading around the chest area indicates anxiety about physical inferiority and weakness [Machover 1978:126, 132].

* **Transparencies** are common in the drawings of young children. However they tend to indicate anxiety in children over the age of 8 years. Where the body of the figure is completely transparent or inadequately clothed so that body parts which are ordinarily covered, are shown, the presence of these transparencies indicate high levels of anxiety [Koppitz 1966b:314]. However, Koppitz [1968:60] later qualified her findings on transparencies and stated that when a child focuses on 'one particular portion of the figure by means of a transparency of a specific and limited area', it is comparable with shading and indicates anxiety, particularly about that specific body part. She concludes that in school-age children, it indicates acute anxiety, conflict or fear, usually in the areas of sex, childbirth or bodily mutilation.

* **Shadows** are indicative of anxiety when drawn by children. According to Hammer [1954:47], shadows drawn as being cast by the person, represent an anxiety-binding factor within the personality at the conscious level.

* **Dark clouds and darkened sun** are also indices of anxiety. These ominous signs are seen in the drawing of unhappy, anxious children [Di Leo 1973:84]. Koppitz [1968:65] mentions that clouds are found especially often in drawings of very anxious children with psychosomatic complaints. According to her, clouds seem to be drawn primarily by children who do not dare to strike out at others and who instead turn their aggressive feelings inward toward themselves. They feel threatened by the adult world, especially by their parents. Hammer [1954:48] maintains that when clouds are introduced into the human figure drawings, they always appear to represent generalised anxiety in reference to environmental relationships.

* **Monsters or grotesque figures** are found in the drawings of children with emotional difficulties. Koppitz [1968:64] found that the drawing of monsters or grotesque figures by children indicates intense inadequacy and very poor self-concepts. Although this emotional indication does not denote anxiety *per se*, it should be carefully considered because of the close relationships between anxiety, inadequacy and low self-concept.

* **The size of the drawing** is influenced by anxiety. Koppitz [1968:59; 1966a:467] states that many researchers concur with her findings that tiny figures indicate feelings of inadequacy, a shrunken ego, concern over dealing with the environment and above all, depression. Hoyt and Baron [1959], Mc Hugh [1966] and Mogar [1962] support these findings of Koppitz and state that children with neurotic traits and a high level of anxiety tend to draw small, slight figures. Waehner [1946:20] reports that small size in drawings indicates anxiety and depression, especially in children. She states that 'most of the depressive, anxious children prefer small sizes' while drawing and that

this applies particularly to children in the latency period of development. Gray and Pepitone [1964:454-455] in their study using the DAP, discovered that subjects with low self-esteem tended to draw smaller total pictures and provided fewer backgrounds than subjects with high self-esteem. As a correlation between low self-esteem and high levels of anxiety has been established [Many & Many 1975:1017], these findings should be considered carefully when assessing for anxiety indices on the DAP.

* **When the legs of the figure are pressed together** it tends to indicate high levels of anxiety. Koppitz's [1968:64; 1966b:314] research reveals that, although rare, drawings depicting the figure pressing his legs together seem to indicate tension and anxiety and a rigid attempt to control his own sexual impulses and/or concern over a sexual attack by others.

* **The omission of body parts** in a drawing also indicates anxiety in the child. Koppitz [1968:68; 1966a:467; 1966b:314] states that when a child omits a body part, depending on his age, it is usually a sign of concern and anxiety about that part of the body. This is most likely true after the age of eight or nine years. Machover [1978:97] mentions that the conspicuous omission of hands, legs and feet are important. Mouths and noses are also sometimes omitted and indicate anxiety or conflicts in these areas.

Koppitz [1966b:314] supports the above findings and lists the following as the more obscure signs of anxiety:

- **Cross-hatching** can indicate an attempt to control anxiety through obsessive-compulsive methods. Burns and Kaufman [1971:17] compare cross-hatching to controlled shading and relate it to obsessive thoughts as well.

- **Weak foundations** drawn in the human figure drawing indicate anxiety. Tiny, unstable feet also indicate basic feelings of insecurity and anxiety [Di Leo 1973:48].

- **Feint, hesitant lines** are a further indication of anxiety. According to Hammer [1954:48], if the child demonstrates very feint and hesitant lines, it tends to suggest high levels of anxiety in him.

(ii) Kinetic Family Drawing [KFD]

The Kinetic Family Drawing technique is a projective test developed by Burns and Kaufman [1971:9-10]. It is their contention that kinetic drawings, in which movement is involved, give more information about the child and more help in understanding the troubled child than do drawings that show no action. Burns and Kaufman [1972:XV] suggest that kinetic drawings should be analysed by taking into account the actions, styles and symbols that appear in them and the meanings these may have for the child who has drawn them.

This technique will be viewed specifically from a perspective of analysing possible signs of anxiety in the child and in his relationships with his family members.

The following indices have been selected from the literature study to signify anxiety, insecurity and/or tension:

* **Erasures and rubbing out** excessively, indicate anxiety. The specific detail that the child rubs out indicates possible anxiety and conflict within that relationship or about that part of the body [Burns & Kaufman 1971:20 & 291].

* **Barriers and the folding of the paper into compartments** indicate a need to shut-off and control energies from one to another. According to Burns and Kaufman [1972:42-43], the drawing of barriers between persons indicates conflict and anxiety. Folding the paper into compartments is characteristic of children with severe fears and insecurities [Burns & Kaufman 1972:142].

* **The omission of self or body parts** in the child's family drawing indicates anxiety. Burns and Kaufman [1972:28] maintain that if individual figures are missing or distorted, deep conflict and tension is indicated. Di Leo [1970:210] states that leaving the self out of a picture indicates anxiety over the person's status within the family.

* **The shading of figures** also indicates anxiety. Burns and Kaufman [1972:41] emphasise that energy is invested or internalised in the self when the child is ill or feels threatened. At such times, he may shade himself in completely.

* **The drawing of a base** in the child's family drawing indicates insecurity and anxiety. Burns and Kaufman [1971:9-10, 1972:123] maintain that a lining or shading in at the bottom of the page also indicates anxiety and a need for security.

* **The inclusion of a lining at the top** of the family drawing indicates the strong possibility of anxiety. According to Burns and Kaufman [1972:126 & 140] 'sometimes when the world is scary and full of storm clouds, darkness and worry', the child will draw a lining at the top of the page which indicates acute anxiety.

* **The underlining of certain figures** tends to indicate unstable relationships and anxiety about the person who is underlined [Burns & Kaufman 1972:124].

* **Figures drawn hanging precariously and the use of ladders** in the child's family drawing are indices of anxiety. Burns and Kaufman [1972:24, 216] state that 'individual figures that are drawn hanging in precarious positions, indicate a high level of tension and anxiety.' Ladders are also associated with tension and precarious balance.

* **Scribbling and the use of the "X"** are found in the drawings of anxious children. According to Burns and Kaufman [1971:32, 1972:108], the anxious child will often use intense scribbling to indicate great anxiety and to control and deny his impulses. With this scribbling he may use the form of "X" to denote an area of conflict around his anxieties.

According to Burns and Kaufman [1972:296], the Kinetic Family Drawing technique is a useful tool in understanding the child's perception of his world and his feelings, thoughts and anxieties. The actions recorded in the pictures are usually simple to observe and record, and obvious styles within the pictures usually serve as defence mechanisms and can indicate severe disturbance among children.

Symbols are more difficult to interpret and analyse and can easily be misinterpreted. However, the 'meaning of the symbol often reveals the heart of the child's problem' [Burns & Kaufman 1972:296].

(b) Incomplete Sentences Blank [ISB]

The Incomplete Sentences Blank [also known as the Sentence Completion Test] was developed by Rotter and Willerman [Daston 1968:276-277]. An attempt was made to keep the items as unstructured as possible so that the person could complete the sentence according to his personal feelings and attitudes, rather than associations. Rotter and Raffarty [1950:3] describe the ISB as a projective, expressive medium which assumes that the child reflects his own wishes, desires, fears and anxieties in the sentences he completes.

A three category scoring system for responses was devised; + for conflict, 0 for neutral and - for positive. According to Daston [1968:277], the average interscorer reliability is 0,87 and correlations with a criterion measure are quite adequate, making this test considerably valuable for psychiatric screening purposes. Daston [1968:286] reports further, that the reliability of all the

sentence completion tests that he has researched, has been highly satisfactory. Rotter [1951:305] mentions a split-half reliability on his test of 0,83 for the female manual and 0,84 for the male manual. However, it is felt that this type of reliability is not really applicable, due to the non-equivalence of items. Daston [1968:286] suggests that test reliability on the sentence completion test is less of a problem than it is with most other projective tests. Validity [concurrent and predictive] is also reported by him to be good. Goldberg [1965:777] agrees with him and states that, 'The Sentence Completion Test is a valid test, generally speaking and probably the most valid of all the projective techniques reported in the literature'.

Daston [1968] also notes the fact that psychologists continue to use such tests and are indeed creating new sentence completion tests, which he maintains indicates their confidence in this type of projection medium. As the Sentence Completion Test lends itself to flexibility and adaptation, many researchers have used it for their specific needs. According to Daston [1968:278-279], they have focused on the following topics or phenomena, i.e.:

* **Stotsky and Weinberg - Work attitudes:**

When Dick failed in his new job, he ...

When they cut his salary, he ...

* **Stein Sentence Completion Test - Specific family attitudes and fears:**

- attitude towards mother

My mother ...

I think that most mothers ...

- fears

I know it's silly but I am afraid of ...

Most of my friends don't know I'm afraid of ...

I wish I could lose the fear of ...

My fears sometimes force me to ...

Daston [1968:279] is of the opinion that it is not necessary to subscribe to the assumptions of any one theory, to use sentence completion tests. The purpose of the investigation will determine how such tests are used. However, he states convincingly, that this method is very valuable in obtaining projected information from the subject on many different aspects of his personality.

As with all projective media, the psychologist should focus on the whole first. He should read through the entire record to gain a global impression, according to Daston [1968:281]. He should get a feel for sequences, clusters and responses which have little reference to the opening words. Finally, he should examine individual sentences and then make inferences and hypotheses based on the information he has gleaned.

For the purpose of this study, the following sentences have been extracted as a means of enquiring about the level of anxiety of the child, within his relationships with his self and significant others.

* **Relationships with Self:**

- I regret ...
- What annoys me ...
- I feel ...
- My greatest fear ...
- I can't ...
- My nerves ...
- I suffer ...
- I failed ...
- My mind ...

- The future ...
- I need ...
- At bed time ...
- The only trouble ...
- What pains me ...
- I hate ...
- At school ...
- I am very ...
- The only trouble ...
- I wish ...
- I ...
- My greatest worry is ...
- I regret ...

* **Relationship with Parents and Family:**

- My mother ...
- My father ...
- The best ...
- At home ...
- When I was younger ...

* **Relationship with Peers:**

- Boys ...
- Other children ...
- Sports ...
- Dating ...
- Dancing ...
- Most girls ...

* **Relationship with Teachers and Objects and Ideas:**

- I want to know ...
- People ...
- Reading ...
- My mind ...
- At school ...

(c) **Thematic Apperception Test [TAT]/Children's Apperception Test [CAT]**

[The following sources were used in researching these projective tests: Bellack 1954; Bellack & Bellack 1980; Du Toit & Piek 1987; Eron 1965; Murray 1971; Shand 1990; Van Rooyen 1990.]

The TAT is suitable for children over the age of 8 years and is described by Eron [1965:504] as 'a diagnostic instrument in the sense that it gives an understanding of the individual in his own life setting'. It helps the clinician to determine the dynamics and content of an individual personality and to understand his preoccupations and conceptions.

The CAT is suitable for children between the ages of 3 - 10 years and is described by Bellack and Bellack [1980:1] as a projective or apperceptive method of 'investigating personality by studying the dynamic meaningfulness of the individual differences in perception of standard stimuli'. It also helps the clinician to understand the child's personality by interpreting the possible meanings his stories have for him. These half-structured tests reveal to the psychologist some of the dominant drives, emotions, sentiments and complexes of a personality. Special value can be seen in its power to expose the underlying, inhibited tendencies and anxieties which the individual is not willing to admit to, or cannot admit to because he is not conscious or aware of them. In this way, an indication of the individual's ego strength and inner

resources can be obtained.

In the same way that the drawing and completed sentences are a reflection of the child's inner world, so are his stories. The rationale behind this projective technique is based on the tendency of the child or adult to interpret ambiguous human and animal situations in terms of his personal, past experiences and present needs. The stories told about the TAT and CAT cards will therefore facilitate access to the child's inner world, to the meaning he has attributed to his world, his inner drives, motives, anxieties and fears as well as his perceptions of his relationships with himself and significant others.

The following have been selected as it is felt that they would help the researcher to gain access into the anxieties, fears and tensions of the child. However, all cards could be used and a person's anxiety may come through at any time, depending on many varied aspects. Each individual will respond in a unique and personalised manner, to the stimulus of each card, making an objective selection of cards fairly difficult.

The following cards of the TAT have been selected on the stimulus value of each card.

- * **Card I:** In many respects this can be viewed as the single, most valuable picture in the TAT. It is non-threatening and, therefore, does not evoke situational anxiety unnecessarily. It is also a good card with which to start. It elicits the child's relationships with his self, his parents and other authority figures and it explores the child's need for or fear of achievement. It may evoke symbolic second responses, and sexual fears and anxieties may be elicited. Obsessive-preoccupation, indicating excessive anxiety, may become apparent if the child becomes over-concerned with detail on the picture.

- * **Card 3BM:** This card is considered to be the frustration card and it is assumed that the child's typical reaction to frustration will be revealed. Considering the close relationship between anxiety, frustration and aggression/hostility [cf. 3.5.2.4], this card is especially relevant. It is important to note whether aggression is absent or present and whether the aggression can be a reflection of the child's deeper anxieties. It will be evident from the child's story, whether he can find solutions to difficulties, or whether he becomes passive, afraid and withdrawn.

- * **Cards 6BM and 7BM [for boys]:** These cards reflect the mother-son and father-son relationships and therefore should be included to understand how the boy perceives his relationships with his parents and possible anxieties that may be present in these relationships.

- * **Cards 6GF and 7GF [for girls]:** These cards reflect the mother-daughter and father-daughter relationships and should therefore also be included for the reasons stated above.

- * **Card 11:** This card operates on a more disguised plane and puts many people off guard, although it may frighten others. Many infantile and primitive fears are frequently brought out by this card since the dragon permits projection of such emotions. If a person experiences fears of being attacked, lost, hurt, etc., this is a useful card since it explores the fine features of the fears of being under attack or vulnerable. Anxiety is often expressed in the content, changing with the various cultural factors of the population being assessed. Stories may refer to everything being killed and this can indicate an intra-psychic state, consistent with very severe emotional impoverishment.

- * **Picture 14:** This card's stimulus often elicits childhood fears in relation to darkness. It can also stimulate the child who worries excessively about burglars or **baddies** breaking in to hurt him. It may elicit suicidal

tendencies or feelings of loneliness and depression.

All the cards of the CAT have been selected, as each card has stimulus value to different aspects of the child. His responses to the cards will reflect his overall anxiety, fear and the quality of his interpersonal relationships.

Card 1: According to Bellack and Bellack [1980:3], this card can reveal difficulties around the oral stage of development. Themes of feeding, over-protection, lack of nurturing at an emotional and/or physical level, sibling rivalry, behaviour reinforcers, etc., are elicited.

Card 2: This card is often seen to highlight the relationship between the child and his parents and the child's perceptions of the relationship between the parents themselves. The parent with whom the child identifies strongly can be revealed. Feelings of conflict or being **pulled** between the parents, are also revealed. Feelings that can be evoked are aggression, anxiety, fear of punishment, etc.. The breaking of the rope can symbolize castration fears as well.

Card 3: This card depicts the authority figure or father-figure and the feelings the child has in this regard. Feelings of overt aggression, passive aggression, anxiety and fear with regard to authority can be elicited. Conflicts between the need for autonomy and dependency are also often revealed.

Card 4: This card may elicit themes of sibling rivalry or focus on the quality of the relationship between the child and his siblings. Mother-child relations may also be revealed. The need to regress or fixate at an earlier age can be made evident. A theme of flight from danger is occasionally introduced. According to Bellack and Bellack [1980:3], an unconscious fear in the area of father-mother relationships, sex and pregnancy, is often related to this need to flee.

Card 5: This card is considered to focus on the primal scene in all its variations. The child's stories often reflect confusion, emotional involvement and observation of this theme. Sexual inquisitiveness and the need for explanation can also be revealed.

Card 6: Again, the focus of this card concerns the primal scenes and the anxieties and fears the child may have in this regard. Often, the child will find it easier to respond to this card, after having responded to Card 5.

Card 7: This card tends to reveal the degree of anxiety in the child, as well as the fear of aggression. It can lead to the rejection of the card totally if the anxiety is very great. However, the defences against the anxiety can also be measured by this card and the child may turn the story into an innocuous one. The child may even change the victim [monkey] into the aggressor or find a way to outsmart the aggressor [tiger]. The tails of the animals may lend themselves to the projection of fears of or wishes for castration.

Card 8: Here the role of the child within the family constellation is often revealed. The parent figure [dominant foreground monkey] is often revealed as punishing or benign. Themes of orality can be aroused by the setting of the tea party.

Card 9: This card may evoke fears of darkness, isolation, being abandoned or deserted by the parents or significant others.

Card 10: This card depicts the possible theme of toilet training and anal stage fixations, punishment, etc. and reveals information about the child's moral development, as well as possible masturbation. Regressive trends in the child may become evident.

The themes for the various cards of both the TAT and CAT should be analysed as a whole and the following aspects, which may indicate high levels of anxiety, could be closely observed [Bellack 1954, Van Rooyen 1990]:

- * the dramatisation of the stories and the presence of intense conflict;
- * a high percentage of verbs;
- * the fantasy and activity levels which are dramatised and tend towards compulsivity;
- * a search for alternatives and vagueness and a tendency towards an inability to identify strongly with the various figures in the pictures;
- * the stories which tend to have no resolutions;
- * a tendency to apologise and make excuses for a lack of imagination and to be emotionally guarded and defensive; and
- * stories with themes of physical accidents or psychic traumas.

In addition, Bellack [1954:74] mentions that it is important to determine the main anxieties of the person and to note his possible defences in this regard. He lists the defences as taking the form of passivity, flight, aggression, orality and obsessions as well as themes becoming more innocuous or permitting more expression of a forbidden drive.

4.2.2 Synthesis

It becomes evident from Chapter Four that the assessment of anxiety in children is closely related to the theoretical frame of reference and the purpose of the assessor/researcher. While a variety of measures exist, some appear

to be better developed and more useful in specific situations, than others.

It would appear that the unstructured interview is the most widely used tool in the assessment of anxiety in children and it has many advantages, such as flexibility, naturalness and comprehensiveness. However, its impaired reliability and validity and the need for one-to-one interaction, makes it unsuitable for nomothetic research. Semi-structured and structured interviews have thus been developed. Rating scales appear to be most extensively used in the normative assessment of children's fears and trait-, state- and situation-specific anxiety. These are often directed at parents, teachers and other adults, but self-reports are becoming more common than in the past.

It is generally believed that projective techniques remain an important method and an important source of information in the study of human problems. However, the validity of these methods is still a thorny issue and needs continued research in order to offer more personality and behavioural criteria and improved assessment tools.

It is felt that a comprehensive assessment of anxiety should include a variety of measures. As pointed out in her previous research, Shand [1990:192] warned that self-inventories and questionnaires need to be used with great caution when conducting nomothetic research with certain groups of children, as they tend to attribute unrealistic significance to themselves for a variety of reasons, e.g. their need to feel accepted, well adjusted, conforming, etc.. They often tend to choose socially-acceptable answers or give a socially-acceptable view of themselves.

Hoehn-Saric *et al.* [1987:544] also warn that anxious children externalise their distress, deny their symptoms and present a façade of bravado [cf. 4.2.1.3.2]. For this reason, it would seem important to include with the questionnaires and inventories, interviews and projective tests in any assessment of anxiety in children.

4.3 CONCLUSION

Chapter Four has attempted to investigate, as widely as possible, the various methods of assessing anxiety in children. This task has been made more difficult by the fact that the phenomenon, anxiety, is not seen as one-dimensional but as multifaceted.

The different types of anxiety which have been highlighted are:

- * state and trait anxiety;
- * general and test anxiety;
- * overt and covert anxiety;
- * free-floating and manifest anxiety; and
- * normal and neurotic anxiety.

The various psychometric measures of these types of anxiety have been investigated and reported on. However, it is this researcher's belief that while these measures may have great value in highlighting certain aspects about the various types of anxiety in the general population, they do not always **measure** what meaning the anxiety has for a particular child. Therefore, a more holistic approach will be adopted in Chapter Six, in viewing each child as an individual and assessing him in his life-world and exploring the effects his anxiety has on his development and actualization.

Chapter Five will investigate the various methods of treating anxiety in children. The different perspectives of play therapy will be explored, with special emphasis on hypnotherapy for children, as an additional **tool** to be used with other forms of play therapy.

CHAPTER FIVE

THE TREATMENT OF ANXIETY IN PRIMARY SCHOOL CHILDREN

5.1 INTRODUCTION

Suinn [1975:519-520] mentions that treatment should involve a corrective experience for the individual so that he is more effective and more stable in his emotional state of adjustment than before treatment.

Suinn offers psychotherapy as a method of treating emotional difficulties which would involve a relationship between the psychologist or psychiatrist and the individual needing treatment. Anxiety may be considered an emotional difficulty that would require treatment.

However, as stated in Chapter One [cf. 1.3], the symptoms of anxiety in children are often treated, such as enuresis, stuttering and poor school performance, rather than the anxiety and the causes of the anxiety. The causes of anxiety are investigated fully in Chapter Three [cf. 3.4] and include unmet emotional needs in the children, disturbed interpersonal relationships, fixation at a specific developmental stage, traumatic experiences the child may have encountered, conditioning from the parents and significant others in his life, a feeling that his existence is threatened in some way and being unable to find meaning in his life. Emphasising the symptoms of anxiety rather than the causes, is further borne out by Wicks-Nelson and Israel's research [1984:392-394] in which no mention is made of the anxious child but instead all the symptoms of the anxious child are listed. They list treatment for asthma, depression, enuresis, learning difficulties, obsessive-compulsive disorders, phobias, sleep disorders, withdrawal behaviour, etc..

Kaplan and Sadock [1989:1849-1852] mention different treatments for the anxiety

disorders in adolescence and childhood, but not for anxiety in general. They mention, as treatments, individual psychotherapy, family therapy, peer group therapy, relaxation techniques and pharmacology.

Rutter and Hersov [1987:371] offer information on treating anxiety states which they define as broader than anxiety disorders and include simple school phobia as well as anxiety-prone children generally.

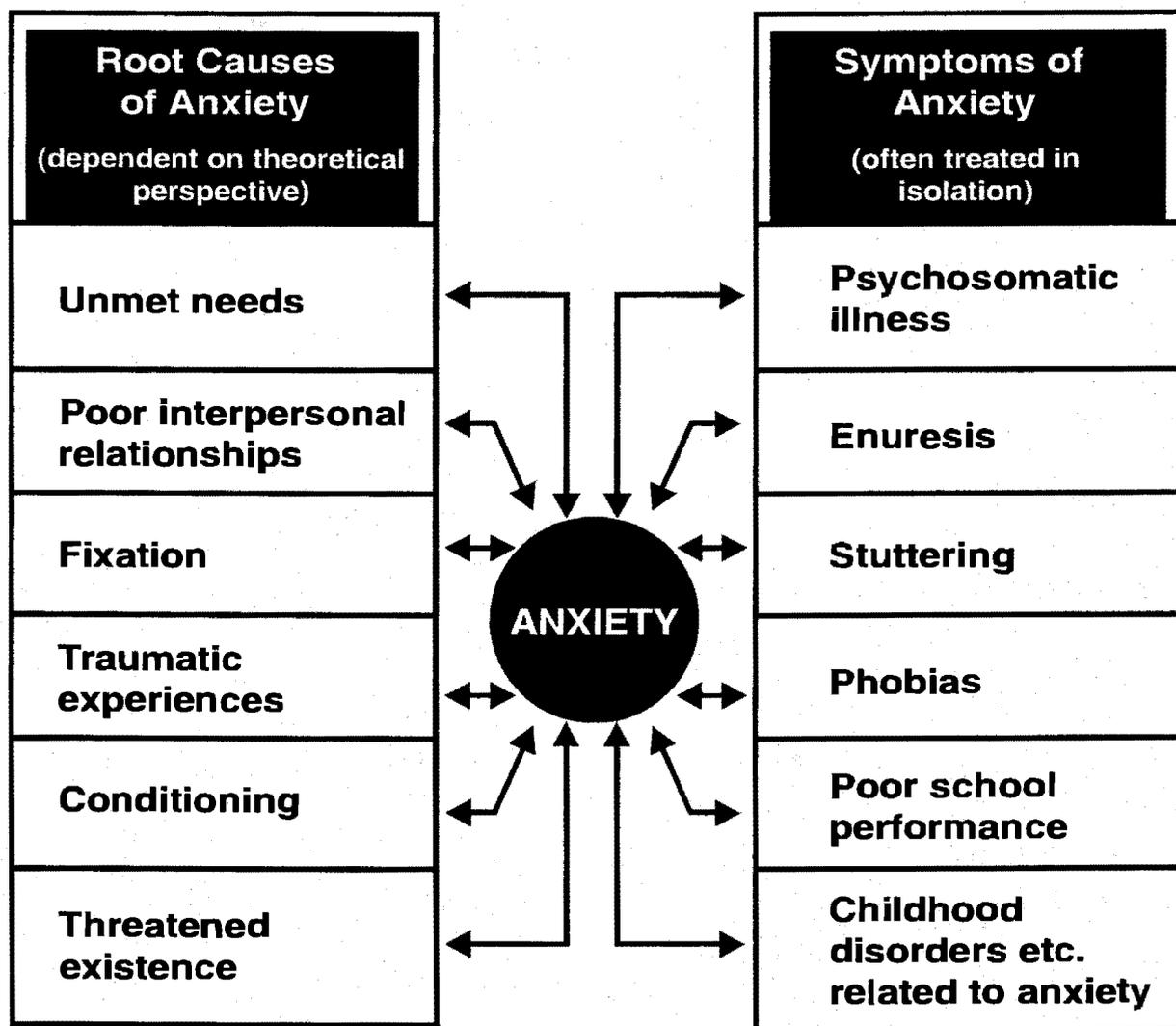
Play therapy is generally considered the best form of therapy for all children, no matter what their emotional problems are. However, play therapy is a very broad concept and differs fairly considerably, depending on the various theoretical perspectives.

This chapter will therefore attempt to research the various methods used to treat anxiety in children, focusing on hypnotherapy and its therapeutic value in treating anxious children.

The following diagram [Figure 5.1] attempts to illustrate the difference between the causes of anxiety and the symptoms that results from anxiety.

FIGURE 5.1

CAUSES & SYMPTOMS OF ANXIETY



5.2 WAYS OF TREATING ANXIETY IN CHILDREN

5.2.1 The Medium of Play

You can discover more about a person in an hour of play than in a year of conversation.

[Plato (Schaefer 1985:95)]

According to Schaefer [1985:105] a common belief is that play has a powerful therapeutic value for a child with emotional and/or behavioural problems.

Winnicott [1974:58] concurs with this belief and states that 'it is good to remember always that playing is, itself, a therapy. To arrange for children to be able to play, is itself a psychotherapy that has immediate and universal application and it includes the establishment of a positive social attitude towards playing'.

Bruner [1986:77-78] maintains that play is an activity that is without frustrating consequences for the child, even though it is a serious activity. He proceeds to set out the fundamental functions of play in the child's activity which are reported below:

- * As an activity, play is for itself and not for any other reason. Therefore it provides an excellent medium for exploration.

- * Play has a very close link between means and end and allows for much flexibility in that the child can change the goals while playing to suit new means or even change the means to suit new goals. In this way, it provides a medium for invention.

- * Play is rarely random or by chance. It follows a scenario that allows for a kind of idealised imitation of life and therefore allows for the child to play out fantasies, wishes and needs.
- * Play is a projection of interior life onto the world and, in this way, is the opposite of learning; when the external world is internalised and made a part of the child. In play, the child is free to transform the world according to his desires instead of conforming to the structures of the world.
- * Play is a source of great pleasure to the child and it allows for problem solving in a fun and joyous way.

However, symbolic play occurs only in the second period of preoperations [cf. 3.2.3.2] and includes games of pretending. Symbols become the way in which the child expresses everything in his life experience that cannot be formulated and assimilated by language alone.

According to Kaplan and Sadock [1989:259], early play can be followed, in its development, through Piaget's six stages of sensorimotor intelligence [cf. 3.2.3.1], which are seen as proactive and exercise play. The six stages are:

- * inborn motor and sensory reflexes;
- * primary circular reaction and first habits;
- * secondary circular reaction;
- * use of familiar means to obtain ends;

- * tertiary circular reaction and discovery through active experimentation; and
- * insight and object permanence.

Rutter and Hersov [1987:537] point out that make-believe or symbolic play serves many functions including:

- * the exploring of feelings;
- * the lessening of fears;
- * increasing excitement;
- * re-enacting an event for understanding;
- * altering stressful behaviour to make it more pleasant; and
- * as a means of rehearsing and developing social skills.

Piaget, according to Reber [1985:553], mentions three classes of play which may be used as a general framework in which to view the different forms of later play:

- * games of make-believe and fantasy;
- * games with rules, such as war games, hide and seek, etc; and
- * games of mastery, building, copying, designing, etc..

Brady and Friedrich [1982:39-40] concur with the previous authors and add that play is linked to a number of cognitive phenomena such as problem solving, language learning, creativity and the development of social roles. They cite Garvey as defining play as pleasurable and enjoyable, intrinsically motivated, spontaneous and chosen voluntarily and involving active participation on the part of the player.

Dinkmeyer and Dinkmeyer [1983:127] maintain that play allows children the opportunity to develop their social interests, change their perceptions of themselves and the world, and improve the quality of their interactions with other people. In this way, the consequences of play allow new approaches to motor, social and emotional functioning.

Katz [1985:311] maintains that by learning to experience the world through play, one learns to play with fear, to play with anxiety and to transform experience so that it becomes more positive.

In summary, Erikson [1940:668] states that 'it is an intriguing idea that even where nobody sees it or does anything about it, children proceed to express their vital problems in the metaphoric language of play; more consistently and less self-consciously than they are able or willing to do in words'.

5.2.2 Play Therapy

Therapy is a broad term which is used for all the treatments of all psychological difficulties. The broader aim of therapy for children, according to Jacobs and Vrey [1982:84] is to help the child:

- * achieve internal control of himself; and

* to reach his full potential in life.

Axline [1986:Prologue] concurs with these goals and explains that the process of psychotherapy, through the medium of play, enabled Dibs [her child-client] to:

come forth and meet the abrupt forces of life and therapy, develop a new awareness of a selfhood and stature and wisdom that was within him. He could accept the precious gift of life, both the sunshine and the rain and could find his security within a stabilising centre deep down inside himself.

Reber [1985:553] mentions that play can be used as a diagnostic tool and/or as a treatment in which the play environment provides a safe place within which pent-up emotions and feelings can be freely expressed and where patterns within the play activities of the child reveal his particular emotional and social-interaction difficulties. He, therefore, defines play therapy as 'the use of play situations in a therapeutic setting'.

According to Piaget [1972:26], the child will only understand something if he constructs it himself and re-invents it. Although Piaget was undoubtedly referring to the cognitive gains of the child, through play, it may well apply to the child's emotional gains. Winnicott [1974:59] mentions also that the significant moment in play therapy is not clever interpretation made by the therapist, but the moment 'at which the child surprises himself or herself'. By this he means that the child needs to become aware of things for himself rather than have them pointed out or interpreted for him. In fact, Winnicott makes the following very strong statement, 'Interpretation outside the ripeness of the material is indoctrination and produces compliance'.

Burns [1970:37] describes seven ways that play can be used in the treatment of

children with emotional difficulties. They are:

- * to bind anxiety; as the child expresses feelings that are upsetting to him, play can assist by reducing his anxiety;
- * for working through difficulties; basic conscious and unconscious struggles and conflicts can be dealt with during play;
- * for ventilation; the child can ventilate his feelings of frustration and anger through play and thus reduce his level of tension;
- * for communication; repeated themes within the play communicate to the therapist his level of awareness of the problem and the amount of directness he can tolerate in dealing with his problems; by helping the child to label his feelings, to differentiate among them and to connect them to events, the therapist assists the child in dealing with his problems;
- * in the service of regression; some children require returning to an earlier stage of development in order to progress to a more mature level and play enables the child to do this while feeling safe and secure;
- * for the development of skills which enhance self-esteem and can be acquired through play; the child can learn to organise a task, withstand frustration and follow through to completion, through play and in this way, he can raise his self-confidence and his expectations of himself; and
- * towards the modification of his life-style; through play the child can be helped to focus on his basic approach to daily tasks; he can learn to risk, to be less defensive and to believe in himself thus challenging his often self-defeating life-style.

Brady and Friedrich [1982:40] describe play therapy as 'a vehicle for the expression of feelings, emotions and affect'. They maintain that play, in therapy, allows for the expression of emotions in a more indirect or displaced fashion. Their eventual goal for play therapy is for the child to gain conscious access to his feelings and to discuss them verbally. It must be noted, however, that Hammer [1958:146] warns that after a short period of therapy, i.e. one month, anxiety in the child or client can be heightened, before being lessened at a later stage and that his basic conflicts may be sharpened, but that there will be generally less confusion about the conflicting impulses and less regression in behaviour.

5.3 DIFFERENT PERSPECTIVES OF PLAY THERAPY

5.3.1 Psychoanalytic and Psychodynamic Perspectives

Wehman and Abrahams [1976:553] emphasise that the two functions of play according to the Psychoanalytic orientation are:

- * to allow the child to gain control over his thoughts and actions; through the activity and repetition of play, the child learns about himself and his environment; and
- * to enable the child to deal with painful or unpleasant situations and to expose his emotions outside the real world.

Anna Freud [1966; Wicks-Nelson & Israel 1984] was one of the first therapists to begin Psychoanalytic work with children on a formal basis. She focused on the ego of the child rather than on the unconscious id impulses that were the focus of Sigmund Freud's work. However, she continued to identify and interpret the unconscious mental activity that the child demonstrated through play

[Freud 1966:50-55].

Oppenheimer [1988:16] states that Psychoanalytic therapy with children focuses on the analysis of resistance and transference, with the function being to resolve the conflicts that may be interfering with the child's ability to utilise his usual resources to maximum capacity. It enables the child to mature emotionally and gain insight into his difficulties. This is done by allowing the components of the mind, the id, the ego and the superego, to harmonise with one another. He mentions four phases through which the therapy passes and these are listed below.

- * **Opening phase:** The child's developmental history is taken as well as the approaches taken by the child in making his problems known; his resistances and some of his unconscious conflicts are observed.

- * **Analysis of transference:** The therapist assumes major significance in the life of the child and the professional relationship may become distorted as the child tries to introduce personal considerations into their interactions. Repressed unconscious fantasy is often revealed at this stage.

- * **Working through the transference:** This stage and the previous one are interlinked and overlap with one another to a large extent. The child is assisted in working through the issues that arise in the relationship between therapist and child. The child's insight into his problems by way of transference, is constantly deepened and consolidated by the process of working through, which consists of repetition, elaboration and amplification.

- * **Termination phase:** The child and analyst are satisfied that the goals of treatment have been accomplished and the transference is well understood.

Often in this phase, initial symptoms may return or become aggravated and previously repressed memories or fantasies may emerge, which then have to be resolved and the therapy is then terminated.

Freud [1966] and Klein [1989] both emphasise the importance of the meaning of play and recognise that children express their unconscious impulses and fantasies [Reisman 1973:5] through play while adults have the language and cognitive development that enable them to communicate verbally.

Peller [1954:178-197] presents a Psychoanalytic perspective of the developmental changes that take place in the child, through play therapy, as well as the secondary play gains for the child. He cites them as follows:

- * The first central theme of play is the relation to the body and anxiety concerning the body. At this stage, secondary gains include increased mastery of the body and an active search for gratification.
- * The theme then becomes preoedipal mother and the fear of losing this primary love object. Concurrent secondary play gains are the ability to tolerate frustration and the initiation of lasting object relations.
- * Oedipal issues are central to the following period \pm 3 years of age and are manifested in physical motions, symbolic play and play with rules. Secondary gains are the utilisation of social convention.

These Psychoanalytic formulations of play in the early stages seem to parallel with Piaget's more cognitive developmental perspective of the developmental stages of play practise or exercise play, symbolic play and rule play cited earlier in the chapter [cf. 5.2.1].

Klein [1989:7] states that the child expresses his fantasies, wishes and actual experiences in a symbolic way through play and games. However, for Klein, symbolism is only part of understanding the child's play correctly. She insists that it must be seen in relation to his whole behaviour and therefore, she favours Psychoanalysis in order to do this. By means of analysis and interpretation, the child is helped to understand himself through his play. Klein [1989:8-15] emphasises working with the conscious and unconscious in the child. She believes that in certain strata of the child's mind, communication between the conscious and unconscious is comparatively easy and that the way back to the unconscious is much simpler to find in the child than in the adult. Klein maintains that if anxiety is resolved through interpretation, the child's desire to play is restored and energy previously spent on repression is used in new, creative play.

For Klein [1989:15], play therapy or play analysis enables the therapist to 'gain access to the child's most deeply repressed experiences and fixations' and thereby 'exert a radical influence on its development'.

Play therapy allows the child to release his tension and anxiety which, in turn, results in bringing the child's repressed ideas, feelings, wishes and memories of the past into consciousness. This process is termed a **catharsis**.

The Psychoanalytic and Psychodynamic perspectives allow for two variations of the play situation; unstructured or structured play.

5.3.1.1 Unstructured play therapy

In this type of play therapy, the child is free to express and act out his fears, fantasies and hostilities that he may be unable to express constructively in his own environment. He may choose to interact with the therapist or play on his

own. All decisions with regard to his play are left up to him.

According to Graham [1975:22-37] certain limits are set for the child's safety and that of the therapist. Graham emphasises that the most important aspect of the therapeutic process in the unstructured or non-directive play therapy, is the relationship between the therapist and the child. It is therefore vital that the therapist is non-judgemental, unconditionally accepting and empathic and has no agenda of his own, which is in keeping with Roger's [1961:47-48] philosophy. In this way, the child is allowed absolute freedom and acceptance in a safe environment that encourages him to venture out and interact with another human being in a way that may have been too threatening to him in the past.

Klein [1989:13] warns that a necessary condition for the success of play or Psychoanalytic therapy for children is, that the analyst should 'refrain from exerting any kind of non-analytic and educational influence upon the child'. This statement has important significance, especially for educational psychologists who may feel obliged to play a part in the socialisation of the child in therapy.

Schaefer [1985:103] makes the assumption that the therapeutic process in play seems to pass through four distinct phases which are listed below.

- * First Stage: Firstly, the child exhibits diffuse, indifferent emotions that are very negative in nature. He may want to destroy everything or be left alone in silence.
- * Second Stage: Later on he may feel free to express anger more specifically towards a parent, sibling, peer or teacher.
- * Third Stage: This may lead to a stage when the child is able to express positive feelings but a considerable amount of ambivalence is demonstrated

at the same time, so that his kindly feelings are interspersed with hostile ones. These ambivalent feelings tend to be intense and irrational and he will hug a doll one minute and then yell at it or try to hurt it the next.

- * **Final Stage:** As his positive emotions become stronger, the child will enter the final stage in which he is able to separate and express more realistically his positive and negative emotions.

Client-centred play therapy [devised by Axline (Oppenheimer 1988:26)], is a form of unstructured play therapy which integrates Roger's philosophy with play therapy. It allows the child the freedom to be himself without the threat of being evaluated, judged or criticised. There is no pressure exerted on the child to change his behaviour in any way. It is assumed that each child has the capacity and ability to solve his own problems satisfactorily and has an innate drive for maturity.

Axline [1986] believes that the child's experience of play therapy should be different to any other experience the child has had. According to her, the child should be given the opportunity for personality reorganisation, through an increase in unconditional self-regard by means of the therapist providing the right environment characterised by empathic, warm and genuine responding. The child is then able to make a new and congruent synthesis of himself and move forward towards more mature and better adjusted behaviour.

According to Klein [1989:9], child analysis allows the child to get back to experiences and fixations, which in the analysis of adults can often only be reconstructed, whereas the child shows them as immediate representations. In this way, the child is able to represent his unconscious in a direct way and live through and abreact the original situation and, thereby, resolve his fixations and conflicts.

Klein [1989:12] concludes that in child analysis, the therapist first applies himself to the child's unconscious and from there gradually gets into touch with the ego, as well, as this is the 'shortest cut across the ego'. By means of reducing the excessive pressure of the superego, which is much heavier on the feeble ego of the small child than on that of the adult, the ego is strengthened and is able to develop. This enables the child to develop more freely and to feel better in his actual environment. His mother will often react in a much less neurotic way as soon as the analysis begins to have a favourable effect on the child.

Klein [1989:12-13] emphasises that a necessary condition for consistent interpretation, gradual resolution of the resistances, steady reference back of the transference [whether positive or negative] to earlier situations, is that the therapist does not exert any kind of nonanalytic or educational influence upon the child. Klein maintains that this will allow the child to be free to regress to whatever stage he needs to. She states that it may 'begin to wet its bed once more or in certain situations ... talk like a small child of one or two'. As the newly gained knowledge is at first mainly consciously worked over, the child is not 'confronted all at once with a situation that calls upon it to revise its relation to its parents'. This development occurs emotionally at first. The gradual working over of the knowledge brings nothing but relief [catharsis] to the child and a marked improvement in his relationship with his parents. The demands of the superego having been modified by analysis, the ego is now less oppressed and consequently stronger and is able to carry them [the demands] out more easily [Klein 1989:14].

The term, **transference**, that Klein refers to, is the projection of the child's feelings, perceptions, attitudes, values and wishes, about the therapist which stem from his relationships with significant others in his life. Racker [1968:13] presents the phenomenon, transference, as a 'highly valuable and even

indispensable element of analytic work'. He views this aspect of the relationship between therapist and patient as there, because it exists in the patient from his early life onwards, because of his relationships with his parents and other significant people. Therefore, in working with a child, the therapist is working with aspects of the child's relationships with his mother and father directly and often without years of repression and denial as would exist in adult therapy. **Counter-transference** [Racher 1968:18] is also seen as a 'technical instrument of great importance ... an emotional response to the transference ...'. It can disturb or help the analyst's understanding and capacity to interpret the patient's unconscious conflicts. It can also determine the destiny of the transference, depending on the analyst's attitude towards the patient. In this way, the counter-transference is 'decisive for the transference and its working through, and it is also decisive for the whole treatment'. Therefore, it is extremely important for the play therapist to understand fully the implications of the child's projections and to be able to handle the counter-transference therapeutically and effectively.

5.3.1.2 Structured play therapy

Schaefer [1985:98-102] reports that Levy stimulated great interest in structured play therapy after reporting his success with children aged between 2 to 10 years. He named it release therapy and controlled the play by selecting the toys he felt the child needed to play out his particular problem as determined by the case history. He concentrated on the child's thoughts and feelings while playing and often played with and sometimes for the child in order to bring out and release the assumed emotions.

The release therapy can be divided into three groups, namely:

- * simple release of instinctual drives, e.g. encouraging the child to throw

objects around the playroom, burst balloons or suck a baby's bottle;

- * release of feelings in a standardised situation, e.g. presenting a baby doll at a mother's breast to stimulate feelings of sibling rivalry; and
- * release of feelings by recreating a particularly stressful experience in the child's life in the play session, e.g. in dealing with a child's fear of bowel movements by offering family dolls, brown clay, toy toilet, nappies, baby oil, cotton and a baby's bottle and allowing the child to express and play through his fears.

Structured play therapy encourages the repetition of play themes and so helps the child to relive and gradually assimilate a stressful event and integrate it rather than deny it or be overwhelmed by it. The child is able to control the situation thereby making the events seem less overpowering and, finally, he is able to master the situation. It also allows for catharsis [which is a form of emotional purging] to take place by allowing the child to play out intense emotions, conflicts, fears and anxieties.

In summary, according to Schaefer [1985:101], 'structuring a child's play so he or she re-experiences a stressful situation cannot only allow for a release of pent-up emotions but also assist the child to cognitively assimilate the event and master it'.

A major advantage appears to be that it increases the specificity of treatment and thereby saves time and money for the client. However, a warning is given that it should only be employed when a positive therapeutic relationship is firmly established between child and therapist and if the child is judged to have sufficient ego-strength to tolerate the emotional upheaval. Emotional flooding, where a release of a massive amount of negative feelings causes the child to

regress or disintegrate or feel overwhelmed, should be avoided at all costs.

Another form of release therapy is Jernberg's [1979:2] Theraplay. Jernberg acknowledges the influence Des Lauriers and Brody had on her work. However, she sees her work differing from theirs in 'intensity, vigour and perseverance and in its regressive dimension; nurturing'. She maintains that while Theraplay retains spontaneity and fun, the sessions need to be carefully preplanned and structured.

Theraplay takes into consideration the basics of the mother-child relationship and the nurturing aspects of mothering. However, along with the nurturing, other aspects are included, such as structuring, challenging and intruding. She explains that all of these aspects are important for healthy emotional development in the child and proposes reasons why some parents, mothers in particular, because of their own emotional development, find it difficult to meet their offspring's needs [Jernberg 1979:7-9].

Theraplay differs from conventional play therapy [insight-dynamic and client-centred] in the degree to which the therapist takes responsibility for the child's therapy. The therapy can be understood as having six phases which can be modified according to the child's age and difficulties. They are introduction, exploration, tentative acceptance, negative reaction, growing and trusting and termination. The therapist decides how each session will be structured and by using the four categories of nurturing, structuring, challenging and intruding, works directly with the child in a fun, exciting and creative way to enable the child to grow emotionally.

5.3.2 Learning Theory

The very Humanistic conception of Psychoanalytic and Psychodynamic play

therapy was challenged, in the 1960's, by treatment approaches from the Learning theorists. These were based on the straightforward and direct application of Learning principles which would modify behaviour and emotional problems in children [Reisman 1973:6-8].

Oppenheimer [1988:32-33] reports that child Behaviour therapy operates on the assumption that psychological disorders are forms of behaviour that have been acquired or modified through 'lawful operations of principles of development, learning, perception, cognition and social interactions'. Their treatment methods have evolved from the principles of respondent conditioning, operant conditioning, social learning, formulations and cognitive mediation. As the child plays or interacts with the therapy, the pathology or problems are expressed and the interventions are then taught to the child and his parents.

According to Stampfl and Levis [1967:496-503] Behavioural or Learning theory approaches to psychotherapy may be divided into several distinct orientations. Some are based on empirically derived techniques such as those of Ayllon, Krasner, Lindsley and Skinner, while others are more theoretical such as Dollard and Miller, and Rutter and Shoben, with the emphasis on reinterpreting conventional therapeutic strategies and goals from a Learning theory framework. A third group, such as Salter, Wolpe and Yates, has applied its Learning theory orientation directly to the development of new techniques and approaches. However, according to Stampfl and Levis [1967:497], the main disadvantage association with these analyses is that very little effort was made to extend their treatment beyond the area of theory into the realm of practice.

Although many therapists appear to view Behaviour therapy as a form of training and not psychotherapy, Reisman [1973:10] argues that it can be included in this category, by his definition which is that 'psychotherapy is the communication of person-related understanding, respect and a wish to be of help'. Although play

therapy, as such, is not used in Behaviour therapy, toys and play are used in a very controlled and directed manner. Real life situations are recreated to assist the child emotionally. For the purposes of this study, three aspects of Behaviour therapy, that can be used with children, will be explored. They are:

- * Systematic relaxation and desensitisation.
- * Implosive therapy.
- * Behaviour modification.

5.3.2.1 Systematic relaxation and desensitisation

Wolpe maintains that deep muscle relaxation is a widely used means of inhibiting anxiety as it has 'autonomic accompaniments that are exactly opposite to those of anxiety' [Ross 1974:185]. Wolpe uses it often [when he cannot use hypnosis] in conjunction with systematic desensitisation, where various situations belonging to an area of disturbance are listed and then placed in rank order in a hierarchy with the most disturbing ones placed first. The weakest scene from the hierarchy is then presented to the imagination of the deeply relaxed person for a few seconds and the procedure repeated until the imagined item no longer evokes anxiety at all.

According to Surman [1979:54], the use of systematic desensitisation in the treatment of anxiety is well-known. The method was first introduced by Wolpe [cf. 2.4.4.3] and was based on the concept of reciprocal inhibition. Relaxation training, the construction of a hierarchy of anxiety-provoking events and guided use of imagery are all important aspects of this method.

Surman [1979:55] reports using this technique of systematic desensitisation, with a slight variation of **post noxious** desensitisation, in that the anxious adult is asked to experience each event in the hierarchy as if beginning from the point of task completion. In other words, the person begins with the goal acquisition and works his way back through the fantasised situation. In fact he starts from a point of success which provides early effective positive reinforcement and an implicit statement of the person's capacity for masking. The therapist remains active, guiding the imagery and emphasising the person's areas of established ego-strength and superimposing positive imagery to minimise anxiety.

Tasto [1969:409] used muscle relaxation and systematic desensitisation on a four year old phobic boy. He found the muscle relaxation techniques to work well but had to use *in vivo* conditioning in the therapy sessions as the child's imagination did not allow him to create the high levels of anxiety normally felt under certain conditions. Tasto [1969:410] states that 'the capacity for imagined stimuli, however, to evoke anxiety is probably somewhat a function of development and more research is needed to determine when, developmentally, imagined stimuli have sufficient capacity to evoke anxiety so that counter-conditioning may be effective'.

According to Miller *et al.* [1974:921] systematic desensitisation has been documented by Lazarus; Miller; Ohler and Terwillige and Tasto, as having been successfully applied to children suffering from phobias and other anxiety-related conditions. Variations of this method are also documented by Miller *et al.* [1974:122]. Emotive imagery, using a doll play technique, to stimulate fantasy rehearsal of assertive behaviours and play techniques, using dolls to act out fearful fantasies, are described.

Emery [1969:26] used systematic desensitisation as a means of reducing test anxiety. He states that a person cannot be relaxed and anxious at the same time

and, therefore, the anxiety can be systematically reduced by pairing the eliciting stimuli with deep relaxation [cf. 2.4.4.3]. He used sixteen sessions, over a period of eight weeks, with his client. The first five meetings were used to prepare the client for desensitisation and the final eleven for carrying out the actual desensitisation process. A total of 70 scene presentations were made to the client and he indicated whether he felt anxious or not. The order of items on the anxiety hierarchy were changed and rearranged at times. Twenty months after the treatment, the client scored 22 points lower on the Test Anxiety Scale indicating that his anxiety levels had reduced and remained constant over time.

5.3.2.2 Implosive therapy

Implosive therapy is an approach which incorporates dynamic systems of treatment which are retranslated and reapplied in terms of learning principles [Stampfl & Levis 1967:497].

According to Miller *et al.* [1974:122] the **then** newest technique in Behaviour therapy was called implosive therapy in America and flooding in England. It has a theoretical base which is similar to systematic desensitisation but in place of gradual introduction of the stimulus, the subject is exposed in 'imagery and sometimes *in vivo* to the most intense stimuli in a very short period of time'.

It is based on the theory that an organism can be made to respond emotionally to an original **neutral** stimulus by pairing the neutral stimulus with a noxious stimulus, e.g. pairing a tone with an electric shock. The organism will subsequently respond to the tone with objectively verifiable changes in his physiological state, e.g. heart rate, blood sugar and skin resistance. Stampfl and Levis [1967:483-503] explain that this state can be labelled as fear or anxiety and the stimulus that produces it can be construed to function as a danger signal or warning stimulus. Therefore, the fear or anxiety state functions as a motivation

of behaviour and the reduction or elimination of the fear state serves as a reinforcer of behaviour. If the tone is conditioned to produce fear, then any action taken which terminates the tone will be strengthened automatically. A danger signal paired with another neutral stimulus will transfer some of its fear-eliciting properties to the new neutral stimulus [higher order conditioning]. The stimulus preceding noxious stimulation, whether applied to subhuman or human fear conditioning, ordinarily involves multiple-stimulus patterns sequentially organised in time. Therefore, a single discrete stimulus does not elicit the fear reaction.

It has been indicated by many studies conducted in the laboratory, that subjects can learn a wide variety of responses in order to terminate feared stimuli. It has also been determined that fear states can be developed in the organism, leading to behaviour that is neurotic, psychosomatic or even psychotic, as reported by Brady, Porter, Conrad and Mason; Liddell; Masserman and Pechtel and Wolpe [Stampfl & Levis 1967:497]. Smith and Sharpe [1970] and Hersen [1968] both report cases in which they have used implosion on children and adolescents. Therefore, Stampfl and Levis [1967:497] believe that it is reasonable to assume that many, if not all, anxiety states experienced in the human being are a product of numerous conditioning experiences in the life of the individual which can be understood in terms of the conditioning model of the laboratory. Past, specific experiences of pain and punishment confer strong anxiety reactions to initially neutral stimuli. These experiences are represented neurally and the neural engram, which is the memory or image, may be considered as possessing the potential to function as a stimulus. The imagery, thoughts or other stimuli correlated with the past experience of pain will be avoided and whatever action or mechanism, which prevents them from reoccurring, will be learned and maintained on the basis of anxiety reduction. The person need not be consciously aware of the dangerous associations for them to function as an elicitation of the anxiety state.

Therefore, a subliminal area of neural functioning is necessary to account for all of the phenomena associated with the defensive avoidance manoeuvres of the individual. Any stimulus object or event in the external environment, i.e. the phobic object or response-produced stimulation such as the impulse to act in a certain way, e.g. aggressively, will tend to reactivate or reintegrate the anxiety-arousing associations or memories [which are the originally neutral stimuli], if associated on a stimulus continuum with the stimulus pattern originally paired with pain. The defensive manoeuvres of the person are then seen as a means of avoiding the dangerous associations.

Pavlov's original principle, that the presentation of the conditioned stimulus [CS] without the unconditioned stimulus [UCS] will lead to the extenuation of the learned response, still appears to be a valid one whether overt action or emotional states have been learned [Stampfl & Levis 1967:498]. This led Kimble [Stampfl & Levis 1967:498] to suggest that the analysis of maladjustment in terms of conflict, anxiety and repression points the direction in which therapy might proceed. He further suggested that the traumatic events be brought to consciousness in the person, so that the fear they evoke may be extinguished.

According to Stampfl and Levis [1967:498-499] the fundamental hypothesis of implosive therapy is that a sufficient condition for the extinction of anxiety is to represent, reinstate or symbolically reproduce the stimuli [cues] to which the anxiety response has been conditioned, in the absence of primary reinforcement. In the implosive procedure the emphasis is on the extinction of anxiety-evoking conditioned stimuli [cues] which provide both motivational and reinforcing properties for perpetuating the person's symptoms [avoidance responses]. The more accurate the hypothesised cues and the more realistically they are presented, the greater the extinction effect would be, because many of the cues presented are believed originally to involve not only auditory, but also visual and tactile modalities. An attempt, therefore, to produce the cues in the person's

imagery is preferable.

Smith and Sharpe [1970:239-243] describe the use of implosive therapy with a boy, Billy, of 13 years who was suffering from a severe school phobia of a relatively long duration. The patient was interviewed on several occasions in an effort to identify relevant anxiety-evoking clues. The specific sources of Billy's anxiety were not identified. He, himself, was unaware of the reasons. He was asked to describe, in minute detail, and to visualise a typical school day, beginning with his awakening in the morning and ending with his return home after school. Note was taken of behavioural inclinations of anxiety while he spoke. It appeared that his mathematic and literature classes were a source of anxiety to him. He became highly anxious at the prospect of being called on to answer questions put to him by his teachers. Visualising leaving home and his mother did not appear to evoke anxiety.

Billy was seen for a total of six consecutive daily sessions. During each session he was asked to imagine, as vividly as possible, scenes involving the hypothesised anxiety-arousing cues. He was helped to focus on detail and how he felt at each image. Each scene described below was presented at a minimum of two sessions and patterned in a smooth-flowing sequence of imagery. Each scene was presented until a visible reduction in anxiety was observed. During the first sessions, Billy demonstrated extreme anxiety. He wept and trembled and complained of severe chest pains. At times, he was unable to respond to questions. He was physically exhausted at the end of the session. However, he ate breakfast the next morning, which he had been unable to do the previous days and returned to school to attend his mathematics class willingly. He experienced only moderate anxiety during the class period. The following three days he successfully attended half-days of school, experiencing only mild and intermittent anxiety. Following the fourth treatment session, Billy was able to return to school on a time basis with only fleeting anxiety. He became more

positive about school and mentioned school-related plans for the future.

After the fifth and sixth implosive therapy sessions, Billy was reporting no anxiety in school. His rapid progress was praised and it was emphasised that he was primarily responsible for the changes that had occurred. Therapy was terminated and at a thirteen-week follow-up, it was revealed that Billy had continued to attend school regularly and with no reported anxiety. His parents reported that he was more relaxed generally and his compulsive behaviours at home had decreased markedly. His marks improved at school and the teachers reported that his peer relationships appeared to have improved.

Smith and Sharpe [1970:243] conclude that a more systematic and extensive evaluation of the efficacy of implosive therapy should be undertaken in the treatment of school phobias and other anxiety-based disorders in children.

5.3.2.3 Behaviour modification

According to Aster [1972:801], behaviourists were first interested in obtaining hard data about the observable, objective behaviour of animals through controlled experimentation in laboratories. When this data was transferred to the counselling situation, contemporary behaviour modification therapy developed. It was an outgrowth of stimulus-response [S-R] theory which involved modification or change of the individual's external, observable behaviour.

Miller *et al.* [1974:123] also mention this form of behaviour therapy and state that it uses primary and secondary reinforcers in the form of operant conditioning and contingency management. The significance of the relationship between the therapist and child was seen as the vehicle for this change and the therapeutic effects of the relationship were not considered important.

Patterson [1965:279] describes how he treated a school phobic child by means of behaviour modification methods. He explains that the general formulation for school phobic behaviour would be the following:

separation from the parent serves as an eliciting stimulus
[E S] -> anxiety reaction -> escape or avoidance behaviours.

Extinction will only occur, according to Patterson, if new responses can be associated with the E S. If the new responses are incompatible with the anxiety reaction, the new associations will result in the escape and avoidance responses gradually extinguishing while the anxiety reaction would diminish. By means of systematic desensitisation, reconditioning, positive reinforcement in the form of sweets, ignoring negative behaviour and parental guidance, Patterson [1965:280-284] was able to assist the child in modifying his behaviour. He reports as follows:

Doll play, structured by the experimenter was the procedure used in the conditioning trials. These sessions occurred four days a week and lasted fifteen minutes; the sessions are described in detail below. Following each conditioning session, both the child and the parents were interviewed. During the early interviews, the procedure was explained in detail to the family.

The nature of the specific interfering response being conditioned was discussed with particular emphasis upon the parents' being alert to its occurrence in the home. When these behaviours occurred, they were instructed to reinforce them immediately and then to describe them in the interview on the following day. Particular emphasis was placed upon reinforcing the appropriate behaviours and ignoring behaviours associated with reactions to separation anxiety. It is felt that these highly structured interviews with the parents are of particular importance in insuring generalisation of conditioning effects from the laboratory to the home.

A summary of one of Patterson's [1965:280-284] case studies is reported on below:

Karl, a seven-year-old attractive child, but with severe articulation difficulties, displayed signs of school phobia and separation anxiety on commencing formal schooling. He would only remain in his classroom in Grade 1 if one of his parents remained with him. He had displayed similar anxiety during his nursery school years. He demonstrated his anxieties at home by frequently **checking** the house to see if his mother was still there, even though he was busy playing with his toys. He began to dislike leaving her presence and refused to stay home if she went out. All attempts to punish, bribe or cajole him to stay at school had failed. No family history of similar difficulties was reported.

Patterson describes his twenty-six therapy sessions with Karl. In essence, he was separated from his mother during the first session but she was allowed to sit just outside the open doorway where he could see her. His chair was placed close by. He and the therapist played with dolls and enacted scenes similar to the ones that Karl was experiencing difficulty with. For each thirty-two seconds that Karl did not look at his mother during play, he was **rewarded** with a sweet [M&M]. After five minutes, the door was closed. The doll play mirrored the situation and the boy doll was left with the doctor while his mother waited outside. Each time Karl was asked where the doll's mother was and he replied, 'Outside', he was rewarded with a sweet. The intervals that the doll's mother left the boy doll with the doctor, were gradually increased and Karl was asked how the boy doll was feeling and what he was doing. Karl was rewarded with sweets each time he gave a positive reply such as, 'He's not scared, he's playing with the doctor's toys' etc..

The mother was encouraged to praise Karl for staying in the room without her. She was instructed to keep track of Karl's **checking** behaviour and to reward him if he stayed away, without looking for her for longer than thirty minutes. She was to announce to the family at dinner time, what progress he had made during the day. Karl appeared pleased with his success on his first encounter with the

therapist and listened closely to the conversation between him and his mother.

Each session, thereafter, Karl was rewarded for all positive attitudes and behaviour with regard to the way he responded to the therapist and the answers he gave the dolls to respond with in play. Structured play relating to the school situation, was initiated each session and Karl was encouraged to allow the doll to say goodbye to his mother, ride to school on a bicycle, walk into school, sit at a desk and read aloud from a book. Other themes such as his fear about physical harm befalling him and being attacked by members of his peer group, were explored through doll play. His parents were instructed to follow through on rewarding **bravery** and attitudes and behaviour that demonstrated that he was **maturing** and that he was giving up on immature and frightened behaviour.

The following is an extract from session 10 and demonstrates the type of conversation that developed between Karl and his therapist:

- Therapist : What shall we have Henry do today?
 Karl : Well, we could have him go to school.
 T : Yeah, I think that is a good idea to have some work on going to school again today. That probably is the hardest thing for him to do. O.K., here he is [picking up the Henry doll.] Where is mamma? Oh here she is [sets up blocks and furniture.] Ah, maybe we had better have Little Henry start off from home; when he does go to school, we won't have him go into the classroom today; he'll just run errands for the principal; no reading or writing this time. So Little Henry is talking to his mother and he says, 'Mom, I think I'll go to school for a little while today'. What does mom say?
 K : O.K.
 T : Is he afraid when he is right there talking to mamma?
 K : No. [one M&M]
 T : And so he gets on his bike and says, 'bye-bye mamma'. He stops halfway to school. What does

he think now that mamma is not there?

- K : Ma-amma [laughs].
 T : Yeah, but what does he do? Does he go back or go on to school?
 K : Goes to school. [one M&M]
 T : Yeah, that's right, he goes to school; Little Henry would go back and look but Big Henry would go on to school... and he goes to the principal's office and says, 'Hi, Mr Principal. I thought I would come back to school for a little while. Can I run some errands for you...?' Henry gives the note to the teacher, then he is coming back to the principal's office. He stops. What is he thinking about now?
 K : Mamma is not there again.
 T : Yeah, he is scaring himself again. Now, does he go back to the principal's office or does he go home?
 K : He goes back to the office. [one M&M]
 T : Yeah, that is right, he does. At least Big Henry would do that; Little Henry would get scarer and scarer; but Big Henry feels pretty good. 'I am back, Mr Principal'. The principal says, 'Why don't you go down to the cafeteria and get a glass of milk. I don't have any more errands for you to run right now'. So he goes and is sitting here drinking his milk. What does he think about now? Every time he is alone he thinks about this.
 K : Mamma again.
 T : That's right, he always thinks about mamma. Does he go home?
 K : No. [one M&M]
 T : That's right, he doesn't. Big Henry doesn't go home.
 K : [laughs] He sure is big.

- a few moments later -

- T : ... and he is lying there on the sleeping mat. What is he thinking about?
 K : Mamma. No, I don't think so because he got a nice neighbour [child] next to him.
 T : So, he is not thinking about mamma.
 K : Nope. [T was too surprised to get reinforcement in on time.]

- about five minutes later -

- T : Well, Karl, what have you been doing at home like Big Henry?
- K : Well, ah, yesterday I done some numbers [very excited] and I went up to a hundred. [one M&M]
- T : You did! Good [with emphasis]. What else did you do like Big Henry?
- K : I made a cake...
- T : Were you outside playing yesterday? Of course, it wasn't stormy weather.
- K : Yes, I was outside playing.
- T : Did you think about mamma when you were outside?
- K : Uh-uh. I wasn't thinking about mamma. [one M&M] I'm not thinking about her now either. [one M&M].

In the past ten sessions, several play sequences had been devoted to Little Henry's return to school for an hour or so with his visiting teacher. The possibility of Karl's actually doing this had also been discussed with him.

To summarise Patterson's last 13 sessions, Karl made his first trip back to school with a special teacher assigned to him who stayed with him all the time. The following day she left him alone in the classroom for a few minutes. Each day she increased the period that she was away from him. This sequence was accompanied by conditioning sequences in the playground as well, combined with a great deal of praise and approval by his family. On the follow-up of Karl's classroom adjustment three months later, there was no further evidence of fearfulness and the school reported a dramatic improvement in his general adjustment.

Patterson concludes that one of the crucial variables involved in this procedure is the reinforcement contingencies being used by social agents other than the experimenter, e.g. the parents, the school, etc. He states further that one of the

the first functions of the therapist is to change the incentive value of social stimuli. Once this is achieved, the therapist can have some effect in changing the child's behaviour. Patterson [1965:284] quotes Anna Freud as strongly urging the pairing of such primary reinforcers as food, with the presence of the therapist, in order to create a relationship with the child. As stated before, the relationship *per se* is not seen as important to the Behaviour therapists and Patterson states, 'It is hypothesised here that whatever such pairing might do for the 'relationship' the effect is to increase the status of the therapist, as a secondary reinforcer, as witnessed by Karl's increased responsiveness to social reinforcers at termination of treatment.'

He suggests that nonsocial reinforcers be used in the earlier phases of conditioning, in children who do not respond to social reinforcers and that the therapist makes a point of becoming associated with a wide range of pleasant stimuli, before attempting any behaviour manipulation. Positive reinforcers, such as stars, earned for certain behaviours and which then represent a reward such as extra TV time, choosing a video, a special outing and extra pocket-money, etc., can all be used. Food is considered a **dangerous** motivator because of the implications it can have for weight and health. Negative consequences can range from time out for the child alone in his bedroom, his behaviour being ignored or privileges being withdrawn. All of the above assist the child in taking responsibility for his behaviour and thereby modifying it.

5.3.3 Existential Theory

Astor [1972:801] mentions four forces in psychology, two of which fall into the category of Existential theory. He lists the first force as cognitions, which he defines as theories developed by field theorists like Freudians, Neo-Freudians and Gestalts to explain the dynamics of inner behaviour. These theorists are interested in conscious and unconscious processes, occurring within the

individual, which determines his cognitive, behavioural and affective insights [cf. 2.4.2 and 5.3.1]. The second force he defines as Behaviourists who attempt to change or modify the person's external, observable behaviour [cf. 2.4.4 and 5.3.2]. The third force he labels as the Humanistic movement which resulted as a response to senseless wars, pollution of the environment, poverty, overpopulation and abusive technology. A heightened interest was placed on self-actualization processes. Methods and techniques were searched for to enable man to make meaning of his life and thereby become a 'full-blown human being' [Astor 1972:801]. This led to sensitivity groups, group encounters, psychodrama and Perlsian Gestalt therapy. It changed the focus of classical Psychoanalytic theory and Positivist or Behaviouristic theory and emphasised creativity, self-actualization, higher values, ego transcendence, objectivity, autonomy, identity, responsibility and psychological health. Theorists such as Perls, Frankl, Adler and Moustakas [cf. 2.4.5], would be included in the third force.

Through Maslow [cf. 2.4.5.4], however, the fourth force was introduced. While the Humanistic psychologists focused on society and the concept of the human race and global means of improving humanity, Transpersonal psychologists focused on the scientific study of those phenomena that have potential for expanding the personal boundaries of the individual. The inner experiencing processes of the person are honoured and credence is given to conditions of the mind as manifested by altered status of consciousness. He concludes that this fourth force is concerned with developing deeper understanding of all the phenomena that expand personal boundaries within a Humanistic context.

Existential play therapy of the third force and the Transpersonal approach of the fourth force will be examined below as to what they offer in the form of therapy for children.

5.3.3.1 Existential play therapy.

The Existential approach to play therapy developed out of what was formerly called Relationship therapy and was based on the work of Otto Rank [cf. 2.4.3.2]. It is similar to Existential adult therapy in that it conceptualised the 'meeting and clashing of two wills ..., the immediately present action and reaction of one on another ... this is the relationship' [Oppenheimer 1988:42].

It encourages children to take responsibility for their own feelings and impulses without resorting to denial or rationalisation, if at all possible. The Existential therapist views pathology in the child as a method that he uses to escape anxiety by escaping from being himself. Pathology in the child is seen to be rooted in the exposure to trauma with which the individual's defences are unable to cope. This can be because the trauma is too great or because it occurs too soon in the child's life, when he lacks the resources which would enable him to cope.

By re-confronting the anxiety in the experiential and nonviolating environment of the playroom, the child can once again gain the courage to live freely and face life positively [Oppenheimer 1988:56]. The various anxieties, that need to be confronted by the child and therapist, are listed below:

- * **Death anxiety:** This serves as a primary source of anxiety and is known to children in some form or another, from as young as 1½ years of age. Oppenheimer [1988:57] views the task of the therapist as assisting the child to deal with this anxiety by 'nursing it, thinking about the death of significant others, personal milestones, difficult decisions, interacting with those who are suffering and dying and using guided imagery involving death themes'. Although anxiety levels may increase initially, it is reported to reduce thereafter with the help of the therapist and the child is then helped to use the existing anxiety in more creative ways to

enhance his awareness and vitality.

- * **Freedom anxiety:** The child is often self-imprisoned by all the **musts** and **must nots** in his life. He is unable to find alternatives and cannot take responsibility for his own freedom. He tends to flee from these feelings rather than explore them. Yalom [1980:215-217] discusses confronting clients with the anxiety of freedom. They can be encouraged to take responsibility for their freedom and change their behaviour if necessary. A client can be invited to take up new ways of thinking, imagining feeling, acting and dealing with his destiny. Frankl's [Oppenheimer 1988:59] paradoxical intention refers to the invitation of the therapist to the client to think in new ways about activities that in the past were anxiety-provoking.

- * **Existential isolation anxiety:** The child has an awareness of his own mortality and the feeling of having **lost** his familiarity in the world. He senses his separateness, which Fromm [cf. 2.4.5.1] viewed as the primary source of anxiety. Oppenheimer [1988:60] points out that a turning point for clients, in this respect, is the realisation that to be a person is to be in relation to others whether or not they are physically present. We can only really know ourselves in terms of a variety of relationships. Because of this concept, Jacobs and Vrey's model for idiographic diagnosis and research was developed [cf. 1.3.1].

- * **Meaningless anxiety:** The child can be prevented from achieving satisfaction in his daily life which then leads to an awareness of meaninglessness. Once the child learns that these meanings are self-made and that he is engaged in a life-long task of discovering, exploring and making sense of his own existence, this anxiety can be challenged.

- * **Violation anxiety:** The child perceives certain situations to be directly or indirectly threatening to his physical or emotional self, which then results in this anxiety. If the child is helped to confront this anxiety, to feel more assertive, more able to protect himself, having more rights and potency, he is able to deal with this anxiety.

In Existential play therapy, the therapist expresses his own reactions in the service of **being and staying, looking and listening, feeling**, and at the same time giving the child space, attention and reference to his feelings, thoughts and actions. Methods used by the therapist include, 'experiential use of concepts, phenomenological description, existential judging [which subsumes support and confrontation], affirmation and confronting anxiety' [Oppenheimer 1988:47-56].

Schaefer [1985:102-105] emphasises that the importance of the relationship between therapist and child in play therapy is evident in the writings of Otto Rank, Friedrich Alln and Carl Rogers, and emphasises that the child should feel fully accepted, respected and understood. In this way the child will be 'free to experience and realise his own inner world and activate his self-curative powers and innate potential for growth'. Self-awareness and self-direction, therefore, become the goals of this approach.

Moustakas [1953, 1966], who appears to have moved from a client-centred approach to an Existential one, stresses the importance of faith, acceptance and respect in the therapeutic relationship. He maintains that it is important to believe in the child's potential for working out his difficulties and discovering what is best for himself in reality. Accepting the child, implies accepting all of his feelings and attitudes and encouraging him to explore and express them. Respect implies that the therapist regards the child as worthwhile and important. Moustakas [Schaefer 1985:104] also stresses the importance of genuineness and authenticity in the therapist-child relationship. In the Existential tradition he

highlights the **here and now** experiences rather than concentrating on the past as the Psychoanalytic and Psychodynamic perspectives tend to do. The child is encouraged to differentiate his own feelings, find meaning in his life and discover his unique selfhood. Moustakas perceives the central problem of the disturbed child to be loss of self. Moustakas' Existential child therapy re-emphasises the therapist's relationship with the child and states that the therapist must communicate his real self to the child.

Moustakas [1953:8] emphasises the role anxiety plays in the disturbed child. He maintains that the anxiety may be diffuse initially and the child may be generally withdrawn and frightened, tense and garrulous or overanxious about being clean, neat or orderly. This attitude of the child can immobilise him and make him unable to start anything or complete anything or even to think clearly and attack problems logically. Fears may also take other forms such as night terrors or bizarre fears of animals, etc..

Moustakas [1953:6] describes the therapeutic process as following a regular pattern. He maintains that in the first phase or level, the child's emotions are diffuse and undifferentiated and the feelings are generally negative. Their emotions are not always tied to reality and are magnified, generalised and easily stimulated and evoked. At the second level, the relationship between child and therapist is clarified and strengthened, and the attitude of hostility is sharpened and more specific. Anger can be expressed more directly and related to specific people and experiences.

The third level involves a change in the child's attitudes and perceptions. He shows more ambivalence towards particular people in his life. More positive feelings are evident. Finally, at the fourth level, positive attitudes and negative attitudes are separated and more consistent with the reality that motivates them. The intensity of feelings, accompanying these stages, also seems to change.

To demonstrate Moustakas' earlier style of therapy, the following extract from the third session of Linda, a seriously maladjusted four-year-old, has been included. The influence of client-centred therapy is clearly evident:

In the third play session Linda shifted radically to a new pattern of behaviour. She talked throughout the entire session. In the first half she wanted to be told what to do. She repeatedly asked for reassurance and often asked for help. Later in the session she made decisions of her own and carried them out. She approached her reported phobia of knives by examining them, asking about them and then using them in her play. She clearly showed her hostility toward people as she expressed a desire to bathe the dolls in red paint: 'I'll put some people in there, and then they'll get all red. They'll be red all over'. Linda, however, did not carry out this threat. Instead she transferred anger to water play, throwing water all over the floor, stamping around in it, and screaming.

- Child : [Enters and carefully examines room. Walks to work bench and points to jars of finger paints.] What is this?
- Therapist: What do you suppose?
- C : [Very softly.] I don't know.
- T : You just don't know what's in there.
- C : Paint. [Tries to open a jar of paint, then hands it to therapist.] Open this.
- T : It's kind of hard to do, isn't it?
- C : What is it?
- T : What does it look like to you?
- C : I don't know. What do we use it for?
- T : Well, you can use it in any way you want.
- C : [Opens all three jars of paint and then dumps a box of crayons on work bench.] Crayons. There's a green and white and brown and yellow.
- T : All different colors, hm?
- C : This is pink.
- T : Mm-hm.
- C : That one's brown.
- T : Mm-hm.
- C : They fell out.
- T : Mm-hm.

- C : [Points to rubber knives.] Can I paint those that are down there?
- T : In here, Linda, you do whatever you like. You decide for yourself.
- C : [Picks up a rubber knife.] Well, what is this?
- T : What could it be, Linda?
- C : I don't know. [Pause.] A knife. It's a knife.
- T : That's what is it, hm? A knife.
- C : [Points to knife sheath.] Why can it come out of here?
- T : Why do you suppose?
- C : I know why. It's to use it. Could I? [Pause.] Could I take it home?
- T : You want to take it home, Linda, I know, but I can't let anything go out of the play-room.
- C : Why?
- T : Why do you suppose?
- C : No child could play with it then. [Picks up small toy table.] Can I paint this?
- T : You can do whatever you like here. It's up to you.
- C : I **want** to paint it.
- T : That's what you want to do, hm?
- C : How do you paint with this stuff?
- T : That's difficult to figure out, isn't it?
- C : [Looks at paints for a long while and then picks up a clown mask.] What kind of face could that be?
- T : You wonder about that.
- C : What is it? It's a silly face.
- T : Silly as it could be.
- C : [Points to a pig mask.] What is this one?
- T : That one's an odd one, isn't it?
- C : Like a pig's. [Indicates the monkey mask.] All of them look the same. This one looks like a man. Oh, it's funny, Ha, ha, ha.
- T : Really funny, and it looks like a man, hm?
- C : [Drops the mask and returns to table. Picks up scissors.] Can I cut this paper here?
- T : That's up to you, Linda.

However, in his later book, Moustakas [1966] demonstrates that the true self of the therapist must be evident to the child, in order for change to take place in the child. Gendlin [1966:266] also states that:

change comes through directly felt experiential steps. Inter - personal relationships carry the experiencing process forward, if the therapist expresses his own actual reactions [as clearly his own] and at the same time gives room, attention and reference to the client's felt reactions as the client's own.

To demonstrate this style of therapy, the following extract of a termination session with nine-year-old Tom, is included [Moustakas 1966:185-186]:

That's understandable after what you've been through. Of course, you know I'm not just saying goodbye once and for all. I hope you will come to visit me from time to time. [Long pause.] Tom, I would like to share something with you that has been on my mind for some time. I tried to talk with you about this last year.... etc..

In conclusion, Gendlin [1966:237] sums up three crucial Existential criteria in any psychotherapy.

They are:

- * the relational **being-in-the-world** and **being-with** character of human beings as primary type of construct with which to study human behaviour;
- * the concrete sentient life process of an individual as not reducible to entities, pictures, contents [supposedly within], but rather as a feeling process; and

- * a mode of thinking in which concepts and words are based on experiencing them directly; they are precisioned or lifted out, creatively fashioned and not merely represented conceptually, but are directly felt as a result of being thought about and differentiated in this way.

5.3.3.2 Transpersonal approach

According to Astor [1972:802], Humanistic therapists believe that growth, learning and development are **becoming** processes that occur in people when someone genuinely cares about them and when they have learnt to be able to value themselves as worthwhile. A relationship of mutual respect, acceptance and understanding is vital and the expansion, facilitation and enhancement of the human condition is stressed at all times.

The Transpersonal approach is concerned with the ultimate or the highest meanings and values of man, and its hypothesis, the possible existence of etheric energies. Transpersonal self includes mental intuition, the possibility of planetary fields of the mind and spiritual and occult rarefied substances. The Transpersonal movement encourages the empirical study of psychism, parapsychology, hypnosis, brainwave feedback and biofeedback, Yoga, imagery, symbols and meditation.

Astor [1972:803] mentions Schultz's and Luthe's technique of autogenic therapy or the training of self-will that involves the use of hypnosis, Yoga and meditation. It was combined in the 1950's and 1960's with a form of operant conditioning and the new technique is called autogenic feedback training. This is used to control internal states which would prevent psychosomatic disorders from developing.

Transpersonal counselling is defined by Astor [1972:804] as training people to 'control their own mental, emotional and physiological processes in order to improve their self-image and become more active and responsible with respect to their inner and outer environment'. This implies the strengthening of willpower and inner self-control for attaining a higher level of self-integration. Astor [1972:805] states clearly that he does not advise the use of transpersonal techniques, for all children, at all times. He believes that suggestion, relaxation and hypnosis should be used with discretion to help the tense, anxious and hyperactive child strengthen his motivation for learning and gain the feelings of control over himself that he needs, in order to have the confidence to grow and learn. If anxiety, connected with the learning situation, can be removed, hypnosis appears to improve recall and retention. He states that as a result, the child's self-confidence will improve. Hypnosis, according to Astor [1972], appears to allow the child to become more self-possessed, independent, confident, competent and disciplined.

In summary, Transpersonal psychology suggests that all behaviours and experience exist on continua. Bodily behaviours, feelings and mind states are all parts of a wholeness that defines the individual, and all behaviours and experiences of the person can be brought up to a conscious, controllable level. It emphasises 'the positive potential of man, his continuities, integrations, inner realities and totalities' [Astor 1972:808].

5.3.4 Hypnotherapy

5.3.4.1 Introduction

Hypnotherapy has been defined by Gardner and Olness [1981:XV] as a treatment with specific therapeutic goals and specific techniques while the person is in a state of hypnosis. Hypnosis is viewed, by most researchers, as an altered state

of consciousness or awareness characterised by receptiveness to suggestion [Callow & Benson 1990; Hobbie 1989; Reilley 1987; Hilgard 1977; Gardner & Olness 1981; Karle & Boys 1987].

Sokel, Landsdown and Kent [1990:228] concur with the above and state, that if the process is successful, the person will be in a state of deep relaxation with focused attention and heightened receptivity to images and suggestions. There are numerous competing theories proposed about the nature of hypnosis and none really seem to explain the phenomenon adequately [Hilgard 1977; Reilley 1987]. Many of the theories fit into one of two main categories which are:

- * psychological - which emphasise factors such as learning, suggestion, role playing and modelling; and
- * physiological - which stress altered metabolic changes in the nervous system and unusual electrical activity in the brain.

According to Ambrose and Newbold [1980:23], Wyke, the then leading exponent of the physiological basis for the phenomenon of hypnosis, stresses hypnosis as 'a physiological state whose production involves the sequential operation of several specific neurological mechanisms.' He states further that, 'hypnotic suggestion directly modifies the passage of sensory impulses, from the periphery into the brain'. He maintains that the induction process in hypnosis involves attention, habituation and conditioning, each behaviour involving its own specific neurological mechanisms. The findings of the electro-encephalogram [EEG] wave pattern in hypnosis, does not have the ordinary sleep characteristics, but is usually not distinguishable from the normal waking state alpha waves. However, if already hypnotised, the person could be further hypnotised by strong suggestion into sleep and the alpha waves could be made to disappear [Ambrose & Newbold 1980:35].

Hypnosis, used in a therapeutic setting, can produce conditions in a person that are helpful and emotionally and cognitively therapeutic for him; such as relaxation, concentration, the ability to use imaginary powers more fully and the capacity to accept suggestions more readily. Ambrose and Newbold [1980:1] point out that hypnotism and its medical application, hypnotherapy, has been used for a very long time, older perhaps than recorded history.

According to Reilly [1987:811], the interest in hypnosis as a 'medical and psychological aid is high and research into its effective use is expanding'. Hypnosis is presently viewed as a 'respectable and useful technique for helping with medical and psychological problems'.

Clarke and Jackson [1983:26] use hypnotherapy to treat anxiety. Their first assumption is that hypnosis reduces anxiety. Therefore if the client can be induced into a trance, he will automatically be able to reduce his anxiety. However, they believe that anxious clients may have difficulty in relaxing and **letting go** of their anxiety. That aspect will be investigated later in the chapter.

Hypnotherapy has been used successfully alone or in conjunction with other treatments in dealing with a variety of emotional problems. Below are a few of the many researchers who have used hypnotherapy in the varied and wide area of psychological difficulties:

- * Anxiety [Ambrose & Newbold 1980; Ballinger 1983; Clarke & Jackson 1983; Karle & Boys 1987; Miller 1986; Schultz 1991]
- * Depression [Shapiro 1988]
- * Trauma [Shapiro 1988]

- * Control of Pain [Hilgard & LeBaron 1982; Husen & Postlethwaite 1985; Olness 1981; Olness, Mac Donald & Uden 1987]
- * Psychosomatic Problems [Ambrose 1968; Diamond 1959; Husen & Postlethwaite 1985; Kohen, Olness, Colwell & Heimel 1984; Olness *et al.* 1987; Williams 1981]
- * Conduct Disorders [Benson 1989; Gardner & Olness 1981]
- * Sexual Dysfunction [Husen & Postlethwaite 1985; Shapiro 1988]
- * Insomnia [Levine 1980]
- * Forensic Work [Orne 1979]

5.3.4.2 Hypnoanalysis

Hypnoanalysis is a term that has evolved from the medical model of psychiatry. Kiefer [1989:127] describes it as a 'very direct and specific therapy' while traditional therapy is more indirect and takes a more general view in addressing a problem. It involves taking an initial history, using a word association test, under hypnosis, as well as dream analysis of the client's dreams. By means of the information gained, the therapist makes a diagnosis. The hypnoanalysis diagnoses consist of a number of syndromes, describing certain problem areas, which are listed below [Ritzman 1990].

5.3.4.2.1 Identity problem syndrome

This concerns the initial thought pattern about the self and is created in the mind of the unborn infant from its perception of the mother's thoughts and emotions

about the fact of the pregnancy.

5.3.4.2.2 Birth anoxia syndrome

This is also referred to as the Death Expectancy Syndrome and includes the terror experienced by the unborn infant in the presence of a falling oxygen level as well as other causes of trauma such as blood chemistry changes, pressure and distortion of the infant's head, with approaching loss of consciousness, as well as the loss of the maternal life support system after birth.

It also identifies the true problem resulting from the ongoing fear of disaster which affects him through his life in the form of anxiety and panic attacks which affect the immune system. According to Ritzman [1990:153] the anxious person finds it difficult to achieve peace of mind, optimism, faith and imagery because of his anxiety and he views relaxation as the key that opens the door to allow healing to take place.

5.3.4.2.3 Separation anxiety syndrome

Ritzman [1990:153] sees this as the source of later emotional problems concerning relationships as well as those leading to 'obesity, smoking dependency, alcoholism, school phobia and rejection fears of every sort'.

It refers to the difficulties the child has, in separating from his mother, which deprives him of the constant awareness of physical support and loving reassurance that he had while still as dependent as a foetus in the mother's womb.

5.3.4.2.4 Ponce de Leon syndrome

This refers to the state of emotional immaturity caused by losses and shattering events in the child's growing years. Such experiences have the power to block the maturing process and therefore damage the personality. These traumas include sexual or physical child abuse, the loss of a parent through death or divorce, which creates loneliness and guilt and can result in suppressed fear and anger which, in turn, can result in psychosomatic illness and disease.

5.3.4.2.5 Jurisdictional problem syndrome

This refers to the problem of guilt which is composed by the self and is very often the cause of the onset of much chronic disease and unexplained pain.

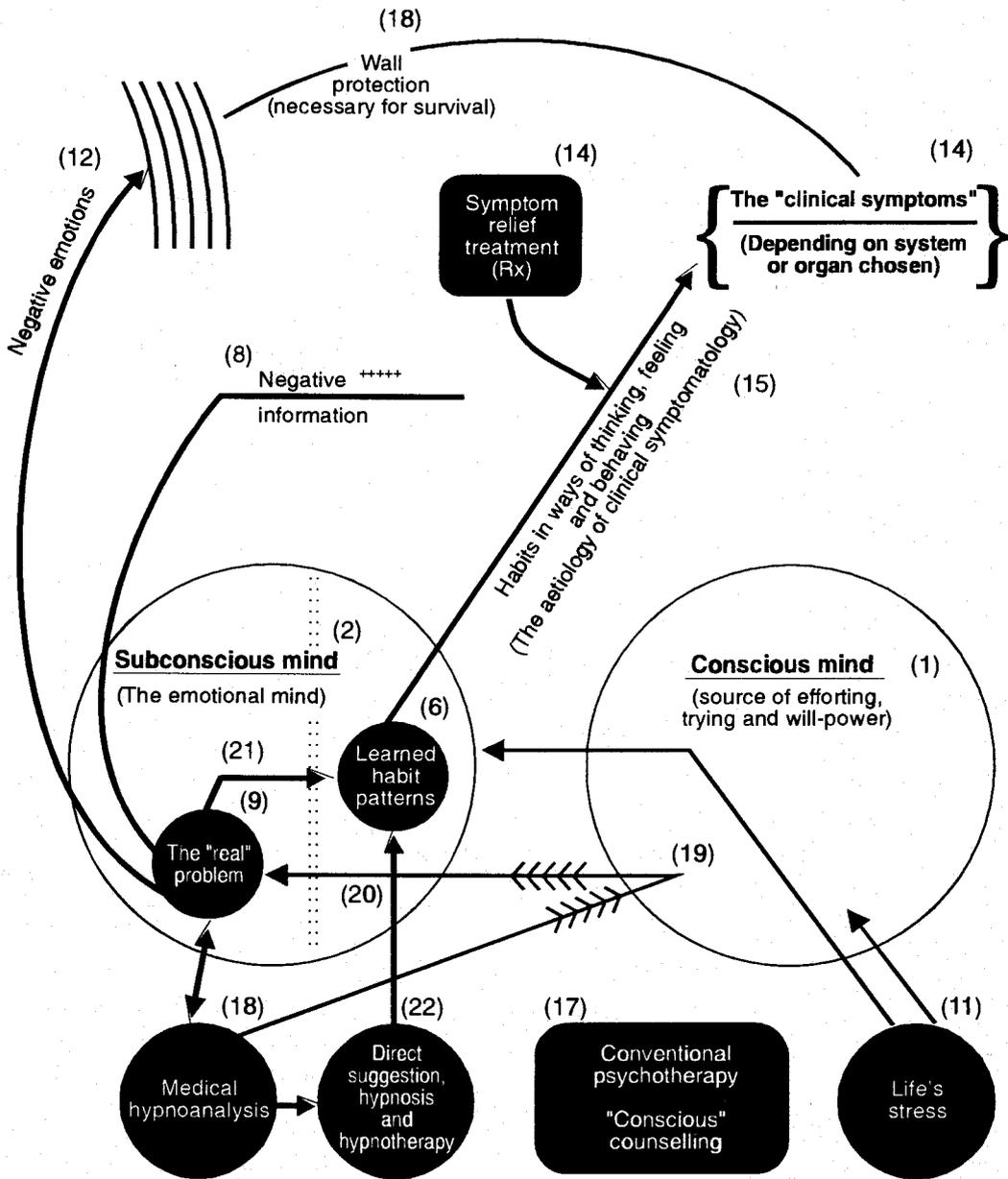
It is the philosophy of Medical Hypnoanalysis [Ritzman 1990:153] to examine the whole personality and its resources first, and repair whatever needs to be repaired so that the entire potential of the healing process is at its best. It is not enough to recognise the symptom of the problem alone for that is only the physical evidence of the disease [cf. 1.3.3].

The following diagrams [Figures 5.2 & 5.3], from Munnik [1993:7-8], attempt to explain how the unconscious [subconscious] and conscious minds receive information and formulate problems from a medical hypnoanalysis and hypnotherapy perspective.

The theoretical basis of the development of emotional disturbance, according to Medical Hypnoanalysis, is demonstrated by the diagrams overleaf. The numbering of the discussion [cf. 5.3.4.2.6] corresponds to the numbers in the diagrams.

FIGURE 5.2

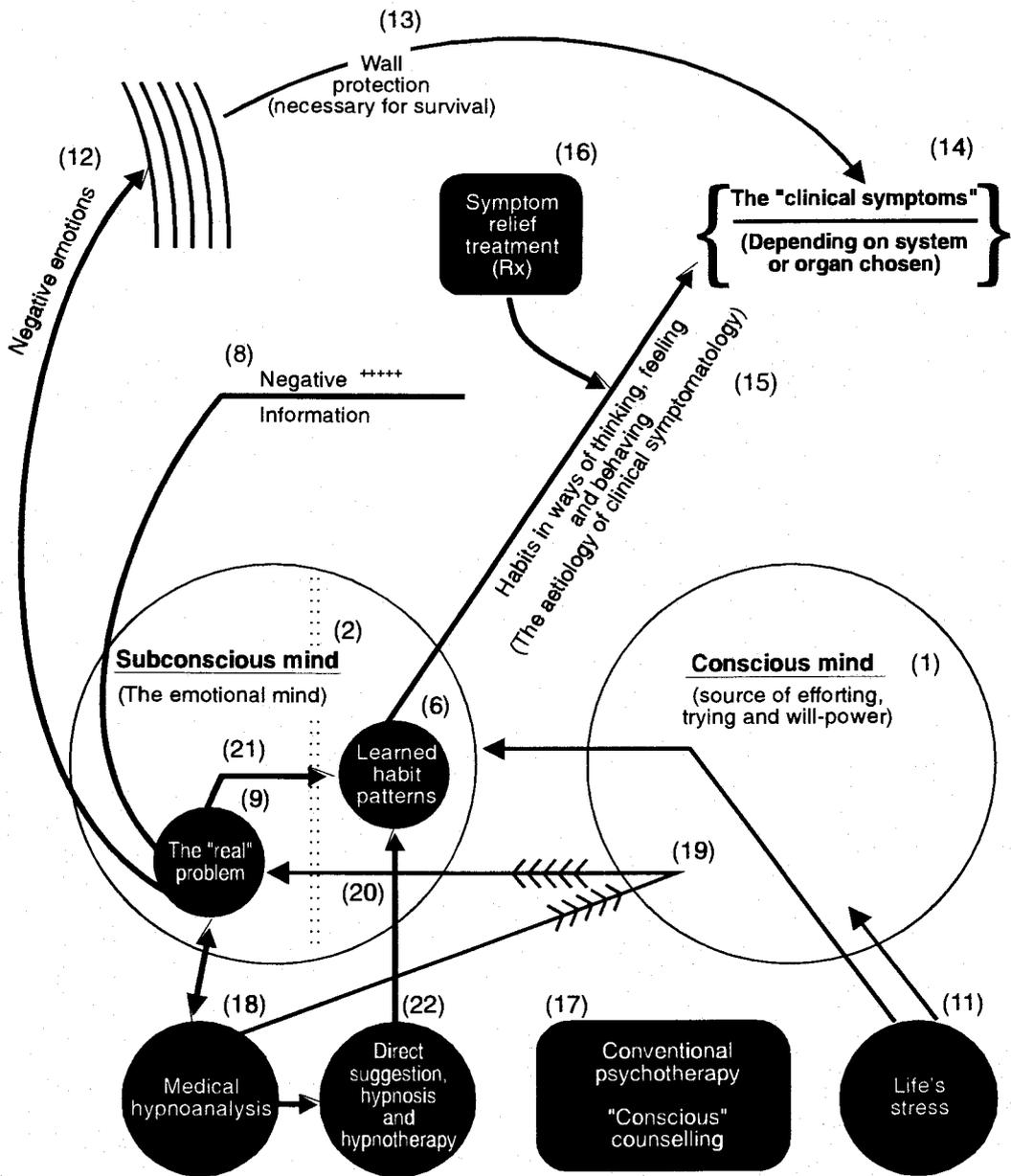
SCHEMATIC DIAGRAM OF PSYCHODYNAMICS OF MEDICAL HYPNOANALYSIS AND HYPNOTHERAPY



The theoretical basis of the development of emotional disturbance according to Medical Hypnoanalysis is demonstrated by the diagrams above. The numbering of the discussion corresponds to the numbers in the diagram

FIGURE 5.3

SCHEMATIC DIAGRAM OF PSYCHODYNAMICS OF MEDICAL HYPNOANALYSIS AND HYPNOTHERAPY



5.3.4.2.6 Numbering of theoretical basis of Medical Hypnoanalysis

- (1) The conscious mind.
- (2) The subconscious mind.
- (3) Information from the senses.
- (4) Memories are stored.
- (5) What is needed by the conscious mind can be recalled.
- (6) Patterns of behaviour develop.
- (7) Other information goes directly to the subconscious.
- (8) Under great emotional stress [fear, anxiety or guilt] highly charged emotional messages are taken into the subconscious.
- (9) These constitute 'the real problem'.
- (10) The brain barrier prevents conscious knowledge of these.
- (11) Life stresses impinge on the conscious mind.
- (12) The highly charged negative emotions cannot be allowed to surface.
- (13) A protective wall is necessary for survival.
- (14) The clinical symptoms constitute the wall.
- (15) The clinical symptoms are habitual modes of thinking, feeling and behaving.
- (16) Treatment targeting the clinical symptoms is essentially symptomatic.
- (17) Conventional psychotherapy only reaches the conscious mind.
- (18) Medical Hypnoanalysis uses Word Association and Dream Analysis to make a Subconscious Diagnosis.
- (19) This information is revealed to the conscious mind.
- (20) Age Regression is used to go back to where the seed for emotional disturbance was sown.
- (21) Releasing the feelings [by abreaction] is done. Realisation that these constitute the real problem is necessary.
- (22) The Real Problem has been dealt with, the protective wall and the symptoms are no longer necessary and changing the habits of thinking,

feeling and behaviour can proceed to effect a real cure.

Medical Hypnoanalysis regards the Real Problem [No.9] as being due to suppressed feelings in the subconscious which come from times of high emotional stress, e.g. 'high voltage events'.

5.3.4.3 Hypnotherapy as a treatment for anxiety

Karle and Boys [1987:116-130] describe hypnotherapy as a treatment strategy for treating anxiety-related conditions. They list these as:

- * mild and generalised [free-floating anxiety]
to
- * anxiety attacks
to
- * severe phobic reactions.

They claim it can also be used to treat depression with that accompanies the anxiety. They are of the opinion that although many conditions can be therapeutically dealt with at a symptomatic level, it is often not adequate to treat the anxiety alone but to view the anxiety as a manifestation of an underlying disturbance [cf. 1.3.3]. If the symptom-directed treatment is accompanied by some degree of recovery and resolution of the underlying processes, it will often be more effective than if it deals with the symptoms alone.

From a Psychoanalytic and Psychodynamic perspective [cf. 2.4.2; 2.4.3], the symptom of anxiety frequently has its roots in traumatic experiences which most often occur in childhood. It is often not enough to uncover the repressed material relating to the trauma and 'working through' the material is often necessary for the symptom and condition to be resolved [Karle & Boys

1987:116]. Hypnotherapy can create a safe environment for this to take place.

From the Behavioural perspective [cf. 2.4.4], systematic relaxation and desensitisation are important for the unlearning of the learnt response of anxiety. Karle and Boys [1987:117] maintain that anxiety and tension cannot coexist with relaxation and peace of mind. Therefore, if the person is taught to relax by means of a hypnotic induction, the anxiety will diminish and even cease over time, and new and healthier responses will be learnt.

Russell, Miller and June [1974:572-573] mention their success with the control in the treatment of anxiety, especially test anxiety. The treatment programme consists of two steps which are:

- * training the person in progressive muscle relaxation, and
- * pairing the relaxed state with a specific self-produced cue word such as calm or peace, etc.

This method is well suited to hypnotherapy as the level of relaxation will normally be deeper and the cue control will take place via the unconscious mind and therefore be better internalised and automatic without the person having to think about it consciously.

From the Humanistic and Fourth Force perspectives, hypnotherapy can be successfully used as demonstrated by Moustakas [1953, 1966] and Astor [1972].

5.3.4.4 The use of hypnotherapy with children

According to many researchers, hypnotherapy can be used very successfully with children for a great variety of problems, some of which are listed below:

- * **Anxiety and Fears** [Ambrose 1968; Boersma, Moskal & Massey 1991; Karle & Boys 1987; Kohen *et al.* 1984; Kroger 1977; LaBaw, Holton, Tewell & Eccles 1975; Lazarus & Abramowitz 1965; Olness 1986; Schultz 1991; Stirtzinger 1983; Valente 1990; Williams 1981];

- * **School Phobia** [Kelemen 1988; Lawlor 1976; Lazarus & Abramowitz 1965; Olness 1986; Smith & Sharpe 1970];

- * **Anxiety Disorders** [Ambrose 1968; Gardner 1978; Gardner & Olness 1981; Karle & Boys 1987; Schultz 1991; Valente 1990];

- * **Performance Anxiety** [Astor 1971; Krippner 1966; Olness 1986; Russell *et al.* 1974; Valente 1990];

- * **Psychosomatic Disorders** [Diamond 1959; Gardner & Olness 1981; Kohen 1986; Kohen *et al.* 1984; Lazar & Jedliczka 1979; Olness 1986; Olness *et al.* 1987; Tilton 1984];

- * **Sleep Disorders and Insomnia** [Gardner 1978; Jacobs 1962, 1964; Olness 1986; Porter 1975];

- * **Night Terrors** [Kramer 1989; Toboada 1975];

- * **Acting Out Behaviour and Conduct Disorder** [Ambrose 1968; Lawson 1987; Thompson, Davis & Madden 1986; Turner 1990];

- * **Traumatized Children** [Friedrich 1991; Kiefer 1989];

- * **Habit Disorders** [Gardner 1978; Kohen *et al.* 1984; Olness 1986; Tilton 1984];
- * **Enuresis** [Ambrose & Newbold 1980; Edwards & Van Der Spuy 1985; Gardner & Olness 1981; Kohen *et al.* 1984; Olness 1986; Tilton 1984];
- * **Encopresis** [Kohen *et al.* 1984; Matthews, Davis & Stanitis 1985; Tilton 1984];
- * **Grief** [Manthorpe 1987];
- * **Multiple Personality Disorder** [Fine 1988; Kluft 1985];
- * **Attention Deficit Disorder and Learning Difficulties** [Calhoun & Bolton 1986; Copeland 1980; Jampolsky 1970];
- * **Pain Control in Children** [Hilgard & LeBaron 1982; Kohen 1986; Kuttner 1988; Olness 1986; Valente 1990; Zeltzer & LeBaron 1986];
and
- * **Mental Retardation** [Mc Cord 1956b; 1960; Sternlight & Wanderer 1963; Woody & Billy 1970].

Hypnotherapy can be used in a variety of ways with children. However, there are two distinct paradigms in hypnotic research, according to Spanos and Chaves [1970:108]. These are:

- * the traditional trance paradigm typically involving a hypnotic induction such as suggestions of eye weariness, eye closure, relaxation, drowsiness, sleep

and a unique state of deep trance; and

- * a task motivational instruction aimed at enhancing expectancies, attitudes and motivations, administered in the waking state.

The first approach can be considered a more direct form of hypnotherapy while the second approach leans towards an indirect form of hypnotherapy. Here the use of story telling, therapeutic metaphors, fairytales as metaphors and paradoxes are used even when the child does not **appear** to be in an hypnotic trance [These techniques will be explored in more depth later on in the chapter].

Matthews *et al.* [1985:27] reports on Rossi and Erickson's findings that the hypnotic trance has outward and inward effects on the person. They list the outward visible effects as being pupil dilation, flattened cheeks, increased skin pallor, lack of movement, slowed blink and shallow reflexes and lowered and slowed respiration. The inward and invisible effects are to suspend the normal framework of rule and logic and the initiation of an internal and possibly unconscious search for the meaning and the significance of the indirect suggestions, metaphors and paradoxes.

Williams [1981:47] states that according to Spiegel 70% of the adult population is hypnotizable, to a clinically significant degree. He states, further, that it has been clearly established that children are more hypnotizable than adults and that cross-sectional and longitudinal surveys concur in finding increases in hypnotic susceptibility scores between the ages of 5 and 10 years which peak in the pre-adolescent years. Place [1984:339] also states that Messerschmidt and Morgan, and Hilgard found a pattern of the responsiveness of the child from the age of 7 years, increasing to reach a peak at the age of 14 years, with a decline in adolescence, to reach a stable picture seen in adults. Bowers and LeBaron [1986:464] stress that children are particularly susceptible to suggestive

therapeutic effects since their imaginative powers are not yet eclipsed or truncated by the demands of reality.

Hilgard and LeBaron [1982:418-419] state that the talent for hypnosis varies with age. It develops slowly during the preschool years, accelerates markedly after the age of 5 and reaches its peak between the ages of 9 and 12 years. According to them, many more children than adults are highly hypnotizable. The talent of hypnosis also varies from child to child and for this reason Morgan and Hilgard [1979:148-169] developed the Stanford Hypnotic Clinical Scale for Children.

According to Hilgard [Long 1968:61] parental influences and identifications are very important in preserving and extending or reducing and destroying hypnotic susceptibility. Pascal [Long 1968:64] claimed that early life experiences formed basic habit patterns which generalised to the current intimate, interpersonal task of hypnosis. The contact variables allow for a very specific definition of the kind of stimulation which assists in forming the fundamental and basic response capabilities. For instance, Pascal found that fathers who were less hypnotizable showed less affection to their children and interacted less with them generally. Mothers tended to use harsher verbal punishment. In contrast, parents who were more hypnotizable presented a broad spectrum of more optional patterns of stimulation to their children. This allowed for freer and more cooperative interaction between parent and child. The hypnotic task requires the child to involve himself closely with the therapist, participate cooperatively in the process and **let himself go** in order to reach the deeper stages of direct hypnosis. The children who are more trusting and more cooperative due to a closer physical contact of a more positive sort with their parents, seem to generalise basic positive response patterns which allow them to be hypnotised more easily.

Barber [1960] stresses the attitude of basic trust towards oneself and others as an essential factor which allows hypnotic induction. It may be for this reason that

children are more hypnotizable generally, compared to adults, as their personalities are still developing and even if they have been subjected to emotional trauma, they are more resilient and flexible.

It would appear from the research on anxiety that the highly anxious child may well fall into the class of the less hypnotizable children, although Collison [1974:109], among others, states that the anxious child responds well to hypnotherapy. This would need further investigation. Therefore, it may be worthwhile to use the less formal and more indirect methods of hypnotic induction with the highly anxious child. However, it would seem, from the research, that the level of hypnotizability in the child is not a crucial factor in the therapeutic intervention and especially concerning the indirect methods just discussed, it is not even a factor at all.

In addition to this, Ballinger [1983:111] mentions that it is interesting 'to note how useful hypnosis seems to be even when the patient perceives herself as not being hypnotised'. She explains how the patient had consulted her because of bouts of acute anxiety and panic attacks accompanied by hyperventilation and how, after age regression to the age of 2½ years, the patient recalled in great clarity the event before, during and after her father's death, but verbalised many times that she did not feel hypnotised. Ballinger stresses that despite her verbalisation there were many indications that, in fact, she was in a deep trance. In this respect, even when the patient perceives himself not to be hypnotised, he may well be.

Sokel *et al.* [1990:229] maintain that it is essential to demystify hypnotherapy for children and to see it as a **normal power**. They cite everyday situations in which children are so absorbed in a story or television programme that they feel as if they are actually part of it and during this time they may not hear that they have been spoken to or called for a meal. At such times they are in a **trance**

and are **hypnotised** by the visual and auditory stimuli they are attending to. Valente [1990:132] also makes mention of this and states that both Fromm and Kohen, Olness, Colwell and Heimel have found that 'the altered state of awareness that hypnosis represents occurs naturally in everyday activities and is similar to the state occurring when one becomes absorbed in movies, games or music'.

Valente [1990:136] concludes that:

hypnosis helps school-age children manage their anxiety, reduce stress, master challenges and improve their ability to solve problems when the fantasies suggested match the child's developmental level. Research found that hypnosis also effectively treats selected behaviour, sleep and anxiety disorders and efficiently controls pain, headaches and asthmatic symptoms. Children respond well to hypnosis that reduces their nausea, sleep disorders and hair pulling and improves their ability to solve problems and improves their self-esteem.

5.3.4.5 Hypnotherapy with anxious children

As stated earlier on in the chapter [cf. 5.3.4.4], hypnotherapy has been successfully used with children suffering from anxiety. Melanie Klein [1989:11] found that neurotic or highly anxious children could not tolerate the anxiety because they could not tolerate frustration. They tended to protect themselves from reality by denying it. She felt that children and young adults suffered from a more acute degree of anxiety than did adults and that they, therefore, needed to be helped to gain access to their anxiety and to their unconscious sense of guilt, and to establish the analytic situation as rapidly as possible [Klein 1989:14]. In this respect hypnotherapy meets all these requirements.

Schultz [1991:127] stresses that anxious children should be carefully handled. A variety of misconceptions about hypnosis may exist, either in the child or in

his parents, which will affect induction. These misconceptions need to be addressed first. Furthermore, anxious children may require additional preparation time, e.g. children with performance anxiety may be particularly concerned with failure or that they will disappoint the therapist and/or their parents. Children with separation anxiety may find it very difficult to be separated from their parents and parents may need to be included in the session. Children with fears of the dark or sleep may be afraid to close their eyes. The perceived loss of control anticipated by the child may be particularly anxiety-provoking for those with social anxieties or panic attacks.

Hilgard and LeBaron [1982:425] assisted children and adolescents with cancer in relieving their anxiety and pain. They concluded that the success of hypnotic intervention ranged from small to large, averaging about 30% during the first trial and that this was statistically significant. A positive correlation was found between success and treatment and the level of hypnotizability in the children. However, a formal eye closure method was used and the children's anxiety was related to their treatments for cancer which involved many painful procedures.

5.3.4.6 Differences in hypnotherapy between adults and children

According to Kuttner [1988] children can rapidly enter a trance state and shift very easily from one cognitive state to another, especially those under the age of 6 years who demonstrate blurred boundaries between reality and fantasy. In this way children's hypnotic states, in contrast to those of adults, are not readily sustained, clearly defined or easily measured.

Williams [1981] explains that because the child's cognitive skills are not fully developed, he generally focuses more on the immediate present. He is, thus, more fully absorbed in what he is doing, as is required in the hypnotic trance used in hypnotherapy. An adult's waking state, however, is usually characterised

by complex intellectual processes involving logical and critical thinking and integration of different ideas across time and space. These processes can be a potential source of resistance to the hypnosis. Williams [1981:48] also emphasises that, according to Piaget [cf. 3.2.3], the young child has a natural tendency towards concrete, literal thinking that allows him to more readily accept the appropriately worded hypnotic suggestions, since they 'involve little consideration of the nature of therapy or related abstract issues.'

The child's greater ease with which he intertwines fantasy and reality and his more limited capacity for reality-testing enables him to accept hypnotic suggestions very readily. Many children of all ages have demonstrated the ability to alter sensations, perceptions and experience, and in the younger children they often do so with their eyes open and sometimes through physical activity [Gardner & Olness, 1981].

Bowers and LeBaron [1986:461] have discovered that many children below the age of 8 years respond to hypnotic suggestions in a way that is difficult to distinguish from childhood play. The child's eyes are more likely to remain open and the imaginative involvement is often acted out physically.

London and Cooper [1969:122] confirm that the largest percentage of children fall in the high susceptibility range, but that they have difficulty with the eye-closure test item. They speculate that it may be that the children are less comfortable than adults in closing their eyes or that they want to resist falling asleep. They conclude that for whatever reason a much smaller percentage of children than adults pass the eye-closure item. Hobbie [1989:85] has observed that children often move about in their chairs during the exercise of relaxation but that this does not seem to affect the outcome of the hypnosis.

Klein [1989:9] suggests that one should take into consideration how the child's

psychology differs from that of an adult, in that his unconscious is, as yet, in close contact with his conscious and that his most primitive impulses are at work alongside of his highly complicated mental processes. She believes that the child, in contrast to the adult, has the ability to represent his unconscious in a direct way and is therefore not only able to experience a far-reaching emotional abreaction, but actually to live through the original situation and therefore resolve his fixations. Although Klein would have used child analysis to do this, it is obvious that hypnotherapy would also meet the requirements, in this regard.

Karle and Boys [1987:149] point out some important differences between hypnotherapy with children and the techniques employed with adults.

They are:

- * the language used, needs to be adapted to the child's level of vocabulary and knowledge;
- * imagery should be tailored to his developmental level;
- * preparation is, generally, simpler;
- * the therapist and child must explore the purpose of the session, so that it is clearly grasped by the child; there is more room for doubt and confusion and possibly also mistrust in the child, than in the adult, if he does not grasp clearly the reasons for the hypnotherapy;
- * the child more readily accepts the process and becomes more rapidly and often more completely involved in the images used than the adults; his imagination is often considerably better developed than the adults;
- * the child will often use self-hypnosis exercises wholeheartedly and

imaginatively and be proud to achieve self-mastery in this way without embarrassment, hesitation or resistance; and

- * the child, before the age of puberty, tends, generally, to be more readily submissive and reliant on adult control and direction even if, on the surface, he appears self-willed and resistant in his manner and behaviour.

5.3.4.7 Techniques of relaxation, induction, deepening and direct suggestions

5.3.4.7.1 Relaxation techniques

According to Ragan and Hiebert [1987:272], one of the major goals of research on stress has been to investigate interventions directed at the acquisition of effective coping skills and strategies. Many programmes and techniques have been developed with the idea that they could be implemented in the classroom by the teacher, to prevent high levels of stress and anxiety developing in the children. Researchers in this area include Hiebert and Eby; Day and Sadock; Little and Jackson; Stroebel, Stroebel and Holland [Ragan & Hiebert 1987:273-274].

Benson [Hobbie 1989:83] also developed a relaxation technique which he named the Relaxation Response. His technique used elements of meditation and relaxation which can help school-aged children to relax at the end of a stressful school day or when they are having difficulty falling asleep at night. It can also help children who become nervous before examinations, performances and competitive sport events.

The following steps describe Benson's Relaxation Response:

- * the child is encouraged to sit quietly in a comfortable position;
- * he is asked to close his eyes;
- * he is encouraged to relax all his muscles deeply, beginning with his toes and working up through the whole body to the face;
- * he is told to breathe through his nose and to become aware of his breathing saying key words silently to himself, e.g. in ... out, etc.];
- * he is told that when thoughts come into his mind he should just let them pass through and not dwell on them; and
- * he is encouraged to continue for \pm 10 minutes and then to sit quietly with his eyes closed for a few minutes more, to open them slowly and then only to get up.

Another relaxation technique for children is the Kiddie QR [Quieting Reflex] adapted from Stroebel's [Ragan & Hiebert 1987:274] adult one and used with elementary school children. It is based on Stroebel's postulation that the quieting reflex is a 6-second response that is incompatible with and interrupts the emergency fight or flight response. QR training is a type of cue-controlled relaxation that consists of arousal cues and faulty muscle bracing, easy abdominal breathing, elements of progressive relaxation and autogenic training. Mental imagery is used to develop the skill of being able to discriminate between tension states and to replace them with feelings of relaxation. **Body friends** are introduced and some are associated with tension spots in the body and others are used to assist the tension spot to remain relaxed; an example of a **body friend** is quoted by Ragan and Hiebert [1987:274-275] as being TMJ [temporomandibular joint]. This is associated with tension in the jaw. **Magic jaw string** is

another **body friend** who can assist TMJ in relaxing. When the magic jaw string is pulled down the jaw sags open and the jaw tension is relaxed and the TMJ is fully relaxed. Another pair of **body friends** are **fighty fists** and **octopus**. **Fighty fists** identifies feelings associated with anger and high emotional arousal. **Octopus** is the feeling in your hand when you imagine that your hand is an octopus floating on water. In this way the child can distinguish between the different body sensations associated with emotions and is taught to:

- * perceive rising tension in his body; and
- * initiate some procedure to counteract tension.

5.3.4.7.2 Induction

Although formal induction techniques can be used, Karle and Boys [1987:150] warn that 'children who are particularly restless and overactive [whether inherently or because of arousal due to anxiety or distress] or who are depressed and withdrawn may have to be approached very indirectly, perhaps through play and physical contact'.

Benson [1989:114] points out that spontaneous trance states occur in conditions where there is habituation to external stimuli, e.g. like listening to a story and when the imagination is being used, e.g. when the child is asked to see, hear, smell things, etc.. Hypnotic inductions for children can rely on these factors to varying degrees. According to Benson, the work of Milton Erickson has allowed for more relaxed and informal procedures which are more acceptable to subjects who are scared of losing control.

Place [1984:340] mentions that the Stanford Hypnotic Clinical Scale for Children has two forms of induction; one, an eye-closure technique for children aged 6 -

16 years and two, a modified version which uses an active imagination induction for the 4 - 8 year old group. It would seem reasonable to use whichever technique appears best suited to the particular child's needs.

Techniques of formal induction will also differ according to the age of the child. For the purpose of this study, as far as possible, techniques suitable for the primary school child will be explained.

Sokel *et al.* [1990:230-231] believe that the key to successful treatment in hypnotherapy is to involve children in developmentally appropriate imaginative material and one of the induction techniques they used for the child over 5 years was eye-closure by means of the child holding a coin in an outstretched arm, focusing on the coin and slowly lowering his arm. When the hand reached his lap he was instructed to let go of the coin, close his eyes and relax. His imagination was then guided to follow a story of a boy in a garden, walking 10 steps to a lower garden with the suggestions that the boy would feel more comfortable with each step he took.

According to Karle and Boys [1987:161-164], children between the age of 7 to 12 years will respond better to a more adult approach of eye fixation or arm levitation than to fairytales. They suggest the following induction procedures which they have named the magic key, magnets, finger lowering and the secret door.

They emphasise that if children request to keep their eyes open or do not voluntarily close their eyes, this should be respected. However, the therapist can make the following suggestion, 'Your eyes are wide open now. Perhaps they will stay that way or perhaps they will close. Perhaps they will be open some of the time and closed some of the time'.

In the first induction they use a foreign coin which is unfamiliar to the child and can therefore, be accepted as having **magic** properties. The coin can be given to him at the end of the session to use in self-hypnosis as well. It is helpful before induction to elicit from the child a description of a happy time or place in the child's life and then to transfer to this memory after successful induction. The following are four extracts from Karle and Boys [1989:161-164] to illustrate their induction techniques, namely the magic key, magnets, finger lowering and the secret door:

The Magic Key:

Have you seen a coin like this before? No? Well, I am going to give you this very special coin. You must keep it very safely, because it is going to be your magic key so that you can go to fairy-land. In a minute, I am going to show you how to use it to go to fairy-land and have all the adventures that we have been talking about. When you go to fairy-land and meet your special fairy there, you will feel so much better, your pain will disappear and you will feel completely comfortable and happy and you will not notice any pain at all.

What you must do is to hold it up there [raising the child's hand until the coin is slightly above a direct line of vision] and look at it. Just hold your magic key up there, make yourself comfortable and stare at it really hard. That's it, good. Keep staring at it until your eyes get tired and want to shut. You will feel that magic key getting heavier and heavier and you will have to try awfully hard to hold the magic key up because it is getting so heavy and your arm is getting heavier too. When your eyes close, the magic key will have got so heavy that it will slip through your fingers and fall down, but don't worry about that because you will find it on your lap when you open your eyes again. It will slip through your fingers when your eyes close and then your arm will sink down and you can be completely comfortable. When all that happens, you will find yourself in fairy-land and you will see your special fairy standing there in front of you with the rabbit you wanted, just waiting for you. Your special fairy is there now, with the rabbit, waiting for you and when you close your eyes you will be able to see them and they will take you for a walk through

fairy-land so that you can do all the things you want to do, so that you can feel better and forget all about the pain.

Magnets:

Let's see how well you can imagine something. Hold your hands out in front of you [arranging the child's arms so that they are held straight out in such a way that the hands, palms facing inwards, are about a foot apart] like that. Good. Now, you know what a magnet is like, don't you? If you had a magnet in each hand, you would feel them pulling towards each other. Because they are a long way apart, you would not feel a very strong pull but if you were to bring them a little nearer together, they would pull harder and harder until, when your hands get quite close, the pull would be so strong you would not be able to keep them apart any longer. Just imagine then that your hands are two magnets, pulling at each other and then move them slowly nearer and nearer together. That's it. Now, feel the pull get stronger and stronger, stronger and stronger, getting really strong until it gets too strong for you to hold your hands apart. There, you see how well you have imagined that. Now, let's do it again, but this time, perhaps you would like to shut your eyes to make the feeling even stronger. Good; that's very good. Now, keep your eyes shut and imagine that the magnets are switched off and your hands suddenly relax and come apart again. Good. Now just let yourself relax all over just like your which hands are relaxed and loose.

Finger Lowering:

May I show you something you can do with your hands? It will help you to get into that special state of mind which you can use to help you with [whatever the treatment target is]. [Arrange one hand so that the heel is resting on the arm of the chair or whatever is convenient, the little finger curved and resting its tip, the other fingers slightly curved but raised.] Now, notice that your little finger is resting on the arm of the chair, but the others are held up in the air. Imagine now that your fingers are getting heavier and heavier, and getting more and more tired, so that they too want to rest and not hold themselves up in the air. I wonder which one will come down first? Perhaps this one [touching it lightly] or this one [touching another]. No, it's that one. Which will be next, I wonder? Good. Now only one is still strong enough to hold

up and that finger too is getting heavier and heavier. Good. Now think about your eyelids. They are getting heavier and heavier too and more and more tired. Soon they too will be so heavy and tired that they will sink down just like the fingers. Good. More and more tired, heavier and heavier. Sinking down, just like the fingers. Good. That's very good.

The Secret Door:

Let's see how you can go to that beach you were telling me about. Just shut your eyes and think about a flight of steps. You are standing at the top of a flight of steps and you are looking down them. There are ten steps and a little way beyond the bottom is a wall with a door in it. What colour is the door? Right. Now in a moment, I am going to ask you to walk very slowly down those steps. I will count them off as you go and when you reach the bottom, you can go over to the door, open it and go through and you will find yourself on that beach. You will be able to feel the sunshine on your body and the sand under your feet and hear the waves splashing. It will be just as real as it was that time you told me about and you will feel just as happy and comfortable in yourself as you were then. Now, take the first step: One ... two... three. You are leaving the ordinary world behind. Four... Five ... halfway down the stairs and soon you will be able to go through the door and be on the beach. Six ... seven... eight ... nearly there now. Nine ... ten. Good. Now go over to the door ... Open it and go through. Shut it behind you. Good. Now you are on the beach.

However, Erickson [Haley 1986:193-195] did not use formal induction techniques in his work with children. In fact, for him 'hypnosis is the way two people respond to each other'. Haley points out that what Erickson called hypnosis is not what many others mean by hypnosis. Erickson used it freely, spontaneously and creatively, often without the child's conscious awareness. For him hypnosis did not require a set of repetitive commands or fixations of the eyes on a device or any other traditional procedures of hypnosis. He often induced a deep trance in the child by conversation or by a sudden act that

precipitated a hypnotic response. An example, cited by Haley [1986:195], demonstrates this clearly.

An eight-year-old boy was half carried, half dragged into my office by his parents. His problem was wetting the bed. His parents had sought the aid of neighbours and prayed publicly for him in church. They now brought him to the **crazy doctor** as a last resort with the promise of a **hotel dinner** following the interview.

The boy's anger and resentment were clearly apparent. I said to him, in the presence of his parents, 'You're mad and you're going to keep right on being mad. You think there isn't a thing you can do about it, but there is. You don't like to see a **crazy doctor** but you're here and you would like to do something but you don't know what. Your parents brought you here, they made you come. Well, you can make them get out of the office. In fact, we both can - come on, let's tell them to go on out.' At this point I gave the parents an unobtrusive dismissal signal and they went out, to the boy's immediate, almost startled, satisfaction.

Then I said, 'But you're still mad, and so am I, because they ordered me to cure your bedwetting. But they can't give me orders like they give you. But before we fix them for that', I said, and I made a slow, elaborate, attention-compelling gesture as I pointed, 'Look at those puppies right there. I like the brown one best, but I suppose you like the black-and-white one, because its front paws are white. If you are very careful, you can pet mine too. I like puppies, don't you?'

The child completely taken by surprise, readily developed a somnambulistic trance. He walked over [to the empty floor] and went through the motions of petting two puppies, one more than the other. When he finally looked up at me, I said, 'I'm glad you're not mad at me any more and I don't think that you or I have to tell your parents anything. In fact, maybe it would serve them right for the way they brought you here if you waited until the school year was almost over. But one thing is certain; you can just bet that after you've had a dry bed for a month, you will get a puppy just about like little Spotty there, even if you never say a word to them about it. They've just got to. Now close your eyes, take a deep breath, sleep deeply

and wake up awful hungry’.

The child did as he was instructed and I dismissed him in the care of his parents who had been given instructions privately. Two weeks later he was used as a demonstration subject for a group of physicians, but no therapy was done.

During the last month of the school year, the boy each morning dramatically crossed off the current calendar day. Toward the last few days of the month, he remarked cryptically to his mother, ‘You better get ready’. On the thirty-first day his mother told him there was a surprise for him. He said, ‘It better be black-and-white’. At that moment his father came in with a puppy. In the boy’s excited pleasure, he forgot to ask questions. Eighteen months later his bed was still continuously dry.

5.3.4.7.3 Deepening

Deepening is a technique used after induction to assist the person in **deepening** his trance. There are different levels of relaxation and trance and most often the depth of trance is not very important, especially in children. However, suggestions of insensitivity to pain or even total anaesthesia of some part of the body may require more preparation and more extensive suggestions of increased depth of the hypnotic state [Karle & Boys 1987:44-45].

Deepening may be carried out without imagery, simply by suggestions of increasing depth of relaxation and trance and increasing detachment from the here and now. By allowing the child, who is already in a trance, to imagine that he is pulling on a glove, filled with magic powder, over his hand and that as the magic powder touches his skin he will feel his hand getting heavier and heavier and more and more sleepy, the therapist will be encouraging a spontaneous deepening of the trance state. Encouraging a child to walk down stairs or slide down a slide will also allow some children to increase their relaxation and

deepen their trance.

If using less direct methods in the form of stories and metaphors, Valente [1990:134] suggests the following technique. After the child has been induced, by means of a science fiction story about going on a Star Trek fantasy voyage and following a process of relaxation, he is told the following, to deepen and intensify the images and trance:

Now, you can raise your finger if you are ready to hold your magic crystal and prepare to voyage to join the Star Trek crew on the Enterprise. As I count from one to ten, you will breathe deeply and feel the blue light from the crystal becoming stronger. Each time I say a number, the blue light will grow stronger. When I say the number ten you will be welcomed aboard the starship.

5.3.4.7.4 Direct suggestions

According to Benson [1989:114], younger children quickly become involved in make-believe games of magic such as spaceships and friendly dinosaurs etc and also relate to a **lovely, comfy, sleepy feeling** and therefore they respond well to direct suggestions of feeling safer, braver, more confident, worrying less, concentrating better and enjoying the learning experience. Benson also maintains that older children whose anxiety may be manifesting itself in school refusal, examination nervousness or even anti-social behaviour can also be helped by direct suggestions to the effect that they are feeling calmer, more in control and by allowing them to rehearse coping strategies in their imagination for previously difficult situations. For example, the child can be asked to imagine he is going into his classroom/hall to write an examination. All the feelings associated with examinations and his possible fear of failure, would be elicited. He can then be taught to use a strategy to become aware of the anxiety and to let go of it by

means of many techniques, e.g. pushing his thumb and forefinger together very tightly and then relaxing them and allowing his mind to relax at the same time.

5.3.4.8 Indirect and post-hypnotic suggestions, centring and anchoring

5.3.4.8.1 Indirect suggestions

Indirect suggestions are more subtle than direct ones and are usually used during stories and metaphors by using fantasy and imagination. Inductions such as eye-fixations or eye heaviness or hand levitations are less likely to be used and the induction would move quite quickly from concentrating on an imaginary TV programme for instance, to a general relaxation of personal choice of a favourite activity on an imaginary beach [Benson 1989:115].

Pleasant imagery like a picnic on a beach or a magic carpet ride to a favourite place is used to help the child relax. Hobbie [1989:85] suggests that using the senses of sight, hearing, touch, smell and taste can assist the child in gaining deeper relaxation and better concentration. Suggestions about the warm sun, cool breeze, favourite food, special people and sounds, all assist the child in using his imagination.

Levine [1980:57] uses indirect suggestions through the telling of personalised fairytales to assist children suffering from insomnia. Much of Erikson's work with children often centred on indirect suggestions and metaphors simultaneously. When Erikson joined the child in therapy, he would sometimes deal directly with the problem but, more often than not, he would communicate indirectly through metaphors and paradoxes. In the following case, which has been summarized, he talked about certain aspects of muscle control in relaxation to one subject, as a way of influencing a different type of muscle response which is typical of Erikson's way of inducing change by communicating in analogies

or metaphors [Haley 1986:199].

A mother called me up and told me about her ten-year-old son who wet the bed every night. They had done everything they could to stop him. They dragged him in to see me - literally. Father had him by one hand and mother by the other and the boy was dragging his feet. They laid him face down in my office. I shoved the parents out and closed the door. The boy was yelling.

When the boy paused to catch his breath, I said, 'That's a goddam hell of a way to do. I don't like it a damn bit'. It surprised him that I would say this. He hesitated while taking that breath, and I told him he might as well go ahead and yell again. He let out a yell and when he paused to take a breath, I let out a yell. He turned to look at me and I said, 'It's my turn'. Then I said, 'Now it's your turn', so he yelled again. I yelled again and then said it was his turn again. Then I said, 'Now we can go right on taking turns, but that will get awfully tiresome. I'd rather take my turn by sitting down in that chair. There's a vacant one over there'. So I took my turn sitting down in my chair and he took his turn sitting down in the other chair. That expectation had been established - I had established that we were taking turns by yelling, and I changed the game to taking turns sitting down. Then I said, 'You know, your parents ordered me to cure you of bedwetting. Who do they think they are that they can order me around?' He had received enough punishment from his parents, so I stepped over on his side of the fence by saying that. I told him, 'I'd rather talk to you about a lot of other stuff. Let's just drop this talk about bedwetting. Now, how should I talk to a ten-year-old boy? You're going to grade school. You've got a nice compact wrist. Nice compact ankles. You know, I'm a doctor and doctors always take an interest in the way a man is built. You've got a nice rounded, deep chest.

You're not one of these hollow-chested, slump-shouldered people. You've got a nice chest that sticks out. I'll bet you're good at running. With your small-sized build, you're undoubtedly got good muscle coordination'. I explained coordination to him and said he was probably good at sports that required skill, not just beef and bone. Not the sort of stuff that any bonehead could play. But games that require skill. I

asked what games he played, and he said, 'Baseball and bow and arrow.' I asked, 'How good are you at archery?' He said, 'Pretty good.' I said, 'Well, of course that requires eye, hand, arm, body coordination'. It turned out his younger brother played football and was larger than he as were all the other family members. 'Football's a nice game if you've got just muscle and bone. Lots of big, overgrown guys like it.

Erickson continued to make conversation with the boy, using metaphors to highlight the control the boy could have over his bladder. He compared the different muscles in the body that can **close off** and **hold**, to illustrate to the boy's unconscious mind the areas that he already had control over, e.g. stomach muscles holding the food. He subtly suggested that the areas that were in control stretched down to and covered the areas the boy was having difficulty with, thus suggesting to the boy that he, in fact, had all the control he needed. Not once did he mention the actual problem of bedwetting. He reported that the boy's enuresis stopped and he did not regress at all over the next few years.

5.3.4.8.2 Post-hypnotic suggestions

These are suggestions that the therapist gives the child so as to assist him in his 'waking' state or when he is not in a trance. The most important appears to be the suggestion that each time he and the therapist work together, he will find it easier and easier to relax and use the sessions creatively. Other suggestions may be to feel less anxious, less worried, less afraid, better about himself, etc..

The Stanford Hypnotic Scale for Children [LeBaron, Zeltzer & Fanurik 1988:285] includes a post-hypnotic suggestion as one of seven items on its scale and for this test the suggestion may not be a therapeutic one but a simple one of 'You will feel thirsty when you wake up, and will ask for a glass of water', 'You will turn on the light once you have finished listening to the story', etc. as an immediate test as to the depth of the trance and the susceptibility to hypnosis

in the person.

However, post-hypnotic suggestions are very important in the therapeutic session to assist the person to make changes and grow emotionally in his everyday life. They are taken in by the unconscious mind and occur spontaneously, often without the person's conscious knowledge.

5.3.4.8.3 Centring

This is a technique which is similar to the relaxation response and can be used with children [Hobbie 1989:86]. According to Hobbie 'centring has been described as the way children feel when their bodies and their feelings and interactions are in balance.' It is used with children who do well with their cognitive thought processes, but have difficulty getting in touch with their feelings.

5.3.4.8.4 Anchoring

Anchoring refers to a technique in hypnotherapy that allows a suggestion or direction to be firmly implanted in the child's unconscious mind. It guarantees deeper impact and is applied by giving sensory input, by letting the child **see**, **hear** or **touch** the symbols in the story. Key words are often used in anchoring. The key word becomes the stimulus which with practise and repetition, becomes conditional. Karle and Boys [1987:118] state that if the conditioned stimulus is associated with relaxation, it will trigger off that reaction no matter how tense the child may be at that moment.

5.3.4.9 Story-telling, metaphors and paradoxes

Callow and Benson [1990:56] maintain that story-telling can be considered a

form of hypnosis and a technique for effecting positive change. According to them [1990:54-55], hypnosis generally appears to be able to increase the effectiveness of words in influencing the way a person feels, thinks and behaves. It also appears to weaken the censorship function of the brain, allowing positive therapeutic suggestions access to effect in the subconscious and unconscious. These then, in turn, appear to facilitate a release from negative attitudes and actions, conditional responses and poor self-image.

Therefore, hypnosis used in conjunction with stories, metaphors and paradoxes, is seen to facilitate an enabling process that increases the probability that the subject will feel different and therefore think and behave differently. They also state that 'hypnosis is the most powerful technique for therapeutic change in our clinical experience; it produces results more quickly than other therapeutic procedures' and 'the resistance to decay of its outcome over time, compares favourably with other therapies which succeed in bringing about behavioural change'. Stirtzinger [1983:561] describes a mutual story-telling technique, based on Gardner's work, which allows the therapist and the child to make up a story together. She believes that by using this method, the child is able to develop the ability to integrate both the good and bad parts of himself; to acknowledge his own anger and to express it without fear of annihilation. It also allows the child to feel his own ego-strength to enable him to explore his external world sufficiently. She maintains that the therapist should identify the general atmosphere and setting of the story, e.g. whether it will be pleasant or frightening, etc., and whether it takes place in space, in the desert, etc..

Furthermore, she perceives the child's emotional reactions when telling the story to be important, e.g. whether he demonstrates anxiety, lack of affect or inappropriate affect. The story begins with distancing words like, 'Once upon a time, long ago, in a far away place', so that the child is separated in time and place from reality, to allow him to deal with more anxiety-producing material.

At the end of the story, the child gives a title which punctuates the theme for the child and assists the therapist in determining the most pertinent aspect of the story for him at that time. The therapist then titles his story to further emphasise the theme. The therapist's return story should provide the child with more alternatives to the resolution of conflict, so that he can become aware of the 'multiplicity of options which are available to replace the narrow self-defeating ones he has chosen [Gardner 1972:34-64]'.

The example of a mutual story-telling session below, is quoted from Stirtzinger [1983:563].

His stories gradually moved to live figures - animals and centering around little animals and big, fearful, murderous ones who usually ate the smaller ones. In my return story, I sometimes substituted the word person for the animal involved since I felt they were representative of people, himself and significant persons. His play at this time was haunted by his constant talk of monsters. Any sound during the session would elicit his immediate total attention, exclaiming, 'Is that the monster? Where is he now? Is he coming in'?

A story in this new phase: 'Once upon a time there was a little rabbit. This little rabbit bounced all over so much that he was nuts. He went boing, boing, boing. All the people wondered why he was bouncing around so crazy'.

I had to help him with the story at this point, supplying open-ended leading, linking statements, so that he could finish it.

Therapist

The little rabbit sometimes wondered about himself but other times he knew that he was....

Joshua

drunk.

Therapist

He drank because....

So his mother was crazy
and....

When he was drunk and seeing
two of everything he was....

This tiredness didn't feel so
good so

Joshua

he wanted to because he had
a crazy mother.

he was drunk and sees two
of everything - when he
looks at her he sees two
tables [sic], when he looks
at the light, he sees two
lights, two fire escapes,
two doors, when he looks
at the microphone, he sees
two microphones.

tired.

he stopped drinking. Then
he was better. He went
exercising. Then the
vampire came and had to
drink. Glug! Glug! Glug!
And all the vampire's
friends and they felt like
boxers and boxed out the
little rabbit.

The End.

**His Title: 'Vampires Aren't Real But They Are Real In This
Story'.**

Joshua's rabbit depicts the hyperactive, destructive behaviour
that Joshua's teachers described of him and which he
demonstrated in many play sessions.

Kuttner [1988:291] explores how story-telling can assist in alleviating distress,
pain and anxiety during medical procedures. She maintains that procedural and
sensory information can be interwoven within the storyline, which includes
weaving indirect and/or direct suggestions for comfort, diminishing pain

awareness and increasing ability to cope, into the story. The central characters, heroes and heroines, can be used as metaphors of courage and feelings of accomplishment.

The metaphor becomes the vehicle of change, suggesting alternative outcomes to problem situations that the child is experiencing. Callow and Benson [1990:54] point out that this is not a new technique, but in fact, has been in use for many centuries, e.g. folklore and Christian parables.

There are many different forms of story-telling, metaphors and paradoxes and they can be used interchangeably, simultaneously or individually. Only a few will be discussed here and they will be handled individually as far as possible.

5.3.4.9.1 Guided fantasy and hypnotic imagery

5.3.4.9.2 Therapeutic metaphors

5.3.4.9.3 The hypnotic hero

5.3.4.9.4 Paradoxes

5.3.4.9.1 Guided fantasy and hypnotic imagery

Guided fantasy is a term used by Porter in his treatment of children with insomnia [Levine 1980:57]. His fantasies have little plot to them but tend to encourage progressive relaxation through imagery conjuring up warmth, heaviness, relaxation and security. These guided fantasies will exploit the power of indirect suggestions [cf. 5.3.4.8.1] and metaphors are generously used in this type of work. Levine [1980:59] makes mention of Bettelheim's work with fairytales to analyse and resolve inner conflicts, Gardner's mutual story-telling

technique to diminish the child's resistances to changing his maladaptive patterns and attitudes by, suggesting alternative outcomes and morals to the stories the child creates, and Porter's guided fantasy, which allows the child to feel that he has the control to change his behaviour.

Guided imagery is a term used by Schoettle [1980:220-227] which is very similar to guided fantasy. The therapist introduces basic archetype themes like walking through a meadow, along a stream or through a forest, which illuminates basic self-concepts, resistances, current moods and urgent problems. The child is then guided along some part of nature, e.g. the course of a stream, which would give the therapist valuable information with regard to how much water the child visualises in the stream, the obstacles that impede the flow of the stream, which represent conflicts within the child and the clearness of the water in the stream which reflects his libido energy. Other themes are, strolling along a beach, meeting a witch in the forest, a wizard on the mountain, a dragon guarding a cave, volcanoes, swamps, keys to special doors and boxes, etc. Schoettle emphasises that it is crucial that the child should, throughout all the phases of guided imagery, confront the conflictual, anxiety-ridden encounters, rather than to attempt to escape them. He maintains that the end result of successful confrontation is a strengthening of the ego rather than a fantasy solution, based on primary-process thinking. However, he warns that a number of special problems may arise in applying his techniques to children. He lists these difficulties as:

- * the problems of separating reality from fantasy, in the very young child, limits the application of guided imagery;
- * maintaining relaxed, eyes-closed posture for more than several minutes;
- * the need of the child to recount television and/or movie plots rather than

use his own creative imagery; and

- * a fear that what the child was imagining would really come true [e.g. an evil thought constitutes an evil deed for which he would be punished].

Elkins and Carter [1981:274] express their views that one of the challenges of the child hypnotherapist is to maintain the child's interest and involvement through the creative use of imagery. They prepare imagery based on the child's fantasy regarding science fiction. They use this technique, incorporating relaxation, dissociation and suggestion. They **guide** the child through an imaginary space adventure and use appropriate suggestions to assist the child with whatever problems he may have.

Lazar [1977:80] explored ways of using hypnotic imagery as a tool for working with a cerebral palsied child to assist him in reducing the athetoid movements [bizarre, purposeless movements] in his right hand which irritated and upset him considerably. Lazar played the **television game** with him, allowing him to keep his eyes open throughout the sessions. He was guided in imagining the television set, complete with controls to change channels and he was encouraged to watch a football game with the ball being kicked across the field on the screen.

He watched a swimmer cross the pool and Lazar reflected on the feelings of the body in the water; the buoyancy, lightness, etc. He was encouraged to imagine that he could synchronise the movement of his hands in time to an imaginary bell. He was discouraged from actually using his hand in the way that he wanted to, by being told 'the time was not right, he must first learn to relax'.

He then learnt to flex and extend his right wrist and the athetoid movements in his hands were metaphorically converted into **movie hands**, which were having

a conversation about swapping places with one another and their feelings about themselves, etc. Suggestions were given as to relaxing the hand rather than holding it down. During a session, he remarked that his hands were at war and hitting each other, and the therapist gave the suggestion that once the war was over, the two sides could make-up. After sixteen sessions, the boy showed considerable improvement and therapy was terminated.

Lazar [1977:84] maintains that the hypnotic imagery allowed the boy:

- * observation of himself with controlled or relaxed hands;
- * revivification of previous relaxing experiences;
- * proprioceptive feedback about the athetoid movements;
- * suggestions that voluntary motion appears involuntary [to reduce the accompanying athetosis];
- * integrative and supportive suggestions concerning feelings about his handicap;
- * the use of his hand by redefining the need for control; and
- * the opportunity to deal with feelings of anger and his need for independence.

5.3.4.9.2 Therapeutic metaphors

A metaphor usually refers to the application of a name or an adjective to a

person, animal or object, to which it is not literally applicable. In therapeutic metaphors, a story is told in a way that the child [or adult] identifies so strongly with it that he becomes the person, animal, etc., and takes on his powers and strengths.

Crowley and Mills [1985-1986:84] report that since research indicates that the processing of language is a hemispheric, cooperative venture, the language of metaphor serves a two-fold function of communicating a meaning that requires an integration of left and right brain processes. This makes metaphor a more balanced form of language in terms of left and right brain activity. Metaphor is therefore 'symbolic language, the language of the unconscious'.

Callow and Benson [1990:56-57] maintain that the therapeutic metaphor must be more satisfying and clarifying and less painful than the **original version** which is the child's perception of his life events. In this way, negative images of the self are replaced with new and more positive images.

According to Thiessen [1985:22], the therapeutic metaphor must be equivalent to the hidden dynamic or systemic conflict of the child. Therefore, in order to stimulate a solution to the child's presented conflict, the dynamic or hidden psychological intentions must be diagnosed by the therapist. By matching the metaphor of the story/fairytale with the dynamic conflict, the therapist allows the message of the story/fairytale to stimulate the unconscious to resolve its own problems.

Erickson and Rossi [1992:49-50] use metaphor technique therapy and explain that its effectiveness is that the conscious mind receives one kind of meaning in the form of concepts and ideas, while the unconscious mind receives another in the form of patterns of meaning via implication and connotation.

According to Callow and Benson [1990:57], children are at their most receptive to stories and metaphors between the ages of four to early puberty, which are Piaget's Pre-Operational and Concrete stages. They report that for some children who need psychological intervention, the danger of lowering their defences by direct hypnotic suggestion, is too great and these children respond well to the trance state that accompanies listening to a story. In this way, the child can choose to identify with the main character if there is a message of comfort and hope. He is also free to choose not to identify with the character, if he so wishes. Therefore, the child perceives that there are none of the risks that direct hypnosis appears to hold for him.

A central character is chosen for the story to act as a metaphor for the child. The child's current interests are taken into account and the character can be a favourite toy, a pet, a TV hero or anything that may have special significance or a positive symbolic interpretation. Often the major life events that the child has experienced, are used as the storyline but emphasis is on the motives and emotions, such as unhappy, hurt, unmotivated, rather than behavioural labels such as naughty, bad, lazy. These feelings are followed through with cause and effect being described and strategies for change and a positive outcome are emphasised.

Sometimes the child's fear or problem is a metaphor for underlying conflict or insecurities. Boersma *et al.* [1991:157-163] report on a creative ten-year-old, Janice, who came for therapy because of a maladaptive fear of the wind which was negatively affecting her life and that of her family. However, her mother was fairly unsympathetic towards her plight and did not want to be part of the therapy. In this case, the wind was symbolic of a power to sustain and regenerate life and her fear was that of her parents marital problems, which they were unable to acknowledge or resolve and a fear of separation from her parents.

Six sessions were used to assist her to deal with her difficulties. While in a trance, she was asked to visualise a ball of warm light in her hands and to allow this light to expand until it enveloped her and she felt safe. She was then asked to look at her body and see if there was any place within, where she was experiencing fear or pain. She put her hand over her abdominal area where the umbilical cord had connected her to her mother. She said that it felt as though there was a **big black blob** at the area of connection. She was instructed to place the blob in a box, to put a lid on the box and to set the box outside of the protective circle. She was then asked to visualise the first time she was afraid of the wind. She regressed to the age of four.

In the third session, she made friends with the wind through stories and a book called *The Girl who Loved the Wind*. The theme of the book was of an overprotective father, who tried to shield his young daughter from all the **hurts of life**. Janice identified strongly with the girl in the story. Session four focused on changes Janice had made over the past week with regard to her relationship with the wind. It was felt that Janice's mother should be included in session five. Using Watkins and Watkins' ego state therapy, it was possible for Big Janice [10 years old] to talk to 4 year-old Little Janice. It was further found that there was unfinished business concerning Janice's fear of the wind and marriage problems between her parents were identified. In the sixth and final session, Janice said the blob had gone and she was no longer afraid of the wind. Her drawings depicted a new sense of security and independence. Marriage counselling was recommended for her parents.

It is Boersma *et al.*'s [1991:165] belief that any desensitisation techniques used in this case would have been inappropriate because the therapist would have failed to acknowledge the child's unconscious and the possible root of the fear [cf. 1.3]. Such treatment may have detrimental effects later in life, especially

if issues like separation anxiety are not addressed and there is evidence that this may lead to social phobias in adults.

Thiessen [1985:25] uses fairytales as metaphors in hypnotherapy and links the story to certain conflicts children and adults may have. He suggests using the following well-known fairytales to resolve specific areas of conflict in the person:

FAIRYTALE TITLE	METAPHOR AND CONFLICT
Bremer Town Musicians	Respect, honour, ageing, suffering in old age;
Red Riding Hood	Obeying rules of authority, controlling tempting behaviour, resurrection, help is forthcoming even if the hero is misguided;
Goose Girl	Faithfulness, loyalty [horse], helpfulness, being rescued, help is provided, justice is done;
Mother Hulda	The just mother image, being helpful, assist others, politeness, reward for following rules and learning self-discipline, consequences of laziness and lack of diligence;
Sleeping Beauty	Learn patience, learn to postpone sexual satisfaction, obey rules, relativity of time, resurrection;
Cinderella	Industrious, conscientious, being exploited, unhappy but being rescued and helped, no reward for laziness and non-caring, mother

reward for laziness and non-caring, mother image of rejection and prejudice;

Frog King

Making a decision, keeping a promise, the metaphor of the golden ball represents the individuation process of the higher self for the female in relation to the presence of the male partner;

The Iron Henry-Hans

The golden ball represents the individuation process of the higher self for the male in relation to the princess and the mother image. Modesty, helpfulness, diligence;

The Ugly Duckling

Self-esteem, misconception, finding self-identity through action and time;

The Ambitious Tailor

Courage, overcoming inadequacies through positive thinking;

Hansel and Gretel

A mother who does not want to be a mother [stepmother and witch], a weak father, courage, mutual caring, risking, help is guaranteed through wisdom, thinking ahead and action; and

Nosetree

Helplessness, lack and gain of control, just punishment for betrayal, suffering will find a positive solution.

5.3.4.9.3 The hypnotic hero

Tilton [1984:366-367] expanded on Gardner's idea of a television hero and developed the hypnotic hero. After rapport has been established, a favourite hero is chosen by the child from many different sources such as stories, memories, cartoons, comics, television, or from the imagination. **The Hero** is used strategically to help the child with his problem. After an induction in which the child imagines himself in the presence of the hero, using his senses to **see, hear, feel** etc. **the hero**, the therapist uses the hypnotic situation to give specific suggestions, as if they were coming from the hero, and by doing so allows for greater rapport with the child and a wider range of choice and creativity in therapy.

This technique is a means of strengthening the child's ego and providing security while allowing the child to feel a sense of autonomy. It can either be used with direct suggestions, as in the example below, or with indirect suggestions in the form of metaphors and paradoxes.

The following extracts from Tilton [1984:370-373] illustrate the use of the hypnotic hero:

J.C., a 5-year-old boy was brought in because of his fear of being kidnapped or killed [a recent kidnapping and killing had occurred in his neighborhood and was reported by the news media]; his fear had become so bad that J.C. refused to go upstairs alone to wash or go to sleep. He was also experiencing frequent nightmares. The mother, who had success with hypnosis with the author, thought hypnosis might help her son.

The coin-drop method of induction was used and the hero chosen was Superman. This was not sufficient as J.C. wanted to see God, so 'Superman' took J.C. to 'God'. 'God' told J.C. that he would be protected while he slept and could

go up to his room without fear. Following this visit there was a resolution of symptoms which returned 1 month later. Several family sessions were utilised resulting in a lot of violent play from J.C., revealing a need for more discipline and control by the mother [a single parent]. Interventions for discipline and control were suggested and the mother was encouraged to suggest to J.C. that maybe he should remain downstairs where it was safe [paradox].

All went well for 1 month but on a return visit for the same problems, J.C. was resistant to any help in either the form of discussion or hypnosis. He was seen again 2 months later because of behaviour problems in school and at home but again related that he did not want to be in the author's office. The author stated that he 'probably could not help J.C. anyway' and who did his mother think she was ordering the author to just fix J.C. This was done to surprise J.C. and to establish a common bond with him against his mother, thus creating a better rapport [Erickson 1958]. Following this outburst, J.C. said that he just could not behave. After a few more minutes he said that he was afraid of his upcoming flight to England because the plane might crash. In hypnosis 'Batman', 'Robin', 'Catwoman', and 'God' said they would protect him and he promised not to misbehave.

Tilton mentions that he then spent several sessions with J.C. using drawings and story-telling. In one session, J.C. revealed that when he was three-years-old, a little girl whom he knew, had been killed in a horrific motor car accident and that this had upset him terribly. Sessions were then used to explore his feelings about death, dying and being separated from his mother. [At this time his mother was also about to fly to San Francisco without him, for a weekend.] Tilton used hypnotherapy and a theme of J.C. becoming the **hero pilot** and flying the aeroplane himself, was employed. Tilton concludes that J.C.'s behavioural problems and fears both disappeared and **he returned to his old self**, according to his mother. Six months later, a follow-up postcard revealed that J.C. was a 'well-adjusted child who had enjoyed his flight to England'.

A second example quoted by Tilton [1984:369] describes the treatment of thumb-sucking, encopresis and enuresis in a nine-year-old boy:

A television screen induction was utilised with J. getting his suggestions from Buck Rogers. 'Buck' taught J to fly a space ship, gave him a shiny new spaceship to keep clean and dry, and told him that if he really wanted he could change all his behaviour and 'Buck' would teach him how. 'Buck' told him to suck each finger whenever he sucked his thumb, and a few sessions later J. was told that he could suck either all his fingers or none. 'Buck' instructed him in how to squeeze his muscles for sphincter control when he had the urge to defecate and how to hold for as long as possible before going to the toilet, in that way he could have a clean and dry bed and pants. Similar instructions were also given to J. in the waking state by the author. After 4 half-hour sessions, there was complete cessation of faecal soiling, thumb-sucking only during sleep and bedwetting reduced to once a week. At 6 months, there was total success. The patient has remained asymptomatic for 2 years.

However, it must be noted that in the second example, the symptoms appear to have been the main focus of the therapy and the causes of the symptoms may have been ignored, to the detriment of the child's emotional growth.

5.3.4.9.4 Paradoxes

Paradoxes are often used in hypnotherapy with children. These can be defined as statements that are contrary to received opinion or statements and suggestions that are seemingly absurd, though perhaps really well-founded. Often they can be self-contradicting and may conflict with preconceived notions of what is reasonable or possible. For example, with an enuretic child, the child may be asked to wet his bed at least 3 to 4 times a week in order to be rewarded. He would be reprimanded if he did not manage to conform to this requirement. However, on the other hand, he would be required to wash his own bed-clothes each morning and hang them on the line to dry. By encouraging the behaviour

that is seen as undesirable, but by allowing the child still to have certain consequences or commitments in dealing with the problem, the child is often totally confused by the paradox and unable to maintain the deviant or regressive behaviour. At a certain point, the requirements would change and the child would then be rewarded for the positive behaviour of having a dry bed.

Kelemen [1988:13-17] reports that he used an innovative metaphoric technique paradoxically to reverse school phobia in a boy of twelve. The metaphor was consolidated by subsequent active participation and in two sessions, the phobia was completely eradicated and this was confirmed on a two month follow-up session. After obtaining a full history from Matthew's parents, Kelemen interviewed Matthew and assessed that although he [Matthew] perceived the problem to be his inability to do his schoolwork in a new school, Kelemen thought that the real reason lay in Matthew's inability to make friends and his perception that he was being picked on and bullied. Kelemen shared with Matthew the problems he had as a child when he attended a new school and how, when he hit back in retaliation, he was left alone. Matthew reported that his parents had told him never to hit back or fight other children, as it takes more courage to walk away from a fight than to fight. Kelemen's [1988:14-16] response to Matthew's dilemma and his interaction with Matthew follows:

I told him that this may be good advice, but sometimes you must do different. I asked him what his 'dearest' wish would be if he could have it with regard to the school bullies. His reply was that he would 'really like to beat them up and show them.

I then asked him if he had seen the Karate Kid movie; he confirmed that he had and also that he loved it. I told him that bullies and other kids can 'sense' a person who will not fight or one that will, they have a sort of instinct. Matthew seemed to understand this and told me a story about a dog he used to have to walk past when he was attending primary school, and how when he was frightened the dog would growl at him. His grandfather told him that if he took a stick with him and made a lot of noise by hitting the fence with it and yelling, the dog would go away and leave him alone, which it did.

I told him that I felt we had talked enough for now and that he should go and sit in the other chair [which I use for hypnosis]. I did not explain to him what we were going to do. I proceeded with the induction and therapy which was in essence [condensed] as follows:

'Matthew, I want you to make yourself comfortable and close your eyes.. the only reason I want you to close your eyes is because that way you will not be distracted when I wave my hands about .. [I have a tendency to do this] ... you may open them whenever you wish but then close them again ... I would now like you to start breathing deeply and evenly ... just the same way that the Karate Kid had to when he was training ... deeply and evenly ... just like the Karate Kid. Wouldn't it be great ... if somehow you could become the Karate Kid ... I suppose you could pretend ... or daydream that you are the Karate Kid ... I can just see you in your special uniform... the headband ... the shirt... loose... the pants... the special belt... And you are in a big hall and there is a very old man sitting on a mat at the end of the hall... and you are doing special exercises in slow motion... turning... balancing... on one foot... moving silently, stealthily... like a cat... moving your arm... then the other one... then like a flash of lightning you kick out and upwards at the same time launching yourself off the ground... and again... and again... your hands both move with the speed of lightning, special... and you feel good... confident... self-assured... brave... positive... you can do anything you want to... Other kids can sense that you are special... nobody will ever bully you again... you have confidence, self respect... keep practising... the old man is talking to you now... he is telling you that you must know your art and not use it as the bullies did... you must never become a bully, that is what your mother and father tried to tell you... You are feeling so good about yourself... Others want to be your friend... let them. [Silence for a few minutes]... I am now going to count from 1 to 3 and on the count of 3 you will open your eyes feeling great... etc.'

Keleman then suggested that Matthew should enrol in a martial arts programme, which he was keen to do, but concerned that his mother would not permit it. Keleman then conspired with him and together they planned that Keleman would ask her rather than Matthew. At the next appointment, two weeks later, Matthew appeared much happier and was enjoying his martial arts classes. He was told by his instructor that he was a **natural** and he had also made new friends. He

became less concerned about the bullies at school and his work improved. He was also able to **handle** a nightmare that he had, which pleased him a great deal.

Keleman suggested that he may like to rearrange his room if his mother would permit him to. He stated immediately that he would like to move his bed. His mother agreed and also reported that he seemed so much happier, his marks had improved and he no longer objected to going to school. She was also pleased with his progress at the martial arts course.

Two months elapsed before Matthew's next appointment, his final visit with Keleman, who reports that Matthew was very pleased with himself because his school marks had improved significantly, he liked his school, had the required number of friends and he felt quite at ease with his peer group. The nightmares had also stopped after he had moved his room around to his liking. Keleman maintains that he used his own experiences to motivate the mechanisms of his unconscious mind to formulate a technique that Matthew could respond to, even if it did break the rules. He concludes that by focusing the induction on a style of story which provided Matthew with a role-model that he could identify with, he was able to change his perceptions and attitudes as well as his reactions. Following this up practically and doing well at the martial arts training, increased his self-esteem and confidence and indirectly, his schoolwork. Finally by allowing Matthew to change his room to his liking, his parents encouraged him to accept the consequences of his own decisions. Here a metaphor, hypnotic hero and paradox were all used creatively and interchangeably.

Erickson [Haley 1986:204-208] made much use of paradoxes, often in the form of metaphors and indirect suggestions and he often sided with the child against the parent in an attempt to assist the child to change his behaviour. The following examples are given in order to explain this more fully:

A boy was brought to me who was supposed to be in the seventh grade in school, but he couldn't read. His parents

insisted that he could read, and he was deprived in every possible way as they tried to force him to read. His summers were always ruined by tutors. He reacted by not reading.

I started working with the boy by saying, 'I think your parents are rather stubborn. You know that you can't read, I know that you can't read. Your parents have brought you to me and they insist I teach you how to read. Between you and me, let's forget about it. I should do something for you, and I really ought to do something that you like. Now what do you like most?' He said, 'Every summer I've wanted to go fishing with my father'.

I asked him where his father fished. He told me that his father, who was a policeman, fished in Colorado, in Washington, in California, and even planned to go to Alaska. He had fished all along the coastline. I started wondering if he knew the names of the towns where those fishing spots were located. We got out a map of the West, and we tried to locate the towns. We weren't reading the map, we were looking for the names of towns. You look at maps, you don't read them.

I would confuse the location of certain cities and he would have to correct me. I would try to locate a town named Colorado Springs and be looking for it in California and he had to correct me. But he wasn't reading, he was correcting me. He rapidly learned to locate all the towns we were interested in. He didn't know he was reading the names.. We had such a good time looking at the map and finding good fishing spots. He liked to come and discuss fish and the various kinds of flies used in catching fish. We also looked up different kinds of fish in the encyclopedia.

Near the end of August, I said, 'Let's play a joke on your teachers and on your parents. You've been told you'll be given a reading test when school starts. Your parents are going to be anxious about how you'll do, and so will your teacher. So you take the first-grade reader and you carefully stumble through it. Botch it up thoroughly. Do a better job on the second-grade reader, and a somewhat better one on the third-grade reader. Then do a beautiful job on the eighth-grade reader'. He thought that was a wonderful joke. He did it just that way. Later he played truant and came over to tell me about the appalled look on his parents' faces and his teacher's face.

If he had read the first-grade reader correctly, it would have been an acknowledgement of failure on his part. But when he

misread that and then went beyond the seventh-grade to do the eighth-grade reading well, that made him the winner. He could confound his teacher, bewilder his parents, and be the acknowledged winner.

In the second example, Erickson explains how his therapy works. Johnny was brought to see him because of consistent bedwetting. His mother was concerned about him, but his father was a **harsh and cold** man who accused his wife of 'babying the brats too much'. His father could show no affection towards him and his mother tried to compensate for this. However, the boy's reaction was, according to Erickson, 'I want love from my father, but he doesn't give it. Mother always steps in and makes it unnecessary for him to give it'. His father had always said that all kids wet the bed and that it wasn't normal for them not to. He had in fact wet his bed as a child, till late into his teens.

Erickson reports further:

I had one interview with the father to size him up. He was a loud-voiced man who walked into this office, sat down and spoke as if I were about sixty feet away from him. He asked me if I didn't know that all kids wet the bed until they got to be about sixteen. That's what he did, that's what his father did, it was very certain that I had done it, and certain that every other boy grew up that way. What was this nonsense about curing his boy of wetting the bed? I let the father explain it all to me. He enjoyed the interview and shook hands with me. He said he was delighted to have such an intelligent listener.

When the son and mother came in together, the woman said, 'My husband told me he had explained things to you'. I said, 'Yes, that's right, he explained at very considerable length'. Her facial expression said, 'Yes, I know'. The son had a pained look on his face. I told them, 'As far as I'm concerned, I'm going to forget about everything that he said. You don't have to, but then of course you weren't there, you only have some ideas of what he said. I'm just going to forget them because the ideas that you and I and your mother have are

important. It's the ideas that you and I have, and that Johnny has, that are important.

Erickson explained his technique in the following manner:

You see what that does? I'm tying myself to Johnny first, and then tying it the other way around. First I'm allied with Johnny, then I have mother allied with me. You see Johnny's going to stand by me - because I'm going to forget what his father said and Johnny would like to forget that. Then I tie mother to me by having her join me in forgetting what father said. This sets father aside, but it's not a hostile putting him aside. I've heard him out, and they know it. Father has come home and told them. I'm just forgetting about it with no particular anger or distress. Father couldn't be included in the treatment because of his absolute opinions, so he needed to be set aside on this issue.

As I sized up the situation with Mother and the boy, it was apparent that Johnny was utterly hostile toward his mother about this bedwetting. He was angry and in a struggle with her about it. I told Johnny that I had a remedy for him that he wouldn't like. It would be an effective remedy, absolutely helpful, absolutely certain to get him over the problem, yet he would not like it - but his mother would dislike it more. Now what could Johnny do? If his mother would dislike it more than he did, that would be fine. He could put up with anything that made his mother suffer more.

My proposal to Johnny was rather simple. I pointed out to him that his mother could get up at four or five o'clock in the morning and if his bed was wet she could rouse him. She didn't have to wake him up if the bed was dry. However, if his bed was wet and she roused him, he could get up and sit down at his desk and copy so many pages from any book he chose. He could put in the time from four to seven o'clock, or from five to seven o'clock, copying material. His mother could watch him do that and watch him learning to improve his script. The boy's handwriting was really terrible and needed improvement.

To Johnny it sounded horrible to get up at four or five in the morning - but Mother had to get up first. It sounded unpleasant

to have Mother sit there watching him improve his script, yet he only had to do that on mornings when his bed was wet. Nothing more disagreeable than getting up at that hour of the morning - to improve his handwriting.

They began the procedure and it wasn't long before Johnny didn't have a wet bed every morning; he began skipping mornings. Pretty soon he had a wet bed only twice a week. Then a wet bed every ten days. Mother still had to get up every morning and check.

Finally it was a wet bed once a month, and then Johnny re-orientated himself entirely. He developed the first friendships he ever had. It was during the summer, and the kids came over to play with him and he went over to play with the kids. His marks in school that following September were greatly improved. His first real achievement.

Now that was playing mother against son and son against mother. It's that simple idea of 'I've got a remedy for you, but you won't like it'. Then I digress to the fact that mother will hate it even more. Johnny wants me to come to just what it is that is a remedy. Then he's all for it. Improvement in handwriting becomes the primary goal, a dry bed becomes an incidental, more or less accepted thing. It's no longer the dominant, threatening issue at hand.

Mother watching her son improve his handwriting, could take pride in her son's accomplishment. The son could take pride in it. When the two of them brought the handwriting to show me, it was just an eager boy and an eager mother showing me this beautiful handwriting. I could go through it page after page and point out this letter 'n', this letter 'g', this letter 't', and discuss the beauty of the script.

Since Johnny has a dry bed, his father has played ball with him - coming home early from the office. The father's response when the boy stopped wetting the bed was surprisingly complimentary. He told the boy, 'You learned to have a dry bed faster than I did; must be you're a lot smarter than me'. He could afford to be generous. He had told me off completely. Besides, it wasn't the psychiatrist who solved this problem for his son, it was the superior brain power he bequeathed to his son. In the family it became a joint achievement that was

blessed by the father and the boy got recognition and acceptance from his father.

Lazar and Jedliczka [1979:287] report on using a paradox with a boy of eleven. In Ericksonian style they use a utilisation technique to circumvent resistance to therapeutic change which involves accepting and using the situation, including the child's behaviour and feelings, which then became part of the treatment strategy or of the hypnotic situation. The following case history, as quoted by Lazar and Jedliczka [1979:288-290] and which has been summarised, explains the utilisation of manipulative behaviour through the use of a paradox. An eleven-year-old boy was referred to the above authors because of his fairly severe asthma attacks which were no longer responding to medication. He was moderately retarded and had cerebral palsy. His mother was concerned about behavioural problems that he demonstrated and complained that he manipulated her with his demands for special care. She was forced to get up for him at four hourly intervals throughout the night due to his coughing, asthma attacks and his physical handicaps. She explained that when she put him on the toilet in the morning, he refused to urinate so that he made himself late for the school bus. Lazar and Jedliczka mention that the boy tried to disrupt the session by tapping continuously on the psychologist's desk which irritated the mother no end. The following extract demonstrates how the psychologist responded:

I wondered, aloud, how many times he could tap the desk, whether he could tap it ten times or 15 times, or maybe 25 times. Eager both to irritate his mother and to show me how many times he could tap, he tapped my desk 25 times, counting after each tap and appearing quite tired and less interested in tapping when he finished.

I asked if they came to see me for any other reason. His mother said that he 'says bad words' to her, which angered and upset her. Again smiling and seeming pleased with himself, the boy nodded in agreement. After determining that he said these

words in his native language as well as in English, I praised him for being clever enough to say the words in both languages.

The boy again attempted to interrupt his mother when she said that he always wanted his own way. I agreed that he did seem to want his own way, but I wondered whether he really knew what he wanted. He said that he did not, so I told him that he had a lot of thinking to do, and a lot of learning to do, and he would have his chance to talk with me later.

When asked if they had any other reasons for coming, his mother said that he told her that he was going to cough at night to wake her up. The boy smiled and agreed. She said that this happened every night, and that she and his father had to get up to give him medication.

She wondered if his misbehaviour was her fault because she never disciplined him. She felt sorry for him 'because of the way he is'. She looked puzzled when I asked what that was. The boy added 'You know, the way I am'. He explained, 'I'm a cripple'. I asked him where he was crippled, and he stared at me blankly. I asked, 'Are your eyes crippled?' Touching his eyes, he said 'No'. 'Are your ears crippled?' 'No'. 'Is your nose okay?' 'Yes'. 'Is your neck okay?' 'Yes'. 'Your arms?' 'Yes'. 'Your chest?' 'Yes'. 'Your stomach?' 'Yes'. 'Your legs?' 'No'. I reflected. 'Your eyes, ears, nose, neck, chest and stomach are okay, and your legs are not'. He agreed.

The psychologist went on to remind the boy that he had a lot of thinking to do and a lot of learning to do. He took him out the office and said he would see him later. The psychologist then went out to ask for the parents' full cooperation and they agreed to do exactly what he told them to. The psychologist made the following suggestions:

- * to put him on the school bus, regardless of whether he was ready or not and his parents agreed that while he may feel uncomfortable, his deliberate behaviour of refusing to use the toilet timeously, would be rendered ineffective and therefore become extinct; and

* to praise him for saying the 'bad words' in both languages and to encourage him to say them over and over, at least ten times each time he uttered them.

The coughing was to be dealt with at a later stage. The psychologist then sent the parents out the consulting room and called the boy back in. He asked him if he would like to chat to him. The boy was hesitant as to where he should start. He mentioned that his mother screamed at him a great deal and that made him say the bad words. The psychologist took out a stopwatch and asked him to say as many **bad words** as he could in a minute. He proceeded with words like **stupid, dumb, shut-up**, etc. and the psychologist displayed his disappointment that the boy couldn't improve on these **bad words**. He suggested that the mother had implied that they were of a far more serious nature. He challenged the boy to improve on them. He was then asked to choose one word to use the next time he wanted to say a bad word. He selected **dumb-dumb** and he was asked to repeat it ten times. He soon lost interest in the task and the word. He was then asked about his problem of urinating, which made him late for school. He was asked how long he urinated for. He replied, 'One second'. He was then asked if he would like to make his mother angry, which he said he would like to do. He was encouraged to urinate for three to four seconds, but that he could decide on exactly how long himself.

The problem of coughing was then tackled with him. He was told that no one, not the psychologist nor his mother, would make him stop coughing. He would do this for himself. He was asked to name the days of the week, which he could recite and was asked to choose a night on which to cough. It was subtly suggested that as that day was Wednesday, it could be Wednesday night or Thursday night or even Friday night. However, Saturday may be a very good night for coughing and Sunday was in fact a better night for coughing, or maybe it would be Monday night or even Tuesday night. He was puzzled by this and

said he would cough Wednesday night through to Saturday night. He was asked if he was sure he could get all his coughing done by Saturday night. He said he could.

His parents were then asked to rejoin the group and he was told that the psychologist would tell his parents something that he might not like. The parents were informed that what the boy and psychologist had discussed was just between them and that the boy would only tell them if he wanted to. His parents were told to wake him up on certain nights, whether he coughed or not. He was asked to select the nights and the time they should wake him. He selected Wednesday through to Saturday, the same nights on which he had planned to cough. He was then asked again whether he would get all his coughing done by Sunday and he said he would. They were all sent home after being given an appointment for the following week. When they returned the following week, his mother said that he was a different boy. He got to school on time, no longer said **bad words**, and did not cough. His parents said they woke him up Wednesday through to Saturday night, and that he did not cough on these nights.

Follow-up three years later revealed no recurrence of the nightly coughing or of the behaviour problems. His parents reported that his academic progress had improved and that he was being considered for a more advanced school placement, although a psychological evaluation done 20 months following the session, still suggested moderate mental retardation.

Lazar and Jedliczka [1979:291] conclude that all suggestions and directions were ego-somatic and capitalised on his behaviour to channel his needs into more constructive and adaptive activity. His need to control his parents, his anger at them and his wish to irritate them were all respected without interpretation and he was encouraged to control his own behaviour, which was his most important need of all and the reason for his manipulative behaviour. Confusion techniques

as to who was responsible for his coughing were accepted by the boy, because of his anger towards his mother and his conscious and unconscious mind perceived his mother as contributing to his coughing.

The intervention that was used, reduced the attention-getting value and the control value of his coughing, his bad language and his lateness for school. His parents gave him attention, by waking him up every night, whether he coughed or not. This also served to remove his control over his parents sleeping habits. He perceived that they were no longer upset by his behaviour and by implication, they were able to handle his anger. The coughing was given no more emphasis than the bad language which reduced its manipulative powers. His attempts to provoke the therapist [and his mother], by tapping on the table, were redefined as cooperating with her, and not irritating to her and he thereafter lost interest in the activity.

The boy's responses, according to Lazar and Jedliczka [1979:291], can be compared with hypnotic phenomena. He was able to focus his attention on specific limited aspects of his environment and at times, stared at the therapist with his awareness appearing to alter. He became absorbed in the tapping and word repetition tasks and in planning ways to make his mother angry. He followed implicit, but not explicit, post-hypnotic suggestions, i.e. he did not cough on the nights he selected, as the therapist had suggested, but he did stop coughing, which was the underlying suggestion.

Although the authors feel that he may in fact not have been **hypnotised**, in the formal sense of the word, it is in fact unimportant as the process and outcome followed very much the same patterns as if he had been fully hypnotised.

5.3.4.10 Ego State therapy and strategies for moving from the present to the past and 'changing' the past

Watkins and Watkins [1979:218] define an ego state as a 'body of behaviors and experiences bound together by some common principle and separated from other such states by a boundary which is more or less permeable'. Alternation of the different ego states appears to be a normal process in personality functioning and the ego state that is in the **here and now**, is said to be **executive**. Ego states can be activated under hypnosis and will then stand out more clearly as they are isolated and **purified** by being singled out from the others. They also occur in multiple personalities and in this sense, they have become totally disintegrated from one another and therefore, can be said to be pathological.

Ego states are like parts of the individual which take on a subjective role and have relative autonomy from each other and from the entire individual, depending on the rigidity or permeability of the ego boundaries which separate them from the whole person and from one another. Transactional Analysis hypothesises three **ego states** in the person; the Child, Parent and Adult. Variations of these have also been differentiated, such as the natural child, the adaptive child, the nurturing parent or the punishing parent. The ego states often develop personal needs and goals, which may not be to the benefit of the whole individual and their aims may clash with one another or with the whole. When that happens, anxiety, cognitive dissonance and internal conflict are created. Therefore, to lessen the anxiety and dissonance and resolve the conflict, Ego State therapy is necessary.

Ego State therapy attempts to work with the **family of self** within the individual and this is more easily done with the use of hypnotherapy. Often these ego states are available only to the unconscious mind. If the person/child regresses in hypnotherapy to the age of five or six, the behaviours and experiences he had at that time of his life, will be activated and he will experience himself as **being there** again. In this way, trauma experienced in the past, can be relived and sometimes, with new insight brought in from the **older and more experienced** part [be it a nine-year-old or twelve-year-old], the pain and suffering can be re-

experienced and healing can take place.

Since hypnosis has the effect of narrowing the field of perception and of intensifying the therapist-patient relationship, energies can be concentrated on **single states** [parts of the person] at a time [Watkins & Watkins 1979:219]. The therapist is then able to evaluate the roles of the ego states more carefully and therapeutic intervention can be more accurate and successful in altering their functioning constructively and in integrating them into a healthier **whole**. In this way dissociation is reduced and intra-psychic conflicts can be resolved. In turn, this could allow the person or child maximal adaptation in both his inner and outer worlds.

Watkins [1971:21] introduced the affect bridge as a technique for assisting the client to move experimentally from the present to a past incident, over an affect or feeling, common to both. It follows the same principle of free association of ideas, but emphasises the feeling rather than the thought. According to Watkins, this technique appears to achieve significant therapeutic change in a comparatively short period of time, possibly because it has considerable value in breaking through the interminable stalemate of an intellectualised therapy. It employs the flexibility of hypnosis, to cross the time lines from present to past, more rapidly and it highlights commodities or **bridges** between the present and past experiences which are emotional in nature. It resembles implosive therapy [cf. 5.3.2.2] in some respects and can often shorten the treatment process. However, it should not be viewed as **an entire system of therapy** but merely as a 'hypnoanalytic method which can often facilitate the process of association, helping the patient to move from present transferred experiences, to their earlier origins' [Watkins 1971:26]. To the best of this researcher's knowledge, it has not often been employed as a technique used with children and the research in this respect is therefore limited, but the possibilities of using it with children appear promising.

Watkins [1971:24] illustrates his use of the affect bridge by the example which has been summarised below:

A thirty-five-year-old woman was referred to Watkins because of a weight problem after the birth of a child. She had a tendency to binge and suggestive hypnosis had had little effect. She was a good hypnotic subject, but post-hypnotic suggestions lasted only a few days. In the eighth session with Watkins, repressed material was elicited by means of an affect bridge. The woman began by describing an afternoon during the previous week when she had been in the nursery caring for her child, when she had an overwhelming desire to eat. She went to the kitchen and satisfied her urge, but felt extremely guilty thereafter. Watkins placed her in a hypnotic trance and assisted her to return to that afternoon. The situation was relived with much description. She then began to experience the intense craving for food. In the following quotation, Watkins describes how he proceeded:

Your craving to eat is becoming more intense. It is becoming so strong that you can think of nothing else. You feel confused. The room is fading. Everything is a great blur. The only thing you can experience is this craving. Craving - craving - craving. The world is full of craving.

It was inferred that **craving** represented that affective element which might be the common **bridge** between the present incident and some earlier significant [perhaps pathogenic] experience. The suggestions were aimed at intensifying this feeling and at ablating other elements in the Tuesday afternoon situation. The patient was induced to pay attention only to this affect and to experience it most strongly. The affect of **craving** was treated as the common bridge between the present and the past, and the patient was moved over this bridge into some, as yet undetermined, situation in the past which, it was believed, might through transference, be unconsciously determining her present behaviour. She was

instructed as follows by Watkins:

Now you are becoming younger. You are going back, back, back into the past over a railroad track consisting of craving. Everything is changing except craving. The craving is the same. And you are becoming younger and younger. You are going back to some time in your life when you first felt this same craving. Where are you? What is happening?

The patient, not the therapist, selects the time and place in the past to which she will move. He only indicates his belief that she will move to some such time and place. At this point, the patient replied, 'I am lying in bed. There are slats up and down the bed. I want to suck my thumb, but Mama has tied a cloth on it with bitter, black medicine'.

Through their common affect of craving, situation A, the incident that Tuesday afternoon in the nursery, and situation B, the frustration of an infantile need to suck, are seen to be related. Something about the care of her own baby must have reminded her unconsciously of the earlier experience and, through transference, stimulated the affect of craving just as she felt it in her childhood.

She was now allowed to gratify this need: 'Mary, you can take off the bad cloth and suck your thumb if you wish'. The patient 'removed' the cloth, placed her thumb in her mouth and lay on the couch vigorously sucking while slobbering. For 15 minutes she continued this sucking while she was encouraged to enjoy this regressed experience to the utmost. Finally, she removed her thumb: 'I don't want to suck any more. I feel so yummy'.

The craving has been traced hypnotically through an 'affect bridge' to this childhood experience of frustration, but is this connection sufficient to account for the patient's overeating or must we know much more? She no longer feels the affect of 'craving', but she does feel the affect of 'yumminess'. Another affect bridge was now constructed in an attempt to discover some even earlier significant experience which would bring greater understanding.

'Mary, you are forgetting all about being in the crib with the slats. You are becoming even younger. Going back, back,

back. But the world is filled with yummys. You feel so yummy as you become younger. You are going back to some time when you first felt yummy'.

At this point, the patient said nothing, but, putting both hands near her mouth, she clutched at an unseen object in front of her. She began opening and closing her mouth and sucking through protruding lips. The therapist only said, 'Do you know where you are?' Enough retention of the adult ego remained that the patient could understand and nod. No more needed to be said. Both were aware that she was nursing at the maternal breast and that this was what felt 'yummy'.

She was next asked, 'Do you think you would like to remember all this, to bring it back when you are awakened? Are you ready to understand it?' A question, not a command, was used to test the integrating ability of the conscious ego and to allow the patient to choose whether or not she was ready for this 'insight'. She indicated agreement.

'All right, you can slowly return to the present time and alert yourself as I count to fifteen. You will bring back with you all the memories, the feelings, the experiencing, and the understanding of this which you have indicated you are now capable of handling. One, two ... fourteen, fifteen'.

The patient opened her eyes and burst into peals of laughter: 'Now I know why I crave to eat cookies and cakes. I don't want to have a baby. I want to be a baby'.

During the following 8 weeks, the patient lost 30 pounds and returned to 132 pounds, her normal pre-pregnancy weight. She commented about the compliments of her friends about her figure. She reported little difficulty with craving to eat.

A central issue of therapy is frequently the struggle to arrive at an acceptable version of one's life. The **stories** the clients and children bring through their conversations and their play, often help them to understand who they are and what has happened to them. By challenging the stories through the use of reframes, either in or out of hypnosis, the therapist enables the client/child to **rewrite** his own story.

Keim, Lentine, Keim and Madanes [1987:2] state that, while we cannot retrospectively change an event in our lives, we can **change** the past, by changing the presentation of it through the stories we tell about our lives. They emphasise that a person tells his **story** with many different motives [**influenced by our emotions, beliefs, thoughts, perceptions, etc.**]. They state that 'narratives ... are offered to impress, to elicit sympathy, to make metaphor for another message'. The strategy of changing the past can be, and is often, a focus of family therapy, especially from a systematic perspective. However, this strategy can also be used individually in hypnotherapy. The child is assisted through direct or indirect hypnosis by means of stories, metaphors and paradoxes, etc., to begin to re-evaluate and recreate his perception of the past.

In training sessions of hypnotherapy, Olivier and Leeb [1992] reported on many varied ways of assisting both adults and children to **change** their past. This can be done by assisting them to review their past experiences in hypnosis or by means of metaphors to assist them unconsciously. They can, in extreme cases, be assisted in **rewriting** their story to change the facts, if this is what they need in order to move on. However, caution needs to be used in this respect, as it is often the trauma and the pain and the survival of them that helps the person to grow emotionally and to mature into a worthwhile, compassionate and caring adult. An example of a strategy for **changing** the past, would be to assist a child who has lost a parent at an early age and who has gained a step-parent, to work through his feelings of anger, rejection, sadness and resentment, in order to **view** the **new** parent in a different light. Although this can be done in play therapy the literature indicates that the use of hypnosis, imagery and metaphors can assist the child in working through the issues more quickly and more effectively and without as much resistance as by conventional methods.

5.3.4.11 Hypnosis and systematic desensitisation

Wolpe [cf. 2.4.4.3 & 5.3.2.1] was the person to introduce systematic desensitisation, which is a behavioural technique based on the concept of reciprocal inhibition. However, Wolpe [1958:140; 1961:194] himself, describes how he uses this technique with hypnosis, with better results. He maintains that patients who cannot or will not be hypnotised, but who can relax, will still make progress by means of systematic desensitisation, but more slowly than when hypnosis is used.

According to Lazarus [1973:26-29], the therapist must take the individual client into consideration when examining the effectiveness of behavioural technique using hypnosis. He maintains that certain clients respond exceptionally well and hypnosis definitely seems to deepen the relaxation levels and increase the vividness of imagery during procedures like desensitisation and emotive imagery. Others, he has found, report no enhancement, even though they report a trance-like state, vivid imagery and profound relaxation. In these cases, he feels the time and effort spent devoted to trance induction, are considered wasteful. However, he makes the observation that if clients ask for hypnosis, their reasons should be investigated, but that usually this indicates that they are motivated to use it and their expectancy fulfilment will augment the therapeutic outcome.

5.3.4.12 Transference and counter-transference

The following sources have been used: Gardner and Olness 1981; Judd, Burrows and Dennerstein 1985:1-15; Karle and Boys 1987:199-299; West and Deckert 1965:95-98.

The hypnotherapeutic relationship between therapist and client/child, is made up of therapeutic alliance, the transference and the counter-transference. The

transference relationship is made up of the client's feelings, perceptions, attitudes, values and wishes about the therapist, which relate not so much to the reality of the present, but to past experiences and relationships [cf. 5.2.1.1]. Hypnosis tends to intensify the transference phenomena, as it does feelings and images, etc. Because the therapist may take on the role of authority, the client may often regress more readily and may come to feel towards the therapist as he previously felt towards a parent or other significant person in the past. Because of the transferential and regressive aspects of the hypnotic relationship, the child's subjectively experienced relationship with the powerful internalised omnipotent parent figure, is elicited. It is difficult for the child to distinguish between self and this figure much of the time. It is important to focus on the child's psychic experiences rather than externally observed reality.

The client/child will often experience a wide range of emotions towards the therapist and erotic sexual feelings are only one aspect of these which need to be handled carefully. However, according to Judd *et al.* [1985:3], transference is not considered an obstacle in therapy, but rather an 'important means of understanding the patient, since past conflicts are revived and arise in the here and now in the relationship with the therapist'. Transference needs to be recognised and interpreted where appropriate. During hypnotherapy, unconscious wishes may be fulfilled in fantasy and, therefore, it is essential that the therapist videotapes all sessions, particularly those that involve sex therapy for adults.

The term, **counter-transference**, refers to the therapist's projecting his or her inner conflicts onto the client/child. Both West and Deckert [1965:96] and Judd *et al.* [1985:4], maintain that when hypnosis is used destructively or dangerously, it is often the result of counter-transference factors. For example, the therapist's unresolved power fantasies may be acted out in hypnosis with negative effects for the client.

5.3.4.13 Resistance

Resistance to hypnosis refers to the child's **working against** the therapist in order not to relax or go into a trance. There appear to be many reasons for this; high levels of anxiety, a fear of losing control, oppositional tendencies, unwillingness to cooperate, the inability to keep still or close eyes and a need to hold onto his symptoms, etc.

Karle and Boys [1987:184-185] mention the resistance of children suffering chronic or life threatening disorders. In such cases, e.g. in children suffering from renal failure, the 'resistance and sometimes outright refusal on the part of some children to employ such techniques, commonly reflects the affective conflicts stemming from their illness experience'. Karle and Boys maintain that these children's anger, resentment and sense of unfairness tend to stimulate markedly regressed behaviour and attitudes and strong impulses, conscious and unconscious, towards death which evoke resistance to treatment.

However, Karle and Boys [1987:185-186] maintain that if these children can experience the effectiveness of hypnosis in dealing with their discomfort and pain through the calming, reassuring effects of retreating to a safe place, the resistance is often weakened and can then be penetrated. They quote the following example:

A boy of sixteen was referred for help through hypnosis for the intolerable pain he experienced when physiotherapy for severe contractures was attempted. He had suffered from renal failure from early infancy and undergone two failed kidney transplants. A side effect of his repeated operations was the development of circulatory inadequacy in his limbs and contractures of both arms and legs. Passive movement of his arms was possible, although painful, but he screamed so violently and was so grossly distressed when his legs were touched, that the physiotherapists found they were unable to proceed with the very necessary treatment. He was brought to his first session [intended to be simply a trial of hypnosis] in a wheelchair. The

proposal to use hypnosis had been discussed with him by the nephrologist.

He opened the interview by saying; 'I don't think you'll be able to hypnotise me!' The first three attempts at induction were fruitless but he was willing to proceed further, albeit with a challenging grin. An assumed manner of casual confidence on the part of the therapist and the use at that point of an induction using distraction and confusion in a very low-key manner, resulted in a shallow trance, sufficient to carry out a few challenges such as arm levitation and hand lock. He was still highly sceptical, but agreed that he must have been hypnotised.

The following week, he was seen with the physiotherapists. He entered trance quickly and found that the moderate pain induced by manipulation of his arms could be suppressed completely. When manipulation of his legs was begun, he winced strongly and whimpered, but continued suggestions of relaxation and dissociation from pain enabled him to tolerate the procedure.

The imagery used to facilitate this was that of electrical wiring with junctions and switches located in the spine. He was taught to 'switch off' the nerves transmitting pain signals from his legs and hips. From time to time, he lost this control but was able to regain it on each occasion.

After some five or six sessions with the therapist present, he became able to maintain trance and analgesia on his own, albeit with an occasional reminder from the physiotherapist treating him. His pride, when eventually he recovered the use of his legs, was heart-warming and stemmed in great measure from the fact that he had himself mastered the problem, rather than having had it dealt with by either chemical analgesia or anaesthesia.

However, there are many techniques that can be used with resistant children, e.g. confusion techniques, distraction, indirect suggestions and metaphors, which may allow the child to enter a light trance which can then be deepened in future sessions, if necessary.

Melanie Klein [1989:9] mentions resistance in the context of psychoanalytic therapy for children, but which applies here as well and she maintains that 'we sometimes encounter resistances which are very hard to overcome. This most usually means that we have come up against the child's anxiety and sense of guilt, belonging to deeper layers of the mind'.

Resistance can be reframed and viewed from a different perspective. According to Thompson *et al.* [1986:89], when therapists experience a difficult case, they sometimes invoke the term **resistant** to characterise the child's behaviour. They quote Eksteen as saying that 'it is not the child who shows resistance, rather it is the therapist who offers the child limited play space and limited language space and must, therefore, redefine the psychotherapeutic situation in such a way that communication will be possible'.

According to Levine [1980:58], resistance can be avoided by the use of guided fantasy and metaphors where the emphasis is placed on the child in the story, rather than the child in therapy. Because he is making the connection at an unconscious level only, he has no conscious need to be resistant. However, certain conflicts at an unconscious level may interfere and cause resistance.

5.3.4.14 Dangers of hypnosis and contra-indications for hypnotherapy

In 1961, the American Psychiatric Association [Judd *et al.* 1985:1] stated:

Hypnosis is appropriately and properly used in the course of therapy, only when its employment serves therapeutic goals, without posing undue risks to the patient.

With this in mind, therapists are expected to use hypnosis in the area of practice in which they are competent. Hypnosis should, therefore, never be used as a form of entertainment.

According to Benson [1989:118], any effective tool can cause some danger if misused and this is her belief about hypnosis. However, she points out that hypnosis does lower the defence mechanisms, which might otherwise be activated to protect emotions and in this way, a child can always be hurt by an insensitive adult. She also views another danger to be a lack of awareness of the range of therapeutic approaches, which can be linked to hypnosis and states that there is too much emphasis on the simple techniques of direct suggestion.

Research on experimental subjects, who have volunteered to undergo hypnosis, has failed to detect any serious complications, other than slight transient headaches, drowsiness, transient nausea and dizziness on waking, in a very small percentage of subjects [Coe & Ryken 1979; Hilgard & Hilgard 1961; Orne 1965].

In psychotherapy, all interventions can be harmful due to inappropriate patient selection, inadequate therapist training, transference and counter-transference and therapeutic techniques and style. Husen and Postlethwaite [1985:2372] report on the misconceptions of hypnosis and hypnotherapy. These include the person believing that he will be in a kind of stupor or coma-like condition, that he will be under the control of the will of the hypnotist and may do something that is in conflict with his own moral code and that he will not **come out** of hypnosis again. However, they conclude that all of these fears are unfounded. It therefore remains the therapist's responsibility to explain hypnotherapy fully, so that the person's myths and fears can be allayed. Williams [1981:50] maintains that 'when used with sound clinical judgement, in an appropriately goal-directed manner, hypnosis is a remarkably safe therapeutic aid'.

However, many researchers [Gardner & Olness 1981; West & Deckert 1965; Williams 1981] conclude that certain precautions should be noted. These are summarised and listed below:

- * checking out the possibility of an undiagnosed organic pathology before embarking on psychiatric treatment;
- * caution at removing a symptom which may be part of a psychodynamically-based symptomatology, a defensive function; in such a case, the client would need to be assisted in 'restructuring his perspective of alternative adaptive manoeuvres that take into account his own autonomy' [Williams 1981:50];
- * using hypnosis as a quick **fix** for complex life problems;
- * aggravating existing emotional problems or creating new ones;
- * using hypnotherapy when another technique or method may be more effective; and
- * using hypnosis to remove a symptom when the clinical diagnosis may be incorrect.

There are also researchers such as Meares, Burrows, Abrams and Wolberg; Lavoile and Sabourin; West and Deckert; and Holland [Judd *et al.* 1985:10] who warn about using hypnotherapy with children suffering from asthma, epilepsy, psychosis, depression, hysterical disorders and other illnesses. However, there are many other researchers who appear to have researched the use of hypnotherapy with children with these illnesses and conditions, who dispute the validity of the former researchers' claims. There appears a need for more controlled research to help throw more light on this debate.

5.3.4.15 Self-hypnosis

According to Gardner [1981:301], the term self-hypnosis, refers to experiencing hypnosis as an event or set of events without the aid of another person. However, for Gardner, this implies that the person would have been previously taught by a therapist to hypnotise himself.

According to Karle and Boys [1987:57], most adults and children are able to use self-hypnosis once they master the 'knack of entering the trance and recapturing the good feelings' it can bring. They can use self-hypnosis to gain respite from anxiety, depression, pain, etc..

Olness [1981:315] reports that self-hypnosis can be used very successfully by children suffering from life-threatening diseases. They are taught certain mental exercises with imagery that they can use alone on a daily basis. Olness mentions one example, in cancer patients, of imagery that builds up a belief of their strong immune system and a weak disease.

According to Karle and Boys [1987:58], it is usually desirable to **teach** the child self-hypnosis while he is already in a trance, as it tends to be more effective and more readily absorbed at such time. He can be taught to sit or lie down, either close his eyes or keep them open, think of an image, a colour, or count down from 5 to 1, find himself in his own special safe place [one that may or may not have already been established in the therapy session], and just let himself enjoy the good feelings. Other routines can be more specific, which allow the child to deal with excessive fear, anxiety, pain, etc. The child can be encouraged to practise the routine while with the therapist, in order to gain confidence in his own abilities at inducing his own trance. Although the self-hypnosis sessions are usually perceived as a less intense experience than the one induced by the therapist, with practice, the child can increase the intensity and therapeutic effect

[Place 1984:341].

The value of a child using self-hypnosis is manifold. In the first place, hypnosis is used in therapy because it appears to facilitate and intensify treatment processes. It is, therefore evident that, if children are taught to use it regularly, in and out of therapy sessions, their treatment will be facilitated still further. In this way, it will prove to be both time and cost effective.

Olness *et al.* [1987:596] remark on the ability of children to self-regulate bodily processes that previously were thought not to be subject to voluntary control, through the use of hypnosis and self-hypnosis.

As with induction for hypnosis, many forms of induction for self-hypnosis are possible. Two are discussed below; one direct and one indirect. Gardner [1981:308] describes a direct method below, in three steps, which can be easily accomplished in one therapeutic session:

Step 1: The therapist employs a variety of hetero-hypnotic induction methods, primarily involving pleasant imagery and ideo-motor techniques such as arm lowering or arm levitation. The ideo-motor techniques are especially useful with children who want some outward and visible sign that they have entered the trance state. For children who have difficulty closing their eyes, eye fixation may also be used with the instruction that the child may stare at anything above eye-level.

The therapist avoids techniques which involve using particular objects or any sort of gadgetry; these things may be entirely suitable for helping the child go into hypnosis, but may not be available when the child needs unexpectedly to go into hypnosis. Likewise, certain ideo-motor techniques are avoided if there is a good chance of their not being suitable at some time [e.g. hands moving together with a child who may have one arm immobilised for intravenous therapy]. After the induction, the therapist says, 'Now you can just enjoy these good feelings [specific images may be mentioned]. Then I will show you how

to come out of hypnosis by yourself, bringing yourself back to the normal alert state, and you can bring these good feelings back with you as often as you like. Which feelings do you like best? [Wait for reply.] Good. Just enjoy them. [Pause for 1-2 minutes.] All right, all you need do, to bring yourself out of hypnosis is count silently to yourself from one to five. With each number, you will be more and more awake. By three, your eyes will be opening and by five you can be wide awake, fully alert, feeling perfectly normal in every way and feeling very good. Go ahead now and bring yourself out of hypnosis'.

If the child is alert within 60 seconds, say 'Thank you. That's fine'. Then proceed to enquire how the child feels. If the child still seems sleepy after 60 seconds, say, 'Take your time until you are fully awake and then I'll teach you some other things'. [The latter statement increases motivation. I have never had a child patient refuse to come out of hypnosis.] A few children indicate that they enjoy the state and do not want to leave it. Casually reply that it is a nice feeling and it will be so much nicer when the child knows that he can bring these good feelings [specify confidence, comfort, etc.] more and more into the waking state. When the child patient is fully awake, say, 'Good. Now you know how easy it is to bring yourself out of hypnosis, just by counting silently from one to five. However, I want you to know that if you ever need to bring yourself out of hypnosis very fast - if there is some emergency, for example - then you don't even need to count to five. You can just decide to wake up right away and right away you will be wide awake. And you will be especially ready to do what you need to do because you have just been relaxing and giving your body and mind a nice rest. The reason I suggest counting to five, is that most people like to take a little time to shift over from hypnosis to the normal waking state, just as most people like to take time to wake up in the morning after a night's sleep. So you can count if you like, or you can just decide to wake up, whichever you wish, whichever would be best for you'.

Step 2: In a waking interview, remind the child that he has already learnt what most people think is the hard part, namely, bringing himself out of hypnosis. Also remind him that he knows he can talk in hypnosis without disturbing the trance state. Then ask him which of the hetero-hypnotic induction methods used in Step 1 appealed to him the most. Ask for details, as many as possible. When the child has replied, say,

'Thank you. You are helping us decide which is the best way for you to go into hypnosis by yourself. We will use [name the child's preferred methods using his terms]. First, I'll show you how to go into hypnosis yourself with just a little help from me, and later I'll show you how to do it all by yourself. Are you ready to let yourself go back into hypnosis now? [Child indicates yes]. Good. Then all you need to do, is tell me in detail, the way you are going to go into hypnosis - describe in detail the things we did before, that helped the most - remember the pleasant feelings of being in hypnosis - and as you talk to me, just let yourself have those good feelings again. Just let it happen'. [Pause - therapist may add sensory details if the child's wording is too general.]

When the child seems to be going into hypnosis, say, 'That's fine. Just let it happen. And you can let me know when you are in hypnosis by nodding your head when you are there'. [Pause until child nods.] 'Thank you for letting me know. Very good'. [If child exhibits difficulty, either coach by mentioning a few details or enquire as to the trouble.]

Then say, 'Now, just enjoy these good feelings. And, if you like, take a minute or two to remind yourself of some of the ways you are learning to solve your problem [specify]. Then, bring yourself out of hypnosis in the way you have been taught'. [Pause for the child to rouse.] 'Thank you. Now, let's talk for a little while'. [Enquire about difficulties, questions, and so on.]

Step 3: 'Alright, now are you ready to learn how to go into hypnosis by yourself without any help from me at all? [Wait for positive reply.] Good. Now, this time, just think about the same things as before [unless changes have been made]; remember all the details of how you go into hypnosis. But this time, don't say anything to me. Just remember how you go into hypnosis and decide to let it happen. It will only happen when you decide to let it happen and you can do that now if you are ready.

Any questions? As before, let me know when you are there. Enjoy knowing that you can do this for yourself, and then bring yourself out of hypnosis in the way you decide it best for you. O.K. Go ahead'.

Unless there is some indication that the child is having difficulty, the therapist remains completely silent, except to say 'Thank you', when the child nods that he is in hypnosis and 'Good', when the child returns to the alert state. If the child has difficulty [a rare occurrence], return to Step 2. I believe it is helpful for the child to know that he can communicate verbally to others while in hypnosis.

Jones [Gardner 1981:309] describes another direct, but more rapid induction technique which is especially useful for muscle spasm, anxiety attacks or other problems which require quick alleviation of pain or anxiety. This technique requires the child to close his eyes and take three deep breaths.

A more indirect method, as described by Karle and Boys [1987:191], allows the child to spontaneously see an image worked on in therapy when he needs to **let off steam**. In this case, it was a boiler, its safety valve screwed down well and the pressure approaching bursting point. He would then release steam from the valve and progressively discharge the steam from the boiler, until it simmered gently, instead of shaking and bubbling. He could release further steam by blowing the whistle while enjoying the good feelings of relaxing his anger, frustration, anxiety, etc.

Sometimes, there will be resistance to self-hypnosis. According to Gardner [1981:304], a child may not be able to use self-hypnosis if:

- * his age, developmental level or emotional problems preclude sufficient grasp of the process;
- * he has little or no motivation to solve his problem;
- * he has a need to maintain a passive-dependent position and no indication to take an active stance;

- * he is directly or indirectly discouraged by his parents to use it; or
- * he manifests strong oppositional behaviour or a strong need for autonomy and sees the therapist's suggestion as one more external demand or a need to control him.

A tape recording made by the therapist with the child, can often be a useful tool to encourage self-hypnosis on a regular basis. At all times, the child's resistance should be understood and can be overcome in most cases. However, his wish not to practise self-hypnosis may also need to be respected.

Self-hypnosis is contra-indicated, according to Gardner [1981:303], in cases where hypnosis is contra-indicated [cf. 5.3.4.14], for acting-out children or those with poor judgement or poor impulse control, as these patients may not be able to resist using self-hypnosis inappropriately for themselves or trying it out on others. Patients with medical problems should be warned to be especially alert to the emergencies of medical complications and should be taught to identify those problems for which immediate contact with a doctor is indicated.

5.3.5 Synthesis

It is important to emphasise that hypnotherapy with children is not usually seen as a therapy exclusive to all other therapies. Its great value lies in it being an extremely valuable, flexible and creative addition to be used with any other therapy available. It therefore complements all the therapies mentioned and can only increase their effectiveness if used correctly. Because of its possible value to anxious children, it has been focused on in Chapter Five and it in no way replaces the other theoretical models of therapy with children.

Its versatility lies in the fact that it can be used directly or indirectly, by means of stories, metaphors and paradoxes. Therefore, if a child is unable to reach a reasonable trance, this does not preclude the use of hypnotherapy. It must, however, be stressed that symptom removal by means of hypnosis or Behaviour therapy, is not recommended and that hypnotherapy allows the experienced therapist to deal with the underlying motives, drives and conflicts for the symptoms. The symptoms are then recognised as a **message** from the **whole** child as to his emotional difficulties and struggles within himself.

5.4 CONCLUSION

Play therapy, from many varying perspectives, has been examined and all aspects of it, from whichever theoretical perspective, have been found to be beneficial to the child therapeutically. These perspectives are:

- * Psychoanalytical and Psychodynamic;
- * Learning theory;.
- * Existential theory; and
- * Hypnotherapy [which incorporates many of the above theories].

The various treatments of anxiety in children have also been investigated. However, anxiety *per se*, appears not to be treated very often. The symptoms of the anxiety, i.e. phobias, enuresis, stuttering etc. appear to receive more attention.

Hypnotherapy has been focused on in this study, as it is receiving more recognition, worldwide, and appears to be **reviving** itself, possibly, because it is able to compliment all the other theoretical perspectives. It also appears to offer great benefits to play therapy and, in particular, to the treatment of the anxious

child.

Figure 5.4, on the following page, attempts to demonstrate the interrelationship of the various perspectives of therapy for children and to show that many aspects of each perspective are similar, in some respects, and often have similar techniques, in order to achieve the same goals of assisting the child emotionally. The numbers correspond to their positions in the text.

Chapter Six will attempt to describe the research design and to select an assessment battery, as well as develop a therapy for treating anxiety in primary school children. An attempt will be made to view the child holistically and individually within his life-world, from an eclectic perspective.

FIGURE 5.4

INTERRELATIONSHIP OF THE VARIOUS PERSPECTIVES OF THERAPY FOR CHILDREN



CHAPTER SIX

RESEARCH DESIGN

6.1 AIM OF RESEARCH

This research is primarily aimed at:

6.1.1 Determining a Specific Approach to Assessing Anxiety in Primary School Children

6.1.2 Determining a Specific Approach to Treating Anxiety in Primary School Children

6.2. DELINEATION OF PROBLEM

- * Chapter Two focused on the phenomenon, anxiety, and explored the various types of anxiety as well as the theories thereof.
- * Chapter Three explored the effects of anxiety on the general development of children.
- * Chapter Four reviewed the different measures used presently in assessing anxiety in children, namely: questionnaires, inventories, interviews and projective media.
- * Chapter Five researched the various forms of psychological treatment for children generally, focusing on play therapy and hypnotherapy for children.

6.2.1 Hypotheses

The problem is, therefore, delineated by means of one main hypothesis and certain sub-hypotheses that evolve from it. They are the following:

6.2.1.1 Hypothesis A:

Anxiety can be identified in primary school children by means of a psychometric assessment and can be treated by means of psychotherapy.

6.2.1.1.1 Hypothesis B:

The psychometric assessment needs to include a variety of measures of anxiety, namely:

- questionnaires and inventories;
- interviews; and
- projective media such as drawings, stories and incomplete sentences,

in order for all the various types of anxiety to be measured, in primary school children, both at a conscious and unconscious level.

6.2.1.1.2 Hypothesis C:

The psychotherapy, used to treat anxiety in primary school children, can be in the form of play therapy and hypnotherapy combined, namely:

- Hypno-play therapy.

This form of therapy will reduce the levels of anxiety in primary school children, as well as address the causes and symptoms of the anxiety.

6.3 METHOD OF RESEARCH

6.3.1 Idiographic Study

An idiographic study views the child as a unique individual. A child is born into a particular life-world and it is within this life-world that he functions. His set of circumstances is unique for him and therefore his fantasies, fears and anxieties must be viewed within this frame of reference.

For this reason, it has been decided to conduct an idiographic study of the assessment of anxiety in six primary school children and the treatment of anxiety in three of those six children.

6.3.2 Research Approach

As mentioned in Chapter One, a model developed by Jacobs and Vrey [1982:56], but modified for this study, will be used [cf. 1.3.1]. This model will investigate the child's anxiety according to five different images, namely:

6.3.2.1 Level 1: Functional image

6.3.2.2 Level 2: Phenomenal image

6.3.2.3 Level 3: Relational image

6.3.2.4 Level 4: Personal image

6.3.2.5 Level 5: Irrational image

6.3.3 Selection of Subjects

6.3.3.1 Preliminary selection.

A letter will be sent out to referring general practitioners and specialists, such as paediatricians and neurologists, as well as principals of private and government schools, informing them of this study and requesting that they refer to the researcher, highly anxious primary school children, who may then be eligible for this study and who may benefit from it.

A selection of subjects for this study will then be made, following the routine assessments that are administered on children who are referred to the researcher's private practice with learning, emotional and/or behavioural problems. This routine assessment usually consists of an intelligence test as well as emotional and/or scholastic tests, depending on the nature of the problem.

6.3.3.2 Choice of subjects

An important aspect of the idiographic study is the choice of subjects for the investigation. As the cases should be typical examples of the phenomenon being researched, certain aspects should be kept constant. The researcher views the following points to be of importance:

- * the children should be of average to above average intelligence; and
- * they should be in mainstream education.

6.3.3.3 Other criteria

Other criteria for selection involve the following:

6.3.3.3.1 Age

This study will be confined to children between the ages of six and twelve years. It has been decided to research this age group as it has been observed that often the child's anxieties become more noticeable at this stage of development and that the anxious child is often hampered, to a large extent in his daily functioning, both at home and at school, by his high levels of anxiety.

Developmentally, the child falls into Freud's latency stage, Piaget's concrete operational stage, Erikson's industry vs inferiority stage and Kohlberg's conventional stage, all of which were dealt with in Chapter Three [cf. 3.2; 3.5].

6.3.3.3.2 Language

The children will be English-speaking to facilitate the assessment process and therapy.

6.3.3.3.3 Sex

Both boys and girls will be eligible for selection.

6.3.3.3.4 Culture

It is felt that children should be selected from one culture so that cultural differences do not need to be considered. For this reason, children from an English-speaking South African background will be eligible.

6.4 THE SELECTION OF AN ASSESSMENT BATTERY FOR PRIMARY SCHOOL CHILDREN

6.4.1 Introduction

A variety of assessment measures need to be selected so that the child's anxiety can be viewed, measured and understood within the wider framework of his life-world. In order to investigate many different types of anxiety in the child, a selection of tests and projective media have been carefully explored and from this selection, certain tests and media have been chosen for the purpose of this study.

6.4.2 The selection of suitable psychometric tests and projective media for assessing anxiety in primary school children

6.4.2.1 Questionnaires and Inventories

6.4.2.1.1 State-Trait Anxiety Inventory for Children [STAIC]

This inventory [cf. 4.2.1.3.1] has been chosen as it is considered, by many researchers, to be the best scale for assessing the difference between situational anxiety and anxiety within the child's personality structure that affects his behaviour, on a far larger scale. It is felt that the STAIC will reveal the child's state and trait anxiety as well as to some extent, his normal and neurotic anxiety. It consists of two self-report scales for measuring State Anxiety [A-State] and Trait Anxiety [A-Trait]. The first scale can be used as an index of drive level or actual levels of A-State, caused by stressful situations, while the second scale measures the anxiety-proneness in children and is also a screening test for detecting neurotic tendencies in primary school children.

Although the reliability and validity of the STAIC appear to be acceptable for research purposes and this test is used extensively, at present, in the United States of America, as well as other parts of the world, certain limitations are highlighted [cf. 4.2.1.3.1]. These include:

- * low predictive validity;
- * the scales being treated as unidimensional instead of multidimensional; and
- * a lack of investigation into correlations between the two states with regard to age and sex differences.

Despite these limitations, Endler [1978:1098] maintains that this is still the best scale for assessing anxiety in children due to its 'good theoretical basis, adequate norms, adequate reliability and moderate validity'.

6.4.2.1.2 The Revised Children's Manifest Anxiety Scale [RCMAS]

This anxiety scale [cf. 4.2.1.3.1] has been chosen as it offers a total anxiety score, a lie score, as well as three factor-analytically devised scales in which anxiety manifests itself. These are in the form of physiological anxiety and somatic complaints, worry and over-sensitivity, as well as social concerns, which may lead to interpersonal difficulties. It is therefore felt that this scale will assess manifest anxiety, overt anxiety [to some extent] and measure the level of trait anxiety in the child.

As it is to be used as one part of an empirical multi-method assessment, it is, according to Mattison *et al.* [1988:147], suitable for identifying children with anxiety disorders. It has, in the past, been successfully combined in research with the STAIC [Stewart 1989:697] and it has also been found to be suitable to use with children outside the United States of America [King *et al.* 1990:70] which indicates that it may well be useful to South African children.

Both the STAIC and RCMAS are scored on percentile ranks. The following ranges correspond to the scores below and will be referred to in Chapters Seven

and Nine.

0 - 20	21 - 40	41 - 60	61 - 80	81 - 100
Excessively Low	Moderately Low	Moderate	Moderately High	Excessively High

6.4.2.2 Interviews

6.4.2.2.1 The Children's Anxiety Evaluation Form [CAEF]

A semi-structured interview, the Children's Anxiety Evaluation Form, has been selected for its flexibility and non-directive approach. It is felt that open-ended questions will allow spontaneous conversation between researcher and child and this may enable the child to volunteer more information about himself.

It involves taking a clinical history of the child. It will focus on the symptoms that the child may volunteer and which may be elicited from the interview. Checklists and clinical ratings will allow the researcher more precise readings of the symptoms and signs of anxiety that the child has.

As this form was correlated with the State-Trait Anxiety Inventory for Children and the Revised Children's Manifest Anxiety Scale in order to calculate the correlation coefficients, it is felt that it is a good measure to combine with these two scales, namely the STAIC and the RCMAS.

6.4.2.2.2 Parent Interview

According to Silverman and Nelles [1988:772] the Children's Anxiety Evaluation Form [CAEF] is based on data obtained from the child only and in their view this may prove to have limitations due to the 'accumulating evidence that parents

and children are quite discrepant in their reports about the child's symptomatology'. They believe there is a need to assess both sources for an accurate assessment. It has therefore been decided to take a history from the parents; either both parents or from the mother, if both are not available.

This interview will focus on taking a clinical history of the child. Aspects that will be included are:

- * pregnancy and birth;
- * first year of life;
- * medical history;
- * milestones;
- * eating and sleeping habits;
- * reaction to separation from parents;
- * fears and worries of the child;
- * nervous habits of the child; and
- * progress at nursery and primary school.

6.4.2.3 Projective Media

It is believed that projective techniques remain an important method of research and source of information in the study of the child. Together with inventories,

questionnaires and interviews, this form of media can assist in viewing the whole child rather than one aspect of him. It seems important to understand the child's anxiety and its symptoms, as well as possible causes and, therefore, the following projective tests have been included.

6.4.2.3.1 Drawings

(a) Draw-A-Person [DAP]

Firstly, this drawing will be analysed as a whole and then indices of anxiety will be analysed. These include:

- * excessive detailing;
- * excessive erasing;
- * the inclusion of shadows, dark clouds and darkened sun;
- * the inclusion of monsters or grotesque figures;
- * the size of the drawing [small];
- * omission of body parts or legs pressed together;
- * cross hatching;
- * weak foundations; and
- * feint, hesitant lines.

(b) Kinetic Family Drawing [KFD]

This drawing will also be analysed as a whole first, taking into account the styles, symbols and actions that are evident in it, as well as the meaning these may have for the child. Secondly, the drawing will be analysed for indices that may signify anxiety within the child or within his relationships with significant others. The following will be noted:

- * erasures;
- * barriers and the folding of paper into compartments;
- * omission of self or body parts;
- * shading of figures;
- * drawing in of a base;
- * lining at top;
- * underlining certain figures;
- * figures hanging precariously and the use of ladders; and
- * scribbling and the use of the X.

6.4.2.3.2 Incomplete Sentences Blank [ISB]

This projective medium has been selected to compliment the drawings. It is rated by Goldberg [1965:777] as being the most valid of all projective techniques

and its reliability appears to be highly satisfactory.

It is also a useful technique due to its flexibility and adaptability and will be used in this study, specifically to investigate the anxieties and fears in the child, as well as in his relationships with significant others.

Certain criteria will be observed and the following questions will be asked to investigate these:

- * Does the child demonstrate any specific anxieties or fears?
- * Is there evidence of any free-floating or covert anxiety?
- * Is there evidence of anxiety in his relationships with:
 - himself?
 - his mother?
 - his father?
 - his siblings?
 - his peers? and/or
 - his teachers?
- * Is there evidence of obsessive-compulsive tendencies?
- * Is there evidence of aggression?
- * Is there evidence of submission?
- * To what extent does the child retreat from reality and escape into fantasy?

6.4.2.3.3 Thematic Apperception Test [TAT]/Children's Apperception Test [CAT]

In order to expose the underlying and inhibited tendencies of the child, as well as his anxieties that he may not be willing or able to admit to, these half-structured tests will be used. The child's dominant drives, emotions and sentiments will be explored as well as his anxieties about himself and his relationships with his significant others. The TAT will be used with children of 8 years and older and the CAT with children younger than 8 years of age.

(a) Thematic Apperception Test [TAT]

The following cards will be used and the motivations for use are given in Chapter Four [cf. 4.2.1.4.3] : Cards 1, 3 BM, 6 BM, 6 GF, 7 BM, 7 GF, 11, and 14.

- Card 1 : Challenge card.
- Card 3 BM : Frustration card.
- Card 6 BM : Mother-son card.
- Card 6 GF : Father-daughter card.
- Card 7 BM : Father-son card.
- Card 7 GF : Mother-daughter card.
- Card 11 : Primitive fears.
- Card 14 : Silhouette

Each card will be analysed separately and the following criteria will be evaluated:

Card 1

- * Does the child feel unable to explore and challenge himself within the situation and to meet external demands?
- * Is he uninvolved, withdrawn and distancing himself from the outside world?
- * Is he unable to deal with anxiety and authority figures?
- * Does he fear failure and/or achievement?
- * Are there any sexual fears and anxieties evident?
- * Are there any indications of obsessive-compulsive behaviour?

Card 3 BM

- * Does the child feel frustrated?
- * Is he unable to deal with his frustration?
- * Does he feel aggressive?
Onto whom does he project his aggression? Himself or others?
- * Is he unable to find solutions?
- * Are there indications of sexual identification difficulties?

Cards 6 BM and 7 BM [for Boys]

- * Does he perceive his relationship:
 - between himself and his mother to be poor?
 - between himself and his father to be poor?

- * Does he feel:
 - overprotected?
 - unnurtured?

Cards 6 GF and 7 GF [for Girls]

- * Does she perceive her relationship:
 - between herself and her mother to be poor?
 - herself and her father to be poor?

- * Does she feel:
 - overprotected?
 - unnurtured?

Card 11

- * Does the child feel threatened?

- * Is there evidence of infantile or primitive fears?

- * Is the child afraid of being hurt or attacked?

- * Does he feel aggressive in retaliation to a possible attack?

Card 14

- * Does this card evoke feelings of anxiety in the child?
- * Does the child feel lonely and scared?
- * Are there signs of intra-aggression in the child?

(c) **Children's Apperception Test [CAT]**

All the cards will be used and the motivations for use are given in chapter four [cf. 4.2.1.4.3]. Each card will be analysed separately and the following criteria will be evaluated:

Card 1

- * Does the child demonstrate any difficulties relating to the oral stage, e.g. feeding, overprotection, lack of emotional and/or physical nurturing, sibling rivalry, etc.?

Card 2

- * Does the child perceive difficulties in the relationship between his parents?
- * Is the child unable to identify closely with his father?

- * Is the child unable to identify closely with his mother?
- * Does the child feel **pulled** between the two?
- * Are there feelings of aggression?
- * Are there feelings of anxiety?
- * Are there fears of punishment?
- * Does the child perceive the rope to break thereby symbolising possible castration anxiety?

Card 3

- * Does the child demonstrate difficulties in dealing with authority or authority figures?
- * Does the child exhibit feelings of:
 - overt aggression?
 - passive aggression?
- * Is there evidence of a conflict between autonomy and dependency?

Card 4

- * Does the child show signs of sibling rivalry?
- * Is there evidence of difficulties in the relationship between the child and his mother?

- * Does the child demonstrate a need to regress to an earlier stage?
- * Does the child flee from danger?
- * Does the child demonstrate any anxieties related to his psycho-sexual development?

Card 5

- * Does the child show sexual inquisitiveness?
- * Does the child demonstrate any signs of sexual confusion or anxiety?
- * Does the child make mention, overtly or by inference, of the primal scene?

Card 6

- * Does the child demonstrate any sexual anxiety?

Card 7

- * Does the child's story demonstrate a high level of anxiety?
- * Is the child fearful of aggression or aggressive impulses?
- * Does the child demonstrate any defences, with regard to anxiety, by:
 - making the story an innocuous one?
 - changing the victim into the aggressor?

- * Does the child mention the tails of the animals which may indicate castration fears?

Card 8

- * Does the child view the interaction between the family as conflictual?
- * Is the parent figure seen as aggressive and punishing?
- * Is the theme of orality mentioned?

Card 9

- * Does the child exhibit fears of:
 - darkness?
 - isolation?
 - being abandoned?
 - being rejected?

Card 10

- * Does the child perceive any punishment to be evident?
- * Does the child reveal any sexual activities, i.e. masturbation?
- * Does the child mention the theme of toilet training?
- * Does the child reveal any regressive tendencies?

The themes for the various cards of either the TAT or the CAT will then be analysed as a whole and the following aspects will be observed and analysed in terms of the level of anxiety they may represent:

- * the feelings that are evoked;
- * the defences that are evident;
- * themes of passivity, flight, aggression, orality and obsessions;
- * strong content and intensive conflict;
- * compulsivity in the fantasy and activity levels;
- * inability to identify strongly with the figures;
- * lack of resolutions;
- * emotional guardedness and defensiveness; and
- * themes of physical accidents or psychic trauma.

6.4.3 Integration of Test Material and Types of Anxiety

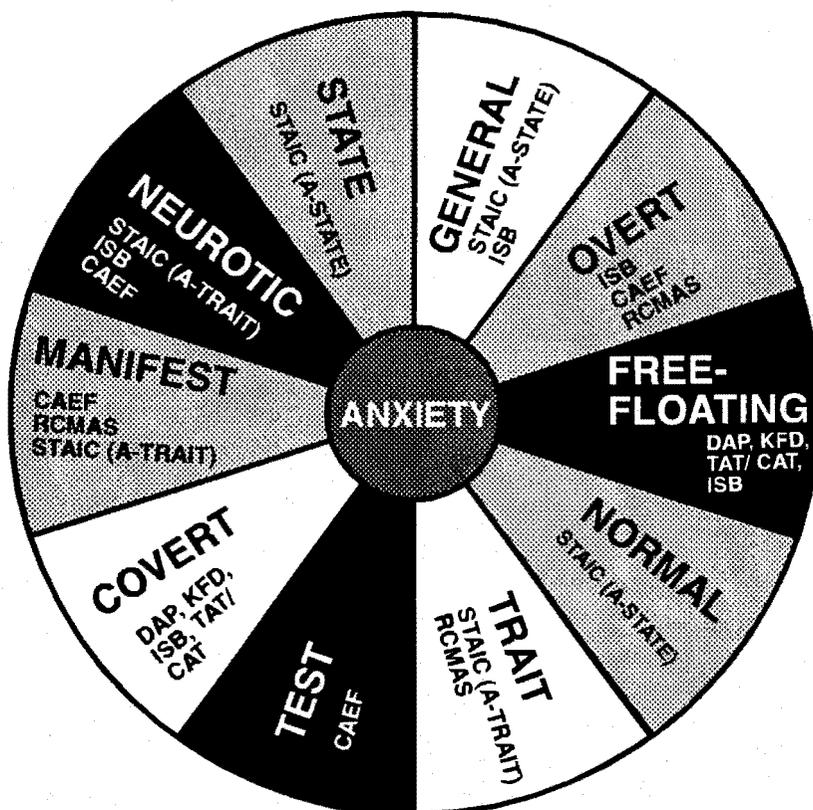
An attempt has been made to select a variety of different anxiety measures so that the child's anxiety can be **measured** as accurately, reliably and validly as possible. This anxiety can be viewed as falling into different categories or types of anxiety, as mentioned in Chapter Four [cf. 4.2.1.1]. The diagram, introduced in Chapter Four, [Figure 4.1] will be used to analyse the various types of anxiety that are revealed by the assessments. The following figure [Figure 6.1] indicates

the specific tests and media that have been selected for this research and the types of anxiety each one measures. The various levels of the different types of anxiety will be demonstrated, on the pie graph, by means of colour. White will represent a low to moderate level; grey a moderate to high level and black an excessively high level of anxiety.

FIGURE 6.1

INTEGRATION OF THE TYPES AND MEASURES OF ANXIETY IN PRIMARY SCHOOL CHILDREN

MEASURES		TYPE OF ANXIETY
State-Trait Anxiety Inventory for Children	(STAIC) (A-State)	state, normal & general
	(STAIC) (A-Trait)	trait, neurotic & manifest
Revised Children's Manifest Anxiety Scale	(RCMAS)	manifest, trait and overt
Children's Anxiety Evaluation Form	(CAEF)	manifest, test, neurotic & overt
Draw-a-Person	(DAP)	especially covert & free-floating (but generally all)
Kinetic Family Drawing	(KFD)	especially covert & free-floating (but generally all)
Incomplete Sentences Blank	(ISB)	overt, covert, neurotic, general, & free-floating (others to a lesser extent)
Thematic / Children's Apperception Tests	(TAT/CAT)	covert & free-floating (others to a lesser extent)



WHITE	Low to moderate level of anxiety
GREY	Moderate to high level of anxiety
BLACK	Excessively high level of anxiety

6.4.4 Synthesis

It is this researcher's belief that both self-report questionnaires and inventories, as well as projective media need to be used in any assessment of anxious children, so that the researcher can become aware of the child's conscious as well as unconscious material and thereby make meaning of it in the context of the child's life-world.

For this reason, a thorough investigation into the child's anxiety is deemed necessary. The different types of anxiety also need to be identified and assessed in the child and then the child should be viewed holistically within his environment. The effect his anxiety has on him and his relationships with significant others should then be assessed. It is hoped that the psychometric and projective tests selected in this chapter will provide the material needed to view the child and his anxiety in a meaningful and holistic way.

6.5 THE DEVELOPMENT OF A THERAPY FOR THE TREATMENT OF ANXIETY IN PRIMARY SCHOOL CHILDREN

6.5.1 Introduction

Children with emotional difficulties, including those suffering from high levels of anxiety, often need professional assistance in order to overcome their problems. While it is the belief of Moustakas [1953, 1966] that the child knows intrinsically what is best for him and while many child authorities may agree with this view, it is felt that at a practical and economical level, the child may need a certain amount of external structure to assist him to grow intellectually, emotionally and socially.

Play therapy is a means of helping the child psychologically. However, play

therapy, as pointed out at the beginning of Chapter Five [cf. 5.2.2], is an extremely broad concept and it is felt that if play therapy and Hypno-play therapy could be combined, it may prove to be cost-effective, both in terms of time and finance. It is proposed that this therapy may be in the form of a combination of traditional play therapy and the less conventional techniques of modern hypnotherapy for children.

6.5.2 Hypno-play therapy

The term, Hypno-play therapy, has been evolved from the terms, hypnotherapy and play therapy. An attempt has been made to combine both these therapies to be used simultaneously, as well as separately and/or interchangeably. The researcher has since come across the same term used by Shapiro [1988:1-10] but in a completely different context. Shapiro uses it to describe a therapy for adults which incorporates hypnotherapy and a process of regression to the client's childhood so that he is able to play again symbolically and physically in many different ways.

This researcher uses the term, Hypno-play therapy, to denote a therapy in which the child can, among other things:

- * play constructively or destructively;
- * play in a structured or unstructured way;
- * draw, paint, colour in or cut out;
- * listen to metaphors told by the therapist or tell stories to or with the therapist;

- * imagine going on journeys to magical places as well as imagine climbing mountains, being caught up in caves, swimming to the bottom of the ocean or being lost in a forest;
- * fantasise and daydream or recall dreams and nightmares;
- * be taught to relax and enter a light, medium or deep trance; and
- * be taught to practice self-hypnosis if so desired, in the sessions or away from them.

Hypno-play therapy must be viewed as only one part of an overall plan to assist the highly anxious child. It is the part for which the psychologist is directly responsible. In addition to this, behaviour modification techniques would be incorporated into the child's daily life, both at home and at school. Parent counselling would, hopefully, also assist the child's parents in understanding his particular needs more clearly and assist them in not consciously or unconsciously sabotaging his therapy.

6.5.2.1 Different perspectives of Hypno-play therapy

The researcher has always worked in an eclectic manner and therefore her ideas and beliefs tend to come from a wide variety of theories and philosophies. It seems important to set out, as far as possible, some of the perspectives from which this therapy has evolved.

6.5.2.1.1 Psychoanalytic and Psychodynamic perspectives

Hypno-play therapy is based, to a large extent, on an acceptance of the Psychoanalytic theory of children [cf. 5.3.1]. The child's psychic structures

such as the id, ego and superego are acknowledged. The presence of drives, impulses and needs are accepted as well as the defence mechanisms that may be employed by the child to protect himself. The unconscious mental activity of the child is seen as equally important as his conscious activity. Resistance, transferences and counter-transferences are all issues that the therapist needs to be aware of and to work with.

The aim of Hypno-play therapy is to allow the child to release his tension and anxiety, which may consciously or unconsciously enable him to deal with previously repressed ideas, feelings and memories. An additional aim is for the components of the child's mind such as his id, ego and superego, to integrate and harmonise with one another and thereby allow the child to reach his full potential in every aspect of his development. Hypno-play therapy should also allow the child to develop a strong sense of self and inner peace of mind.

(a) The use of unstructured and structured play therapy [cf. 5.3.1.1; 5.3.1.2]

The child would be free to express his fantasies, fears and anxieties as well as his hostilities, through the medium of play. He would be free to use certain toys and to play on his own or with the therapist. Certain limits would be set to secure his safety as well as that of the therapist.

His relationship with the therapist would be viewed as possibly the most important aspect of the therapy and would necessitate that the therapist attempts to be non-judgemental, empathic and unconditionally accepting. However, this would not prevent the therapist from challenging the child appropriately and giving the child feedback on how his behaviour and/or actions affect him as well as the therapist and the significant others in his environment. It may also not exclude exerting some educational influence, to which Klein [1989:13] is

opposed, over the child and his behaviour at certain stages of the therapy, if it is felt that this will benefit the child. This may be in the form of stories, metaphors and/or paradoxes which would attempt to assist the child in reframing problem areas and allow creative and more flexible patterns to develop.

Structured play will be incorporated as a form of release therapy for the child and will entail the therapist or child choosing one activity to play together or for the child to play alone. The form of this play could be in drawing, painting, boxing, kicking a ball, playing with puppets, a dart gun and darts; all of which may allow an individual child to play out his particular anxieties, determined by the case history. In this way, the child will be encouraged to release repressed or pent-up emotions and also cognitively assimilate/reassimilate past events and thereby master them or possibly come to terms with them. The therapist would take responsibility for employing this technique of structured play only when a positive therapeutic relationship existed between child and therapist and when the child was judged to have sufficient ego-strength to deal with the possible emotional upheaval that may result.

Forms of theraplay would be used but in a less active environment than Jernberg [1979:2] describes. Activities such as face painting, painting of fingernails, rubbing of cream onto limbs, could well be used as a means of nurturing, soothing and relaxing the child, especially at times in which the hypnotherapy may be incorporated.

6.5.2.1.2 Learning theory perspective [cf. 5.3.2]

The basic principles of learning theory are accepted and would be used to modify the behaviour of the child as well as his thoughts and feelings, where appropriate. Care, however, would be taken to assure that the symptoms that the child presents, would not be treated in isolation by means of learning

techniques. Wherever possible, the root causes of the symptoms would be dealt with as well.

(b) The use of systematic relaxation and desensitisation, implosive therapy and behaviour modification [cf. 5.3.2.1, 5.3.2.2 and 5.3.2.3].

It is felt that deep muscle relaxation is extremely important in the treatment of the highly anxious child and that if this can be achieved, the child's anxiety will have to decrease as it is physically impossible to achieve deep muscle relaxation and remain overtly anxious. Hypnotherapy could often follow directly after this has been achieved. However, it is also felt that this is not always possible to achieve in certain children and therefore cannot be made a standard procedure.

Implosive therapy would be used where appropriate, especially during the hypnotic trance and although behaviour modification will not be used directly in the Hypno-play therapy sessions, it would be incorporated into a larger programme for the child, both at home and at school.

6.5.2.1.3 Existential therapy perspective [cf. 5.3.3.1]

As mentioned under the Psychoanalytic and Psychodynamic perspectives, the relationship between the child and therapist is considered as important in Hypno-play therapy as it is in both the Psychoanalytic, Psychodynamic and Existential perspectives. Closer to the Existential perspective however, is this researcher's belief that the child should be encouraged to take responsibility for his feelings and impulses. He should be encouraged to re-confront his anxiety in the playroom, so that he has the courage and confidence to face up to life's demands and live his life positively [Oppenheimer 1988]. However, the child's specific anxieties will be confronted, rather than the more existential ones of death and freedom, etc.

Moustakas' [1953,1966] belief in the importance of genuineness, authenticity, faith, acceptance and respect in the relationship with the child, as defined in Chapter Five [cf. 5.3.3.1], is fully endorsed and would be attempted in every possible way.

6.5.2.1.4 Transpersonal perspective [cf. 5.3.3.2]

From this perspective, the relationship with the child is seen as central to the child's **becoming** and overall emotional growth. It is felt that the importance of the therapist's commitment to the child cannot be overstressed. It is perceived to be vital to Hypno-play therapy that the therapist genuinely cares about the child and values him as a worthwhile, lovable and capable individual. Although many of the more extreme aspects of the Transpersonal parapsychology will not be used, other areas such as hypnosis, imagery, symbols and meditation in the form of self-hypnosis will be used. To a large extent, the philosophy of Transpersonal counselling, as defined by Astor [1972:804], will be attempted in that the child will be assisted in controlling his own 'mental, emotional and physiological processes' as far as possible in order to improve his self-image and become more active and responsible with respect to his inner and outer environment.

6.5.2.1.5 Hypnotherapy perspective [cf. 5.3.4.]

Hypno-play therapy will incorporate a fair amount of hypnotherapy but this will operate on two different levels [cf. 5.3.4.4]. These are:

- * the traditional trance paradigm, typically involving a hypnotic induction with possible suggestions of eye weariness, eye closure, relaxation and drowsiness, etc; and

- * the task-motivational instruction aimed at enhancing expectations, through fairytales, metaphors and paradoxes while the child is fully awake.

There may be no set pattern as to how the hypnotherapy and the play therapy evolve during a session and the researcher would need to be alert to all possibilities and opportunities open to her, to assist the child in any way she can.

(a) Use of hypnotherapy.

It would be deemed important to explain fully to the parents, the concept of relaxation and hypnotherapy and the value it may have for the children. Misconceptions, both in the parents and in the children, need to be very carefully handled and dispelled.

Certain important aspects of hypnotherapy with children would be adhered to, as far as possible. These are:

- * the language would need to be at the child's appropriate level of knowledge and vocabulary;
- * the images used would need to suit the child's developmental phase, as well as his interests and preferences;
- * the child may need to be made aware of the reasons why this type of therapy is being used. However, when the more informal or indirect methods are employed, it would be left to the child's unconscious mind to process the information and deal with it if he so chooses;
- * the child would be encouraged but not forced, to use self-hypnosis

if he found it useful to him; and

- * the child's possible resistance would be carefully explored and ways found to overcome it, if at all possible.

(b) Techniques employed during hypnotherapy [cf. 5.3.4.7]

The following techniques, as explained earlier in Chapter Five, would be employed:

- * **Relaxation Techniques [cf. 5.3.4.7.1]**

At such time, the child would be encouraged to lie on a mat on the floor and different exercises of relaxing and tensing muscles would be explored. Once the child has consciously and cognitively become aware of his own physical tensions, they would be worked with, at a physical level, e.g. massaging and stretching and then at a psychic level in his mind. Physical activities such as dancing, skipping and moving may need to be incorporated for the anxious child so that he is able to let go of his tensions.

- * **Formal Induction [cf. 5.3.4.7.2]**

This would be attempted with all children, as part of the exploration of how children react to it. However, it will not be considered a necessity for the hypnotherapy to be used and it may need to be abandoned if it increases the child's anxiety levels dramatically.

Many different formal inductions would be applied in an attempt to find ones that the child enjoys and relates to. Some of these may be:

- Magic coin: the coin is held, in an outstretched hand, and either lowered to touch his lap or brought forward to touch his nose;
- Magnets: his hands are held out in front of him, palms facing inwards and pulling toward one another;
- Finger lowering: his little finger and the heel of his hand rest on the arm of the chair and all the other fingers of that hand are held in the air. Suggestions to weariness and eye closure would be given; and
- The Secret Door: the child is asked to close his eyes and to imagine walking down a flight of stairs, relaxing his body as he walks.

* Informal Inductions [cf. 5.3.4.7.2]

These inductions would follow the lines of Erickson's informal inductions which may take place during a conversation or while the child is playing by means of a sudden unexpected act that could precipitate a hypnotic response in the child.

- Deepening [cf. 5.3.4.7.3]

This technique may be used to assist the child in gaining a deeper trance, if necessary. Examples of this could be:

- Magic glove: where the child imagines pulling on a glove filled with magic powder, which allows his hand to get heavier and heavier; and
- Helium balloon: where the child imagines helium balloons pulling his arm up into the air so that it becomes lighter and lighter.

* Direct Suggestion [cf. 5.3.4.7.4]

When applicable, the child may be asked by direct suggestions to find a safe place in his mind where he feels comfortable, warm and safe, etc. Direct suggestions may be used in the play therapy, as well as the hypnotherapy, to assist the child in dealing with his feelings of anxiety and thereby allowing him to let go of them. Coping strategies may be employed by direct suggestion to assist the child in dealing with his anxiety, e.g. in school, before an examination or test, etc., by means of counting down and then squeezing his forefinger and thumb together and letting go of the tension.

* Indirect Suggestion [cf. 5.3.4.8.1]

Indirect suggestions may be used to a very large extent during the whole Hypno-play therapy session. These may take the form of metaphors and using fantasy and imagination. The use of the child's senses, such as his sight, hearing, touch, smell and taste, would be incorporated here.

* Post-hypnotic Suggestions [cf. 5.3.4.8.2]

These are considered to be very valuable, when working with hypnotherapy, as they are taken in by the unconscious mind and occur spontaneously. Suggestions of feeling less worried, anxious and fearful, etc., as well as the positives of more relaxed and safer, etc., would be incorporated into the trance state or indirectly through metaphors and stories. An example would be to say to the child, while in a trance, 'When you wake up you will feel so much lighter, so much calmer and during the week it will seem as though there are fewer things to be concerned about and to feel scared of, etc.'

* Centring [cf. 5.3.4.8.3]

With the relaxation techniques, this method of helping the child to **centre** himself by aligning his body, feelings and interactions and gaining a sense of balance can be used. It is felt that it is extremely important to get the child to kinaesthetically, emotionally and cognitively feel centred and to accept that any real feelings of safety and confidence will come from his own centre and not from external aspects.

* Anchoring [cf. 5.3.4.8.4]

This technique will be incorporated whenever possible, as it enables an idea or suggestion to be firmly implanted in the unconscious mind of the child. Key words or images would be used to help the child link the idea to the stimulus [by word or image], which would become conditioned by means of practise and repetition. An example could be the colour or word **white** which may allow the child to associate it with the feeling of relaxing and use it whenever he feels anxious.

* Story-telling, Metaphors and Paradoxes [cf. 5.3.4.9]

Although the research has not highlighted the difference between stories and metaphors, this researcher, in conversation with Olivier [1994], has concluded that a distinction should be made between them. The child will tell a **story** and use material from his own life-world to express himself. In this way, he projects important information about himself into the story. The therapist will tell a **metaphor** to the child, which is a **story** with a specific intention of assisting the child psychologically. Instead of being literal, the story takes a figurative meaning which attempts to aid the healing process in the child.

Story/metaphor-telling, [both mutual story-telling based on Gardner's work (Stirtzinger 1983:561) and metaphors told by the therapist], would

be used during the therapy sessions. It is in these metaphors that more alternatives to the resolutions of conflicts that the child may have, would be explored.

It is therefore felt that the therapy may differ in this respect to the Psychoanalytic and Psychodynamic perspective, in that some socialising/educational influences may be offered, but care would be taken that these influences would not hamper the child in any way from expressing his needs, impulses and desires. It is felt that if no rights and wrongs are suggested, but only subtle alternatives to how he is dealing with issues at the time, he will not feel threatened or judged by his behaviour and will be free to explore his own inner self. However, it has become evident to this researcher that if the child between the ages of 8 - 12 years, feels that the story may be moralising in any way, he automatically turns off and tunes out of it. Themes will be used to highlight the different and often difficult situations that one encounters in life, such as wandering aimlessly, being lost and meeting danger in all its forms, etc. These will include strolling along a beach, meeting a witch in the forest or a dragon in a cave or a volcano erupting, etc. Science fiction themes would be used where appropriate, as well as favourite programmes on Television.

Therapeutic metaphors would be incorporated into the Hypno-play therapy wherever possible. It has been reported by Callow and Benson [1990:57] that children, between the ages of 4 years and puberty, are at their most receptive to stories and metaphors. At this stage, the danger of lowering their defences by allowing a therapist to use direct hypnotic suggestion, is too great for certain children and, therefore, where direct methods of hypnotherapy could fail, indirect ones may reach their goals. The function of the metaphors is seen as allowing the child to replace negative images

of himself and his life-world, with new and more positive ones. In order to use the therapeutic metaphor successfully, it would be deemed necessary for the researcher to understand the child's anxieties and their possible covert psychological causes. This information would be made available from the psychological assessment, administered prior to the therapy.

Paradoxes appear to be useful when working with hypnotherapy. On the surface, they appear to be contrary to general opinion and the suggestions may be seen as absurd or self-contradictory. Often, by giving permission for the behaviour that is, in fact, seen as undesirable, the therapist confuses the child, who now no longer has the power to decide to act out in that particular and often rebellious, angry or anxious way. It appears that the giving of permission negates the need for the behaviour. However, it is felt that the behaviour should be viewed as having meaning for the child at a conscious and/or unconscious level and that to take away the behaviour may leave the child helpless and vulnerable within his particular situation. It is therefore seen as important to help the family to understand the child's behaviour and to make a shift in their behaviour to accommodate the child's needs.

It is also felt that paradoxes need to be carefully thought through and although Keleman [1988:13-17] and Erickson [Haley 1986:204-208] tended to side with the child against the parents, it is felt that there could be dangers in doing so, especially when the family is expected to work with the therapist, in the family sessions. However, if a separate family therapist was available to work with the family, it may be appropriate in certain situations, for the therapist to collude with the child.

* Transference and Counter-transference [cf. 5.3.4.12]

It is accepted that transference and counter-transference occur both in play therapy and in hypnotherapy. Therefore, both these phenomena need to be carefully examined and interpreted in the therapy sessions. For this reason, the sessions should be audio-taped and/or video-taped, wherever possible so that the therapist can review them and become more aware of these aspects.

* Resistance [cf. 5.3.4.13]

Resistance appears to be a very real issue in certain aspects of play-therapy and to an even larger extent, during hypnotherapy. It would appear from the researcher's personal experience and from the literature read on this aspect of therapy [Klein 1989:9; Karle & Boys 1987:185-186, and Levine 1980:58 among others], that there may be many factors involved in the child's resistance to therapy, with play- or hypnotherapy. These may be the child's:

- anxiety and sense of guilt which Klein [1989:9] believes belong to the very deep layers of the mind;
- need to resist his parents' attempts to cure him;
- anger at being the **identified patient** and being singled out for therapy;
- resentment at losing free time in which to play at home or with friends;
- feelings of being overpressurised at school and at home with homework, extra mural activities and possibly other forms of

therapy, such as speech, occupational and/or remedial therapy;
and

- reluctance to leave his mother and spend time with a **strange** adult.

Pertaining more specifically to the hypnotherapy, the resistance may be the result of the child's:

- fear of losing control;
- high levels of anxiety;
- oppositional tendencies;
- inability to concentrate for long periods;
- restlessness;
- need to be expressive, rather than receptive;
- fear of closing his eyes [although this is not necessary with the more indirect methods of induction using story-telling and metaphors];
- need to retain his symptoms for his own gains; and/or
- need to retain his symptoms for some other member of the family, e.g. mother or problems in the marriage, etc..

(c) Dangers of Hypnosis [cf. 5.3.4.14]

It is believed that hypnosis is a powerful technique and needs to be used, at all times, with caution and respect. The therapist should acknowledge that, when working with hypnosis, a co-therapist is always present in the form of the unconscious mind. This co-therapist needs to be respected and acknowledged and permission needs to be sought from it before the child is encouraged to change his behaviour. Possible questions that the therapist could ask of the child's unconscious may be whether it is safe for him to give up the behaviour in question, e.g. to stop wetting his bed. However, when metaphors and stories are used, permission is not often sought and this may cause problems for the child. It is possible to incorporate this permission by asking the child, for instance, if he thought it was safe for the animal or hero in the story or metaphor, to do something specific like giving up a certain behaviour, as mentioned above.

Certain precautions need to be taken, when using hypnosis, and these are:

- * first checking if any physical or undiagnosed organic pathology may be causing the symptoms, e.g. headaches and enuresis, etc.; and
- * removing symptoms only after the psychodynamically-based symptomatology has been carefully considered and alternative structures have been put in place.

(d) Self-hypnosis [cf. 5.3.4.15]

It is felt that if self-hypnosis can be taught to the child, it can be very beneficial to the progress made in therapy and to the child, once therapy has been terminated. However, in the researcher's personal experience, only a few

children appear to want to use it away from the playroom and those who do, then appear to make very good progress with it. Others seem to find many excuses as to why they cannot use it and maybe these children need the help of the therapist to enable them to **tune in** to themselves. When metaphors and stories are used, self-hypnosis is not considered to be a necessity for the child. However, it has been found that certain techniques taught to the child and anchored with actions or images, are often used in situations outside the playroom. These may include pushing the thumb and forefinger together to release anxiety or tension before an examination or thinking of an image, when angry, in order to let go of the anger. These often happen spontaneously in the child and he may then report good results with them. It is not known for how long they remain effective and whether at a certain stage their impact fades and they become extinct.

6.5.3 Proposed Guidelines for Hypno-play Therapy Sessions

6.5.3.1 Introduction

It is not possible to plan fully for each therapy session, ahead of time, because the word **therapy** is used here in the sense of allowing the child his own space and time to enable inner healing to take place. If the therapist is to encourage this to happen, it is important that he does not have an agenda or preconceived idea of how the therapy session should be. It is essential to deal with whatever comes up in each session, as it arises. However, certain structures and guidelines can be explored; especially in an experimental situation. It is therefore this researcher's aim, to see if certain guidelines can be set for the sessions of Hypno-play therapy and then to assess, to what extent, these may or may not have been useful to the therapy.

In addition, goals for therapy need to be set by the therapist. It is important to

analyse the assessment carefully and to use all the relevant information from it so that the therapy is planned, as far as possible, to assist the child in dealing with, and thereby reducing, his high levels of anxiety. In this way, time can be saved and the therapy can become more cost-effective.

The specific goals for the child's therapy, as a whole, have been formulated below:

- (a) to reduce the child's high levels of anxiety and symptoms of anxiety as well as investigate the root causes of the anxiety;
- (b) to reduce certain obsessive-compulsive behaviour, if present;
- (c) to reduce anxiety-provoking factors within the home setting by means of parent guidance and behaviour modification programmes;
- (d) to change wrong/irrational perceptions which have been programmed within the child's unconscious mind;
- (e) to allow the child to develop a sense of control over his anxiety and behaviour;
- (f) to enable the child to distinguish between normal anxiety and neurotic anxiety;
- (g) to encourage the child to use self-hypnosis, whenever necessary, to assist him in feeling in control of the situation;
- (h) to encourage communication of and insight into his feelings in order for the child to deal with them more effectively.

General and secondary goals have also been formulated:

- (i) to encourage the child to improve his self-image, self-esteem and body-image through therapy;
- (j) to enable him to utilise his own inner resources and cognitive functions fully, e.g. develop creativity, lateral thinking patterns, etc.; and
- (k) to encourage the healthy integration of all aspects of the child's personality.

It is proposed that twelve sessions be planned for the purpose of this research. However, in reality, each child will require different amounts of therapy. The depth of each child's problems will determine, to a large extent, the amount of therapy he may need. Secondly, different children make progress at different rates and this will have an influence on how many sessions the child may need. It is felt, however, that twelve sessions should begin to help the child to deal, either consciously or unconsciously, with his anxiety, whether in fact the anxiety increases initially [Hammer 1958:148] or decreases, as is hoped for.

It may seem more appropriate to allow the child to play out his frustrations and anxieties first and then to relax, but it has been this researcher's experience, in the past, that many children find it difficult to relax and let go, after playing in the session. It has been apparent that these children resent having to stop playing and then the relaxation appears to take second place and much resistance is built up against it .

As this therapy is focused on the anxious child and his need to relax, it has been decided to reverse the usual procedure and to begin each session with the relaxation and formal hypnotherapy technique and then to encourage free play

while using some of the more indirect methods of hypnotherapy, such as metaphors, stories and paradoxes.

Before the first session of therapy, the researcher should discuss, with the parents and the child, the type of therapy that he would receive. The researcher would have met the parents previously, to obtain a history of the child before the assessment was administered, and then again to give feedback to the parents, and possibly the child as well, on the results of the assessment and to recommend therapy. She would, therefore, need to deal with the issues surrounding therapy at this time. It would be important to explore with the parents and child, what play therapy and hypnotherapy are, to elicit their preconceived ideas about it and to allay any possible fears they may have. The reasons why Hypno-play therapy has been chosen, for the particular child, would be explored. Goals for therapy would be set and a behaviour modification programme for home and/or school, would be implemented.

6.5.3.2 First Session: Preparation for Hypno-play therapy

Additional goals:

- * to establish rapport with child;
- * to establish the perceptions and feelings the child has about being in therapy;
- * to protect the child from being hypnotised in the future by unqualified persons;
- * to become aware of normal anxiety and abnormal or excessive and unnecessary anxiety;

- * to learn to relax, both mentally and physically.

This session will focus on getting to know the child, allowing him to become familiar with the therapist and the therapy room. His likes and dislikes with regard to stories, heroes, TV programmes, foods, colours, etc., may be explored. The researcher will then introduce him to the relaxation mat and explain that this **magic mat** may allow him to start feeling better and more relaxed inside; alternatively, a comfortable chair, surrounded by cushions will be used, if the child feels uncomfortable on the floor. Activities of tensing and relaxing his muscles will be explored and his reactions to his physical body and to letting go, will be noted. He will be encouraged to close his eyes and see how this feels for him.

Work will be done with breathing exercises; deep, slow breaths, short, fast ones, etc.. Sensations, he experiences with the breathing, will be explored. His senses will be explored, possibly in the form of a game. He may be asked to guess what articles he is being tickled with, e.g. cotton wool, paper, string, etc.. He may need to identify different articles by means of their fragrance or smell. He may be asked to touch different surfaces and to describe them, view scenes through a view-master, while relaxed and lying down. He may be encouraged to look at the pictures and then imagine them in his head and to explore different sounds on the tape recorder.

The first half of the therapy session may end with a theraplay activity of a nurturing nature. The child may be asked if he would like his face to be painted and if so, what would he choose to be. In this way, he will usually relax his body and close his eyes and the researcher may explore some techniques of induction with him while she paints his face with children's face paint. If he is not keen on the face painting, another similar activity may be suggested. Thereafter, he could be free to choose an activity or game from the cupboard to play, either alone or with the therapist.

6.5.3.3 Second Session: Building of rapport, physical and mental relaxation and establishing a safe place, entering and deepening the trance, metaphors and free play

Additional goals:

- * to build on the rapport established in previous session;
- * to encourage the child to relax sufficiently in order to enter a trance by means of formal or spontaneous inductions;
- * to establish the depth of trance for research purposes, as well as to use the trance to work with the unconscious mind;
- * to encourage the child to deepen his trance spontaneously, by means of suggestions;
- * to establish firmly, a **special safe place** for the child within his mind;
- * to explore different feelings [emotions], to increase his awareness of them, to expand his vocabulary of them and to work on the rudiments of Ego State therapy in the future, as well as preparation for the use of an affect bridge [cf. 5.3.4.10].

The session may begin with feedback from the child, generally and specifically, about his last therapy session, [if this is brought up spontaneously] or if the therapist considers it important, to reflect on the progress of the therapy.

Further induction methods will be explored, to assist the child in entering a trance, in order to reach his unconscious mind. The child's hypnotizability scale

will be calculated for research purposes, although this may be done at a later stage, depending on how the therapy progresses. It is felt that the depth of the trance in the child is not important and that each child will experience the trance differently. However, it is important for the purpose of this study, to objectively determine the level of trance, when the therapist has built up enough rapport with the child, to be able to test this accurately.

Deepening techniques will possibly be employed to allow the child to reach a deeper trance and thereby work with unconscious material. Any material the child may offer, will be worked on. The child will be helped to find a special place in his mind where he can feel relaxed, warm and loved. This will be the **sanctuary** to which he will be encouraged to return, over and over again in therapy sessions. A discussion about feelings may follow and faces demonstrating these feelings may be coloured in and cut out. Free play, stories and metaphors may also follow.

6.5.3.4 Third to Seventh Session: Practising the skills of relaxation, entering trance, working with unconscious material [relating especially to the child's anxieties] and preparing for Ego State therapy

Additional goals for Third to Seventh Session:

- * to enable the child to become familiar with the feelings related to relaxing his body and mind;
- * to learn to use these skills/talents away from the therapy room in the form of self-hypnosis and autogenic feedback;
- * to deal consciously and unconsciously with his anxiety;

- * to explore the root causes of his anxiety;
- * to reduce/remove the symptoms of the anxiety when the causes have been addressed;
- * to assist his family in coping better with his **anxious** behaviour;
- * to **work** on the theme of emotions and build on the therapy done in the previous sessions;
- * to prepare the child for more intensive Ego State therapy [cf. 5.3.4.10] in the future sessions.

The child will be encouraged to relax and practise techniques of hypnotherapy to use out of therapy sessions, as well as self-hypnosis if he so chooses. He will be encouraged to deal with his anxieties directly and indirectly throughout the Hypno-play therapy sessions. Any material that arises from previous sessions, will be worked through. Feelings will be explored with the child and metaphors for his feelings will be sought. The child will be assisted in realising that different feelings dominate the whole person at different times and under different circumstances. This forms the basis of Ego State therapy. By means of **faces** that depict the different feelings the child has [that he has already drawn and coloured in], a game will be played for the child to understand how a feeling is evoked and felt and then acted out in a variety of ways. Free play will be encouraged, after the initial relaxation period, and metaphors and paradoxes will be used where appropriate.

6.5.3.5 Eighth to Twelfth Sessions: Ego State therapy and working with the child's anxieties

Additional goals for Eighth to Twelfth Sessions:

- * to lower the levels of the child's anxiety;
- * to continue to encourage full relaxation of both body and mind;
- * to encourage the practice of self-hypnosis;
- * to explore root causes of the anxiety, whenever possible;
- * to desensitise the child to the events which cause excessive anxiety;
- * to encourage the integration of ego states and to assist the child in improving his self-concept, self-esteem, body-image and general level of confidence; and
- * to assist the child in becoming well-adjusted so that he can reach his full potential; emotionally, socially, morally, intellectually and physically.

6.5.4 Synthesis

Children with high levels of anxiety are often in need of therapy as their anxiety negatively affects their development emotionally, socially, intellectually, morally and physically. It also negatively affects their relationships with themselves and significant others in their lives. For this reason, a specific therapy, namely Hypno-play therapy, has been devised to assist the child emotionally and to help him to deal with his high levels of anxiety, directly and indirectly.

Specific goals have been formulated for each session, as well as secondary goals for the therapy generally. This has been done to help the researcher **measure**, to some extent, the effectiveness of the therapy. However, therapy is well-documented as being extremely difficult to define adequately and to assess effectively, and it is this researcher's view that the limitations of Man have not, as yet, allowed him to understand this concept fully. Children often tend to **improve** in therapy when there appears to be no overt reason for this, and other children remain **stuck**, despite any amount of intervention and support given to them. Many covert factors also appear to affect progress in therapy.

Therefore, this researcher does not expect to be able to make meaning of everything that may take place in the therapy sessions with the children and suspects that much of the process of therapy may remain **grey** and indescribable.

6.6 CONCLUSION

It is hoped that the formulation of a specific approach to the assessment and treatment of anxiety in primary school children, will assist the professionals such as psychologists, teachers and doctors to understand the phenomenon, anxiety, better and enable the psychologists to deal with a child's anxiety and causes thereof, in a systematic and holistic manner and thereby alleviate much pain and suffering in children generally. It is imperative that certain types of anxiety are not splintered off and dealt with individually, possibly in the form of the symptoms only, but that the child will be viewed in the full context of his life-world. It is further hoped that, in addition to obtaining knowledge relevant to this investigation, the researcher will assist the children taking part in the study, to gain valuable self-knowledge about their anxieties and then to work through these anxieties in a non-threatening and safe environment.

Chapter Seven will report on the assessments of anxiety in six anxious primary school children, so that their anxiety can be understood more fully and that therapy can be recommended, if necessary. Chapter Eight will record the empirical investigation into the treatment of three of the children who were assessed and who were recommended for therapy.

CHAPTER SEVEN
EMPIRICAL INVESTIGATION OF THE ASSESSMENT OF ANXIETY
IN PRIMARY SCHOOL CHILDREN

7.1 INTRODUCTION

This chapter records the findings of the empirical investigation into the assessment of anxiety in primary school children. Questionnaires and inventories, interviews and projective media have been used in an attempt to ascertain the level as well as the various forms of anxiety in the child, and to view the child and his anxiety holistically within his life-world, so as to understand the impact his anxiety has on the various relationships between himself and others.

Because of the limited scope of this thesis, only six anxious children will be assessed, of which two assessments will be discussed in full and the information concerning the remaining four will be given in summary form.

For ethical reasons, the children's names have been changed and the cases will be referred to as Cases A, B, C, D, E and F.

7.2 CASE A.

7.2.1 Functional Image

7.2.1.1 Identifying particulars

Name	: Katherine
Standard	: One
Date of birth	: 1985 04 01
Age at testing	: 9 years 1 month

Position in family	: Second
Siblings	: Sister and Brother
Number of schools attended	: One
Number of standard repeats	: None
Socio-economic status of family	: Above Average

7.2.1.2 Reason for referral

Katherine's mother reported that she was concerned about Katherine's emotional development. She stated that Katherine appears to be highly anxious, lacking in self-confidence and demonstrating fairly compulsive behaviour at times. She is afraid of 'big fierce dogs' and she worries about tests and examinations, although she has not as yet been exposed to any examinations in Std. 1. Both parents feel they can no longer cope with her anxiety and perfectionistic tendencies.

It is, tentatively, hypothesised that:

Katherine is suffering from a possible overanxious disorder as well as obsessive-compulsive tendencies.

7.2.2 Phenomenal Image

7.2.2.1 Parent interview

The information was obtained from both parents during the initial interview, but it appeared evident that the mother was the more dominant partner of the two.

7.2.2.1.1 Family background

Katherine is the second oldest of three children. Her sister is $\pm 2\frac{1}{2}$ years older and her brother $\pm 1\frac{1}{2}$ years younger than she is. She lives with her mother, father and siblings in a house in the Northern suburbs of Johannesburg. Her father is a chartered accountant for a government concern and her mother runs her own creche, away from home, as well as a nursery school at the family home.

7.2.2.1.2 History of pregnancy and birth

Katherine's mother reported that Katherine's birth was planned. Three weeks before her due date, labour was induced due to decreased foetal movement. The labour and birth were reported to have been difficult and her mother haemorrhaged badly. Katherine was born with jaundice and she was placed under lights for 10 days. Her father was present at the birth.

7.2.2.1.3 Child's early development

Katherine's mother reported that Katherine was breastfed for 8 weeks but after the family moved location, the mother's milk dried up. Katherine experienced no problems changing to a bottle. However, her mother feels she had to 'grow up' sooner than other children, due to the birth of her brother and her mother's other responsibilities. Her first year was relatively easy and no specific difficulties were reported during her first six years of development.

Katherine's mother continued to work in her creche and nursery school while the children were small and they were taken along with her to the creche. Katherine's parents have also fostered new-born babies, 12 in total, over the past 6 years, often having more than one baby at a time.

Milestones

Motor	:	walking	13 months
Speech	:	first words	8 months
	:	sentences	16 months
Weaning	:	breast	8 weeks
	:	bottle	1 year
Toilet training	:	Katherine was trained spontaneously at 22 months during the day and at 2½ years at night. No difficulties were noted.	
Discipline	:	Discipline appears to be a problem in Katherine's family. Her mother states that she 'can't tolerate badly behaved children'. Yet she also states that there is not much consistency from the parents in handling the children's behaviour. Katherine's parents tend to differ on the method and degree of punishment. Her mother reprimands Katherine verbally and her father punishes her; TV games are usually suspended for 3 days. No temper tantrums were ever reported and Katherine's mother mentioned that Katherine has 'never tried to assert herself'.	

7.2.2.1.4 Medical history

At the age of 11 weeks, Katherine contracted bronchitis. She was chesty thereafter and had croup at 15 to 18 months. Grommets were inserted in both ears at 15 months and again in 1991/2. Sinus problems led to her adenoids being removed in 1994 and she has received ultra-sound physiotherapy fairly regularly. She recently had her sinuses rewashed and she suffers from a facial muscular spasm.

7.2.2.1.5 School history

Katherine attended a play school for 3 mornings a week at the age of 2 years. She then attended a nursery school with her brother, at the age of 3 3/4 years.

She remained there for 2 years and then entered Grade 0 when she was 5 3/4 years old. Her Grade 1 teacher described her as being 'kind, sensitive and always helping everyone'. At present she is regarded as a model child by her teachers. Her mother feels that Katherine's poor spelling ability is the result of her anxiety and that if she makes mistakes while drawing, she refuses to complete her pictures. She worries about being late for school or any school event. Katherine's marks at school are usually above her class average, although she struggles with her spelling when she becomes nervous. Her teacher is satisfied with her school progress and is unaware that she is being assessed. Her father is actively involved in the taking to and fetching of children from school, as her mother is often 'tied up at the creche'.

7.2.2.1.6 Anxiety-related aspects of development

*** Eating and Sleeping Habits**

Katherine is reported to have a fixation about being fat although she is thin and slightly built. Her fear of being late for anything seems to affect her appetite on certain days. She often refuses to eat breakfast in case it makes her late for school. She goes to bed early but she is often still tired in the mornings.

*** Reaction to separation from parents**

No separation anxiety is reported by Katherine's mother and Katherine separated easily from her mother for the assessment.

*** Fears and worries of the child observed by parents**

Her mother reports that Katherine worries about being late for school. She gets up very early to wash her hair each day so as to be on time for school. She insists on washing her hair every day as a child once remarked at school that her hair looked 'funny'. She packs her school case and lays out her school clothes at 3 p.m. on a Sunday afternoon to be sure she will be ready for school the next

day and she puts her suitcase next to the front door each night so she won't be late for school. She refuses to complete her drawings if she makes any mistakes and she is compulsive and perfectionistic all of the time. A certain amount of stranger anxiety was reported [when she was younger] and she now seems apprehensive of her environment at times. She recently wrote a letter, after being sent to her room for fighting with her brother, in which she said that she would 'rather be dead than living'.

*** Nervous habits of the child**

Although no specific nervous habits have been reported, Katherine's anxiety appears to be resulting in an involuntary muscular spasm in her facial area.

*** Socialization and relationships at nursery and primary school**

Her mother reports that she poses no threat to any child. She seems to be kind and helpful towards her peers. However, she is overly sensitive to the way they respond to her and at times, feels lonely and victimised.

7.2.2.2 Qualitative analysis of behaviour during testing

Katherine presented as shy, quiet and cooperative. She was extremely polite and well-behaved and she seemed anxious to please. At times, she appeared to be tense and nervous and she was especially passive in her approach to the assessment.

Katherine was unable to converse spontaneously and seemed to find difficulty in expressing her thoughts and feelings much of the time. Her movements were slow and deliberate. Her need to be precise, neat and accurate was especially noted during the drawing tasks and she seemed overly concerned regarding her intellectual performance. She gave up easily after failure and delayed reaction time was observed during the emotional and intellectual assessments. Katherine

seemed to require additional time to organise and direct her thought processes to the task at hand. Her need to formulate and express the 'correct' answer, was especially noted. Sighing was frequently observed and she appeared to lack confidence in her own abilities.

7.2.2.3 Intellectual functioning: Wechsler Intelligence Scale for Children [Revised] [WISC.R]

108	101	105
VERBAL	PERFORMANCE	FULL SCALE

Katherine's overall intellectual abilities, as measured by the WISC.R Test, fall within the Upper Limits of the Average range, as do her Verbal abilities. Her Performance abilities fall in the Mid Average range. Intra-test scatter on both scales indicates erratic attention, possibly due to underlying anxiety, tension and emotional conflict. Her lowered reality perception and lack of attention to visual detail further emphasise the presence of underlying anxiety.

7.2.2.4 Psychometric and projective tests conducted for the assessment of anxiety

- * **State-Trait Anxiety Inventory for Children [STAIC]**
- * **Revised Children's Manifest Anxiety Scale [RCMAS]**
- * **The Children's Anxiety Evaluation Form [CAEF]**
- * **Draw-A-Person [DAP]**
- * **Kinetic Family Drawing [KFD]**

* **Incomplete Sentences Blank [ISB]**

* **Thematic Apperception Test [TAT]**

7.2.3 **Relational Image**

7.2.3.1 **Questionnaires and inventories**

7.2.3.1.1 **State-Trait Anxiety Inventory for Children [STAIC]**

Katherine scored a percentile rank of **48** on the **State Anxiety Scale** and one of **99** on the **Trait Anxiety Scale**. This indicates that Katherine demonstrates a moderate level of **A-State Anxiety** [situational anxiety] [**48%ile**] and that she did not appear to find being assessed a very stressful event. However, her generalised or **A-Trait Anxiety**, about most aspects of life, is **excessively high** [**99%ile**] and is affecting her general functioning very negatively and severely.

7.2.3.1.2 **Revised Children's Manifest Anxiety Scale [RCMAS]**

Katherine's scores on this scale are as follows:

	RAW SCORE	PERCENTILE RANK	T-SCORE
TOTAL SCORE	20	87 %ile	61
	<u>Raw Score</u>	<u>Percentile Rank</u>	<u>Scaled Score</u>
I. Physiological	6	72%ile	11
II. Worry/over-sensitivity	11	99%ile	16
III. Social concerns	3	55%ile	10
L. Lie Scale	5	75%ile	12

These scores [cf. 6.4.2.1.2] indicate that Katherine has an **excessively high** level of **manifest anxiety** overall [87%ile]. **Level II, Worry/oversensitivity** appears to be the area of most concern for Katherine [99%ile] and according to Mattison *et al.* [1988:147] indicates an anxiety disorder. Her **Physiological** level, **Level I**, of anxiety is in the **moderately high** range and her **Level III, Social concerns**, appears to be a **moderate** concern to Katherine. Overall, this pattern of elevated scores indicates that she is experiencing a **moderately high to excessively high degree of anxiety**, which will affect her overall functioning.

Her **moderately high** score [75%ile] on the **Lie Scale** is elevated for her age group. [Katherine's raw score = 5; mean = 2.25]. This appears to indicate her strong need for approval. She also demonstrates a **high level of defensiveness** and a **need** to present herself in a **socially desirable** way.

7.2.3.2 Interviews

7.2.3.2.1 The Children's Anxiety Evaluation Form [CAEF]

Katherine obtained a global rating score of **12** [out of a maximum of **12**] indicating that her **level of anxiety** falls in the **excessively high** range and is **severe, continuous** and **dominating** her life at present.

(a) History Suggestive of Anxiety

Katherine reported that she has many fears and worries and that they are severe, continuous and dominate her life. She has moderate sleep disturbances and experiences severe and incapacitating bouts of nervousness and unhappiness. Her appetite is not always good and she complains of severe somatic symptoms, such as headaches and stomachaches.

(b) Child's Subjective Assessment

Katherine's target anxiety symptoms in order of intensity are: nervous, anxious, upset, frightened and worried. They appear to be more situational than generalised. She could describe what each feeling felt like for her, i.e. worried, 'I have butterflies in my tummy'. Other anxiety symptoms, in order of highest global ratings, are as follows:

- * **anxious mood:** fearful anticipation, family getting hurt, tests at school, friends getting hurt or feeling sad;
- * **fear:** when bad things happen, darkness, strangers, being left alone, big dogs, school [speaking in front of others, tests];
- * **intellectual:** difficulty in concentrating, waking up in the night, poor memory;
- * **sleep difficulties:** in falling asleep;
- * **somatic complaints:** feelings of weakness in her legs and prickling sensations like pins and needles;
- * **cardiovascular:** not applicable;
- * **respiratory:** a tendency to sigh;
- * **gastro-intestinal:** appetite changes, vomiting and sometimes constipation; and
- * **genito-urinary:** a need to urinate quite often.

(c) Types of Anxiety

Katherine appears to be suffering from the following types of anxiety:

- * **generalised anxiety;**
- * **social anxiety;**
- * **performance anxiety; and**
- * **phobias [moderately].**

(d) Observations by Researcher

The following observations were made by the researcher re: Katherine's behaviour during the interview:

- * **tenseness;**
- * **strained and embarrassed look;**
- * **close to tears;**
- * **motionless and speechless with anxiety at times;**
- * **overly eager to please;**
- * **moderately disorganised thinking;**
- * **average amount of tremulousness;**

- * sometimes restless and fidgety;
- * moderate stuttering;
- * moderate swallowing;
- * moderate sweating [wet palms]; and
- * dilated pupils.

From this interview, it became obvious that Katherine is a very anxious child who is struggling to cope with her symptoms of anxiety.

7.2.3.3 Projective Media

7.2.3.3.1 Drawings

*** Draw-A-Person [DAP]**

Interpretation: Behaviour and Drawing analysed as a whole:

Katherine showed a need to be meticulous, precise and careful whilst drawing. Certain obsessive-compulsive tendencies were evident, as well as uncertainty and anxiety, e.g. frequent erasures. Her drawing, of an 8 year old girl, indicates a need to be younger than her chronological age and thus to remove herself from her present difficulties and anxieties. A certain amount of emotional immaturity is therefore evident. Dependency needs were noted, as well as a need to control and inhibit her behaviour. She appears to perceive her environment as threatening and this results in tense and insecure feelings.

Indices of Anxiety:

- * excessive detail; and
- * excessive erasing.

Another possible indication of anxiety:

- * features of face drawn last.

Figure 7.1, on the following page, indicates the Draw-A-Person that Katherine was requested to draw. [All the drawings in this chapter have been carefully worked over with a black pen so that they are suitable for printing. It is therefore sometimes difficult to observe how feint and hesitant the lines were initially. They have also been reduced from an A4 to an A5 size.]

* **Kinetic Family Drawing [KFD]**

Interpretation: Behaviour and Drawing analysed as a whole:

Katherine experienced difficulties in drawing her family members. She needed to delay this task and she drew the table first. Close attention to detail, frequent erasing and precise, careful drawings were again noted. A close-knit family group, enjoying their meal at the table, was drawn. Figure 7.2 indicates Katherine's family drawing.

FIGURE 7.1
A'S DRAW-A-PERSON

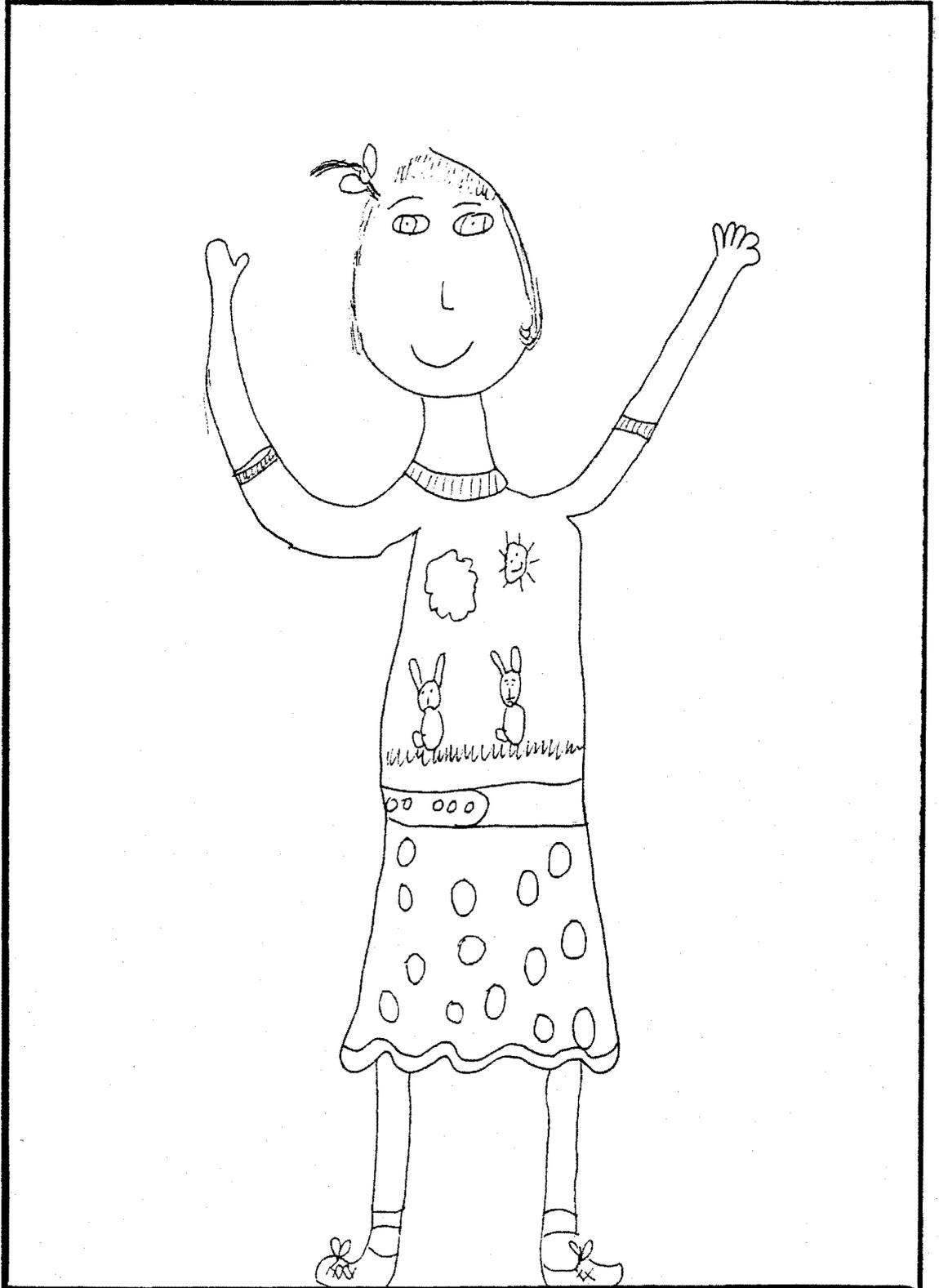
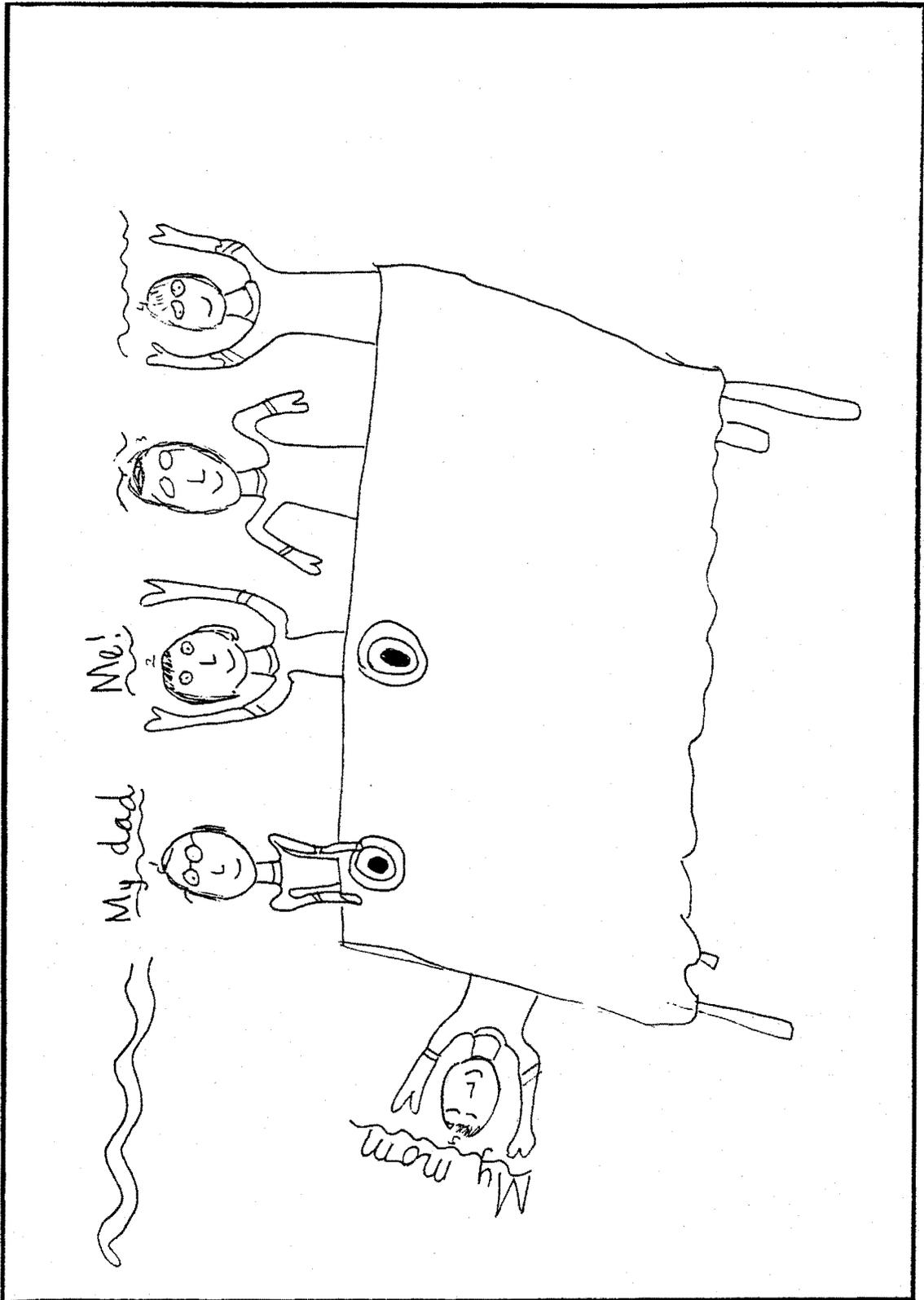


FIGURE 7.2
A'S KINETIC FAMILY DRAWING



Key to K F D

1. My dad
2. Katherine
3. My brother
4. My sister
5. My mom [this was a difficult task for her and she finished off the table cloth first and rubbed out the legs of the table and re-drew them before completing the drawing of her mother. It was evident that she was procrastinating and having great difficulty with this task.

Katherine perceives the father as being very important to her and drew him first. She places herself next to him. This appears to indicate that she sees herself as important within the family group and she seems to look towards her father for protection and security. Katherine appears to be experiencing difficulties communicating with and expressing her feelings towards her mother. She seems to regard her brother as being domineering, bossy and aggressive. Her mother is perceived as being emotionally distant and preoccupied with her own needs.

Themes to emerge from K F D

- * close-knit relationship with her father;
- * need to be seen as important within the family unit;
- * domination by younger brother and feeling threatened by him;
- * emotionally separated from mother and difficulties communicating and expressing her needs and feelings;

- * unsatisfied emotional nurturing and dependency needs.

Indices of Anxiety

- * erasures
- * barriers
- * omissions of self/body parts
- * lining at top

Other possible indications of anxiety

- * focus on irrelevant details
- * reluctance to complete drawing

7.2.3.3.2 Incomplete Sentences Blank [ISB]

Sentences that are relevant to Katherine's level of anxiety and difficulties within relationships have been analysed under the following headings:

- Relationship with self**
- Relationship with parents**
- Relationship with siblings**
- Relationship with teachers, objects and ideas**
- Relationship with peers**

(a) Relationship with self

- * I know it's silly, but I'm afraid of very big dogs.
- * Most of my friends don't know I'm afraid of big dogs.
- * When I get worried, I don't feel nice.
- * When I am older, I haven't thought about this.
- * When I think about my body - I don't.
- * If I were the boss around here, I'd be kind.
- * When I can't do what I want to do, I get a bit cross.
- * When I was a baby, I fell down the stairs. [1 years old.]

Interpretation

It is evident that Katherine has certain fears and anxieties, i.e. big dogs, which appear to indicate fears of being attacked or harmed unexpectedly. She seems to have a poor body-image and prefers not to think about her physical appearance. Feelings of anxiety and difficulties in expressing her own needs are noted and she appears to find difficulty in facing up to the challenges of the future. She seems to want to remain at her present stage of development, possibly as she fears the responsibilities and added demands of growing up.

(b) Relationship with parents

- * My mother is very busy with the Creche near to our house.

- * I like my mother but - like her as she is.
- * I sure wish my father would - nothing.
- * I like my father but - just as he is.
- * When my parents tell me to do something - I listen, always.

Interpretation

Katherine is a very loyal, well-behaved child and she finds it difficult to comment on her parents. She cannot express her own thoughts freely and she seems to be suppressing any negative attitudes and feelings. She appears to feel that her mother is not always available to her.

(c) Relationship with siblings

- * My family is the best.
- * My family treats me like - treat me well.

Interpretation

Katherine appears to find it difficult to be spontaneous and open in her responses. She seems to show a need to emphasise the good qualities in her family and is possibly shying away from and denying any negative aspects.

(d) Relationship with teachers, objects and ideas

- * My teacher is nice.
- * In school, my teachers are kind.

- * When I see my teacher coming, I'm quiet.
- * When I grow up, I want to be a physiotherapist - Ruth is one, a friend of my mother.

Interpretation

Katherine appears to see her teachers as being supportive and kind. She is reportedly well-behaved at school and she shows a need to listen to and respect her teachers. A fear of being in trouble and a preference of being quiet and not being noticed by her teachers, is noted. She has high ambitions for herself with regard to a future career.

(e) Relationship with peers

- * The other kids in school are nice.
- * I think most girls are kind.
- * The thing I want to do most of all is be nice.
- * I don't like people who cheat, at school, in exams and tests.
- * I think most boys are silly.

Interpretation

Katherine has an overwhelming need to only show positive feelings towards others and to perceive her peers as being kind and nice. Her need to be recognised, respected and liked by others is especially noted and she seems unable to perceive any negative qualities in others. Her reliance on the goodwill of her peers, may possibly act as compensation for feelings of insecurity, anxiety

and timidity.

(f) Synthesis of Incomplete Sentences Blank

Katherine demonstrates certain fears and anxieties and she shows a need to suppress any negative, hostile emotions. She prefers not to think about her physical appearance and she shows difficulties in asserting herself and expressing her needs and opinions.

She describes her relationships with others in a positive, but possibly, unrealistic manner. Her need to be perceived by her parents and teachers as well-behaved and obedient, is especially noted. She sees her peers as kind and she, in turn, reciprocates these positive feelings. Katherine does not appear to want to see any negative qualities in those around her, nor does she wish to think of any bad incident or unhappy time in her life. Her reality perception seems to be disturbed and she shows a need to express thoughts and feelings that she thinks are expected of her and not, necessarily, her own true feelings. Her need to be seen in only a positive light is, therefore, strongly noted.

7.2.3.3.3 Thematic Apperception Test [TAT]

The sources consulted for the interpretation of the TAT are the following: Bellack 1954; Du Toit and Piek 1987; Murray 1971.

Card 1: Challenge Card

'A little boy, a violin, thinking about what he should play. He'll play something, the music. He's puzzled, not sure what he's doing. A bit sad'.

Interpretation

Katherine worries about achieving good results. She shows a need to do well, but she is uncertain as to how she can achieve her goals. A lack of imagination and creativity is noted and she appears to find it difficult to immerse herself in fantasy. Overcontrol of needs and impulses seems to be present and her creativity appears to be stifled. She lacks enthusiasm when faced with a challenge and will persevere mainly to comply and adhere to the demands of others. A certain amount of dependency on others, is noted.

Card 3 BM: Frustration Card

'A girl. She is crying. Someone had been very nasty to her - one of her friends at school. She told her she looked very ugly. One of her good friends will come and talk to her and play with her'.

Interpretation

Katherine shows a need to be accepted and liked. She appears to be overly sensitive to peer criticism and she is very concerned regarding her outer physical appearance. Her reaction to frustration is to cry and feelings of helplessness and being defeated, are noted. She does not seem able to stand up for herself and she finds it difficult to be assertive and to retaliate, where necessary. Her need to rely on her friends and seek comfort and reassurance, is especially important to her. Her uncertainty, confusion and feelings of inadequacy and dependency are noted on this card.

Card 6 GF: Father-daughter card

'A woman and a man. They're talking to each other. They're friends'.

Interpretation

Katherine perceives a close relationship between the two people in the picture. She describes them as being able to communicate and she can recognise the intimacy between them. It would seem that this reflects her close relationship to her father and that she feels comfortable and secure with him.

Card 7 GF: Mother-daughter Card

'A girl, her mother. The little girl's holding a doll. The mother's telling the little girl a story and the little girl's listening very carefully. She'll go and play after the story. She enjoyed the story. It was about a little girl and her dog'.

Interpretation

Katherine recognises the relationship between the child and her mother. She shows a need to be seen as 'little' or young and she appears to be looking for greater protection and recognition of her needs from her mother. She perceives 'good children' as obedient and well-behaved and she seems to need to value her mother's advice and opinions. She clearly respects a mother's authority and shows a need to please her own mother. A lack of emotional expression and a holding back of feelings, is noted on this card, as well as a strong need to depend on her mother.

Card 11: Primitive Fears

'Lots of rocks' [could not see anything else].

Interpretation

Katherine could not respond to the stimuli presented on this card. Her fear of the unknown and her inability to deal imaginatively and creatively with an unstructured situation, is evident. She inhibits, controls and suppresses her

impulses and she cannot act freely, independently and without fear and anxiety.

Card 14: Silhouette

'A little boy sitting at the window because he's thinking about how he's going to do in the test tomorrow. He's going to sit for a little longer and then go and play'. [This card was very difficult for her to describe.]

Interpretation

It is obvious that this card evoked anxieties for Katherine. Her need to regress and to remove herself from the situation [by describing a boy], is noted and she appears to be worrying about and brooding excessively over her school performance. Her inability to face up to her present difficulties is evident and she does not seem to be able to think of any solutions to her problems. Her need to escape by involving herself in play activities, is noted. In this way, she can avoid her worries and fears and delay taking any positive action towards coping better with the demands and challenges of her everyday life.

Themes that emerge from the TAT

- * Feelings of uncertainty, helplessness, dependency, confusion, unhappiness, inadequacy, anxiety, insecurity, sadness, [Cards 1, 3BM, 7GF & 14];
- * Interpersonal difficulties and emotional guardedness, [Cards 3BM, 7GF & 11];
- * Lack of resolutions/facing up to demands and challenges, [Cards 1, 3BM, & 14];

- * Lack of imagination/creativity, [restriction and inhibition (Cards 1 & 14)];
and
- * Ability to identify strongly with the victim, [Cards 1, 3BM & 14].

It is evident that at present, Katherine is emotionally constricted and she has a great need to suppress and control her feelings, needs and impulses. She feels obliged to please those around her and in this way, she feels she can attain the affection, support and acceptance she so greatly desires. Her anxieties, unhappiness, insecurities, fears and difficulties in coping with her environment are very evident.

7.2.4 Personal Image

7.2.4.1 Relationships with self and significant others

The information has been gathered from the phenomenal and relational images and integrated so as to understand how Katherine's relationships have influenced her level of anxiety and vice versa. This image also serves to understand Katherine within her life-world and to attempt to comprehend what **meaning** her anxieties may have for her.

7.2.4.1.1 Relationship with self

(a) Sexual/emotional self

* Oral stage

It would seem that the first few months of Katherine's life were stressful for her and her family. She was only able to be breastfed for 8 weeks because her mother's milk dried up. The family moved house at such time, which can be

described as a significant stressor to a family with a new-born baby. Therefore, she was weaned from the breast at a very early age and at a very stressful time for the family. It is therefore very likely that she did not successfully master Freud's Oral Stage, the crisis of which is weaning. She was weaned from a bottle at the age of a year, which is also relatively early and her mother remarked that Katherine needed to grow up 'fast' because her brother came along soon afterwards and she also had Katherine's elder sister to look after. It is interesting to note that she chose to draw her family eating a meal, in her KFD indicating strong oral dependency needs.

* **Anal stage**

No problems were reported at this stage and Katherine was toilet trained at 22 months in the day and 2½ years at night. No regressions have ever occurred, except for the odd accident, common to most children. However, she has a tendency to be constipated [CAEF] which may indicate passive-aggressive behaviour.

* **Phallic stage**

There is evidence to suggest that Katherine had difficulty in identifying closely with her mother during this stage, as her mother was extremely busy with her three small children, a creche and a nursery school, as well as fostering new-born babies. Therefore, it may be hypothesised that Katherine's psycho-sexual needs at this stage, may not have been adequately met. She has however fully accepted her feminine role and appears comfortable with it.

* **Latency stage**

Katherine appears to have been struggling emotionally, before entering this stage and it would appear that many basic needs for security and love were not met in the previous stages. It is evident, from the psychometric assessment, that Katherine has difficulty in expressing her needs and emotions and passive-aggressive behaviour is evident. Fixation at a previous stage, possibly the oral-passive stage, is probable.

* **Dependency and separation anxiety**

Katherine's history does not indicate any separation anxiety, only a certain amount of stranger anxiety at the age of $\pm 1\frac{1}{2}$ years. This coincided with the birth of her brother. From the assessment, a high degree of dependency was noted. [TAT (Cards 1, 3 and 7GF); KFD (unsatisfied dependency needs); DAP (need to draw someone younger than herself)]. Katherine's behaviour at home also demonstrates a large amount of dependency, particularly on her mother and sister, for assistance with her homework. She insists that she can't do projects and drawings as well as they can and manipulates them into doing her work for her.

* **Fear, hostility and anxiety**

Katherine appears not to be able to deal with her fears and anxieties adequately. She lists her fears as bad things happening, darkness, strangers, being left alone, big dogs, school, performing in front of the class, taking tests and saying English orals. There is much evidence to suggest that Katherine suppresses most of her negative feelings because she is unable to deal with her aggressive and hostile emotions. Her mother reported that she 'can't tolerate badly behaved children'. According to Psychoanalytic theory [cf. 3.4.2.3.1], the child fears the loss of his parents' love as well as rejection and abandonment. It is therefore highly likely that Katherine is unable to show any hostility for fear of losing her parents' love. This situation, according to Horney [cf. 3.4.2.3.2], leads to anxiety which in turn causes repression.

Katherine complains of getting headaches from time to time and experiences appetite changes and she has a tendency to vomit easily as well as a tendency to urinate frequently. Certain perfectionistic tendencies, e.g. the manner in which she approached her drawings and the fact that she is never satisfied with them or with her project work, are noted. Obsessive-compulsive behaviour, mentioned under the Latency stage, is also evident. Katherine's self-concept appears to be low. [TAT (Cards 1 and 3BM); DAP (need to be younger, dependency needs) and her body image appears to be disturbed, i.e. she believes she is overweight

and worried about 'getting fat' while in reality she is extremely thin and skinny)]. Her eating habits are also disturbed because of a fear of being late and possibly also of putting on weight. The Incomplete Sentences Blank also indicates a poor body-image and her preference of 'not thinking about my body'. Katherine's overwhelming need to be accepted and approved of by everyone does not allow her to be in touch with all of her feelings and thoughts. She appears to need to idealise all situations so that she does not have to deal with any friction or confrontation. In this way, she appears to compensate for her intense feelings of insecurity, anxiety and timidity, but at the cost of disturbing her perception of reality.

(b) Social Self

*** Psychosocial stages of development**

- Stage I: Basic trust vs mistrust

Kaplan and Sadock [1989:399] explain that trust depends on consistency and sameness that the infant experiences from his primary caretaker and that the quality of this care initially, determines to a large extent the degree to which the infant comes to trust the world, other people and himself in later life.

Katherine appears to have had to 'grow up quickly', according to her mother and therefore was perhaps not given much time, consistency and care at this particular stage of her life. The family's move and her mother's milk 'drying up', possibly due to stress, indicate a time of upheaval and tension for Katherine.

Presently, Katherine appears to 'mistrust' her world and does not perceive there to be any safety or security for her. She appears to feel overly responsible for everything that happens to her, especially the negative events.

- **Stage II: Autonomy vs shame and doubt**

Katherine appears to have been a very 'good' child who did not challenge authority at all. Her mother also reported that she has never tried to assert herself.

Erikson [1977:226] believes that the child's environment must encourage him to stand on his own feet but that it must protect him against meaningless and arbitrary experiences of shame and early doubt. It appears evident that Katherine did not perceive her environment as 'protective' and, at an early age, received the message that she should become emotionally independent as soon as possible.

- **Stage III: Initiative vs guilt**

At this stage, the child's conscience begins to govern his initiative and purpose becomes the rudiment of the ego-strength [Kaplan and Sadock 1989:406] and at this stage, guilt develops in the child. There is evidence that Katherine is very aware of right and wrong and worries about doing anything wrong. In this way, she tries hard to protect herself from feeling guilty [ISB (e: I don't like people who cheat ...); TAT (Card 7GF, overriding need to be good)]. Katherine appears to be stifling her initiative and creativity by her rigid and compulsive behaviour for fear of doing wrong and being made to feel guilty.

- **Stage IV: Industry vs inferiority**

According to Erikson [1977:233], the child realises, during this stage, that 'there is no workable future within the womb of his family' and that this realisation frees him to apply himself to skills and tasks outside of the family.

Katherine has not begun to master this stage, even though she has had three years in it and therefore is midway through it. She is not yet free to explore her own industrious side and constantly reminds herself of her perceived 'inferiority'. In reality, she is able to do things quite adequately and her marks are usually above the average of the class. In many respects, Katherine is achieving at, or even above, her intellectual potential, but she cannot accept this perspective and

continues to put herself down and feel inferior to others.

*** Social needs**

Both Sullivan [Burhmester and Furman 1986:41-42] and Horney [May 1950:141] believe that anxiety is the result of disturbed interpersonal relationships, resulting in the child's social needs being left unmet. It would seem as if Katherine may have experienced difficulty in having her need for tenderness met at a very young age. At the age of eight weeks, she no longer had the comfort of being held by her mother at the breast and was then fed, by a variety of care-givers, at the creche her mother ran.

Her need for companionship appears to have been adequately met and she developed a close relationship with her father at an early age, which is still very evident at present. [ISB (b: I like my father - just as he is); TAT (Card 6GF); KFD (drawing her father first and placing herself next to him)]. She appears to be having her need for acceptance met at school and gets along with her peers but is unable to assert herself in any way, leaving herself vulnerable and easily dominated and manipulated by her peers.

(c) Cognitive self

Katherine's behaviour, during testing, indicated overt anxiety and a great deal of passivity in the manner in which she approached the various tasks. Her need to be precise, neat and accurate interfered with optimal functioning on many of the timed tests. She tended to give up easily and did not persevere when the items became more difficult. Her lack of confidence in her cognitive abilities was very evident.

However, she is managing well at school and her teacher is very pleased with her standard of work. It therefore seems evident that she has successfully reached Piaget's Concrete Operational Stage and can think logically [WISC.R sub-tests: Similarities - 12, Block Design - 11, Object Assembly - 10], has the concept of

reversibility, part-whole relationships and conservation [sub-tests: Arithmetic - 10, Block Design - 11, Object Assembly - 10]. She is also able to see other people's points of view, often to the exclusion of her own.

(d) Moral self

Katherine's moral self appears to be especially well developed. Her family appear to place much emphasis on helping others and on what is 'right' and 'wrong'. Her mother reported in the interview, that Katherine's teachers said she 'posed no threat to anyone' and that she was 'kind and helpful to everyone' and a 'model child'. This would indicate that Katherine has reached Kohlberg's Level 2 : Stage III of interpersonal concordance [cf. 3.2.4.2.1], in that she is far less egocentric than younger children and is now focusing on her relationships with those around her and perceiving their needs and interacting with them to a large extent. It seems possible that Katherine is doing this to the detriment of her own needs and that she is unable to find a balance between the two. The thing she says she wants most of all 'is to be nice' [ISB] and she appears to look for external measures of this 'niceness'.

Her high score [75 %ile] on the Lie Scale of the RCMAS [cf. 7.2.3.1.2] indicates her strong need for approval, a high level of defensiveness and her own inability to view herself objectively. Katherine is not able to challenge authority in a healthy way and her anger and resentment, in this respect, needs to be repressed and/or denied. This, in turn, creates tension. Katherine appears to have so strong a need to please others and for social approval, that much of her energy is spent worrying about something she may say or do that is considered 'wrong' by others. This inhibits her spontaneity and ability to interact meaningfully with others.

7.2.4.1.2 Relationship with parents

Katherine appears to have difficulty communicating her needs to her mother and perceives her as 'very busy with the creche' [ISB]. She also had difficulty completing the drawing of her mother [KFD]. She perceives herself as needing to 'listen very carefully' to her mother [TAT] and her mother's comments, that she cannot tolerate 'badly behaved' children, indicate a certain rigidity and inflexibility in her handling of the children. Her mother's need to continuously foster small, very dependent babies, possibly at the cost of her own family, also indicates difficulties her mother may have in her relationship with a daughter who is growing up.

Katherine appears to have a warm and loving relationship with her father who is the less dominant parent and who does many things for Katherine, e.g. fetching her from school.

7.2.4.1.3 Relationship with siblings

Katherine appears to regard her younger brother as being 'domineering, bossy and aggressive' [KFD]. Sibling rivalry appears possible and it is noted that her brother was born when she was 1½ years of age and is the reason why she had to 'grow up' so quickly. Katherine only refers to her siblings as her 'family' and not as individuals [ISB], indicating her need not to have to 'deal' with them consciously. She thinks 'most boys are silly' [ISB], also indicating possible negative feelings for her brother.

7.2.4.1.4 Relationship with teachers, objects and ideas

Katherine views her teachers with a great deal of respect. She sees them as 'nice' and 'kind', but needs to be 'quiet' when they are around [ISB]. She appears

fearful of challenge and new ideas [TAT (Cards I and 14)] and appears unable to deal spontaneously and creatively with her environment. However, there is evidence that Katherine's excessively high levels of anxiety are affecting aspects of her school- and homework. She complained of having difficulty while trying to concentrate at school and of not being able to remember things she learns easily [CAEF]. She has a high level of fear about writing tests [CAEF; TAT (Card 14)], meeting challenges [TAT (Card 1)] and speaking in front of the class [CAEF].

7.2.4.1.5 Relationship with peers

Katherine appears to feel accepted by her peers and she reports that the girls are 'nice' and kind' [ISB]. However, her sensitivity to others 'being nasty' to her is heightened by her projection on the TAT [Card 3BM] and her dependency on others to make her feel better, is noted.

7.2.5 Irrational Image

Katherine does display evidence of irrational thoughts and obsessive-compulsive behaviour, e.g. washing her hair every morning before school, packing her suitcase and getting her clothes ready long before the event and refusing breakfast because she may be late for school.

Certain symptom formation is also evident, such as headaches and stomachaches, prickling sensations in her legs, appetite changes and the need to urinate frequently.

Katherine can be diagnosed as suffering from an overanxious anxiety disorder. Her age of onset appears to have been around the age of 8 years. The four diagnostic criteria, in which Katherine's anxiety is manifested, are the following:

- * unrealistic worry about future events, e.g. examinations, talking in front of the class and running in cross-country meetings, etc.;
- * overconcern about competence in a variety of areas, e.g. academic, as well as social and athletic;
- * somatic complaints such as headaches or stomachaches, for which no physical basis can be established;
- * marked self-consciousness or susceptibility to embarrassment or humiliation; and
- * marked feelings of tension and inability to relax.

Katherine has been troubled by this unrealistic and excessive worry for a period of \pm 12 months, if not longer. Her parents were the source of referral because they became very concerned about her anxiety and perfectionistic behaviour.

7.2.6 Synthesis

* **Functional image**

Katherine presented as a highly anxious child who lacked confidence in her own abilities and who demonstrated compulsive behaviour much of the time at home.

* **Phenomenal image**

A history was obtained from both Katherine's parents and was essential in that it gave a different perspective to Katherine's anxiety and the meaning it had for her. Without that information, a far less complete picture of Katherine would

have been obtained. Katherine's intellectual abilities fall in the Average range, with no significant discrepancy between Verbal and Performance scales. Erratic attention and anxiety were highlighted by this test.

* **Relational image**

The test material was then analysed and her various relationships with:

- self;
- parents;
- siblings;
- teachers, objects and ideas; and
- peers

were examined and special attention was given to the way in which her anxiety affected these relationships and vice versa. Katherine has a low self-concept and a disturbed body-image. She demonstrates intense dependency needs and feelings of inferiority, insecurity and unhappiness. Katherine demonstrates a troubled relationship with her mother, in which she perceives that her mother is not able to meet her emotional needs fully. She has a close and warm relationship with her father, but a poor relationship with her siblings, especially her younger brother, who is only 1½ years her junior. Katherine appears to be wary of authority figures and cannot challenge them or assert herself in any way. She desperately needs to be viewed as the model child. She has a few close friends but is hypersensitive to comments that they or other peers may make about her.

* **Personal image**

Meaning was then attributed to these relationships and the self was analysed according to four different aspects, namely:

- sexual and emotional;
- social;
- cognitive; and
- moral.

The various stages of Katherine's development were carefully analysed and assumptions made as to possible reasons for the anxiety that manifested itself during her development.

Major contributing factors appear to have been:

- a difficult labour and birth;
- premature weaning from the breast at eight weeks of age due to mother's inability to feed her and a stressful relocation to a new home;
- contracting bronchitis at the age of eleven weeks;
- the birth of her younger sibling at the age of 1½ years;
- her mother continuing to work, both at the creche and nursery school, while raising three young children;

- her mother's perception that she had to 'grow up sooner than other children';
- the fostering of twelve new-born babies over the past six years; and
- inconsistency in the parents' handling of the children.

Emotionally, Katherine appears to have fixated at or regressed to earlier stages of her development, i.e.:

- oral stage: oral-passive phase
- phallic stage: inability to identify closely with maternal figure

Katherine has a low self-concept and self-esteem and a very negative and distorted body-image. She demonstrates feelings of dependency, inadequacy, fear and anxiety. Obsessive-compulsive and perfectionistic tendencies, as well as symptom formation, are very evident.

Socially, Katherine appears not to have mastered Erikson's and Sullivan's stages appropriate to her age group. She demonstrates the following:

- basic trust vs mistrust: mistrust
- autonomy vs shame and doubt: doubt
- initiative vs guilt: guilt
- industry vs inferiority: inferiority

Cognitively, Katherine appears to be developing well, although her anxiety appears to be interfering with some of her intellectual abilities. Her spelling, delivering oral speeches and completing drawing tasks, appear to be the areas affected the most. In addition, strong indications of rigidity and compulsivity in her thought patterns appear to be hampering her development at this stage.

Morally, Katherine appears to have developed strong views on right and wrong. She appears to have reached Kohlberg's Level 2, Stage III: Interpersonal Concordance.

* **Irrational image**

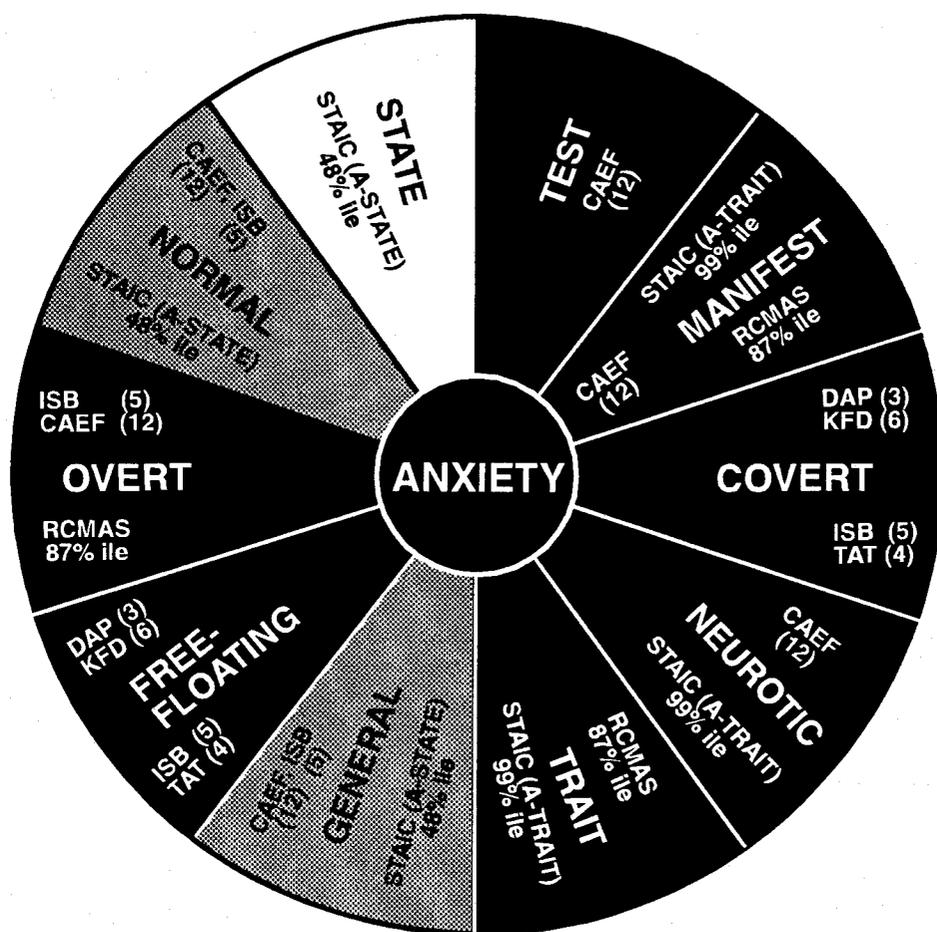
Katherine can be diagnosed as suffering from an overanxious disorder, as described by the DSM III classification. Symptom formation is evident as well as irrational thoughts and obsessive-compulsive behaviour.

* **Recommendations after the assessment:**

Play therapy was recommended for Katherine and parental counselling and guidance were recommended for her parents.

The following diagrams, Figures 7.3 and 7.4, highlight the main areas of concern with regard to her anxiety and its effect on her various relationships, as well as the different types of anxiety that are affecting her. Wherever possible, scores from the psychometric tests have been included.

FIGURE 7.3
CASE A's TYPES OF ANXIETY



WHITE	Low to moderate anxiety
GREY	Moderate to high anxiety
BLACK	Excessively high anxiety

FIGURE 7.4

DIAGNOSTIC MODEL OF CASE A's ANXIETY

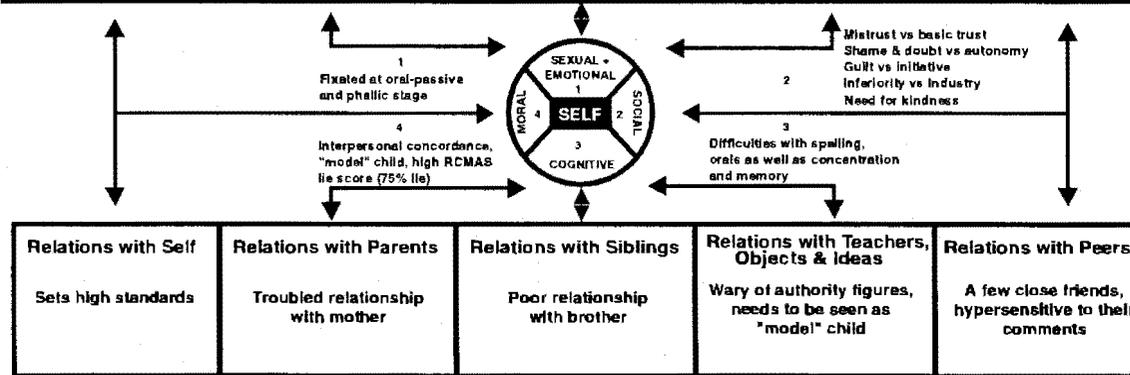
Level 5
Irrational Image

The Level of the Irrational:
(Development of Anxiety Disorders, etc.)
Overanxious Disorder
Symptom Formation & Obsessive - Compulsive Tendencies

Level 4
Personal Image

Meaning Attributed To:				
Self Low self-concept, disturbed body image, feelings of: inadequacy, inferiority insecurity & unhappiness	Parents Perception of needing more love & affection from mother	Siblings brother seen as dominating, bossy & aggressive	Teachers Objects & Ideas Respects teachers & authority but unable to challenge them or assert self	Peers Feels accepted but over- sensitive to & over-dependent on them

Level 3
Relational Image



Level 2
Phenomenal Image

The Problem as Phenomenon: Anxiety
Parent interview and psychometric assessment
to obtain information

Level 1
Functional Image

Functional Image:
Highly Anxious Child
Presented with compulsive behaviour

7.3 CASE B.

7.3.1 Functional Image

7.3.1.1 Identifying particulars

Name	: Kate
Standard	: Three
Date of birth	: 1984 03 11
Age at testing	: 10 years 1 month
Position in family	: First
Siblings	: Sister
Number of schools attended	: Three
Number of standard repeats	: None
Socio-economic status of family	: Above Average

7.3.1.2 Reason for referral

Her mother described Kate as 'very neurotic'. Separation anxiety was reported throughout the primary school years and had increased since Kate moved to a new province. Kate worries that she will not be fetched from school by her mother. She has many cuddly toys that she keeps with her, at all times, to comfort her. Her parents and teachers are concerned about her high level of nervousness and fear.

It is tentatively hypothesised that:

Kate is suffering from a separation anxiety disorder, as well as other types of anxiety.

7.3.2 Phenomenal Image

7.3.2.1 Parent interview

The information was obtained from the mother alone and it was evident that she handles 'these problems with the children single-handedly'.

7.3.2.1.1 Family background

Kate is the elder of two girls. Her sister is \pm 3 years younger than she is. She lives with her mother, father and sister in a house in the Northern suburbs of Johannesburg. Her father is a national sales manager for a well-known motor company and her mother is a nursery school teacher, who resumed teaching for the second time, when Kate was in Grade ii.

7.3.2.1.2 History of pregnancy and birth

Kate's mother reported that Kate was a planned baby, even though her parents were not married at the time of her conception. They married when her mother was three months pregnant. Her mother said that this was a happy time for them and no additional stressors were mentioned. Her birth was normal and no difficulties were experienced. Her father was present at the birth.

7.3.2.1.3 Child's early development

Kate's mother reported that Kate was breastfed for eight weeks but became

'colicky' at that stage and was changed to a Soya bean formula. Her father was sent to an army camp for three months when she was six weeks old and her mother recalls that this was an extremely stressful time for the family. When Kate was four months old, her mother stated that it was a 'terrible' time and Kate cried incessantly. However, this did not last long and her mother described her first year as being 'good and healthy' overall.

However, at nine months of age she was subjected to **drown-proofing**. Her father, an ex-lifeguard, wanted to know she would be **water safe** as he was concerned about the possibility of her drowning.

She developed a fear of water through this experience and only learnt to swim at the age of five years.

Kate's mother first went back to work when Kate was 14 months old and her grandmother cared for her during the day. No extreme anxiety was reported at this time.

Milestones

Motor : walking 9.5 months

Speech : first words 10 months
: sentences 2 years

Weaning : breast 8 weeks
: Bottle \pm 1 year

Toilet training : [under the age of 2] - She was trained by her grandmother because her mother had gone back to work.

Discipline : Her mother is the main disciplinarian of the family and reported that she smacks her if she's really naughty. She usually only has to reprimand her verbally and she maintained that Kate is a very 'good' child, who does not challenge authority in any way.

7.3.2.1.4 Medical history

At the age of three years, Kate had an operation on her eye due to an ulcer. She was hospitalised for five days and her mother remained with her throughout. Her mother remembered that this was a very traumatic time for the whole family. Shortly afterwards, her sister was born. Her mother reported that Kate became particularly 'clingy' at this time and tended to burst into tears fairly easily.

7.3.2.1.5 School history

Kate attended a mornings-only playgroup at the age of 2 years and then spent the afternoons with her maternal grandmother. She then attended a nursery school at the age of 3½ years until she completed Grade 0, at the age of 5 ¾ years. No school-related difficulties were reported during this time and her mother believed that this was due to the fact that her cousins, with whom she was very close, attended the same school. Although she was young [turning six in March the following year] and emotionally immature, it was decided that she should commence formal schooling.

She entered Grade i at a Government primary school in Durban and in the third term of that year her father was transferred and the family, as well as her grandmother, who was not living with the family, moved to

Johannesburg. She then attended a Government school in the Northern suburbs of Johannesburg and did not settle in well. She cried everyday for ± five months. Her mother made sure she 'handed' her over each morning to her teacher but Kate displayed severe signs of separation anxiety and was convinced her mother would not return to fetch her. No incident of her mother ever being late for her was reported.

In the second term of Grade ii, her mother returned to teaching and Kate had to remain for an hour after school until her mother could fetch her. This was a traumatic time for her and her mother said that she was mostly in tears when she fetched her. In Std. 1, her teacher recommended a psychological assessment to ascertain how to help her. This was not followed up on. In Std. 2, she settled in better, at which time her sister also commenced Grade i at this school. However, Kate still became extremely upset at the end of the day if her mother was not one of the first to fetch the children, as they came out of the classroom. Kate's mother mentioned that all her teachers have remarked on how good and obedient she always is, but that they worry about how anxious she is. She then changed schools as her school became private and her parents decided on a Government school closer to their home. She settled in but had difficulty becoming 'one' of the class. Her mother reported that her other 'neurotic symptoms' increased at this time

7.3.2.1.6 Anxiety-related aspects of development

*** Eating and Sleeping Habits**

Kate is reported to be a fussy eater, who will eat no meat or chicken if it has not been deboned. She also refuses to eat any skin on the meat. She only eats certain vegetables. She has great difficulty in falling asleep at night and

will not sleep in her own room. She sleeps with her younger sister. She uses many delaying tactics, like going to the toilet many times or requesting drinks of water, before she finally falls asleep.

*** Reaction to separation from parents**

From the age of six and after a move to a new province, Kate's separation from her mother became a problem for her and she displayed severe anxiety at such times. It is presently one of the reasons why her parents have requested an assessment of her.

*** Fears and worries of the child observed by parents**

Her mother reported that Kate is very fearful of the dark and that she worries continuously that something 'bad' will happen to her. She also sets extremely high standards for herself and in the past, would destroy her paintings as she felt they were not 'good' enough. She tends to be perfectionistic and compulsive.

She likes everything in her room to be in a precise order and can never take pride in the standards she produces, either academically or sport-wise.

*** Nervous habits of the child**

She bites her nails and needs constant reassurance from her family. She is extremely possessive over her mother.

*** Socialization and relationships at nursery and primary school**

Her mother reported that she has never made friends easily. She got along well with her cousins, but tended to shy away from her peers. She says she wants only one friend, but can't find the 'right' one.

7.3.2.2 Intellectual functioning

As Kate was referred for an emotional assessment only, her intellectual functioning was not measured. However, judging from the age that she reached her milestones, as well as the quality and detail of her drawings and stories on the Thematic Apperception Test [TAT], she appears to be at least of Average intelligence, but more likely to fall in the Above Average range of intellectual functioning. Her mental age score on the Goodenough Test was 11 years 6 months, which is 1 year 5 months above her chronological age.

7.3.2.3 Psychometric and projective tests conducted for the assessment of anxiety

- * **State-Trait Anxiety Inventory for Children [STAIC]**
- * **Revised Children's Manifest Anxiety Scale [RCMAS]**
- * **The Children's Anxiety Evaluation Form [CAEF]**
- * **Draw-A-Person [DAP]**
- * **Kinetic Family Drawing [KFD]**
- * **Incomplete Sentences Blank [ISB]**
- * **Thematic Apperception Test [TAT]**

7.3.2.4 Qualitative analysis of behaviour during testing

Kate was uncertain about being separated from her mother on the morning of the assessment. She hesitantly agreed to be left, on condition her mother came early and waited for her outside the assessment room. She was friendly

and cooperative throughout the assessment but played consistently with her 'special' fluffy toy that she had brought along to accompany her. She appeared to console herself by stroking and touching it often. She also brought her own cold drink 'in case she got thirsty'.

She became fearful and anxious when relating various incidents in her life and when expressing her feelings. She seemed particularly sensitive, tense and insecure at such times. She was, however, able to express her fears and anxieties in an open, spontaneous and descriptive manner.

On the drawing tasks, she worked slowly and meticulously and neatness appeared to be an 'issue' for her. At times, Kate did not seem to listen carefully and misinterpreted instructions and acted impulsively. External noise appeared to distract her and disturb her concentration. This however appeared to be the result of her high levels of anxiety, timidity and fearfulness, rather than as a result of an Attention Deficit Disorder, which is more neurologically than emotionally based.

7.3.3 Relational Image

7.3.3.1 Questionnaires and inventories

7.3.3.1.1 State-Trait Anxiety Inventory for Children [STAIC]

Kate scored a percentile rank of **58** on the **State Anxiety Scale** and one of **95** on the **Trait Anxiety Scale**. This indicates that Kate demonstrates a **moderately high level** of **A-State Anxiety** [situational anxiety] [**58%ile**] and that she finds being assessed a **moderately** stressful experience. However, her generalised or **A-Trait Anxiety**, about most aspects of life, is **excessively**

high [95%ile] and is affecting her functioning very negatively and severely.

7.3.3.1.2 Revised Children's Manifest Anxiety Scale [RCMAS]

Kate's scores on this scale are as follows:

	RAW SCORE	PERCENTILE RANK	T-SCORE
TOTAL SCORE	22	92 %ile	64
	<u>Raw Score</u>	<u>Percentile Rank</u>	<u>Scaled Score</u>
I. Physiological	5	65%ile	11
II. Worry/over-sensitivity	11	98%ile	16
III. Social concerns	6	93%ile	14
L. Lie Scale	4	70%ile	11

These scores indicate that Kate has an **excessively high level of manifest anxiety** overall [92%ile]. **Level II, Worry/oversensitivity** and **Level III, Social concerns** appear to be the areas of most concern for Kate [98%ile], but her other level, **Physiological**, is in the **moderately high range**. [Her **excessively high score on Worry/oversensitivity** on this test, according to Mattison *et al.* [1988:147], suggests the likelihood of an anxiety disorder.] Overall, this pattern of elevated scores indicates that she is experiencing an **excessively high degree of anxiety**, which will affect her overall functioning.

Her **moderately high score [70%ile]** on the **Lie Scale** is somewhat high for her age group. [Kate's raw score = 4; mean = 2.70]. This appears to indicate that she has an **unrealistic and unhealthy need for approval**. She also demonstrates a **high level of defensiveness** and a **need to present herself in a socially desirable light**. This, in turn, would affect the quality of her relationships with others.

7.3.3.2 Interviews

7.3.3.2.1 The Children's Anxiety Evaluation Form [CAEF]

Kate obtained a **global rating score of 9** [out of a maximum of **12**] indicating that her **level of anxiety** falls in the **moderately high range** and will affect her life to a certain degree.

(a) History Suggestive of Anxiety

Kate reported that she has been plagued by fears and worries for the past five years, since she commenced formal schooling in Grade i. She complained that she has struggled with sleep disturbances for the past two years and she has recurring nightmares about monsters and ghosts. Tests and examinations also serve as stressors in this regard. She mentioned that she has been aware of her nervousness and general unhappiness since Grade i. It affects her appetite, because she tends to eat less when she feels more anxious and this has been happening for the past three years, since Std. 1.

She complained of having bad headaches since Grade i, as well as less severe stomachaches from time to time. She complained of other anxiety-equivalent symptoms, such as panic attacks [3 in total] and bed-wetting, the last incident being \pm three months ago.

(b) Child's Subjective Assessment

Kate's target anxiety symptoms in order of intensity are: frightened, worried, anxious, upset and tense. They appear to be more generalised than

situational. She could describe what each feeling felt like for her and could distinguish between this sufficiently, e.g. worried, 'I have to squeeze my muscles tight to be brave and my eyes water'. Other anxiety symptoms, in order of highest global ratings, are as follows:

- * **anxious mood:** fearful anticipation, something bad happening to her mother;
- * **fear:** darkness, strangers, being left alone, closed spaces, storms, crowds, animals [live insects and snakes], school [speaking in front of others in class and taking tests and examinations];
- * **intellectual:** poor memory and concentration problems, daydreaming;
- * **sleep difficulties:** falling asleep, waking in the night and nightmares;
- * **somatic complaints:** blurred vision, hot flushes, feelings of weakness in her legs and prickling sensations like pins and needles;
- * **cardiovascular:** faint feeling, pains in chest;
- * **respiratory:** pressure in chest and sighing;
- * **gastro-intestinal:** not applicable; and
- * **genito-urinary:** a need to urinate frequently.

Her depressed moods and mood swings appear to be less severe. Of interest however is the fact that Kate connected her feelings of anger at times to her

anxiety, e.g. 'when I get angry I feel the most tense'.

(c) Types of Anxiety

Kate appears to be suffering from the following types of anxiety:

- * **generalised anxiety;**
- * **social anxiety;**
- * **performance anxiety;**
- * **phobias; and**
- * **panic attacks.**

(d) Observations by Researcher

The following observations were made by the researcher re Kate's behaviour during the interview:

- * **tenseness;**
- * **strained and embarrassed look;**
- * **close to tears much of the time;**
- * **overly eager to please;**
- * **thought processes became disorganised;**
- * **tremulousness;**

- * fidgetiness;
- * nail biting; and
- * rapid respiration and sighing.

From this semi-structured interview, it became obvious that Kate is a very highly anxious child who is struggling to cope with her symptoms of anxiety.

7.3.3.3 Projective Media

7.3.3.3.1 Drawings

- * **Draw-A-Person [DAP]**

Interpretation: Behaviour and Drawing analysed as a whole:

It was apparent that Kate needed to draw careful, precise pictures and certain obsessive-compulsive tendencies in this regard were noted. She also asked many questions before she could carry out the instructions, indicating anxiety about making mistakes. Her drawing was of a six-year-old girl, which appears to indicate a need to be younger and to regress to an earlier time in her life. This demonstrates a certain amount of emotional immaturity. She also drew a portrait at first and only on request a full person. Signs of dependency and immaturity were evident from her drawings.

Indices of Anxiety

- * excessive detail
- * excessive erasing
- * omission of body parts

Figure 7.5 indicates the first drawing that Kate did; a portrait of a girl aged six. Figure 7.6 indicates the full Draw-A-Person that Kate was then requested to draw.

FIGURE 7.5
B'S DRAW-A-PERSON

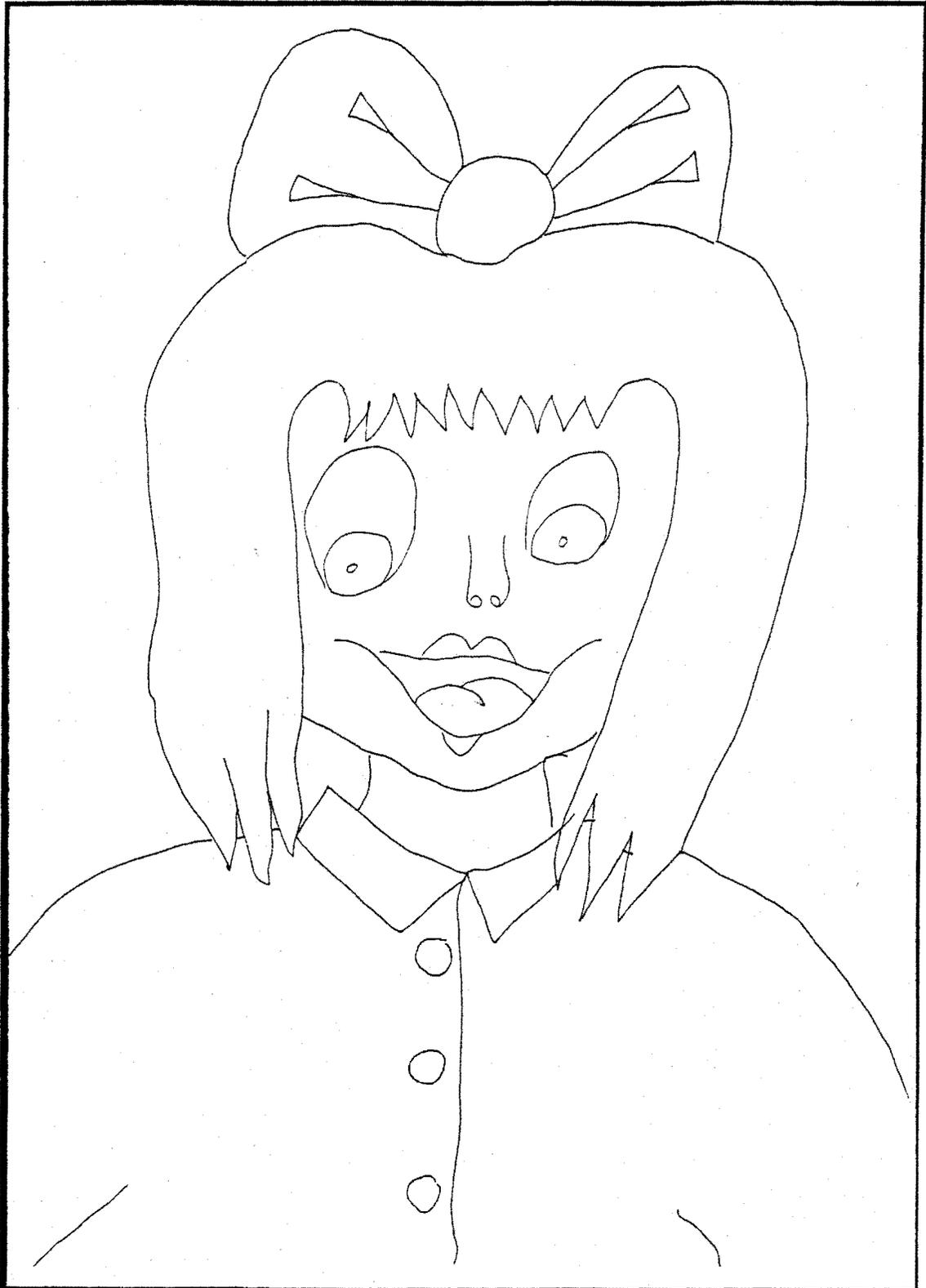


FIGURE 7.6

B'S SECOND DRAW-A-PERSON



* **Kinetic Family Drawing [KFD]**

Interpretation: Behaviour and Drawing analysed as a whole:

Kate spent a long time drawing her family and again gave much attention to detail. A theme of enmeshment appeared very evident and no interaction between family members was possible [because they were drawn hunched together], even though Kate described each in a separate activity.

Figure 7.7 indicates Kate's Kinetic Family Drawing.

Key to K F D

1. Mother - sunbathing and smiling
2. Sister - pulling a horrible face, making a noise and 'bugging' everyone
3. Father - gardening, but always getting strict and shouting at everybody and getting irritated
4. Kate - swimming and playing with her dog
5. Kate appeared to persevere in thought at this stage and said, 'If you want, I can draw my dog', which she then did. Her need to please is strongly demonstrated, as well as her need for a 'cuddly animal' close by her

The fact that Kate drew herself last appears to indicate a low self-concept and it is interesting to note that despite her separation anxiety, she drew herself relatively far away from her mother and between her father and her dog. This would appear to lend some weight to Horney's [cf. 2.4.3.4] suggestion that below the surface of the child's anxiety can be elements of hostility, directed at the parent for not allowing the child to express his true feelings. She also described both parents engaged in activities that did not involve herself. Her father appears to be perceived as the more nurturing parent; 'gardening' while her mother is perceived to be fairly self-indulgent; 'sunbathing'. Kate is

swimming which can be said to indicate depressed and sad feelings.

It appears possible that Kate resents her sister's relationship with her mother and is jealous of her sister [by the comments she makes about her sister], as well as resenting her mother for their symbiotic relationship.

Themes to emerge from K F D

- * family enmeshment
- * lack of freedom to draw what she said each member of the family was in fact doing, i.e. sunbathing, gardening, etc.; rigidity and restriction are evident in this regard
- * low self-concept, drew self last, despite being the elder daughter

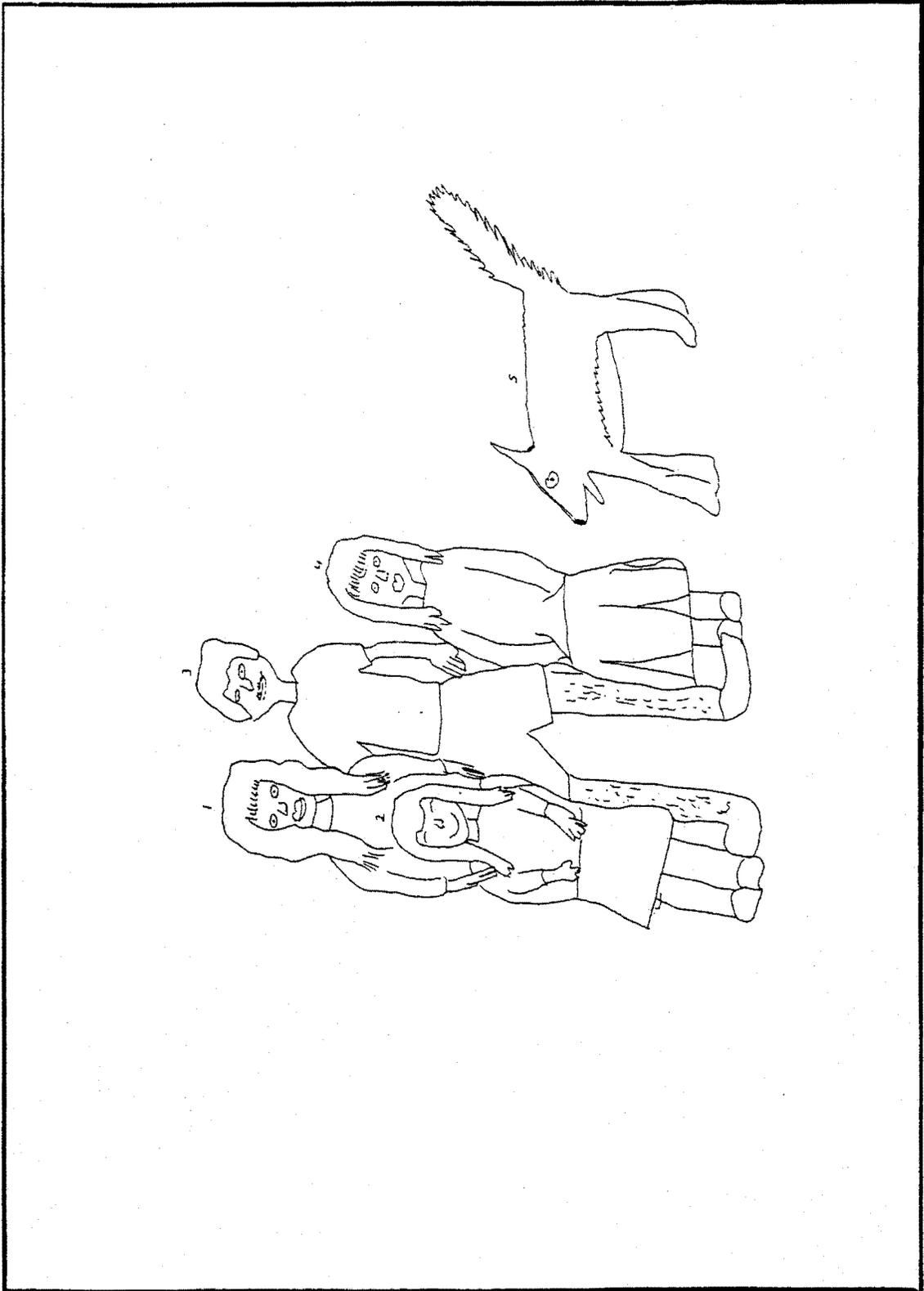
Indices of Anxiety

- * erasures

Other possible indications of anxiety:

- * excessive detail; hair on father's legs

FIGURE 7.7
B'S KINETIC FAMILY DRAWING



7.3.3.3.2 Incomplete Sentences Blank [ISB]

Sentences that are relevant to Kate's level of anxiety and difficulties within relationships have been analysed under the following headings:

- (a) Relationship with self
- (b) Relationship with parents
- (c) Relationship with siblings
- (d) Relationship with teachers, objects and ideas
- (e) Relationship with peers

(a) Relationship with self

- * I know its silly, but I'm afraid of ghosts.
- * My mother will never forget me at school [demonstrating a strong fear of being left at school].
- * Most of my friends don't know I'm afraid of scary movies.
- * When I get worried, I sometimes cry.
- * When I am older, I hope I'll be prettier than now.
- * When I think about my body - sometimes I don't like my birthmark on my thigh.
- * If I were the boss around here, I'd make everything nice and tidy.
- * When I can't do what I want to do, I just know that I can't do it.
- * When I was a baby I was naughty.

Interpretation

It is evident that Kate has certain anxieties and fears [some of which are not age appropriate], e.g. ghosts, being left at school and scary movies. She also demonstrates a low self-concept and body-image, e.g. not pretty enough, concern about a birthmark on her leg and certain possible obsessive-compulsive tendencies towards neatness and order. She also demonstrates feelings of helplessness, e.g. 'When I get worried, I sometimes cry and I just know I can't do it'. Kate appears to perceive herself as having been a 'naughty baby', possibly fearing that she could not then have been loved.

(b) Relationship with parents

- * I like my mother but she gets irritated a lot.
- * I sure wish my father would swim a lot with us but he's too tired or busy planting things in the garden.
- * I like my father but he almost never spends time with us.
- * When my parents tell me to do something, I just do it.

Interpretation

Kate appears to feel that her parents get irritated quickly and spend less time with her than she would like. She also appears to feel helpless and unable to challenge their authority in any way.

(c) Relationship with siblings

- * My family treats me like - not quite special when they scream at me. I feel they don't like or love me my sister lies about me.
- * My mother and I like going out without my sister, as she always

- * My mother and I like going out without my sister, as she always whines, cries, wants sweets and has tantrums.

Interpretation

Kate does not actually mention her sister in a positive way in any sentence. She perceives her sister as lying about her and causing upsets to get attention. Sibling rivalry appears evident.

(d) Relationship with teachers, objects and ideas

- * My teacher is more strict than kind.
- * In school, my teachers are extremely strict.
- * When I see my teacher coming, I just rush into line.
- * When I grow up I would like to study marine biology.

Interpretation

Kate appears to see her teachers as strict and restrictive. She appears to fear authority and authority figures and finds their demands difficult to meet. She does not volunteer much information about her ideas and feelings towards objects in her life. She does however have high ambitions for herself with regard to a future career.

(e) Relationship with peers

- * The other kids in school are much older and bossier than me.
- * I think most girls are nasty like strict teachers.

- * I would really be happy if children would stop teasing me. I'm too young for my class, but I like to be with older ones as they help me when I'm scared.

Interpretation

Kate appears to feel younger and possibly more inferior to her peers. She perceives them as 'bossy', 'nasty' and 'teasing', yet she feels she needs them to lean on when she feels scared.

(f) Synthesis of Incomplete Sentences Blank

Kate demonstrates anxieties and fears which are not appropriate to her stage of development. She appears to have a low self-concept, body-image and self-esteem. She appears to feel helpless and unable to assert herself. Her relationships tend to be frustrating for her. She appears to need more time with her parents and for them to be less irritated and restrictive with her. Her relationship with her sister appears to be troubled and sibling rivalry is evident. Kate perceives her peers as being older and possibly superior to her and to bossing her around. She perceives them as being nasty and as teasing her, yet she appears to be, to a large extent, dependent on them. She perceives her teachers as strict and less kind and authority appears to pose a problem for her in that she feels helpless in challenging it and has to accept it unconditionally. Although Kate appears to still be in contact with reality and has not yet escaped into fantasy, her fears, phobias and compulsive behaviour appear to be symptoms of her high level of anxiety.

7.3.3.3 Thematic Apperception Test [TAT]

The sources consulted for the interpretation of the TAT are the following: Bellack 1954; Du Toit and Piek 1987; Murray 1971.

Card 1: Challenge Card

'He looks as if he doesn't know what to do ... He is feeling worried because he doesn't know how to play it. In the future he will learn how to play it and he will enjoy it'.

Interpretation

Kate does not feel able to explore and challenge herself to meet the demands and expectations of her environment. She appears to feel overwhelmed and cannot deal with the unknown, 'not knowing'. An immediate response of worry is evoked. However, Kate demonstrates some inner strength or possibly some wishful thinking when she concludes that 'he will learn' to play it and to 'enjoy it'. Yet Kate chose this card as the one she likes the least.

Card 3 BM: Frustration Card

'She looks sleepy. She is feeling very tired and what is going to happen in the future, is that she is going to wake up in a fright'. [Fright?] 'The thing on the floor is going to tap her. Looks like a play-play gun'.

Interpretation

Kate appears unaware of any feelings of frustration. She chooses to allow 'the hero' to withdraw as 'sleepy'. She appears unable to deal with any negative feelings at all; neither frustration nor aggression. However, she then acknowledges the gun and says the person will wake in a 'fright', but she minimises the impact of the gun by calling it a toy gun. She is unable to find any solutions and her only reaction to the external stimuli is fear and fright.

Card 6 GF: Father-daughter card

'She looks surprised. She is feeling shocked because the man may have tapped her on the back and she thinks it's someone else. She is surprised because she didn't know he was going to be there. In the future she isn't going to feel so scared and shocked'.

Interpretation

Kate fails to recognise the close relationship between the two people in the picture. She perceives them as strangers and that this is an unexpected encounter. She acknowledges feelings of surprise, shock and fear. She appears to feel unprepared for any close interaction, yet she yearns for it and wishfully states that these feelings will change in the future. There are strong feelings of being unnurtured and neglected, expecting something else, never what she gets. The world appears to be a scary and threatening place for her, with little security and intimate warmth. This is the card she chose as the one she liked the most.

Card 7 GF: Mother-daughter Card

'The little girl looks sad. She's feeling hopeless and in the future she is going to learn all her reading like a speech she's got to learn'.

Interpretation

Again, Kate fails to recognise the relationship between the child and her mother. She ignores the adult in the picture and appears to identify strongly with the little girl. Feelings of sadness, hopelessness and inadequacy are evident. Kate appears to feel that the little girl needs to learn harder; that she must learn her reading off by heart. It is evident that Kate appears to set very high standards for herself, even reading must be learnt like a speech. It would appear that mistakes are not permitted and should be avoided at all cost. A sense of pressure to perform is very evident.

Card 11: Primitive Fears

'Can't really see what it is! [Pause ...] It looks like um ... elephants charging through the water, feeling nice and cool ... In the future the elephants are going to trip over the lizard that is walking down the walls. The elephant will fall and hurt itself and the lizard will be dead'.

Interpretation

At first, Kate reacts to her initial shock of the stimuli, but refuses to recognise any forms on the picture. However, Kate's primitive fears are symbolized in the elephants and the lizard. She appears to feel threatened by the 'elephants charging', yet they are 'nice and cool'. As a response to her fear of being hurt or attacked, she makes one elephant 'trip' over a lizard [possibly her] and although the elephant will fall and hurt itself, she, the lizard, will be overcome and killed by this greater force.

Card 14: Silhouette

'It looks like a man walking into a dark room. He is feeling scared that something might be down in the room. In the future he will find a light and turn it on and see that it is a beautiful place'.

Interpretation

It is obvious that this card evokes anxieties for Kate. She appears to feel scared and imagines that there could be 'something in the room'. However, she feels the need to challenge herself on this and finds the solution of turning on a light to discover a 'beautiful place'. It is evident that Kate feels a deep, basic fear, but has to rationalise this 'irrational fear' by turning on the light and convincing herself that everything is all right after all.

Themes that emerge from the TAT

- * Feelings of surprise: worry, tiredness, fear, shock, sadness and hopelessness are evident [Cards 1, 3BM, 6GF, 7GF & 14]
- * Accidents and trauma: lizard dying and elephant being hurt [Card 11]
- * Inability to identify the relationships between the people on the cards and emotional guardedness [Cards 6GF, & 7GF & 11]
- * Ability to identify strongly with the victim: identification with the passive, helpless character in the story [Cards 1, 3BM, 6GF, 7GF & 14]
- * Lack of resolutions: inability to find rational solutions; many instances of wishful thinking and glib, unrealistic endings to stories [Cards 1, 3BM, 6GF, 7GF & 14]

It is evident that Kate has two strong forces which are often in conflict with each other. It would appear that her unconscious mind responds to the primitive fears and impulses and yet her conscious mind, tries to rationalise her fears away but is unable to console her deeper insecurities.

7.3.4 Personal Image

7.3.4.1 Relationships with self and significant others

As in Case A [cf. 7.2.4.1], this information has also been gathered from the phenomenal and relational images and integrated so as to comprehend how Kate's relationships have influenced her level of anxiety and vice versa. It also serves to view Kate within her life-world and to understand what 'meaning' her anxieties may have for her.

7.3.4.1.1 Relationship with self

(a) Sexual/emotional self

* Oral stage

It is evident from Kate's history that she had certain emotional difficulties early on in life. Her mother reported that she became 'colicky' at eight weeks of age and was therefore taken off the breast. The colic may have been caused by the anxiety of her father having to leave his wife and new baby, to go into the army, when she was six weeks of age. Consequently, she was weaned from the breast at a very early age and at a very stressful time for the family. It is therefore very likely that she did not master the developmental crisis of Freud's Oral Stage [weaning] successfully. It would also seem that her fixation was at the oral-passive stage, as opposed to the oral-aggressive stage, and that she did not obtain enough gratification from sucking [at her mother's breast and from a bottle when she was weaned at the age of one].

This would therefore, to some extent, explain her 'fussy' eating habits and that she insisted on eating only deboned meat and refused to eat the skin on the meat. It would appear to be a reluctance to have to bite or chew.

* Anal stage

Kate was toilet trained at a relatively young age [under the age of two], but this did not seem to be a particularly difficult time for her. It is very possible that her grandmother, who trained her, was patient and understanding. She has remained close to her maternal grandmother ever since.

* Phallic stage

This stage did not appear to be a difficult one for Kate. She did not demonstrate any excessive anger or resentment towards her mother at this

time. In fact she appeared to identify strongly with her mother and accepted her feminine role.

* **Latency stage**

Kate appears to have developed her severe separation anxiety during this stage. Although, from all accounts, her sexual and aggressive impulses are more subdued, it is evident that there is repressed aggression and hostility, demonstrated by the psychometric evaluation. However, according to Freudian theory [cf. 3.5.2.1], it is most likely that Kate is fixated at an earlier stage of development, probably the oral stage and that her anxiety is central to her symptom formation.

* **Dependency and separation anxiety**

Wicks-Nelson and Israel [1984:149] report that the basic notion behind separation anxiety in the primary school child is the existence of a mutual and excessive dependency between mother and child. In Kate's case, a strong attachment towards her mother and possessiveness about her mother has led to a fear that something terrible will happen to her mother. However, the assessment did not reveal an excessive dependency of her mother towards her. It is possible that this could be covert in nature and not observable to an outsider. It is also possible, in keeping with the Psychoanalytic view [cf. 3.5.2.3], that Kate's mother had/has a poorly resolved dependent relationship with her own mother. Evidence that supports this assumption is the fact that Kate's maternal grandmother was brought in to care for Kate in her mother's absence and she also moved up to Johannesburg when Kate's father was transferred from Durban, even though she was not living with them at the time.

* **Fear, hostility and anxiety**

There is evidence to suggest that Kate suppresses all her negative emotions and is not able to deal with aggression and hostility. It is therefore very possible that Kate has unconscious, aggressive wishes towards her parents,

especially towards her mother, e.g. being hurt in an accident, which she is not able to express for fear of abandonment. [Her KFD reflected a feeling or need to be 'away' from her mother and she drew herself on the other side of her father, far away from the maternal figure.] It would appear that Kate has resorted to regressing to an earlier dependency stage and projects her anger indirectly, e.g. through her fear of the outside world generally, and her school environment, in particular.

There is also evidence that her experience of being 'drown-proofed' by a swimming teacher at the age of nine months, was extremely traumatic for her and because of it, she developed a fear of water. She would have experienced extreme feelings of fear, anxiety and possibly abandonment, which may still significantly contribute to her high level of anxiety at present.

Another aspect to be considered is the early separation from her mother, at the age of fourteen months, when her mother returned to work. Although this did not outwardly appear to be a stressful time for her, as her grandmother cared for her, if all the other factors are considered, she may have felt additional feelings of abandonment and rejection.

She appeared to struggle with the trauma of being hospitalised at the age of three, even though her mother remained with her throughout her period in hospital. She also responded to the birth of her sibling, which happened shortly afterwards, by becoming 'clingy' and tearful.

Presently, Kate is expressing many fears, e.g.

- ghosts;
- the dark;
- being abandoned;

- something bad happening to her mother;
- being left alone or forgotten at school;
- closed spaces;
- crowds;
- live insects and snakes;
- school;
- speaking in front of her class;
- taking tests and examinations; and
- scary movies.

She complains of many somatic complaints [cf. 7.2.3.2.1] and of having had \pm 3 panic attacks and suffering from enuresis [cf. 7.2.3.2.1]. She further states that her sleeping and eating patterns are affected by her anxiety. She also appears to demonstrate definite signs of perfectionistic tendencies and obsessive-compulsive behaviour. She sets very high and often unrealistic standards for herself and when she can't meet them, she becomes distressed and unhappy. Her projective drawings and stories reveal a very insecure child who is fearful of making mistakes and being ostracized. She is struggling with a conflict of dependence vs independence and appears to regress in times of stress. She has a low self-concept and body-image, as well as poor self-esteem [cf. 7.2.3.3.2]. Kate experiences many feelings of inadequacy, fear of the unknown, shock, surprise, sadness, abandonment and alienation from her fellow human beings. She appears to perceive the world as a scary and threatening place for her, with little emotional warmth and inner security.

(b) Social self*** Psychosocial stages of development****- Stage I: Basic trust vs mistrust**

According to Erikson [1977:222], the first signs of social trust in the infant is 'the ease with which he feeds, the depth at which he sleeps and the relaxation of his bowels'. It has been reported by Kate's mother that she did not feed well, that she developed 'colic' from being breastfed and that she did not sleep well, but 'cried incessantly' when she was about four months of age.

It would appear that the consistency and sameness [cf. 3.2.2.1.1] upon which trust in the infant is built, was lacking for Kate. Her father 'left' the family due to an Army call-up and her mother experienced this time as traumatic for her. It is very evident from the history that Kate's mother felt 'abandoned' by her husband, at a time when she was vulnerable and unable to cope emotionally.

The 'drown-proofing' incident would have negatively affected Kate's sense of the world being a safe and caring place and that people are trustworthy and dependable. It is therefore most likely that Kate developed an attitude of mistrust, fear and suspicion of the world, in general, and people in particular, which would significantly contribute to her separation anxiety in particular and her feelings of being abandoned and rejected.

Premature weaning from the breast may also have contributed to Kate's sense of mistrust of the world, which prevents her from being able to be fully trusting.

- **Stage II: Autonomy vs shame and doubt**

Kate's toilet training was concluded with very little difficulty, according to her mother. There is no evidence of feelings of loss of control. In fact, over-control appears to be a difficulty for Kate [Erikson 1977:228]. Therefore, she appears to have mastered the crisis of 'will'. She appears to have succeeded in believing 'I am what I can will freely [cf. Table 3.1]. She is not focused on her negative qualities. In fact, her story on Card I, the Challenge Card of the TAT, very clearly demonstrates that Kate does not feel she is not able to meet the challenges of life because she is 'useless' or 'hopeless', but rather that she feels unprepared, unsupported by those around her, because she 'does not know what to do ...'.

- **Stage III: Initiative vs guilt**

There is no evidence of difficulty for Kate during this stage of her psychosocial development. She appears to have developed a sense of initiative and is able to do extremely well academically at school. No feelings of guilt were highlighted by the projective tests either.

- **Stage IV: Industry vs inferiority**

Kate appears to have mastered the intellectual aspect of this stage to a certain extent and is academically 'industrious' at school. She sets extremely high standards for herself and although her parents report that they and her teacher are extremely proud of her, she remains unhappy with what she produces. In addition, at a social level, some strong feelings of inferiority were highlighted by the TAT [Card 7GF] and the ISB [cf. 7.3.3.3.2; birth mark, not pretty enough, can't do what she wants to do, has to do certain things, being teased, other kids being nasty and bossy].

* **Social needs**

According to Sullivan's social needs stages [cf. 3.2.2.2], he views anxiety as a result of disturbances of close interpersonal relationships. This appears to be valid in the case of Kate. She appears to have had difficulty at the very first stage of tenderness. It would appear that this need was not met for the reasons mentioned under Erikson's Stage I, basic trust vs mistrust. It is probable that she did not receive 'protective care, delicately adjusted to the immediate situation' [cf. 3.2.2.2.1] in her infancy. She did however, appear to have the second stage, 'companionship', met by her parents and grandmother during childhood. However, during the juvenile stage, she appeared to become more aware of the differences between herself and her peers and she has not felt accepted by them. Evidence for this comes from the history that Kate has never made friends easily, according to her mother and that she wants just one friend, but cannot find the 'right' one.

Although Kate just falls into the pre-adolescent stage [9 - 12 yrs], it is evident that she has not developed a sense of intimacy and this is borne out by the responses to the TAT cards [cf. 7.3.3.3.3], which did not recognise relationships between people or even any degree of intimacy between them. According to Sullivan [cf. 3.2.2.2], the need for acceptance usually promotes the formation of close peer relationships, but Kate's focus appears to be on regressing to an earlier stage and not on moving forward in an emotionally mature manner. Therefore, the 'chumship' [cf. 3.2.2.2.4] that Sullivan maintains is so important at this stage, is not a part of Kate's life-world and this leaves her feeling sad and alone. ['I'm too young for my class, but I like to be with the older ones, as they help me when I'm scared' (cf. 7.3.3.3.2)].

(c) **Cognitive self**

As Kate's Intelligence Quota was not assessed [she was referred for an emotional assessment only (cf. 7.3.2.2)], it is not possible to analyse this

aspect in detail. However, it is evident from her school reports and the comments her parents and teacher make about her, that she has developed this aspect of herself optimally. She appears to have successfully reached Piaget's Concrete Operational Stage and demonstrates logical thinking, the concept of reversibility, part-whole relationships and conservation. Kate can think abstractly and can see other people's points of view.

However, there is evidence that Kate's high levels of anxiety are beginning to affect aspects of her schoolwork. She complained of poor memory, concentration problems and of frequently daydreaming in class. She also complained of a fear of taking tests and examinations and of speaking in front of the class. It was also noticeable, during the assessment, that Kate had difficulty at times in organising her thought processes adequately.

(d) Moral self

Kate's moral self appears to be well-developed. Both Piaget and Kohlberg believe that the moral development depends on the advances in the cognitive development of the child [cf. 3.2.4]. As Kate's cognitive development is at an advanced level, compared to her chronological age, it stands to reason that her moral development has been able to develop optimally. Kate does not challenge authority in any way and, in fact, her 'overdeveloped' conscience does not always allow her to be open and spontaneous. She obtained a 70%-ile on the Lie scale of the RCMAS, which indicates that she has an unrealistic and unhealthy need for approval. She also demonstrated a need to be defensive as well as a need to present herself in a socially acceptable light. This would also therefore affect her ability to socialise spontaneously and freely and it indicates a great need to be 'moral' and good, so as to be accepted by others.

7.3.4.1.2 Relationship with parents

Kate appears to have ambivalent feelings towards her parents. She perceives the family to be very closely knit, possibly almost enmeshed and appears to hanker after even closer emotional ties with her parents, especially her mother. Yet she perceives them as being fairly negative towards her, i.e. 'irritable, over-controlling and too tired to play'. She drew herself far away from her mother, despite her separation anxiety, possibly indicating a need for more space or angry feelings towards her mother. She was unable to identify with close intimate relationships on the TAT cards, indicating her own difficulty in initiating and maintaining close relationships.

7.3.4.1.3 Relationship with siblings

Kate appears to have difficulty dealing with her younger sister. She perceives her to be closer to her mother, as demonstrated by her KFD drawing. She also appears to perceive her sister as more powerful/ important in the family unit and thus drew her second and herself last. She described her sister as 'pulling a horrible face, making a noise and bugging everyone', indicating her irritation and frustration with regard to her sister. She only mentions her sister indirectly in the ISB and says that she, her sister, tells lies about her, causes family upsets and demands a lot of attention.

From the parent interview, it became evident that although Kate's mother was aware that Kate became clingy and tearful around the time of the birth of her sister, she was not concerned about it and appeared not to take much notice of Kate's behaviour, as she was very busy with the new baby. Her sister's birth also coincided with her spell in hospital, for an operation on her eye, which was an extremely traumatic time for her, according to her mother.

7.3.4.1.4 Relationship with teachers, objects and ideas

Kate's mother reported that Kate has always got along well with her teachers and that they have found her to be a 'good and obedient child, who works hard'. Yet, Kate's perception of her teachers is that they are more strict than kind, that she needs to be fearful of them and 'rush into line', if they are around. She does not appear to see them as adults that she can confide in or rely on. Authority appears to pose a problem for Kate, in that she feels unable to challenge it in any way and has to accept it unconditionally.

Kate made little mention of her feelings towards objects in her life and her ideas. However, it was evident that she sets very high standards for herself and would like, one day, to become a marine biologist. She also appears to be struggling with object relations in her life and this necessitates her needing fluffy toys with her and around her to comfort her, no matter where she is. She also tends to use food and drink in this way.

7.3.4.1.5 Relationship with peers

Kate appears to be having a very difficult time socially and is not able to initiate and maintain social relationships easily. She perceives the other children as being 'older and bossier' than her and yet she acknowledges her dependency on them to keep her 'safe'. She perceives her peers as teasing her and picking on her and is very aware of the 'nasty' side of the girls in her class. She volunteers that she wants 'one' best friend, but can't find the 'right' one. It is, therefore, very evident that her high level of anxiety is indeed affecting her ability to make friends and find a 'chumship', as Sullivan describes [cf. 7.3.4.1.1].

7.3.5 Irrational Image

It is evident that Kate is not able to attribute rational meaning all of the time and that she displays pathological behaviour at times. She knows that her mother will not physically abandon her at school and that she will be safe, but she cannot get rid of the irrational fear that something bad will happen to her. Other forms of her pathological behaviour are evident in some severe symptom formation, such as somatic complaints, like blurred vision, hot flushes, weak feelings in her legs, prickling sensations, headaches, stomachaches and chest pains and she experiences mood swings, even though she is so young. She could also describe three incidents which, without exaggeration, can be viewed as panic attacks. She suffers from enuresis as well. Her sleep and eating patterns are disturbed by her high levels of anxiety.

Kate can be diagnosed as suffering from a separation anxiety disorder. Her age of onset appears to have been around the age of six to seven years. The six diagnostic criteria [only three are required for diagnosis], in which Kate's excessive anxiety is manifested, are the following:

- * Unrealistic worry about possible harm befalling major attachment figures or fear that they will leave and not return. In Kate's case, she worries most about harm befalling her mother, e.g. car accident, as well as her mother not returning to fetch her when she is separated from her.

- * Unrealistic worry that an untoward calamity will separate the child from a major attachment figure. Kate's stories on the TAT, as well as her ISB, indicate strongly that Kate feels helpless and vulnerable. Although she did not voice a fear of being kidnapped, killed or being a victim of an accident, it is very evident that these fears are certainly present at an unconscious level.

- * Persistent reluctance or refusal to go to sleep without being next to a major attachment figure or to go to sleep away from home. To a large extent, Kate has great difficulty getting ready for bed. Although she does not demand that her mother stay with her until she falls asleep [it is most likely that her mother would refuse to do this as she is very strict with Kate in this regard], Kate is not able to settle down and continually gets up to go to the toilet and to drink water. Kate does not sleep away from home.

- * Repeated nightmares involving a theme of separation as in disaster, death, kidnapping, etc.. Kate does suffer from repeated nightmares involving monsters and ghosts, but did not elaborate on the contents of these dreams. However, judging from her responses on the TAT, these themes are very evident.

- * Complaints of physical symptoms on school days, e.g. headaches stomachaches, etc.. Kate does suffer from such symptoms and her cardiovascular, respiratory and genito-urinary systems all appear to be negatively affected by her anxiety.

- * Social withdrawal, apathy, sadness and difficulty concentrating on work or play when not with a major attachment figure. Kate appears to be struggling to make friends and to feel that she 'fits in' socially. She does mention difficulties in concentrating on her work and daydreaming very often in class, but at present this does not seem to be affecting her quality of work dramatically. Sad feelings are very evident from the projective tests of the assessment.

Her parents were the chief source of referral because they were concerned about her 'neurotic behaviour'. She has never refused to go to school but she complained that she did not like to get up on school mornings. No lengthy periods of absenteeism were reported. She manages well with the academic

requirements of school, but the problems she encounters at school are socially related, e.g. a loss of contact with peers and/or an inability to become emotionally intimate with classmates or even to find a 'best' friend.

7.3.6 Synthesis

* **Functional image**

Kate presented as a highly anxious child and she is fully aware of her high level of overt [observable] anxiety, as well as separation anxiety. She is also aware of the symptom formation that the anxiety is manifesting.

* **Phenomenal image**

A history was obtained from Kate's mother and proved most informative and useful in making meaning of the development of anxiety during Kate's developmental stages, as well as how the anxiety affected her life and growth at the various stages. No intellectual assessment was done, but there is little doubt that Kate qualifies as a subject for this investigation, as she presents as bright, alert and coping admirably, despite being of a young age for her class.

A battery of psychometric and projective tests was conducted on Kate and her behaviour during testing was carefully observed. Many indications of anxiety were observed.

* **Relational image**

The test material was then analysed and her various relationships with:

- self;

- parents;
- siblings;
- teachers, objects and ideas; and
- peers

were examined, noting especially to what extent her anxiety affected these relationships or the extent to which these relationships caused herself anxiety. It appears that Kate has ambivalent feelings about her relationships with her parents, a very poor and troubled relationship with her sibling and was fearful and mistrusting of her teachers. She appears to have no meaningful social relationships with her peers at all and this seems to contribute to her feelings of loneliness and isolation. It appears that she was unable to form meaningful relationships because of certain unresolved conflicts and crises in her past.

* **Personal image**

The various stages of Kate's development were carefully considered and assumptions made as to possible reasons for the anxiety that manifested itself during her development.

Major contributing factors appear to have been:

- her father's sudden departure from home when she was six weeks old;
- premature weaning from the breast due to 'colic' at eight weeks of age;
- drown-proofing at nine months of age;

- possible interdependency between her mother and grandmother;
- her mother's return to work when Kate was fourteen months old;
- hospitalisation for an eye operation at the age of three years;
- the simultaneous event of the sister's birth, shortly after being discharged from hospital; and
- many changes, both of home and school in her primary school years.

Kate appears to have fixated at or regressed to earlier stages of her development, i.e.:

- oral stage: oral-passive phase;
- basic trust vs mistrust: mistrust; and
- social needs stage: need for tenderness.

Cognitively and morally, Kate appears to be developing well, although certain signs of rigidity and compulsivity are evident and interference in the cognitive functioning is beginning to become evident.

Emotionally and socially Kate is at risk. She has a low self-concept and body-image and demonstrates many feelings of inadequacy, fear, anxiety, helplessness, insecurity, loneliness and sadness. Her anxiety is affecting her eating and sleeping patterns, as well as her general functioning, very severely. Many examples of symptom formation are evident.

* **Irrational image**

Kate can be diagnosed as suffering from a separation anxiety disorder, according to the DSM III classification. She demonstrated six diagnostic criteria where only three are necessary. Of concern, is the length of time that these symptoms have been in duration [\pm 5 years]. Although her parents were advised in the past by her teachers to have her assessed, they waited until recently to assist her.

The following diagrams Figures 7.8 and 7.9, highlight the main areas of concern with regard to Kate's anxiety and its effect on her various relationships, as well as the various types of anxiety that are affecting her. Wherever possible, scores from the various psychometric tests have been included.

FIGURE 7.8

CASE B's TYPES OF ANXIETY

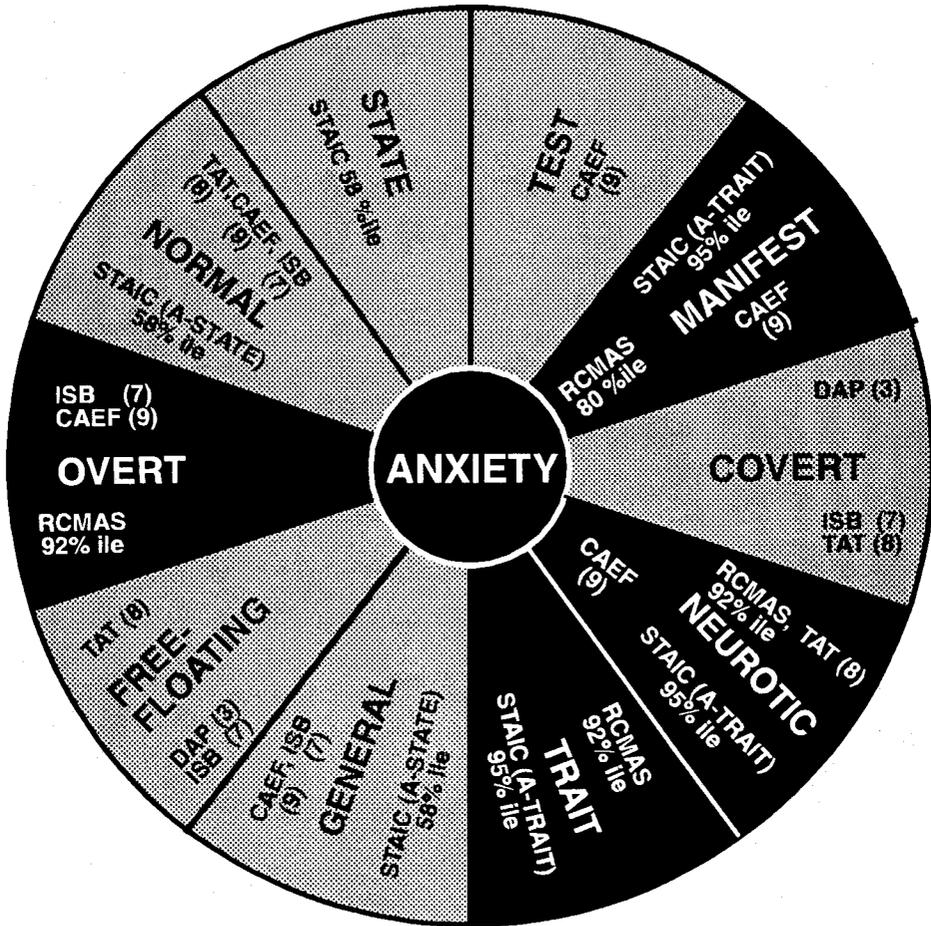


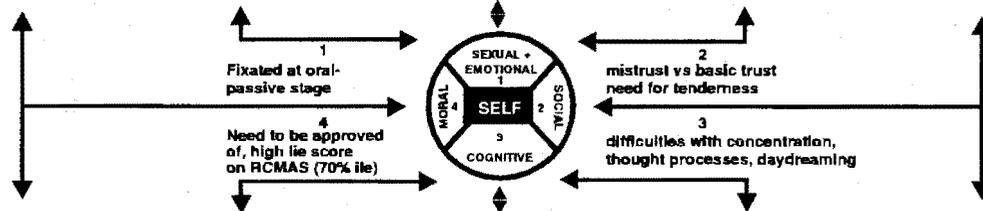
FIGURE 7.9
DIAGNOSTIC MODEL OF CASE B's ANXIETY

Level 5
 Irrational Image

The Level of the Irrational:
 (Development of Anxiety Disorders, etc).
 Disorders: Separation Anxiety & Symptom Formation

Level 4
 Personal Image

Meaning Attributed To:				
Self Low self-concept, body image, self-esteem, feelings of inadequacy, loneliness, sadness	Parents Ambivalent feelings, perceives herself as wanting more love	Siblings Rivalry and extreme dislike of sister	Teachers Objects & Ideas Poor interaction with teachers, too good child	Peers No intimate or social contact at all



Level 3
 Relational Image

Relations with Self	Relations with Parents	Relations with Siblings	Relations with Teachers Objects & Ideas	Relations with Peers
Sets unrealistically high standards, unsure of self	Perceives them as strict, irritable and preoccupied	Sister tells lies about her and bugs her	Scared and mistrustful of authority figures, lacks confidence in her own academic ability	Perceives them as teasing and bullying her

Level 2
 Phenomenal Image

The Problem as Phenomenon: Anxiety
 Parent interview and psychometric assessment to obtain information

Level 1
 Functional Image

Functional Image:
 Highly Anxious Child
 Presented overt anxiety & psychosomatic symptoms

7.4 CASES C, D, E AND F

The following four cases have been analysed and then compared to one another in a summarised form. The drawings of each child have been included at the end of the summary, together with a key to explain the Kinetic Family Drawings.

7.4.1 Functional Image

7.4.1.1 Identifying particulars

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
NAME	Sandra	Rosemary	Kirsten	Kelsey
STANDARD	Three	Five	Grade i	Grade ii
DATE OF BIRTH	1983 05 27	1981 09 05	1987 10 17	1986 10 22
AGE AT TESTING	10 yrs 9 mths	12 yrs 9 mths	6 yrs 8 mths	7 yrs 9 mths
POSITION IN FAMILY	Second	Second	First	First
SIBLINGS	Sister	Brother, Sister	Sister	Brother
NO. OF SCHOOLS ATTENDED	One	One	One	One
NO. OF STANDARD REPEATS	None	None	None	None
SOCIO-ECONOMIC STATUS OF FAMILY	Above Average	Above Average	Above Average	Above Average

7.4.1.2 Reason for referral

<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
Parents concerned re underachievement at school, weepy, demotivated child, unable to interact socially.	Doctor and parents concerned re history of stomachaches, headaches, nausea, nervous disposition, muscular spasms. Perfectionist by nature.	Mother concerned re dislikes school - tantrums every day, cannot make friends - adjustment difficulties.	Doctor concerned re symptoms of restlessness and inattention. Parents feel her emotions fluctuate and negatively affect her family. Underachieving - lack of concentration.

7.4.1.3 Tentative hypotheses

<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
High levels of anxiety and possible depression.	High levels of stress and anxiety. Need to achieve.	Separation anxiety, high levels of anxiety,	Emotional instability, acting-out behaviour, oppositional.

7.4.2 **Phenomenal Image**

7.4.2.1 **Parent Interview**

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.2.1.1 Family background	<ul style="list-style-type: none"> - Family highly artistic. - Father authoritarian and demanding. - Mother frustrated at having to give up her career to bring up two daughters. - Mother 'neurotic' and overprotective. 	<ul style="list-style-type: none"> - Family very artistic [father a good musician]. - Mother suffers from depression. - Brother has learning problems. - Father has a motor neurological disorder which causes a lot of stress. 	<ul style="list-style-type: none"> - History of asthma in both parents' families. - Hearing problems on father's side. - Sibling jealousy. - Father struggled academically. 	<ul style="list-style-type: none"> - Father's parents experienced marital problems with physical and emotional violence and alcohol-related problems. - Father tends to become loud and argumentative after alcohol. - Mother lacks warmth and understanding. - Impatient with Kelsey.
7.4.2.1.2 History of pregnancy and birth	Pregnancy unplanned. Natural birth by epidural. No difficulties reported. Father present.	Pregnancy planned. Natural birth - No difficulties reported. Father present.	Planned. Medication for nausea during pregnancy. One of a twin, lost other baby at 9 weeks. Premature birth, forceps delivery. Father present. Foetal distress.	No difficulties reported.
7.4.2.1.3 Child's early development	Mother found first year extremely difficult. Felt she could not cope. Unable to establish a routine.	Mother reports wonderful first year. Afraid would be like first baby [depression].	Screamed all of the time. Mother back to work when child 2 mths old. Mother anxious all the time. Unhappy baby. Father not involved.	Mother reports that Kelsey was 'never a baby and never cried' and became 'adult' at a very young age.

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
Milestones				
Motor : walking	13 months	1 year	14 months	8½ months
Speech : first words sentences	15 months 24 months	On time Good vocabulary	6 months 22 months	Early.
Weaning : breast bottle	1 year 3 years	5 months, difficulty drinking milk from bottle.	6 months 3 years	Not breastfed; bottle at night until 2 yrs.
Toilet training	2 years; no difficulties reported.	Wet bed till 6 years - still enuretic, medication to develop bladder.	4 years; bladder problems. Urinate frequently.	No problems.
Discipline	Parents inconsistent but used to smack often, now no punishment [only threats and screaming].	Temper tantrums at 4 yrs. Shouts and becomes angry now. Father disciplines. No smacking. Mother used to smack and put her in bedroom.	Listens to father. Mother has to smack before she responds. Upsets mother. Sent to room. No TV.	Does not cry or respond to pain. Always questions authority. Strong-willed. Difficulties accepting parental discipline. Sent to room and chastised.
7.4.2.1.4 Medical history	Tonsillitis on regular basis; pneumonia at 5 yrs.	No health difficulties.	IGG deficiency. Kidney and bladder infections. Glandular fever, whooping cough, tonsillitis, German measles, ear infection. Developed asthma when sibling was born.	Nothing serious - 4 fillings by age of 5 yrs. Ritalin in Grade i due to restlessness.

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.2.1.5 School history	<p>Play group once a week at 2 yrs. Different play group three times a week at 3 yrs.</p> <p>Nursery school five times a week at 5 yrs.</p> <p>Formal school: Grade A [between Grade 0 - i at 6 yrs; declared schoolready but emotionally immature. Has remained at same private school for past 6 yrs.</p>	<p>Play group twice a week at 3 yrs to the age of 4 yrs.</p> <p>Nursery school five times a week at 5 yrs and 6 yrs.</p> <p>Formal School: Grade i at 7 yrs.</p> <p>Has remained at same school for past 7 years.</p>	<p>Play group at 2½ yrs until she was 3 yrs old.</p> <p>At 4 yrs Nursery school until end of Grade 0. Assessed: visual perceptual and fine-motor coordination problems noted. Therapy was received.</p> <p>Formal School: Entered Grade i at the age of 6 yrs.</p>	<p>Play group at age of 2 yrs for 2 yrs. Creche at 4 yrs.</p> <p>Nursery school for 2 yrs, turned 6 in Grade 0. Did not settle in well</p> <p>Formal School: Assessed and emotional instability and immaturity found. Play and occupational therapy recommended. Entered Grade i at local Government school and is presently in Grade ii. Underachievement has been reported as an ongoing problem.</p>

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.2.1.6 Anxiety-related aspects of development	Tends to eat for comfort, on plump side.	Always thin as a baby. Mother tried to feed her extra milk and food.	Certain foods avoided because of asthma. Has to be forced to eat.	None reported.
Eating and sleeping habits	Sleep disturbances, wakes up and goes to parents' room.	Not easily woken up. Stomachaches from 6 yrs old.	Difficulties falling asleep, except in mother's bed.	
Reaction to separation from parents	Separation anxiety demonstrated after sister's birth [\pm 3.5 yrs old]. Violently jealous at first. Unhappy at nursery school during 2nd year [\pm 6 yrs old].	None reported.	Never been separated from mother for any length of time. Separation anxiety [mother]. Always a problem since play school at 2½ yrs. Needs to be near mother at all times.	Separation anxiety at 5 years old. Worried that she would not be fetched from school.
Fears and worries observed by parents	Needs cuddly toys. Scared of aliens. Bolts her windows each night. Complains of nightmares. Mother holds hand to get her to fall asleep at night. Fears the dark.	Dislikes competition. Perfectionist, has very high standards. Worries excessively. Extreme nervousness [ballet performances and oral work].	Has to have lights on at night. Stranger anxiety at 6 mths old. Could not cope with work at school in first weeks of Grade i.	At 5 yrs old she could not 'live with mother or without her'. Clingy. Could not go into a room unless the door or windows were open. [had been accidentally locked in a room before].
Nervous habits of child	Needs much reassurance. Gives up easily.	Sucked 2 fingers as baby. Urinates frequently. Suffers from nausea and stomachaches.	Bites nails.	Argumentative and volatile.
Socialisation and relationships at nursery and primary school	Made friends easily at 5 yrs. Difficulties started at 6 yrs. Very sensitive. Best friend dropped her and she was devastated. Does not mix easily now.	No problems reported until this year. Bad fall-out with close friend.	Difficulties making friends since nursery school till present. Prefers younger children. Severe adjustment difficulties.	Insecurity appeared to begin at 5 yrs old. Reported to be independent and strong-willed before this time.

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.2.1.7 Intellectual functioning	Wechsler Intelligence Scale for Children - Rev. [WISC.R]	Wechsler Intelligence Scale for Children - Rev. [WISC.R]	Wechsler Intelligence Scale for Children - Rev. [WISC.R]	Wechsler Intelligence Scale for Children - Rev. [WISC.R]
Verbal :	122 - Superior range	97 - Average range	94 - Average range	91 - Average range
Performance :	124 - Superior range	104 - Average range	88 - Below Average range	123 - Superior range
Full Scale :	126 - Superior range	100 - Average range	90 - Average range	105 - Average range
7.4.2.1.8 Psychometric and Projective tests conducted	same as Case A	same as Case A	same as Case A except CAT for TAT	same as Case E

7.4.3 Relational Image

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.3.1 State-Trait Anxiety Inventory for Children [STAIC]				
State-anxiety scale				
Percentile Rank	94%ile	89%ile	63%ile	90%ile
Raw Score	42	38	31	39
Mean score for age group	31.2	30.6	30.3	30.3

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
Trait-anxiety scale				
Percentile Rank	93%ile	100%ile	62%ile	34%ile
Raw Score	49	57	40	36
Mean Score for age group	38.7	37.3	38.1	38.1
7.4.3.2 Revised Children's Manifest Anxiety Scale [RCMAS]				
Total Score %ile Rank	94%ile	99%ile	63%ile	44%ile
I Physiological	92%ile	97%ile	73%ile	57%ile
II Worry/oversensitivity	93%ile [suggestion of an anxiety disorder]	98%ile [suggestion of an anxiety disorder]	28%ile	28%ile
III Social concerns	84%ile	97%ile	92%ile	66%ile
L Lie scale	44%ile	15%ile	84%ile	94%ile

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.3.3 Interview				
7.4.3.3.1 CAEF				
Global Rating Score [max.12]	11	12	9	9
Level of Anxiety	Excessively high.	Excessively high.	Above average.	Above average.
Types of Anxiety	Social, test and generalised anxiety.	Generalised, social performance anxiety.	Separation anxiety, generalised and social anxiety.	Social, test and generalised anxiety.
Psychosomatic complaints	Phobias.	Cardiovascular respiratory, somatic gastro-intestinal and autonomic symptoms.	Fears and sleeping difficulties.	Many physical symptoms, fears, tension, depression, cardio-vascular symptoms and sleep difficulties.

7.4.3.4 Projective Media

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.3.4.1 Drawings				
(a) Draw-A-Person				
- excessive detailing	X	X	X	
- excessive erasing	X	X		
- inclusion of shadows, dark clouds and darkened sun				
- inclusion of monsters or grotesque figures			X	X
- size of the drawing [small]	X		X	X
- omission of body parts or legs pressed together	X	X		X
- cross hatching				
- weak foundations	X			X
- faint, hesitant lines	X	X		X
- others		jagged, sketchy lines	excessive pressure	
No of Indices	6	5	4	5
X = YES				

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
(b) Kinetic Family Drawing				
- erasures	X	X		
- barriers and folding paper into compartments		X		X
- omission of self or body parts	X	X	X	X
- shading of figures		X		
- drawing in of a base				
- lining at top				
- underlining certain figures				
- figures hanging precariously and the use of ladders		X		
- scribbling and use of the 'x'				
- others	feint, hesitant lines	encapsulation, use of symbols and actions	dependency [mother]	left out father
No of Indices	3	6	2	3

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.3.4.2 Incomplete Sentences Blank				
- does the child demonstrate any specific anxieties or fears?	X	X	X	X
- is there evidence of any free-floating or covert anxiety?	X	X	X	X
- is there evidence of anxiety in his relationship with: himself/herself? his/her mother? his/her father? his/her sibling[s] ? his/her peers? his/her teachers?	 X X X X X	 X X X X X	 X X X X X	 X X X X X
- is there evidence of obsessive-compulsive tendencies?				
- is there evidence of aggression?	X			
- uses fantasy excessively? to what extent does the child retreat from reality and escape into fantasy?	has excellent imagination and is in touch with reality.	non-imaginative and lacks creativity - not always in touch with reality.	seems to be in touch with reality, but uses fantasy to deal with fears.	in touch with reality.
No of Indices	8	7	8	8

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.3.4.3 Thematic Apperception Test/ Children's Apperception Test (a) TAT <u>Card 1</u> * Does the child feel unable to explore and challenge himself by the situation and meet external demands?	X	X		
* Is he uninvolved, withdrawn and distancing himself from the outside world?		X		
* Is he unable to deal with anxiety and authority figures?	X	X		
* Does he fear failure/achievement?	X	X		
* Are there any sexual fears and anxieties evident?				
* Are there any indications of obsessive - compulsive behaviour?		X		

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
<u>Card 3 BM</u>				
* Does the child feel frustrated?	X	X		
* Is he unable to deal with his frustration?	X	X		
* Does he feel aggressive? Onto whom does he project his aggression?	X	X		
Himself?	X	X		
Others?	father and sister	parents		
* Is he unable to find solutions?	X	X		
* Are there indications of sexual identification difficulties?				
<u>Cards 6GF and 7GF [for girls]</u>				
* Does she perceive her relationship between herself and her mother to be poor?	X			
* between herself and her father to be poor?	X	X		
* Does she feel overprotected? or	X	X		
* unnurtured?	X	X [father]		

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
<u>Card 11</u>				
* Does the child feel threatened?	X	X		
* Is there evidence of infantile or primitive fears?	X			
* Is the child afraid of being hurt or attacked?	X	X		
* Does the child feel aggressive in retaliation to a possible attack?	X			
<u>Card 14</u>				
* Does this card evoke feelings of anxiety in the child?		X		
* Does the child feel lonely and scared?		X		
* Are there signs of intra-aggression in the child?	X	X		
No of Indices	17	19		

<p>(b) CAT</p> <p><u>Card 1</u></p> <p>* Does the child show signs of oral fixation/regression?</p>				X
<p><u>Card 2</u></p> <p>* Does the child perceive there to be difficulties in relationship between parents?</p>			X	
<p>* is the child unable to identify closely with:</p> <ul style="list-style-type: none"> - the father? - the mother? <p>* is there evidence of the child feeling 'pulled' between the two?</p> <p>* Are there feelings of:</p>				
<ul style="list-style-type: none"> - aggression? 			X	
<ul style="list-style-type: none"> - anxiety? 				
<p>* Are there fears of punishment?</p> <p>* Does the rope break? Castration fear?</p>				

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
<u>Card 3</u>				
* Are there difficulties dealing with authority figures?			X	
* Are there feelings of: - overt aggression? - passive aggression?				
* Is there a conflict between autonomy and dependency?				
<u>Card 4</u>				
* Are there signs of sibling rivalry?				
* Are there difficulties between child and mother?				
* Are there signs of regression?			X	X
* Does the child flee from danger?				
* Are there anxieties related to his psycho-sexual development?				
<u>Card 5</u>				
* Is there sexual inquisitiveness?				
* Is there sexual confusion or anxiety?				
* Is the primal scene referred to either overtly or covertly?			X	X

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
<u>Card 6</u>				
* Is there sexual anxiety?				
<u>Card 7</u>				
* Is there a high level of anxiety?			X	X
* Is the child fearful of aggression from:				
- others?			X	X
- self?				
* Is the story reduced to an innocuous one?				
* Does the victim become the aggressor?				
* Are the animals' tails mentioned?				
<u>Card 8</u>				
* Is the interaction viewed as conflictual?			X	X
* Is the parental figure seen as aggressive?			X	
* Is the theme of orality mentioned?				

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
<u>Card 9</u>				
* Does the child show fear of:				
- darkness?				X
- isolation?			X	
- abandonment?			X	
- rejection?			X	
<u>Card 10</u>				
* Is the theme of punishment evident?			X	X
* Does the child reveal any sexual activity, e.g. masturbation?				
* Is the theme of toilet training mentioned?				
* Are there any signs of regression?				X
* No of Indices	n/a	n/a	13	9
<u>Themes that are evident</u>				
* Primary feelings?	jealousy, aggression, neglect	hostility, unhappiness, guilt, unworthiness, lack of support, helplessness, insecurity	loneliness, rejection, fear, abandonment.	being overly reprimanded, punished, threatened, socially unacceptable and insecure.
* Defences?	X	X	X	
* Passivity?	X	X	X	X
* Aggression?	X	X	X	
* Orality?				

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
* Strong content and intensive conflict?	X	X	X	X
* Compulsivity in the fantasy and activity levels?				
* Inability to identify strongly with the figures?				
* Lack of resolutions?	X	X	X	X
* Emotional guardedness and defensiveness?				
* Themes of physical accidents or psychic trauma?	X	X	X	X
No of themes	6	7	6	5

7.4.4 Personal Image

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.4.1 Sexual and Emotional image	Adjustment difficulties evident; feelings of inadequacy noted. Unable to meet parental [and teacher] expectations.	Lacks self-confidence; feelings of inferiority, insecurity and inadequacy, excessive worrying, withdrawal/ depression.	Adjustment difficulties at school. Feeling rejected. Needs special time. Dissatisfaction, inadequacy.	Adjustment difficulties and feelings of insecurity and inadequacy. Worries that her parents and teacher are displeased and angry with her. Nightmares. Focus on death.
7.4.4.2 Social image	Difficulties with interpersonal relationships, e.g. family members, especially parents, as well as teachers and peers.	Feels victimised. Interpersonal difficulties with brother. Cannot share intimacies with mother. Withdrawn socially.	Needs to cope with fears and to deny and suppress interpersonal difficulties with family and peers. Feels neglected by father. Attention-seeking.	Feels threatened by peers. Arguments, anger towards brother, communication difficulty with mother.

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.4.3 Cognitive image	Underachieving. Concentration and attention affected, as well as poor memory.	Feels pressurised. Work too difficult and too much. Afraid of failing.	Cannot cope with scholastic demands, avoidance, homework very difficult, regression in speech and vocabulary, drawing and cutting problems.	Difficulties with Arithmetic. Denial of other difficulties, tries to escape through play.
7.4.4.4 Moral image	Unable to accept authority figures. Needs to rebel or become passive-aggressive.	Feels blamed by family for everything; passive-aggressive.	Cannot accept maternal authority. Oppositional towards father. Underlying hostility.	Seems more passive towards authority figures than was reported. Underlying anxiety and fear more overt, in this regard.

7.4.5 Irrational Image

	<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
7.4.5.1 Anxiety Disorder(s)	Overanxious disorder.	Overanxious disorder and separation anxiety disorder.	Overanxious disorder and separation anxiety disorder.	Overanxious disorder, two of three criteria necessary for separation anxiety disorder.
7.4.5.2 Irrational thought processes	Certain fears and phobias: darkness, being left with strangers, social anxieties.	Fears, worries, unpleasant thoughts. Phobias: being harmed or family hurt, victimised, academically inadequate.	Fear of going to bathroom at night, fantasy figures, denial of many anxieties, separation anxiety, need to escape.	Fears and phobias; shadows at night, only feels safe when parents go to bed, nightmares.
7.4.5.3 Psychosomatic symptoms	Headaches and certain stomach complaints.	Nausea, headaches, stomach-aches, muscle spasms, enuresis.	Many health problems, asthmatic.	Repeated stomachaches, cold and flu symptoms.

FIGURE 7.10
C'S DRAW-A-PERSON

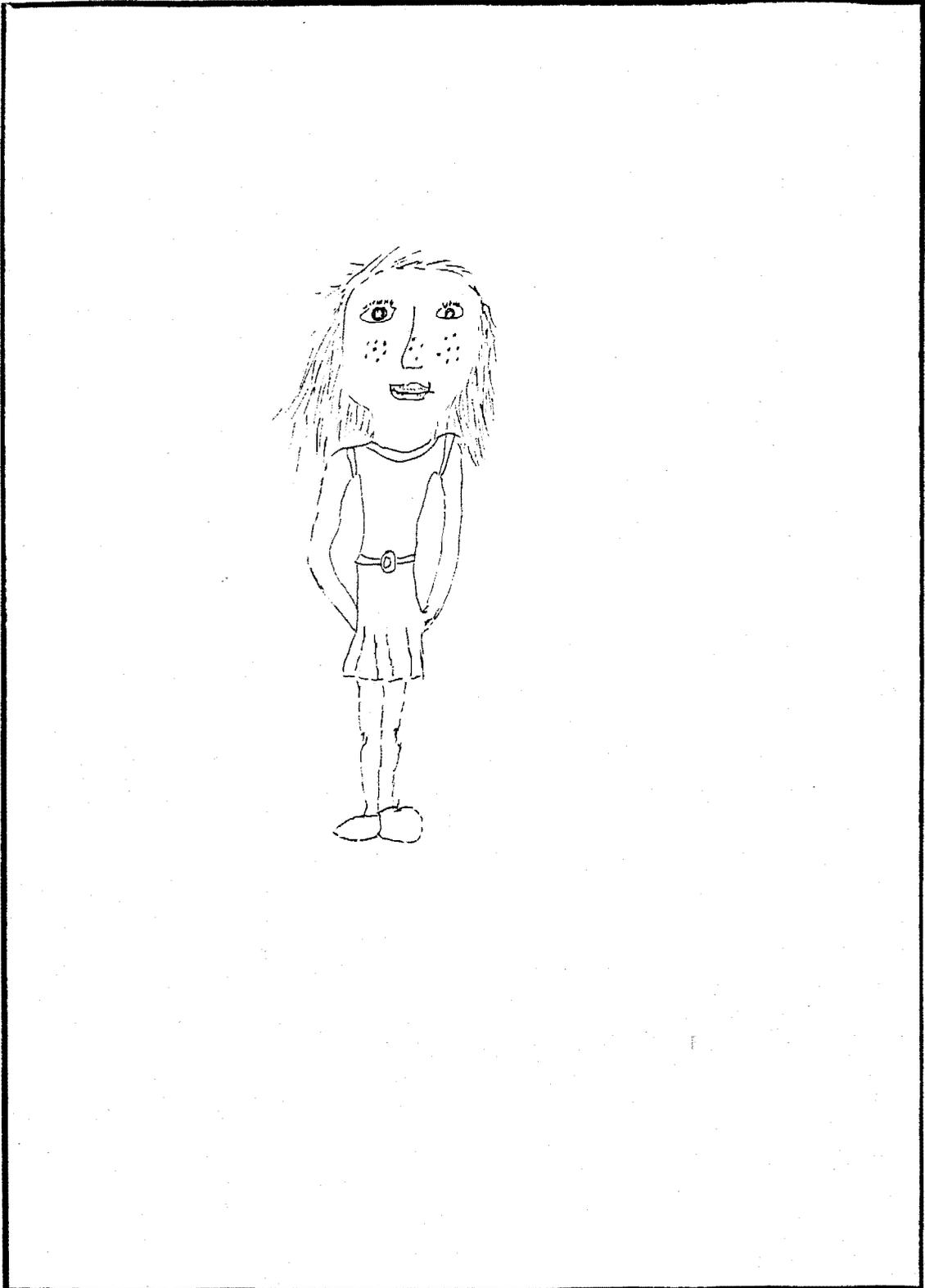


FIGURE 7.11
D'S DRAW-A-PERSON

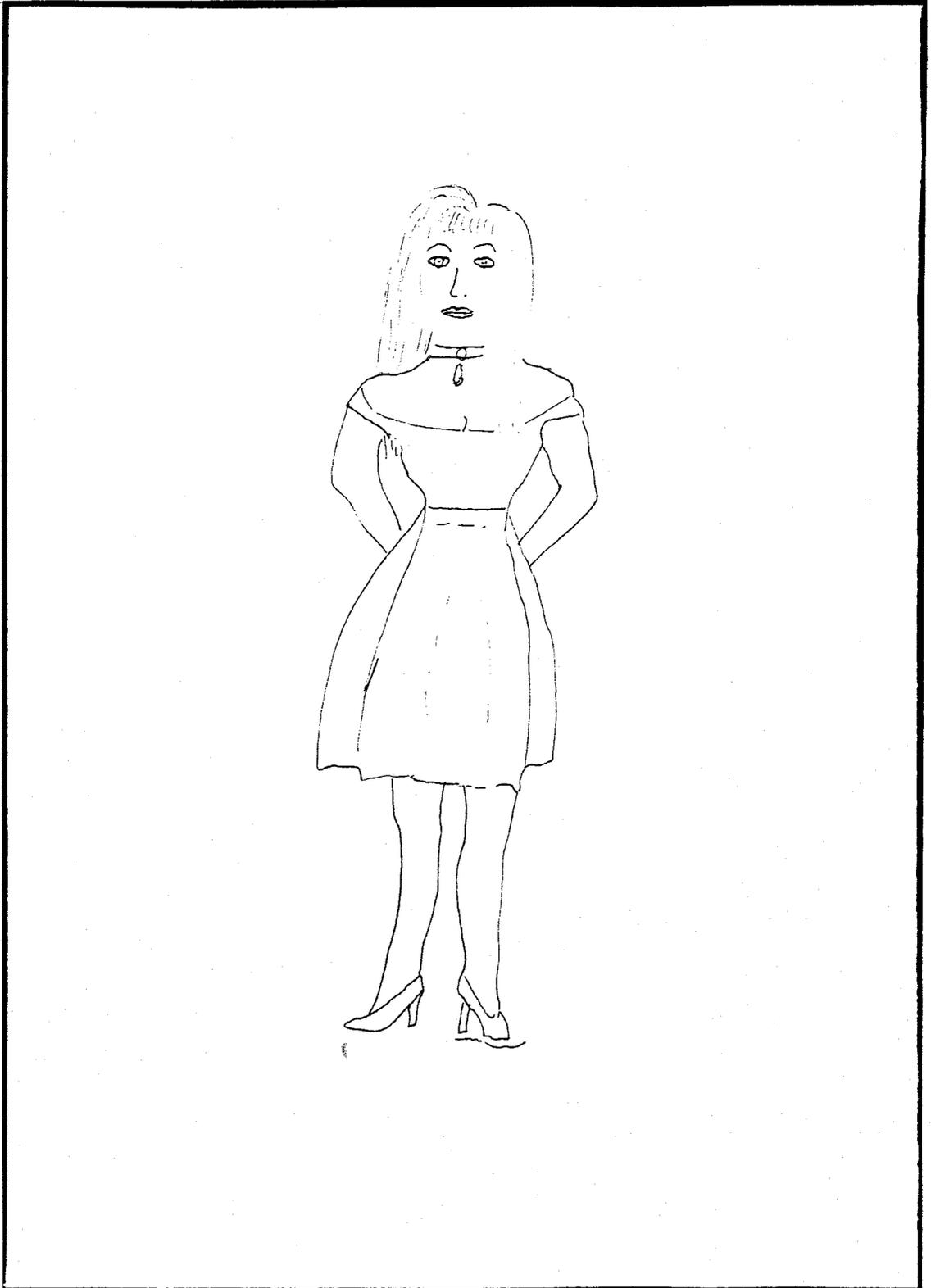


FIGURE 7.12
E'S DRAW-A-PERSON

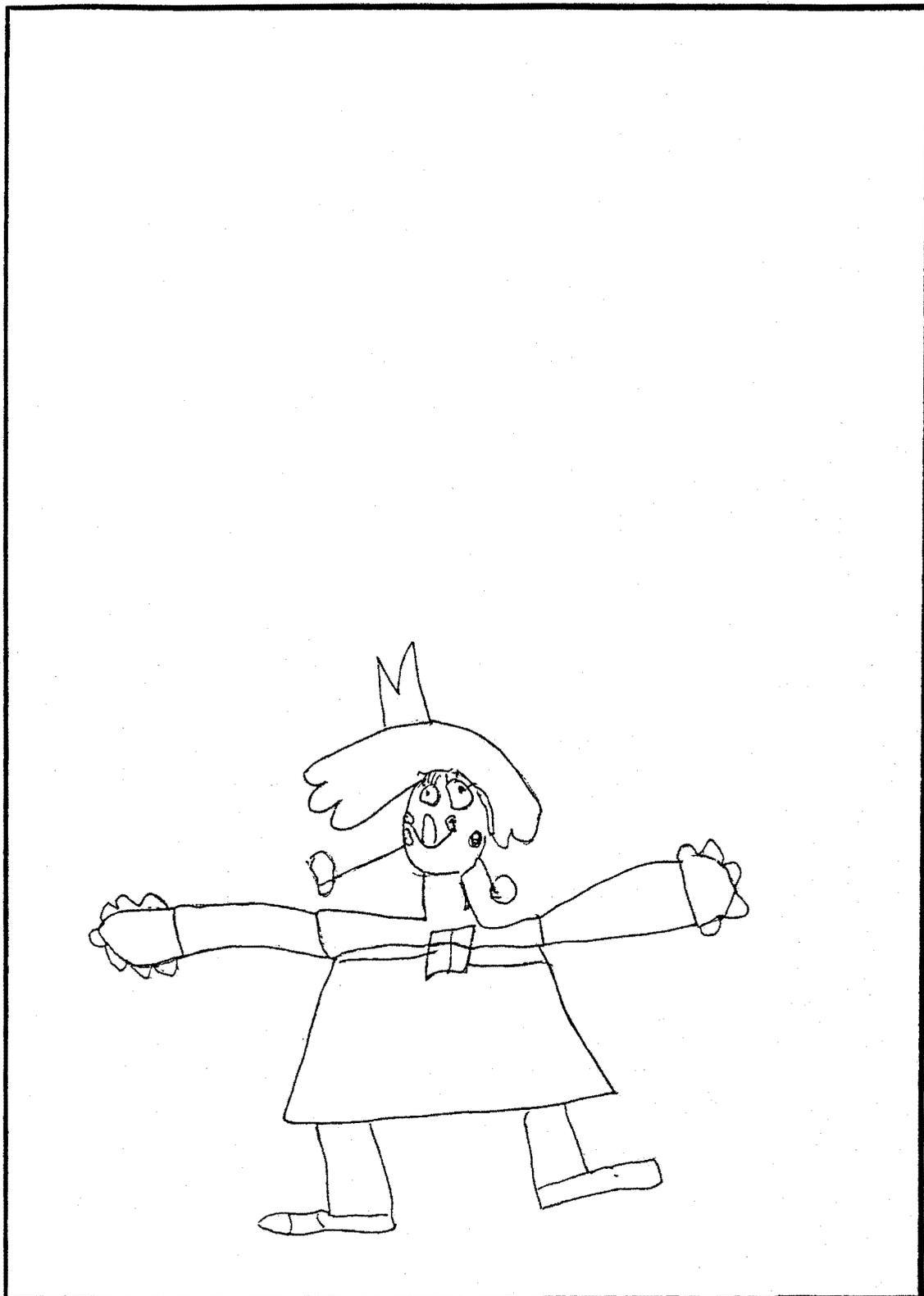
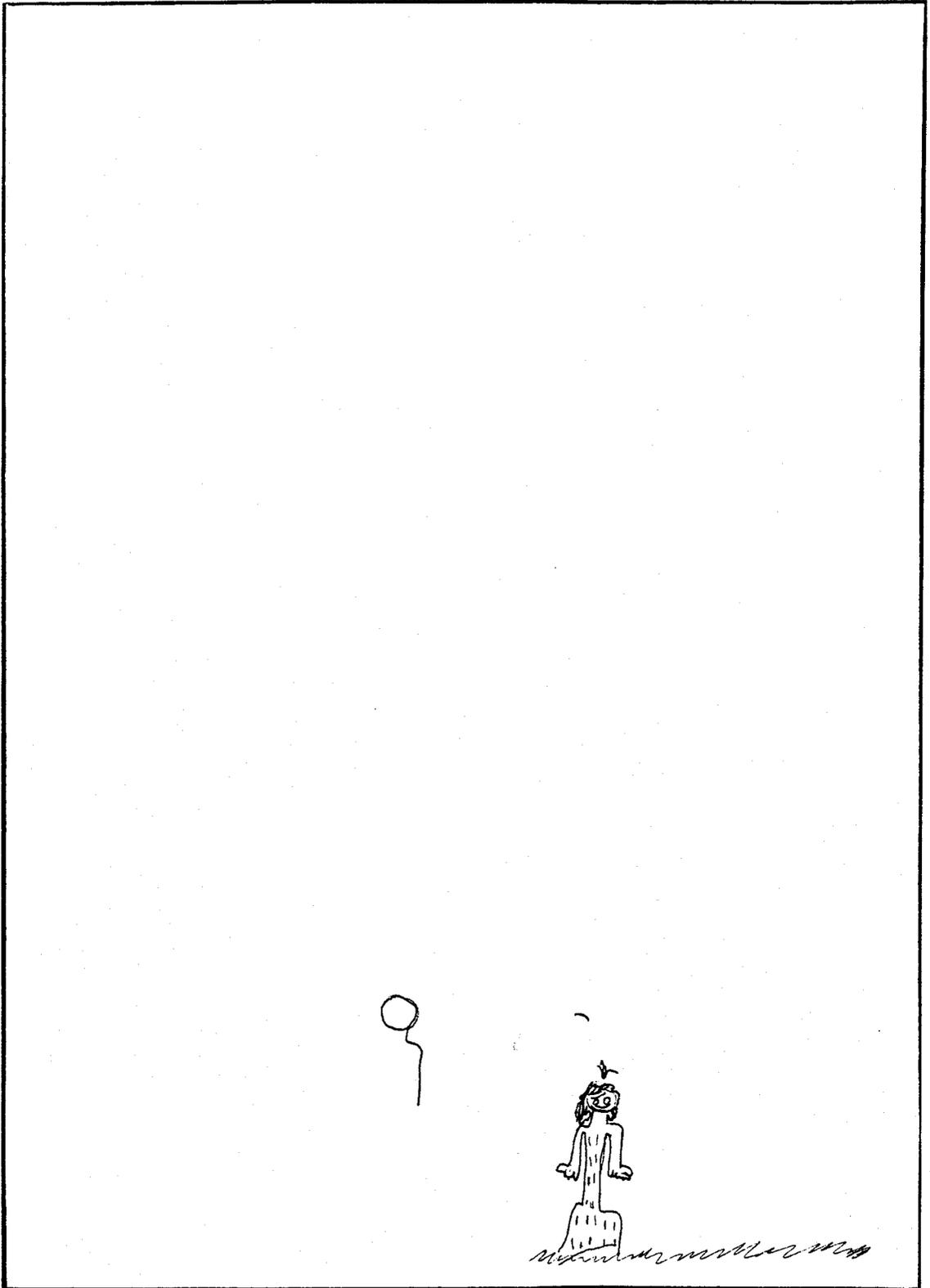


FIGURE 7.13
F'S DRAW-A-PERSON



KEY TO KINETIC FAMILY DRAWINGS

<u>CASE C</u>	<u>CASE D</u>	<u>CASE E</u>	<u>CASE F</u>
1. Sister - crying because she's wearing the wrong outfit - she needs to choose her own clothes, but Mum chooses them for her and she doesn't like this one.	Darren - he's smiling and feeling very happy that he's going to play soccer.	Ashleigh - she's just standing. She has long hair but its not as long as in the picture.	Me - laughing because someone told me a joke - my friend did.
2. My mum - she's thinking about what she's going to pack for the holidays at the sea. She doesn't have to cook or clean there.	Myself - I have lots of work to do so I'm very unhappy.	Mummy - she's talking to her daddy, my grandpa and there's a bow in mummy's hair.	My mom - she's watching TV.
3. Me - laughing at my dad in his funny rhino shirt. There's a drunk man with a horn on it and he got it from his work.	Peter - he's trying to limp around with his leg which he broke recently.	<u>No self was drawn.</u>	My brother - he's playing soccer.
4. My dad - he's in his 'Save the Rhino' T-shirt. His job keeps him very busy but on holidays he's lots of fun.	My dad - he's having a swim.		Father was left out.
5.	My mum - she's having a bath.		

FIGURE 7.14
C'S KINETIC FAMILY DRAWING

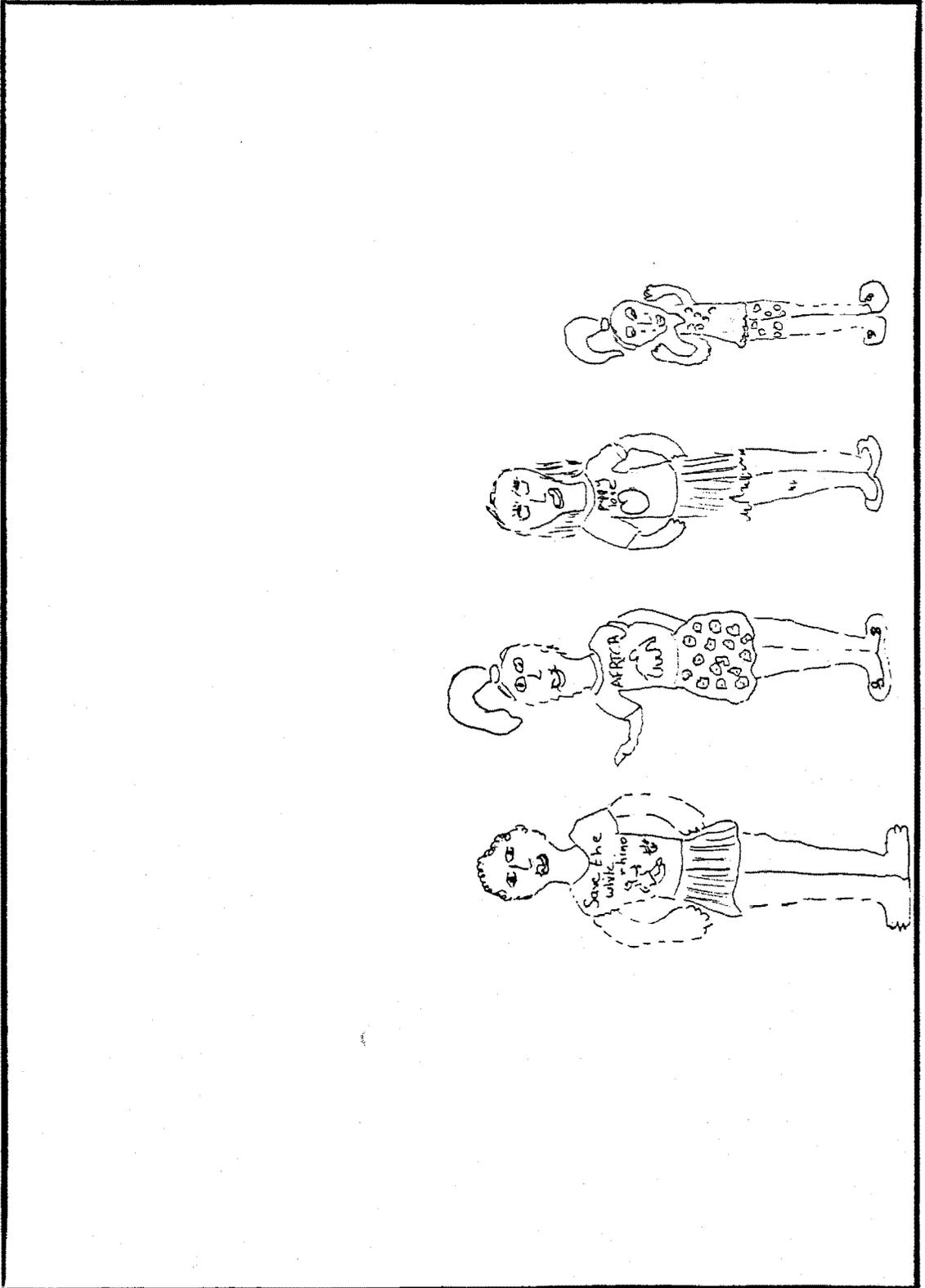


FIGURE 7.15
D'S KINETIC FAMILY DRAWING

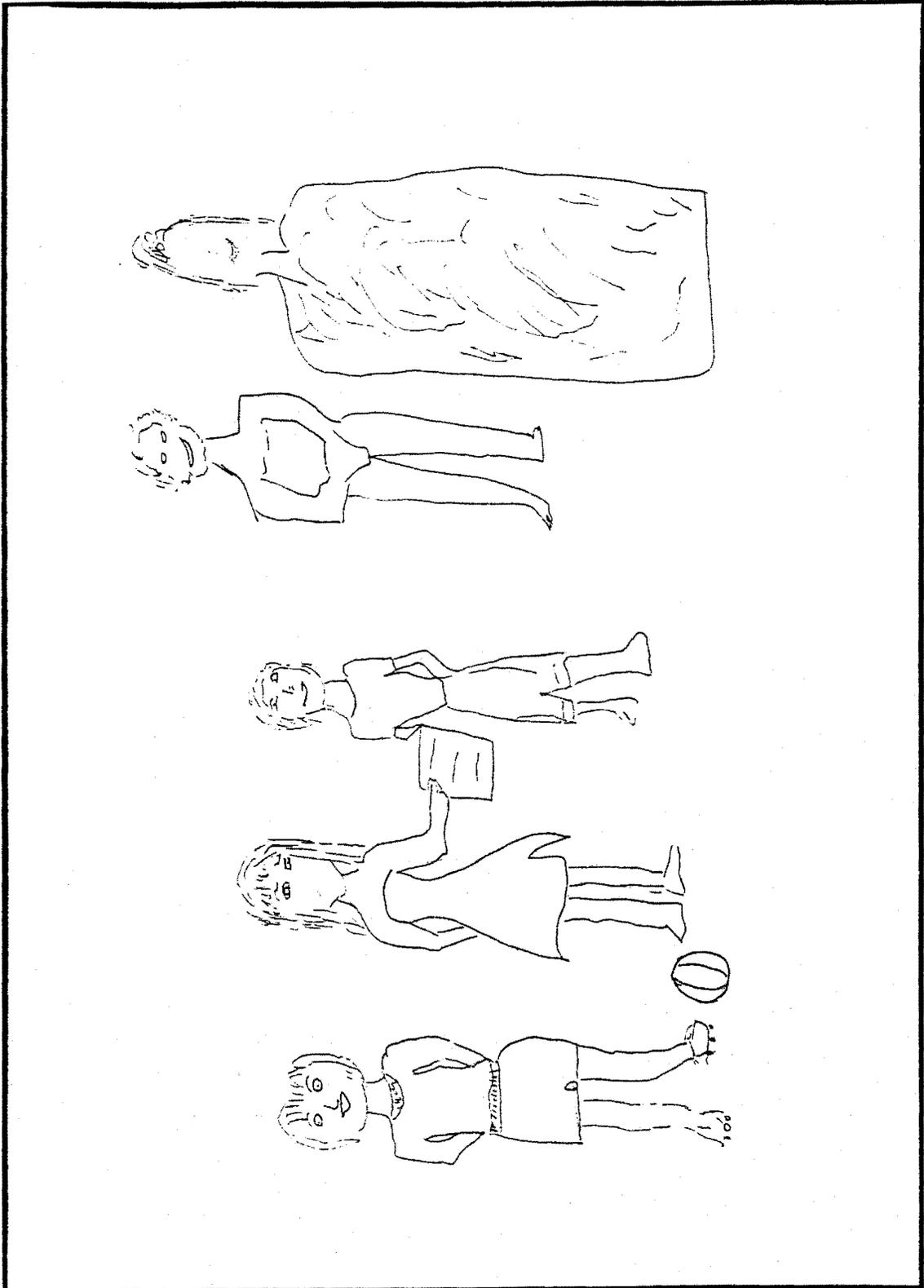


FIGURE 7.16

E'S KINETIC FAMILY DRAWING

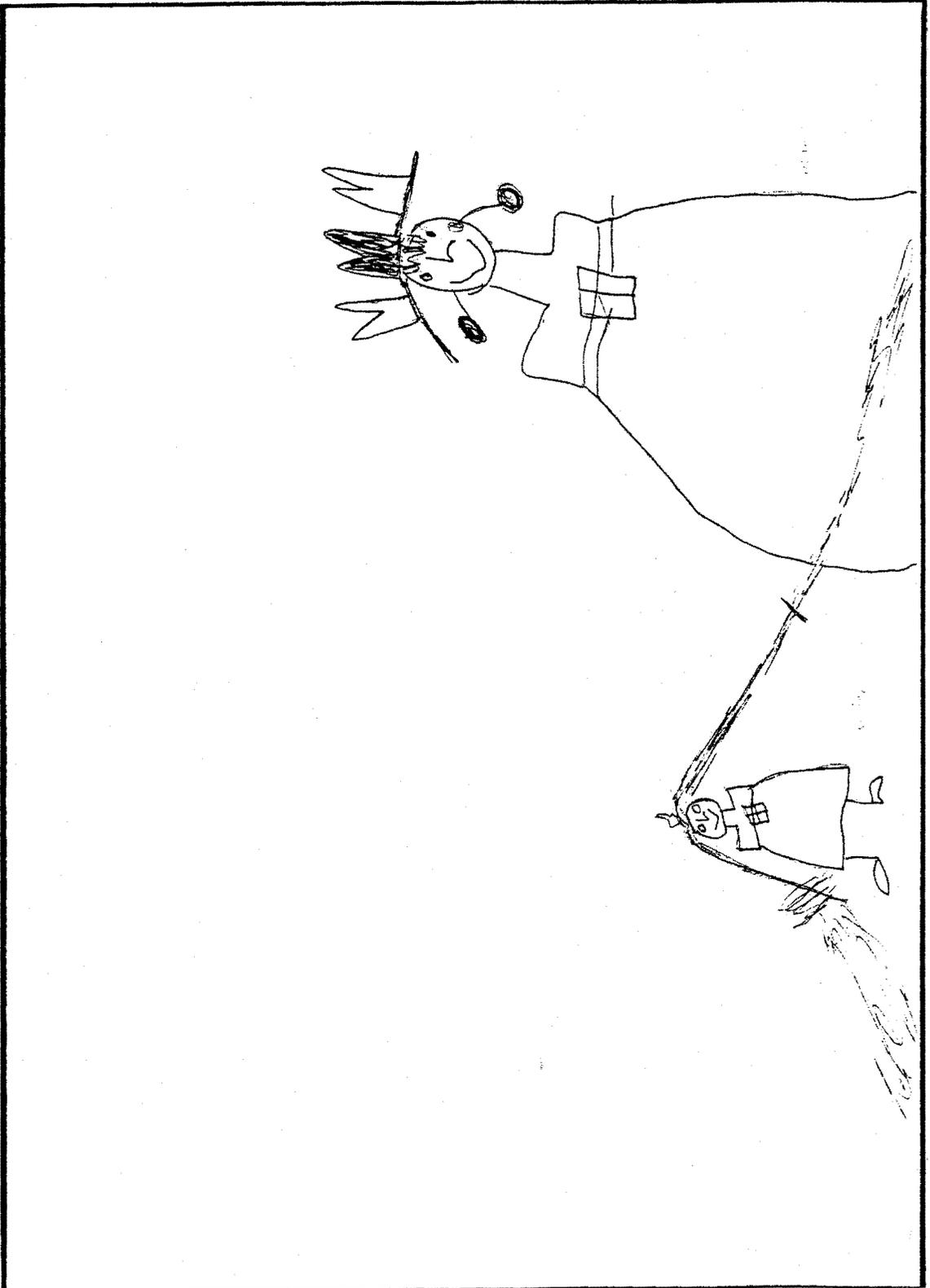


FIGURE 7.17
F'S KINETIC FAMILY DRAWING

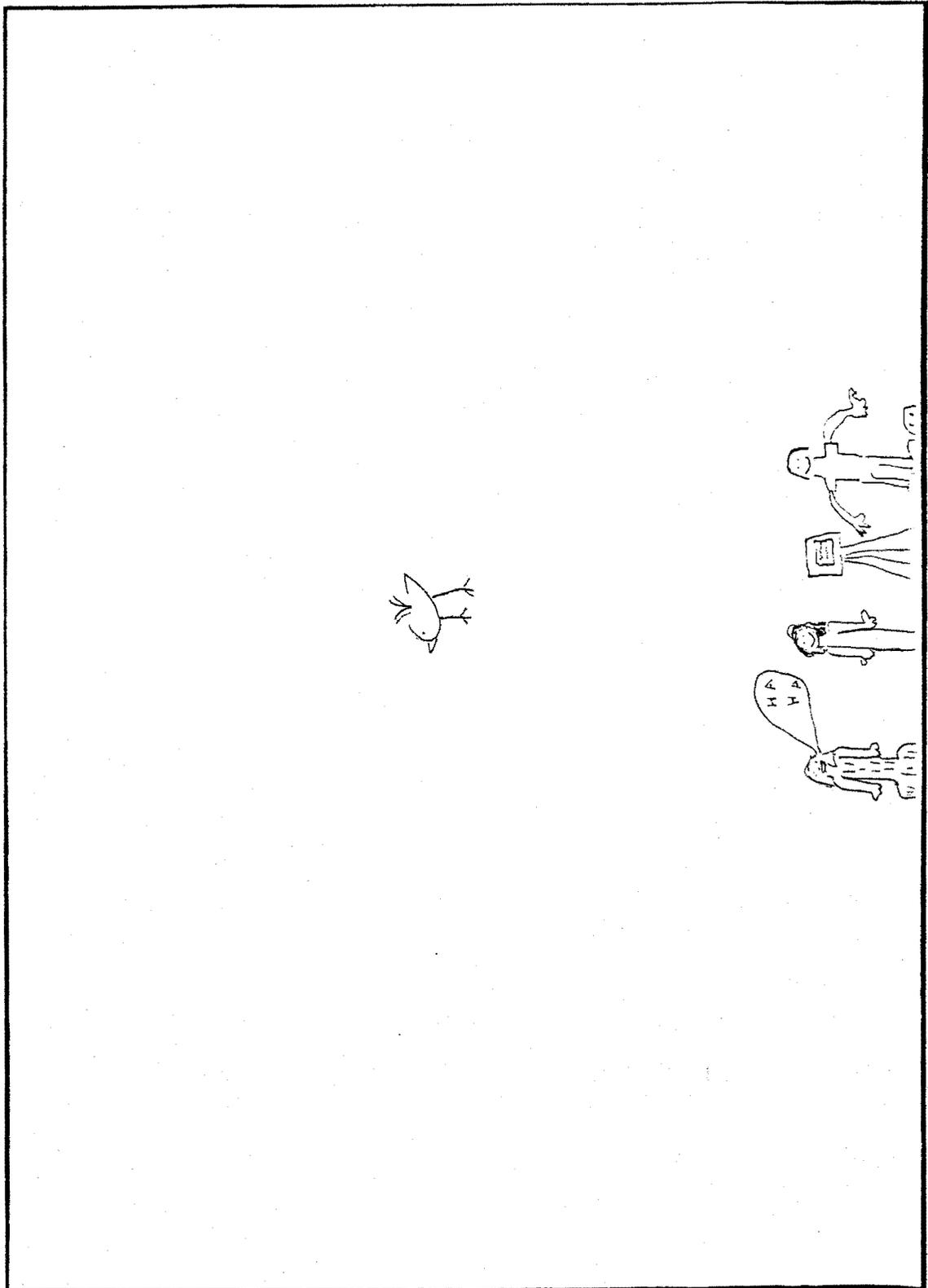


FIGURE 7.18
DIFFERENT TYPES OF ANXIETY FOR CASES C - F

CASE C



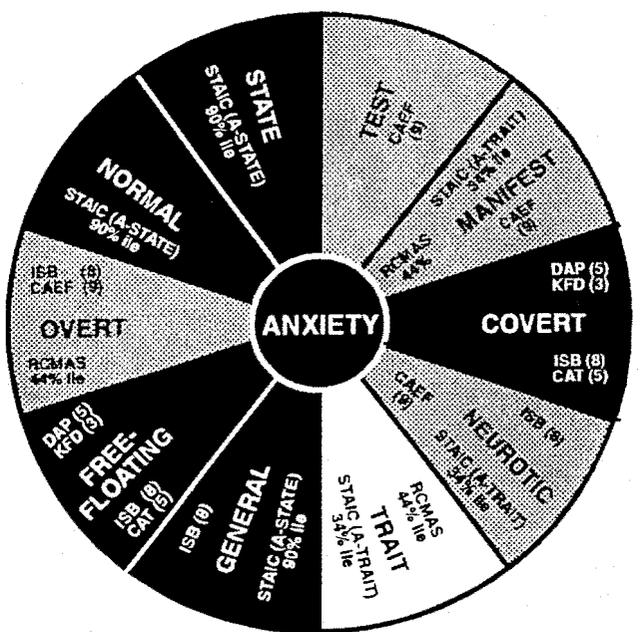
CASE D



CASE E



CASE F



Low to moderate anxiety

Moderate to high anxiety

7.4.6 Conclusion

The use of both self-report questionnaires and inventories, as well as projective media, such as stories and drawings, appears to have been most beneficial in the assessment of anxiety in the six primary school children. Interesting observations were able to be made because of the variety of tests used in the test battery. Some tests proved to be more beneficial than others under certain circumstances, but it is felt that the combination of the various tests enabled the researcher to measure many types of anxiety, i.e. state, trait, general, test, overt, covert, free-floating, manifest, normal and neurotic in the children. By combining projective media with questionnaires and inventories, it is evident that both conscious and unconscious material was revealed by each child, which enabled the researcher to make a more in-depth study of each child's levels of anxiety and how this anxiety affects him in his life-world. This, in turn, will enable the researcher to use the material in the child's therapy, if therapy is recommended. The results of the battery of tests of each child have been recorded in Figure 7.18 [on the previous page]. The key to understanding the diagrams has been explained earlier in the chapter [cf. Figure 7.3].

The significance of the various tests in assessing anxiety in primary school children will be discussed extensively in Chapter Nine and conclusions will be drawn, wherever possible, as to the usefulness or difficulties experienced with the tests, as well as comparing the tests with one another, where appropriate.

CHAPTER EIGHT
EMPIRICAL INVESTIGATION OF THE TREATMENT OF ANXIETY
IN PRIMARY SCHOOL CHILDREN

8.1 INTRODUCTION

This chapter records the findings of the empirical investigation into the treatment of anxiety in primary school children. A therapy, devised by the researcher, namely Hypno-play therapy will be used to treat the highly anxious primary school children assessed in Chapter Seven. In addition to this, behaviour modification techniques will be incorporated into the children's daily routine, to assist their parents in coping with their behaviours. Parent counselling will also be used to assist the parents in understanding the children's particular needs more clearly and in supporting the therapy wherever possible.

Due to the limited scope of this thesis, the therapy with three individual children will be reported on. Cases A, C and D have accepted the recommendation of therapy. The sessions with these children will be recorded and analysed so as to evaluate the effectiveness and possible short-comings of this type of therapy. Twelve sessions will be allocated to the first child, Case A, for research purposes and these sessions will be analysed in this chapter. The first eight sessions of the therapy of Case A will be reported on in full and the remaining four sessions will be summarised, while the remaining two therapies, of approximately eight sessions each, with the two other children [Cases C & D], will be analysed fully and summaries thereof will be reported on in this chapter. Comparisons and conclusions will be made with regard to the three therapies in Chapter Nine and the children will be retested on the STAIC, as well as the RCMAS, after their final therapy sessions. These results will be analysed and reported on in Chapter Nine.

The behaviour modification programmes and parent counselling sessions will not be included in this evaluation, except for brief mention of possible strategies that affect the reduction or increase of the child's anxiety or anxiety-related behaviour and achieve, or further the goals of the therapy or, if relevant, sabotage the goals of therapy.

As mentioned in Chapter Six [cf. 6.5.3.1], each therapy session will not be able to be planned completely, as the basic philosophy of Hypno-play therapy is to allow the child his own space and time and the freedom to choose how he would like to spend it. It was deemed important that the child does not feel pressurised in any way and that he feels safe and secure to be himself at all times. However, certain general goals have been formulated in Chapter Six and certain guidelines proposed for the sake of this research and will be followed wherever possible. Specific goals will be formulated for each session for Case A and for each therapy in Cases C and D.

Permission for using the children in this research project will be obtained from the parents and explicit details will be given to them with regard to the type of therapy that will be used. Each session will be carefully recorded, by means of a video camera and/or audio cassette player. Due to the fact that all three subjects are girls, the pronoun **she** will be used when referring to the **child** in this chapter.

8.2 FIRST SESSION WITH CASE A: KATHERINE

8.2.1 Synopsis of Assessment of Katherine

Katherine's assessment revealed that she was experiencing very high levels of anxiety [A-Trait: 99%ile; RCMAS: 87%ile; CAEF: 12 out of 12]. There was more evidence of anxiety and other psychopathology on her projective tests. Her

high anxiety levels were affecting all of her relationships negatively and she was diagnosed as suffering from an overanxious disorder, according to the DSM III. There was also evidence of symptom formation and psychosomatic complaints, as well as obsessive-compulsive behaviour. The following areas of difficulty were especially noted:

- * low self-concept;
- * low self-esteem;
- * disturbed body-image;
- * feelings of anxiety, inferiority, insecurity and unhappiness;
- * difficulties in relationship with mother and brother;
- * wariness of authority figures.

Therefore certain specific goals for each session of therapy were formulated, focusing on Katherine's areas of difficulties and especially on her high levels of anxiety. The main aim of her therapy was, therefore, to assist her in improving her self-concept, self-esteem and body-image, so that she would be better able to utilise her own inner resources and cognitive functioning, as well as her creativity. It was hoped that therapy would encourage the healthy integration of all aspects of her personality so that it would thereby be strengthened.

8.2.2 Goals Set for First Session:

- 8.2.2.1 to develop rapport between Katherine and the therapist;

- 8.2.2.2 to explore with Katherine her perceptions and feelings about being in therapy and to clarify certain aspects of the therapy with her, e.g. weekly sessions, confidentiality, limit setting;
- 8.2.2.3 to assist Katherine in relaxing her body physically and to enable her to become aware of the difference between a tense and a relaxed body state;
- 8.2.2.4 to allow Katherine to feel that she has control over her own tension and anxiety;
- 8.2.2.5 to help Katherine to become more aware of her five senses, i.e. sight, hearing, smell, touch and taste and to be able to use them creatively in order to alter her own level of consciousness, so as to enter an unconscious state or trance;
- 8.2.2.6 to explore, with Katherine, body sensations and kinaesthetic feedback of being in motion, e.g. on a train, floating on warm water, etc., and for her to become aware of her breathing patterns;
- 8.2.2.7 to allow Katherine to distinguish between normal and neurotic anxiety and to understand that there are times when anxiety/fear is useful and in fact vital to a person's safety, but that at other times when used irrationally, it can have a negative and crippling effect on the person's development;
- 8.2.2.8 to enable Katherine to experience a trance-like state, either spontaneously or by means of a formal induction, in order to reach the unconscious mind;

- 8.2.2.9 to encourage Katherine's unconscious mind to accept a post-hypnotic suggestion that can reduce the anxiety and change wrong and/or irrational perceptions that she may have;
- 8.2.2.10 to protect her from being hypnotised by unqualified and unauthorised persons;
- 8.2.2.11 to make conscious suggestions wherever possible to her that she can relax more often and more deeply and can begin to enjoy and create positive thoughts and feelings for herself;
- 8.2.2.12 to teach Katherine about emotions and to increase her vocabulary with regard to her feelings so that she can identify and express the different emotions she may be feeling; this in turn may assist her family in meeting her needs more efficiently;
- 8.2.2.13 to allow Katherine time in which to play freely, either on her own or with the therapist; and
- 8.2.2.14 to assist Katherine's family in the family sessions to understand her behaviour better and to enable her to change/modify certain aspects of it, by their reactions to her behaviour.

8.2.3 Summary of First Session

The child, Katherine, was welcomed into the therapy room and spontaneous chatting developed for the first few minutes. Katherine was asked whether she knew the reasons for her being with the therapist. She replied that she did not. The therapist then explained that Katherine was there to help her to learn to relax and to 'let go', because it seemed that a big part of her worries were about a lot

of things like school, tests, exams, friends and also some things at home. She would be taught 'relaxation' that would help her to help herself, so that life could become easier, more fun and that she could start feeling happier and less worried about everything. Katherine responded positively and said, 'that would be fine'. The therapist then explained that Katherine would visit her each week for about an hour, for the next couple of weeks. The therapist mentioned that they may discuss feelings and learn about what feelings do to a person, how they make the body relax or tense up. Katherine was also told that she and the therapist would share 'stories' together each week. The therapist would tell her stories [metaphors] and she would be free to tell the therapist her stories or news and perhaps they could make up stories together. Katherine was reassured that she would not have to talk about anything that she did not want to. She was also reassured that anything she said in therapy was 'just between her and the therapist' and that while she may choose to tell her mother and father about the sessions, the therapist would not, as it was Katherine's and the therapist's 'special time' together, just for them.

Katherine was then introduced to the **magical mat** and the **comfy chair**, the places where she would learn her **relaxation**. She was told that in the **comfy chair** she would fly off to different places in her mind and have lots of fun exploring them. She was asked where she would choose to visit and she replied, 'The beach'. Some of the sensations of the beach were then explored, e.g. what could be seen, heard, touched, tasted and smelt. She replied that she could see the colour of the sea; it was bluish-green and she could feel the soft sand under her feet.

All the five senses were explored briefly in this way. Other places were also discussed, like the magical mountains, the friendly forest, etc.. Katherine mentioned she would like to go on a train the rhythm of the train was discussed and explored together.

Then Katherine explored the **magical mat** on the floor. The lights were dimmed so as not to **worry the eyes** and Katherine made herself comfortable, flat on her back, on the mat placed on the floor. She declared that she felt **comfortable** and by all appearances, she seemed to be enjoying herself and involving herself fully in the activity.

On the mat Katherine was **taught** about **body friends**. These were described as **parts of the body that help you**. The following are a series of short extracts from the session, to explain how these were introduced to her:

'Katherine, sometimes your body needs to be stiff and it needs to know if there is danger around. Say a fire broke out; you would need to smell the smoke and see the flames and your body would react by getting tight and tense'.

Katherine was asked what she thought she would do if this happened. She replied that she would run away from it. The need to flee was acknowledged and the possibility of staying to fight it, if the fire was small, was also explored. Thus the basic instinct of fight or flight was dealt with. Anxiety and fear, under these types of situations, were therefore presented as normal and healthy. It was explained that these were times when the body needed to be tight and tense. However, other times the body did not need to be on guard or tight and then it needed to let go or relax.

'Your **body friends** that I am going to tell you about today, will help you to be on guard and tight at certain times and their partners will help you to relax and let go at other times, when there is no danger'.

The following pairs of **body friends** were introduced to Katherine and she experienced how they helped the body to either tense up or relax:

(a) **Jarring jaw and lazy jaw:**

Katherine was helped to feel the difference between when her jaw was tightly closed and all the muscles around it tense and tight. Then the magical jaw would relax and open slightly and become a **lazy jaw**.

(b) **Shivering shoulders and swan-like neck:**

Katherine was taught to feel when all the muscles in her shoulders and neck were tense and tight and **shaking and shivering with fear** and then when she let go she could imagine turning into a beautiful swan with a long graceful neck that stretched and stretched...; the muscles had lots of space to stretch out and relax.

(c) **Puppy panting and balloon breathing:**

Katherine was made aware of the rhythm of her own breathing. She was then asked to pant like a little puppy, with very shallow, short breaths. Then she was encouraged to **deepen** her breathing and to feel that she was slowly blowing up a balloon with deep, relaxed breaths. In this way, she could feel the difference between the two different types of breathing.

(d) **Fighty fists and octopus fingers:**

Katherine was asked to make tight **fighting** fists and to conjure up the feeling of anger, as she did so. Then she was asked to imagine that her fists were turning into a floating octopus with all the tentacles relaxed and free. Now she could feel the anger had gone and a peaceful, quiet feeling was in its place.

(e) **Butterflies and turtle tummy:**

Katherine was asked to imagine that she had lots and lots of little butterflies flying around in her tummy, all trying hard to get out into the sunlight. She could hear and feel their wings beating against her tummy's walls. Now they were gone and all she could feel was the turtle tummy swimming and floating on the warm, clear water.

(f) **Tight toes and floppy feet:**

Katherine was shown how to pull her toes in very tightly and to feel the pressure in all her muscles of the toes, feet and even her legs. Then she was taught to relax and to feel how floppy her feet had become, with no tension at all in them, just like a rag doll's.

Katherine was then helped to imagine a time when she needed all her right **body friends** to help her get out of danger and then to imagine the danger had passed and that the partners of the **body friends** could help her let go ... to relax. An image was conjured up of her floating in the warm water of a tropical sea - everything was calm and beautiful. She was floating past the rainbow fish and all the other beautiful fish in the sea. Little turtles were swimming by to remind her of how relaxed her tummy was feeling. There was no danger in this special, safe pool, her own 'sea-pond'. She was becoming the mermaid, dressed in silver and wearing a crown of sea jewels, that sparkled in the 'sea-light'. Everything was relaxed and comfortable. The therapist then counted very slowly from naught to five, for her to come back slowly to the therapy room, away from the beautiful warm pond, but she was assured that she would still keep the lovely feelings she had had there. The post-hypnotic suggestion was given, that each time Katherine and the therapist worked together, she would feel 'more and more relaxed, safer and safer'. She was assured that she would only let herself 'go

into this deeply relaxed state if she was with a therapist, or on her own and if it was safe for her to do so'. [This served to protect her from being able to be hypnotised by possible amateurs or unscrupulous people.] Katherine enjoyed these exercises very much and closed her eyes spontaneously most of the time she was relaxing.

During the last guided imagery she went spontaneously into what appeared to be a fairly deep trance. Her whole body was deeply relaxed, did not move at all and her eyes were closed and her eyelids fluttered a little. When she 'woke' up, she was asked how she felt and she replied, 'Very nice'. She was asked to hold onto 'those nice feelings' and to feel them a little while longer, so she could get to know them well. The suggestion was made that she would often feel this way in the future.

Katherine took a few minutes to re-orientate herself and then she was asked to sit back in the **comfy chair** to meet some **new friends**.

Life-size and colourful cut-outs of boys and girls were introduced, each one depicting a basic feeling by the expressions on their faces and by the names of the feelings written under the pictures. The following feelings were discussed: happy, lonely, angry, afraid, proud, love, frustrated and sorry. Katherine was asked what images or memories came to her with each trigger word. Her experiences were then discussed.

Katherine was then shown the cupboard containing the toys and games and allowed to explore these. She was fairly withdrawn and unwilling to show much excitement and anticipation. She was not really able to engage spontaneously in this activity but the various options were explained to her. She was then introduced to all the animals and pets, [two dogs, three cats, one rabbit, two birds, fifteen ducks, three pheasants and ten Koi fish]. This was done so that

she could identify more strongly with the safety of the therapy place and that she could feel welcome and a part of it. She immediately warmed to the animals and began to initiate spontaneous conversation, while feeding the bunny.

The therapy session was then concluded and she was told that she would be able to choose an activity or game, the following week, that she could play or that she could again choose to feed the animals. She appeared eager to return.

Between the first and second sessions, a session for Katherine's parents was arranged at their request. They complained about her neurotic and obsessive-compulsive behaviour that was upsetting the family and asked how they should deal with it. When asked to specify exactly which behaviours they were having difficulty with, they mentioned the daily hair washing at six o'clock each morning, as well as her 'performance' each time she had work to do. Her mother was especially angry that Katherine 'manipulated' her in this way.

It was suggested that they give Katherine permission to wash her hair two mornings a week and one afternoon a week and that she could choose the days on which to wash her hair. This choice was to be done each Sunday night and marked off on the calendar. If she chose not to wash her hair on the days she had selected, that was fine, but she could not wash her hair on any of the other days.

Her parents were encouraged to avoid doing any of Katherine's work for her, which they had been doing, as it was suggested that this might reinforce her own feelings of self-doubt and lack of worth. It would also stop them feeling manipulated. They were advised to assist her by helping her to find the right books and to encourage her as best they could, but to walk away from and avoid her 'performances' if possible or send her to her room for **time out**, if they couldn't ignore them. They appeared happy to try these suggestions.

8.2.4 Analysis of First Session

It was felt that initial rapport was established and that Katherine felt comfortable and relaxed within the setting [cf. 8.2.2.1]. Confidentiality was dealt with [cf. 8.2.2.2] and Katherine was given a post-hypnotic suggestion to protect her from being hypnotised by unqualified persons [cf. 8.2.2.10].

Katherine was asked about the reasons why she was in therapy and these were then explored with her [cf. 8.2.2.2].

By playing the **body friends** game, Katherine became aware of her ability to control the amount of tension in her body, as well as to differentiate between feeling relaxed or tense [cf. 8.2.2.3; cf. 8.2.2.4]. Her awareness of her five senses [sight, hearing, touch, taste and smell] was also heightened during the imagery games, stories and metaphors [cf. 8.2.2.5].

The difference between normal anxiety and neurotic anxiety was established and Katherine was helped to understand that at times it was necessary for the body to tense up and be prepared for danger. However, the danger needed to be real and not imagined [cf. 8.2.2.7].

A second post-hypnotic suggestion was given that Katherine would find it easier and easier to relax with each session that she had with the therapist. This was done to help build rapport between therapist and client, as well as allow the unconscious mind the choice of accepting or rejecting the suggestion, that Katherine could relax more each time, as well as the subliminal suggestion that Katherine need no longer be so tense and anxious all the time and that it was **safe** to relax [cf. 8.2.2.9].

During the guided imagery Katherine went into a trance-like state spontaneously.

It was therefore unnecessary to use a formal induction to help her reach a deeper level of relaxation [cf. 8.2.2.8].

Katherine's vocabulary re feelings and emotions, was extended during the play activity, in which she was introduced to life-size cut-outs of children. She was also encouraged to express her feelings directly and to explore when she had felt these feelings intensely [cf. 8.2.2.12].

It was hoped that by introducing her to the animals at the therapist's house, she would identify closely with them and feel safe and secure in this setting [cf. 8.2.2.11]. Free play would follow in the second session [cf. 8.2.2.13]. Finally, the session spent with Katherine's parents between the first and second sessions, appeared to help them to relax and feel better able to deal with her behaviour at home. It also appeared to give them some insight into her emotional difficulties [cf. 8.2.2.14].

8.3 SECOND SESSION

8.3.1 Goals Set for Second Session:

8.3.1.1 To continue to build rapport with the therapist; and

8.3.1.2 To reaffirm goals [cf. 8.2.2.3; 8.2.2.4; 8.2.2.5; 8.2.2.6; 8.2.2.8;]

8.3.2 Summary of Second Session

Katherine entered the therapy room with her mother and chatted spontaneously to the therapist. She seemed happy for her mother to leave. She talked about her netball practice she had just come from, explaining that this was why she was flushed and a little breathless. She was asked about how she felt after her

previous play session and she said it had made her feel 'nice and relaxed'. She said she had especially enjoyed the **magic mat**. More information was gathered from Katherine to ascertain her likes and dislikes and the therapist commented that Katherine had said the previous session that the beach was a favourite place for her to be at. She was asked what her favourite TV programme was and she replied, 'Where is Wally?'. She said she liked different stories, but didn't have a special one. Purple was her favourite colour and macaroni her favourite food, while the elephant was her best animal.

Katherine was then invited onto the **magic mat** and asked what she could remember about the **body friends** she had met the week before. It is interesting to note that she remembered all the partners of the tense friends, i.e. **lazy jaw, swan-like neck, octopus fingers, balloon breathing, turtle tummy and floppy feet**. These she enjoyed practising and the difference between tense and tight muscles and loose and relaxed ones, was again emphasised.

At one point, while she was relaxing, the therapist started to count down from ten to naught and Katherine spontaneously closed her eyes and went into a trance. The therapist then guided her through imagery at the seaside. What she could see, hear, smell, taste and touch was explored. She was encouraged to feel warm from the sun, to feel the soft sand trickle through her fingers and toes and to hear the comfortable sounds of the sea, swishing in ... and swishing out ... The therapist spoke slowly and softly and emphasised the rhythm of the sea.

A suggestion was then made that Katherine would have pictures come into her mind and she would perhaps tell the therapist what they were. She said she was on a horse, a magical horse, golden brown in colour. She was asked to name the horse, which she promptly named Patches. She was on Patches' back feeling safe and comfortable. It was then suggested that Patches could fly and his soft wings would keep her safe and warm. She allowed the images to develop and

Patches took her to the edge of the sea, where she then went by boat to visit the mermaids. Katherine kept her eyes closed throughout and appeared to be in a deep trance. She visited the mermaids for a tea party and felt safe and warm under the ocean. It was suggested that the Queen Mermaid would tell her a secret to help her not to worry so much. She then said the Queen had put all the worries in a big tin chest under the sea, to keep them from worrying her. It was suggested that they would be locked up and guarded by the little mermaids, so that they couldn't get out and worry her for a while. It was suggested that in the future, she would 'unpack' them one by one and explore them to see if they really needed to be worried about or dealt with in some way. The therapist suggested that Katherine would feel much lighter and calmer when she came to the surface of the sea and then started to count slowly for her to surface. When the therapist reached ten, she spontaneously opened her eyes, seemed a little confused as to where she was, but soon re-orientated herself.

She was invited to move into the **comfy chair** from the mat. A sensory game was then played with her to see 'how good her guessing' was. She was given a South African Airways eye mask to put on and asked to identify different smells, e.g. vinegar, lemon, perfume, etc and to taste different tastes, salt, jelly, etc.. She was also asked to identify the objects with which she was tickled, e.g. cottonwool, string, steelwool, etc.. She has a good sense of smell and touch and could identify most articles correctly, which made her beam with pride. The mask was then removed and she was then given the viewmaster to view a cartoon of dinosaurs and encouraged to comment on the shapes, images and colours she saw. She was also asked to say what she could hear and to make up conversations for them. This was done to help her explore pictures and sounds in her head. She had no difficulty with this task, although some small children find it very difficult to form images under similar conditions.

A formal induction of the 'magic key/coin' was then administered.

Here is a coin. It's an old one Rand coin. Have a look at the Springbuck on the one side. Yes... that's right. Now, this coin is very special. It will help you to travel to fairyland. What you must do is to hold it up here [Katherine's hand was raised, until the coin was slightly above her direct line of vision] and just look at it. Just hold your magic coin up there and let your body become as comfortable as possible. Let all your **body friends** relax your muscles so you feel loose and floppy. Stare really hard at the coin. That's right. Good. Your eyes will get very heavy and tired and they may want to close, just keep watching the coin as long as you can. You will feel the magic coin get heavier and heavier and your arm will feel heavier and heavier. When your eyes close, your hand will just drop the coin and will come to rest on your lap. That's right, just let your eyes close and let go of the coin. You are now ready to enter fairyland. Ten, nine, eight... one.

Katherine immediately became sleepy with the suggestion of heaviness and sleepiness. She held out the coin and watched it and then allowed it to drop into her lap, never again taking any notice of it. She 'climbed' down the staircase which led to fairyland. Again she went into a deep trance. Katherine was then guided through fairyland, meeting all the special fairies who told her it was quite safe to be there and she could feel comfortable and relaxed. She was then brought out of the trance by encouraging her to walk up the staircase as the therapist counted from naught to ten.

Free play was then encouraged and Katherine chose a game called Mousie Mousie, in which the mice have to escape the catcher. Again, the theme of tightness and tenseness vs looseness and relaxation, was highlighted. The mice needed to respond to the colours red and blue by becoming tense and tight, in order to 'run away'. However, when white, green, black or yellow came up, the mice could relax and let go. Katherine thoroughly enjoyed this game and appeared relaxed and amused by it.

The session was then terminated with the parting suggestion that she would often recall the feelings of relaxation and safeness during the week and that her relaxed **body friends** would be there to help her. However, if she needed to be alert, the partners of those **body friends** would be there to assist her. Underlying this suggestion was the suggestion that she had everything she needed within herself to keep herself safe.

8.3.3 Analysis of Second Session

It was evident Katherine was beginning to build up a positive rapport with the therapist. She appeared very trusting and willing to interact personally with the therapist [cf. 8.3.1.1] which surprised the therapist, as the assessment had highlighted her general mistrust of the world to some extent. It was hypothesised that she demonstrated a strong need to please the therapist and to be acknowledged by the therapist and that this encouraged her to 'let go'.

By sharing information about herself, Katherine enabled the therapist to get to know her better and to use this information in the therapy session [favourite colour, TV programme, etc.].

Goal 3 [cf. 8.2.2.3] was achieved when Katherine shared that she had remembered the **body friends** from the previous week and could once again identify them and use them in the therapy session.

Goal 8 [cf. 8.2.2.8] was achieved when Katherine spontaneously went into a trance, as the therapist counted down from ten to naught. Goals 5 and 6 [cf. 8.2.2.5 and 8.2.2.6] were also achieved during this spontaneous trance.

Goal 5 [cf. 8.2.2.5] was achieved again when Katherine thoroughly enjoyed the **sensory guessing game**.

A post-hypnotic suggestion was used to help Katherine to relax deeper and allow the Queen Mermaid to lock up all her worries and free her from them for a while, until she was 'ready' to look at them, possibly at a later stage. [cf. 8.2.2.4]

It was decided to use a formal induction on Katherine, even though she went into a trance so easily. This was done for two reasons; firstly, to explore whether she would go into a deeper trance this way and secondly, to see how she would respond to the formal induction for research purposes. It was evident that she could respond well to a formal induction and she had no difficulty achieving Goal 8 [cf. 8.2.2.8].

8.4 THIRD SESSION

8.4.1 Goals Set for Third Session:

- 8.4.1.1 to continue to develop rapport with Katherine and to gain her trust in the therapy sessions;
- 8.4.1.2 to assist her to continue to use the metaphor of **body friends** to help her to relax her body and ultimately, her mind;
- 8.4.1.3 to become aware of the rhythm of her breathing and aware of her own energy flow;
- 8.4.1.4 to use ideo-motor signals with her fingers so that she does not have to verbalise her thoughts if she does not want to;
- 8.4.1.5 to enter a trance easily and confidently so as to assist her unconscious mind in dealing with her fears and anxieties;

- 8.4.1.6 to challenge her unconscious mind as to the rationality of and need for her fears, by means of suggestions, metaphors, etc.;
- 8.4.1.7 to administer the Stanford Hypnotic Clinical Scale for Children for research purposes, as well as to benefit Katherine with the relevant suggestions that are made to her through the use of the scale;
- 8.4.1.8 to encourage Katherine to return to her **safe place** easily and comfortably, so that she can use this technique anytime she needed it; and
- 8.4.1.9 to work with the concept of feelings and being able to express feelings, as well as prepare for Ego State therapy [cf. 5.3.4.10] at a later stage.

8.4.2 Summary of Third Session

Katherine arrived alone, without her mother and let herself in at the gate. She was cheerful and eager to engage in conversation. Spontaneous chatting was encouraged and in the course of conversation, Katherine was asked if any **body friends** had helped her that week. She replied that, '**lazy jaw, swan-like neck and turtle tummy**' had reminded her to relax. She said that when she got scared, her jaw became tight and **lazy jaw** helped her to relax. The other **body friends** were then also dealt with.

She was asked if there had been any reason for the tight **body friends** to help her and if anything really awful had happened. [This was done to make an implicit suggestion that there is very seldom a need for the tight **body friends** to work.] The following extract attempts to illustrate this technique.

- T. Was there anything to shiver about [**shivering shoulders** being the opposite body friend to **swan-like neck**] this week, except maybe the cold?
- K. No.
- T. Any other tight **body friends** to help you?
- K. No.
- T. No? No fires? No major disasters? No difficulties at school?
- K. No.
- T. Did you need **panting puppy** at all?
- K. No.
- T. So all your relaxed **body friends** could be with you all week ... no need for the others

Katherine was then asked to start blowing up a balloon in her mind and to slowly allow her breathing to become more relaxed and deeper. She chose a big purple balloon to blow. As she got into the rhythm of her own breathing, she was encouraged to relax her tummy, hands, feet, etc.. In this way progressive relaxation of her whole body was achieved.

At this stage, Katherine was taught ideo-motor signals; how to use her different fingers to **talk** to the therapist. Her index finger was to be her **yes** finger, while the thumb indicated **no** and her little finger, **I don't want to say**.

She was then encouraged to walk down a beautiful glass staircase, leading into a magical park, where anything could happen ... anything she may like to happen ... By counting down from ten to one, the therapist encouraged Katherine to relax still further. Her eyes closed immediately the counting started and she appeared to enter a deep trance fairly rapidly. It was suggested that she would enter the park feeling very calm, relaxed and happy. Katherine was then asked to share with the therapist what she could see, hear, feel, etc.. The following extract records her responses:

I can see a big beautiful glass slide that I can slide down ... [It was suggested to her that she could just let go and let the wind

blow through her hair and enjoy the feeling of being free as she slid down ... that there was no danger at all ... that she need have no fears, but that she could feel safe and happy and excited. She was then encouraged to explore the park further].

There are magic rabbits for me to ride on. [She was then encouraged to go for a long ride on a rabbit's back and to feel how soft his fur was ... to let the rabbit look after her and protect her from anything that may want to harm her. She was asked to explore any dangers that could be out there, as she had a magic rabbit with her to help her. It was evident from her facial expressions that she was on a journey and at times, she pulled all the muscles in her face tightly. When she gave the signal that she had finished the ride, she was encouraged to talk about it.] She responded by saying: 'I was going to fall off the rabbit's back into a deep pit of dark water and the rabbit bent down and caught me before I reached the water'. [Katherine then climbed down some imaginary steps in the park to a lower level - which implicitly suggested that her trance could become deeper if she so wished].

The Stanford Hypnotic Clinical Scale for Children was then administered. This was done for two reasons; firstly, for research purposes, to ascertain to some degree the depth of Katherine's trance and secondly, as part of the therapy. Each activity/technique was linked to some suggestion that may help Katherine to relax more deeply in the future and to feel more confident and sure of herself. The arm lowering technique was tested first.

Katherine was asked to hold out her hand and to relax it completely and to feel how heavy it was becoming; heavier and heavier, so heavy that it could not stay up any more. It would come down slowly to touch the pillow. Katherine had no difficulty following these suggestions. Her eyes remained closed and her arm and hand lowered all the way down by the end of ten seconds. The therapist then took her arm and held it up and suggested that a balloon filled with helium gas was tied to it. It was further suggested that as the therapist counted, Katherine's arm would rise up all on its own, pulled up by the balloon. On the

count of three, her arm began to rise very slowly and not very high. The imaginary balloon was then released and the suggestion given that as her arm came down by itself and touched the pillow, she would relax, breathe out and go into a very deeply relaxed state. [This deepening technique was explored to see how deeply she could allow her trance to become]. As the hand touched the pillow, she did breathe out loudly and appeared to relax deeply.

The second technique included in the test was arm rigidity. To help her get into touch with her own strength of mind and body, it was suggested to her, as she held one arm out straight, that she wouldn't be able to bend the arm once she had decided it was so straight, so strong and so solid, that it just could not bend. Her arm was supported by the therapist and gently **stroked** to make her aware of her **strength**. At a point, the therapist said, 'Now when you feel your arm so straight and so strong... so very straight ... just like a steel rod ..., when you are sure it can't bend, then I want you to try to see how strong you are ... Go on, try to bend it'.

Katherine appeared to make an attempt to bend it, but it remained straight all of the time. There was less than two inches of bending in the ten second interval. Katherine was then reminded of her strength that when she decided something, she could achieve it. If she decided not to be scared and frightened, without a good reason, then she wouldn't be. If she didn't need to be tense and anxious any more, then she wouldn't be. This implicitly suggested that she could give up her anxiety when she no longer needed it.

The third and fourth items were then tested, i.e. visual and auditory hallucination [using a TV]. Katherine was encouraged to see a television set in front of her and to imagine her favourite programme playing. She said it was Tin Tin. She was then encouraged to tell the therapist exactly what she could see. She said, 'Tin Tin and his dog and his aeroplane and his friends are sitting next to him'.

When asked what Tin Tin was dressed in, she replied, 'He's wearing a blue/green shirt and yellow pants'. She was then asked what colour his dog was and she replied, 'White'. She was able to describe their adventure in the aeroplane in a fair amount of detail. When asked what she could hear, she replied, 'Lots of people talking ... saying what they are going to do ... The dog's barking and he wants to tell them he also wants to talk'.

Katherine was then encouraged to relax again deeply and to return to her **safe place**. When she was there it was suggested that she would have a dream ... a dream about something happening and that she would be able to relate the dream to the therapist when she was ready. She would wiggle her yes finger when she was finished her dream so that the therapist would know she was ready to talk about her dream. The therapist then counted for her to go down the staircase to her **safe place**, where she would have the dream.

After about two minutes, she reported on the dream in the following manner: 'My friends and I were on a magic carpet and went for a ride to a magic place and we saw a show with Mickey Mouse and Minnie Mouse in it. Then afterwards we came home'.

The following test was age regression. It was suggested to Katherine that she would relax very deeply and that then she could go on a journey backwards in time. She could travel on a spaceship, train or any other way she liked. She chose the train. It was further suggested that each station would indicate a year for her. She would start at Station Nine and then travel back to Station Eight, Seven, Six, etc.. If she wanted to get out at any station, she just had to wriggle her yes finger and the train would stop. She then indicated by moving her finger that she was ready to stop the train. She was then told the train had stopped and she could get out at the station. On enquiring how old she was, she replied, 'Five years old'.

She was asked where she was. She reported that she was at home with mum and dad and that it wasn't a special day. She was encouraged to explore what was happening. She said her parents were asking her about her day at school and that it was her friend, Kate's birthday and they got cake to eat. When asked what she was wearing she said, 'Yellow shorts and a purple T-shirt'. She was asked what it was like being five years old and she replied, 'Very nice', indicating a close identification with this age and possibly a reluctance to grow up ... to take on the responsibilities of a nine-year-old. She was then invited to climb **back** on the train and to journey back past Station Six, Seven, Eight and Nine, to reach her present age.

A post-hypnotic suggestion was then made, that when she was back in the therapy room and fully awake, the therapist would clap her hands loudly and Katherine would immediately close her eyes and become very relaxed ... so relaxed that she would find herself **back** in her **safe place**. When the therapist counted from five to ten, she would then 'wake' up, feeling very relaxed, calm and happy and be ready to play a game and draw some drawings if she wished.

She responded by coming slowly out of the trance, opening her eyes only at the count of ten. When the therapist clapped, she immediately closed her eyes and went back into a trance. The therapist then counted from five to ten and Katherine opened her eyes.

The following figure [Figure 8.1] records the findings of the scale.

FIGURE 8.1

STANFORD HYPNOTIC CLINICAL SCALE FOR CHILDREN
 STANDARD FORM [AGES 6 - 16]
 Scoring Form

NAME: Katherine DATE: July 1994 TOTAL SCORE: 7
 AGE : 9 yrs 4 mths HYPNOTHERAPIST: The Researcher

SUMMARY OF SCORES

		Score (+ or -)
1.	Hand Lowering	(1) <u>+</u>
2.	Arm Rigidity	(2) <u>+</u>
3.	TV - Visual	(3) <u>+</u>
4.	TV - Auditory	(4) <u>+</u>
5.	Dream	(5) <u>+</u>
6.	Age Regression	(6) <u>+</u>
7.	Posthypnotic Response	(7) <u>+</u>
TOTAL SCORE		<u>7</u>

Comments:

It is evident that Katherine has the ability to use her imagination, creatively and freely, when she is completely relaxed. She is therefore an excellent hypnotic subject. It is felt that the level of her trance is deep and does not fluctuate much. She does not appear to come out of it spontaneously at various times during the activities, as many children do. She appears to have a good length of attention span and good concentration for her age. She also was not at all anxious about 'letting go' and going into a trance,

which, according to the research, is often difficult for highly anxious children. She also did not demonstrate any resistance at any stage of the hypnotherapy session and took a little while to readjust to the light and re-entering the room.

After the scale had been administered, free play was then encouraged and Katherine chose a game she could play with the therapist as opposed to playing alone.

Katherine was introduced to the faces that depicted feelings and the different feelings were discussed. She was asked to choose a feeling that she could remember having had that week. She chose to colour in the feeling, **thoughtful**, after discussing it fully. The therapy session then ended and a suggestion was made that she would feel very relaxed and carefree that next week and that she would feel more sure about herself and everything that she could do.

Between the third and fourth sessions, Katherine's mother reported back that things were going better at home and that Katherine appeared to be happier now that she could select the two mornings on which she could wash her hair. Less fuss was being made about it and no performances occurred on the mornings she wasn't allowed to wash her hair. However, problems were still being encountered with regard to her homework. She still tried to demand that the family members get involved and help her, because she could not do it right. Mostly, the family were responding to her pleas but were becoming increasingly agitated and angry because they felt trapped by her behaviour. If they didn't give in, she performed and everyone suffered, according to them. Her sister, in desperation, told her mother that perhaps she, the sister, should consult the psychologist about Katherine. The therapist reassured the mother that it may take time to break the old patterns and that the family should encourage Katherine to do her own work and to reassure her that she was quite competent to do so. She was to be rewarded with a star on a behaviour modification

programme each time she completed work on her own and without a performance. They could assist her by helping her find the right books for projects, etc., but were to refuse to actually do the work for her. If she performed, they were again encouraged to ignore her or send her to her room for **time out**, if it disrupted the family excessively. It was decided that they would again make an effort to follow through on the suggestions.

8.4.3 Analysis of Third Session

It appeared that Katherine was able to relax in the therapy session and rapport was felt to be good between her and the therapist. She appeared to have no difficulty trusting the process and no resistance was evident at any stage [cf. 8.4.1.1].

She was also able to identify strongly with the **body friends** and was aware of her own areas of tension [cf. 8.4.1.2] and the rhythm of her breathing [cf. 8.4.1.3].

Katherine was taught and encouraged to use ideo-motor signals [cf. 8.4.1.4] and she had no difficulty entering the trance [cf. 8.4.1.5] easily and comfortably.

It is not evident to what extent her unconscious mind was challenged by the metaphors and suggestions that many of her anxieties and fears are unfounded and counter-productive to her emotional growth. It is felt that this may become more evident as therapy progresses and by the extent to which she is able to 'give up on' some of her symptoms [cf. 8.4.1.6].

The Stanford Hypnotic Clinical Scale for Children was administered and it demonstrated that Katherine has a very high level of hypnotic suggestibility and that she reaches a deep level of trance, rapidly and easily [cf. 8.4.1.7].

Katherine could return to the **safe place** and she could report on the dream she had while in her **safe place** [cf. 8.4.1.8].

She was then introduced to faces that depicted certain feelings and she was asked to recall which feelings she could remember having had the previous week. She chose the feelings of **thoughtful** which may indicate her ability to think about the things that are happening to her and to use them cognitively and creatively [cf. 8.4.1.9].

8.5 FOURTH SESSION

8.5.1 Goals Set for Fourth Session:

- 8.5.1.1 to encourage Katherine to feel safe and able to explore conscious as well as unconscious material in therapy;
- 8.5.1.2 to explore her feelings of fear and anxiety and to enable her to deal with them consciously and unconsciously;
- 8.5.1.3 to encourage Katherine to enter a trance easily and without anxiety or fear;
- 8.5.1.4 to allow Katherine to deepen her trance at any stage, to enable her to deal with more of the unconscious material if necessary;
- 8.5.1.5 to assist Katherine in entering her **safe place** in her mind so that at any time during therapy or outside of therapy, she can use this technique to calm herself physically and mentally;
- 8.5.1.6 to encourage Katherine to find ways of releasing her anxiety and fear

at a conscious and unconscious level;

- 8.5.1.7 to help Katherine to set realistic standards for herself, which she can attain and to encourage her self-concept, body-image and self-esteem to improve;
- 8.5.1.8 to assist Katherine to use age regression, so that she is able to explore incidents and events that she had experienced previously and that may be crucial to finding some of the causes of her anxieties and fears; and
- 8.5.1.9 to encourage the exploration of Katherine's feelings, so that she can express how she is feeling spontaneously and freely.

8.5.2 Summary of Fourth Session

Katherine was on half-term on the day of her therapy session and had come from her mother's creche, so she had lots of news about the day's events which she wanted to share. Her feelings about her mother having so many babies to care for, was explored. Katherine found it extremely difficult to discuss her feelings about this matter and she appeared to suppress her need for 'more of her mother' totally. She appeared resigned to the fact that her mother had many other children to nurture each day.

Katherine had been ill the previous week and had been off school and her mother had reported that she was terrified of missing work and getting into trouble with her teacher. Katherine was encouraged to explore her fears. She was able to express these verbally. She said she was scared her teacher would shout at her. She was asked if her teacher had ever shouted at her and she replied, 'No, but

she does shout sometimes at the other children'. She was asked what would happen to her if the teacher did shout at her. She said she was scared she would then have to stay in at break and she really wanted to be with her friends. She didn't mind doing extra work at home, just not at break. This clearly demonstrated that she enjoys socialising with her friends and values the time she spends with them.

Her need to rely on her family to do her homework was explored with her. She said it was very hard for her to make decisions as how to draw her pictures or do projects. She then needed her mother or sister to 'help' her, to trace the pictures for her and to find the books for her. However, she was aware that she was never really satisfied with the work she reproduced. She said when she thought 'other people' would like her work, she felt better about it. Her strong need for approval and recognition was noted.

Katherine then made herself comfortable in her **comfy chair**, with the lights dimmed. A formal induction was administered. The following is an extract from the session:

'Now, Katherine, can you imagine a big balloon? What colour is your balloon? Yellow? A beautiful big yellow balloon and this balloon is filled with helium gas. Now imagine that this balloon is floating on water. Put your hand on the balloon, that's right, any hand, to stop the balloon floating away. Hold it down on the water and you will feel the balloon push your hand up. If you push down a little more, you can feel it push harder against your hand. Good, now let it up a little way, but don't let it float away. You can bounce it up and down on the water. Let's see you bounce it. [Katherine's hand automatically began to move up and down]. That's right, up and down, up and down on the water. Now imagine that the balloon is getting bigger and bigger so that it's getting harder and harder to hold down. Perhaps it would be easier to imagine the

balloon getting harder and harder to push down, if you close your eyes. [At this point, Katherine's eyes closed.] That's right, your eyes have closed and you can feel the balloon pushing harder and harder against your hand. Now, if you were to stop pushing it down and just let your hand rest on the balloon, your hand and arm would slowly float up in the air, as the balloon goes up and up. [Katherine's hand slowly began to rise up]. That's right, higher and higher. Right up to the top. Oops, now the balloon has floated away ... up and up ... and your hand will come down ever so slowly and as it touches the pillow, you will breathe out the last bit of tightness in your body. That's right, letting all those **body friends** help you relax'.

A deepening technique was then introduced to allow Katherine to deepen her trance: 'Now I'm going to count for you to go down the magic staircase so that you can go on a journey in the **comfy chair**. You're on the tenth step going down. Just letting go, nine ... eight ... letting go ... deeper and deeper ... seven ... six ... all your **body friends** are helping you to relax, five ... four ... three ... two ... one and now you're entering your own magical place. Just enjoy being there ... just allow this place to become alive for you ... as if you are really there. Become aware of what you can see ... hear ... smell ... touch and taste in this very **safe place** for you. When you are ready, you can tell me about it without waking up. [A few seconds pause].

- K: I can see beautiful trees with apples on them and bushes with berries growing.
 T: Can you hear any sounds? Any water running by?
 K: Yes, there's a river running by.
 T: What else can you hear?
 K: Little animals.
 T: Which animals can you hear?
 K: A horse.
 T: What is the horse doing?
 K: He's eating grass.
 T: Can you smell the grass that he is eating?

- K: Yes, its a fresh smell.
T: Yes, I can smell it too.

Here the therapist was helping the child to explore her imagination and the use of her senses, while in the trance. The therapist then continued to assist Katherine in relaxing deeper.

Just relax on a blanket in your **safe place**. Lie down in the warm sun. Feel the sun's warmth on your skin. Just letting go and watching the horse eating grass ... the apples growing on the tree ... everything is so quiet and peaceful ... and you're feeling so relaxed and happy, nothing to worry about, nothing to be upset about. It's all so restful. Just allow yourself to let go and capture that feeling. Enjoy the feeling of not worrying about anything. Being so free ... Enjoy it a little while longer.

[A few minutes later...]

Now in your mind, I want you to leave your **safe place** for a moment and go back in time, a little way. You're in your own home and you are sick. It's last week sometime and you're in bed. Are you there yet. Yes? Fine, now you're going back to school tomorrow and you haven't got all your homework finished ... Now what kind of feelings can you feel coming up from inside of you? ... [long pause]. Now those other **body friends** are coming into play now and they're making you scared and frightened and upset; tight jarring jaw, butterfly tummy and **shivering shoulders** ... **tight toes**. Feel those feelings now. [Katherine began to let her body tense up, pulling her fingers in to make fists and stretching her toes out straight. Her face also began to tense up noticeably]. That's right. It's not a nice feeling is it? Now, I want you to allow your body to get even tighter. That's right, make your body tighter and tighter. [Here the therapist suggests that if Katherine can make herself more anxious and physically tense, she can also make herself relax more and become less anxious]. What are the voices saying? Katherine you are going to get into trouble ... Katherine, your work isn't done ... Katherine, the teacher

will be angry ... Katherine you'll have to stay in at break ...

Now Katherine, take the thumb and forefinger of any hand and push them tightly together. So tightly that it begins to hurt ... and allow all that tightness in your body to come out ... to relax through your thumb and forefinger, [The therapist is giving an autogenic signal that can allow Katherine to unconsciously use this technique to release her tension and anxiety whenever she needs to]. That's right, now just relax ... your whole body is relaxing ... all the other **body friends** are helping you to relax ... no more voices ... everything's quiet and peaceful... You have let go of the fear, the worries and anxieties ... and all the things that were troubling you have gone out through your thumb and finger. Every time you start worrying about anything, whether you are at school or at home ... no matter how scary it seems, you will be able to push that finger and that thumb hard together and just let go, close your eyes and count down from five to one and find yourself in your **safe place**. [The therapist introduces the idea of self-hypnosis whenever Katherine may need it]. And, when you open your eyes after that, you'll feel different ... quite calm and relaxed and ready to deal with whatever needs to be dealt with.

The suggestion was also made that Katherine would find it easier and easier to accept herself and her work, that she would become less dependent on her mother and sister to help and that she would feel much more confident about whatever she did and that she would be free to explore more options open to her with each day that passed.

Katherine was then encouraged to just allow her mind to wander .. to let it go wherever it wanted to go ... maybe to some place she had been before or maybe to a place she had never been to before. It was suggested that it could have been a happy time or maybe an unhappy time ... She was encouraged just to let go and see what happened. Quite a few minutes passed and then she responded that

she was on a beach in Cape Town.. that she knew it well and that she was eating an ice-cream. When asked how old she was, she replied that she was eight years old. She was encouraged to explore how her ice-cream tasted ... rich, creamy chocolate melting on a hot, hot day. She described what she was dressed in and what she was watching, while sitting on the beach. It was evident that she felt she was actually on the beach and that she had regressed \pm one year. A post-hypnotic suggestion was given that when she came back to the therapist's room, she would switch on the light again so that they could play a game. This was done to test whether her unconscious mind would accept a post-hypnotic suggestion. Katherine was then brought back to the therapy room very slowly by the therapist, by counting from one to ten, as she climbed up the staircase from her safe, relaxing place. She opened up her eyes on ten and stretched and yawned and took a while to readjust to the room. She then asked if she should switch the light on and proceeded to do so. She then chose to play a board game called Scottish Roulette and coloured in some of the faces that depicted feelings which she had begun to work on the previous sessions. She chose the feelings, **frightened** and **sad**, to colour in for the last minutes of the therapy session.

The therapy session was then terminated with the suggestion that she would be able to let go and relax during the week and that all her **body friends** would be there to help her.

8.5.3 Analysis of Fourth Session

Katherine was fairly relaxed and excited on entering therapy and chatted spontaneously about her news. She appeared to need to 'let go' and share her thoughts with the therapist [cf. 8.5.1.1]. However, it was noticeable that she had great difficulty exploring her deeper feelings, especially with regard to her mother and her mother's commitment to the creche that she owned.

Katherine was able to consciously explore her fears of school and being shouted at [cf. 8.5.1.2]. She was also, to some extent, able to explore her dependency needs of her sister and mother.

Katherine had no difficulty entering a trance [cf. 8.5.1.3], nor did she have difficulty deepening her trance [cf. 8.5.1.4], or entering her **safe place** [cf. 8.5.1.5].

She was taught to push her thumb and forefinger together when she was feeling particularly anxious and tense and this she did without any difficulty [cf. 8.5.1.6]. It would need to be explored in future sessions, whether she is able to use this method spontaneously and unconsciously whenever she feels frightened or anxious, both at home and at school.

Time is needed to see whether Katherine is able to set more realistic standards for herself, both at home and at school and whether her conscious mind could accept the suggestion of her feeling more confident about herself and her abilities [cf. 8.5.1.7].

Katherine had no difficulty regressing in age and appears to do so spontaneously and easily [cf. 8.5.1.8]. She chose the faces depicting the feelings of **sad** and **frightened** to colour in, in the last minutes of the therapy session and it was felt that she tends to focus in on all her negative feelings much of the time, but is unable to express them verbally at a conscious level [cf. 8.5.1.9].

8.6 FIFTH SESSION

8.6.1 Goals Set for Fifth Session:

- 8.6.1.1 to encourage Katherine to use **body friends** in her everyday life and to concentrate on being able to let go physically as well as mentally;
- 8.6.1.2 to allow her to relax deeply by means of formal and informal inductions;
- 8.6.1.3 to allow her to deepen her trance, so that she is able to work with unconscious material related to her anxiety and the causes of her anxiety, in therapy;
- 8.6.1.4 to assist Katherine in integrating parts of her body and mind by means of a process called **centring** [cf. 5.3.4.8.3];
- 8.6.1.5 to enable Katherine to go back in time, so as to relive and re-experience the feelings, thoughts and sensations she had in the past, with regard to her anxiety;
- 8.6.1.6 to use metaphors and stories to assist Katherine in dealing more rationally with her anxieties and fears; and
- 8.6.1.7 to allow Katherine time to play freely or to draw and paint if she so wished.

8.6.2 Summary of Fifth Session

Katherine entered the therapy room with the news that her mother's car had nearly been stolen and that her father had had to fetch her from school. She appeared quite upset and excitable. Once she had related the story, she appeared to calm down. All the aspects of danger and the need for certain **body friends** to help, such as **fighty fists**, **jarring jaw**, etc., were explored and discussed.

She decided that her mother, who saw the scene from a window of the house, must have needed those **body friends** to allow her to shout at the burglars and to chase them away. The need for her mother thereafter to relax and become calm again, was also explored.

Katherine then relaxed in the **comfy chair** with the **body friends** to help her. She reported that she most often struggled with **fighty fists** because whenever she became very frustrated or angry, her hands would curl up into tight fists. She was asked what usually caused these feelings of anger and frustration and she replied it happened most often when her sister was too busy to help her with her homework. When asked how she coped with these feelings, she said she usually pushed her forefinger and thumb together tightly, as we had done in therapy and let out all those feelings. The therapist then asked her which relaxed **body friends** seemed to help her most, which ones she was most familiar with and she replied, '**Turtle tummy, swan-like neck and octopus fingers**'. She appears to be able to relax her hands, shoulders and stomach the most often. An informal induction was then done. The following extract demonstrates this:

Katherine, you remember you told me how much you liked the beach in Cape Town, the one you visited and ate ice-creams on? Well, let's see how you can go back to that beach and enjoy yourself. Just shut your eyes and see a flight of stairs in front of you ... leading down to the beach. Below is the soft, warm sand that you will feel between your toes. There are ten stairs down and I will count for you to go down. Are you ready? You're on the tenth step and just letting go ... nine, eight... seven, six ... one ... and now you can feel the sand under your bare feet. It's a lovely soft feeling. Feel the sun on your body. You're dressed in your favourite shorts, what colour are they? purple? and a T-shirt. Just keep walking ... walking. Feel the light breeze blowing through your hair. Just letting go... everything so peaceful and quiet. No worries ... nothing to fear ... Now you have found a sheltered spot to sit down, to watch the waves and the little fish in the rock pools ... See the fish swimming

round ... and round ... everything's going round ... and round ... so relaxing ... just letting go. Now let yourself be in your very **safe place** ... feeling safe ... and comfortable ... and warm ...

Katherine's trance was then deepened further. She was asked to imagine that she had magic stardust on her hand, which allowed her hand to go to sleep on the count of five. She was told it would become warm, heavy and asleep. Special Tinkerbelle Powder was sprinkled on her hand which glittered and sparkled in the light [although she only became aware of this when she opened her eyes towards the end of the session].

At this stage a centring activity was attempted. Katherine was asked to allow herself to enter her **safe place** and to bring all the different **body friends** together so that they all could balance, just like a see-saw balances. She was encouraged to feel a central point deep inside of her which felt calm and together. She chose a spot between the bottom of her ribs and stomach, which she said felt like her centre. She could relate to the feeling of calmness and solidness. It seemed to be like a heavy ball for her.

She was then regressed in time and she chose to travel by boat. She was encouraged to see the harbour from which she departed, Number Nine, and the boat took her back to Harbour Eight, Seven, etc.. She was told to say the number out loud as she reached the harbour and to raise her yes finger if she wanted the boat to stop and allow her to disembark. She chose Harbour Seven. There she met three friends who had bought a little white and brown puppy for her to keep ... a warm cuddly puppy who needed her love and care. She called it Emma. She was encouraged to give the puppy a big hug and ask her friends to look after it a little while longer, while she journeyed on. She would fetch it on her way back.

She was then encouraged to go to a time, while she was seven, that made her feel sad and worried. She reported that she was at home in the bedroom and she had lost her reading book and she felt scared and frightened that she would get into trouble with her teacher. When asked what the voices were saying in her head, she replied, 'You're going to get into trouble, you're going to get into trouble'. She said this in a chanting voice. This whole episode was explored with her, her options each point of the way were discussed and the reactions she got from those round her were explored. She came to the conclusion that she always expected the worst to happen and it never really did. The teacher who was going to be so mad with her, turned out to say she would have to do the reading she missed, for homework. She gave a big sigh and relaxed more deeply. At no time did she open her eyes, scratch herself or even move in the chair. Her body remained completely still and her breathing was fairly deep and regular. Her eyelids occasionally fluttered but never opened.

It was then suggested that she and the therapist could make up a story together [mutual story-telling as suggested by Stirlzinger (cf. 5.3.4.9)]. The story would be about a small frightened little rabbit and was started off by the therapist in the following manner:

Once upon a time, long, long ago, in a far away place,
lived a little rabbit ... a very scared, frightened little
rabbit ... and this rabbit ...

Katherine continued the story by saying that the little rabbit had lost his mother in the forest. Each time she stopped, the therapist would continue and highlight the rabbit's feelings of fear and anxiety or she would attempt to offer new options and solutions to the little rabbit. It was felt that the story needed to be a metaphor for Katherine, but to be distant enough so that she would be separated in time and place from its content so that she could be encouraged to

deal with the more anxiety-provoking material.

The story ended with the little rabbit finally finding his way home, having spent a night away, but making a plan to stay warm and dry on the rainy, winter night and realising that he could care for himself far better than he thought and that he did not really need his mother so much anymore. She titled the story 'The rabbit who never ever gave up'.

The session ended with free play and Katherine enjoyed beating the therapist at a **numbers** game and skipped back to the gate to meet her mother.

8.6.3 Analysis of Fifth Session

Katherine related a story of an attempted robbery of her mother's car and this allowed for the use of **body friends** to be explored. It is felt that both the relaxing **body friends** and the tensing **body friends** should be highlighted whenever possible. In this way, the first goal [cf. 8.6.1.1] was accomplished.

Katherine was induced into a trance by means of a fairly informal induction. She was asked to find herself on the beach which she had talked about the previous week. This she was able to do spontaneously [cf. 8.6.1.2].

Her trance was deepened by means of her walking down steps to the sand below [cf. 8.6.1.3]. A further deepening technique was used to help Katherine to dissociate her hand from her body, in order to let go even further [cf. 8.6.1.3].

She was then encouraged to feel all of the different parts of her body and mind **coming together** and **balancing** [cf. 8.6.1.4].

A time regression was done in order to take Katherine back into the past, so as

to recall and re-experience incidents, feelings, conversations, etc., that may have contributed to the **initial sensitising event** [cf. 8.6.1.5]. Katherine was able to go back easily and chose **seven** as a year to **explore**. She recalled an incident in which she had lost a school book and had been in trouble with the teacher. Her anticipation of the worst happening each time, was challenged and she was able to 'let go' of some of the need to punish herself so harshly.

A metaphor was then used to help Katherine to deal with some of her anxieties and fears [cf. 8.6.1.6]. A little bunny was lost, but managed to look after himself and find his way home safely.

Katherine then played freely for the remainder of the session. She enjoyed the interaction with the therapist immensely and chose to play a competitive game, rather than a non-competitive one [cf. 8.6.1.7].

8.7 SIXTH SESSION

8.7.1 Goals Set for Sixth Session:

- 8.7.1.1 to allow spontaneous chatting to develop;
- 8.7.1.2 to continue to build rapport;
- 8.7.1.3 to use a spontaneous induction, through guided fantasy, to allow Katherine to relax more deeply and enter a trance;
- 8.7.1.4 to allow Katherine to identify with a **hypnotic hero** named, Tin Tin, whom she had selected as her favourite and who could help her to relax more deeply;

- 8.7.1.5 to encourage Katherine to become more aware of her ability to control her anxiety herself;
- 8.7.1.6 to teach Katherine the first step in self-hypnosis, namely coming out of hypnosis spontaneously and without effort;
- 8.7.1.7 to personify her fear into an animal and to transform this animal into something less scary; and
- 8.7.1.8 to encourage Katherine to participate in free play.

8.7.2 Summary of Sixth Session

Katherine arrived at the therapy session with her mother and a new-born baby of twenty-seven days who was being fostered by her parents. She had asked her mother if she could show the baby to the therapist. Her mother then left with Zane and Katherine chatted about her week. While talking, Katherine wrung her hands and appeared fairly anxious. She could not be drawn out to discuss her feelings about her new, adopted brother.

However, as soon as she was encouraged to relax, her body became noticeably less rigid and active and her hands became completely still. She identified three **body friends** she could remember; **swan-like neck**, **octopus fingers** and **turtle tummy**. Each time she mentioned a **body friend**, she was encouraged to close her eyes and **feel** what it felt like. This she was able to do easily. Katherine was able to recall an imaginary journey she had experienced the week before. The beach was discussed as to how peaceful she found it and how relaxing it was for her to be there.

The therapist then told Katherine she had written a **story** [metaphor] especially for Katherine and that she would learn a **secret**. The therapist then proceeded to tell her the following **story**, after dimming the lights and making her comfortable in her **comfy chair**:

Katherine, I have made up a story for you to listen to and you will learn an important secret from it. How about letting your whole body relax, breathing deeply and letting all the tightness out? Just let your eyes close and feel how very warm and still you have become. Think of your very special friend Tin Tin. He is also feeling very warm and comfortable and very, very tired, after just coming back from an adventure on the moon. He is with Snowy, his little white dog and Captain Haddock. Professor Calculus and Frank Wolff have all gone to sleep. Now, Tin Tin has a magic wand which was given to him by someone very special and he's allowed one special wish. He has eaten his supper and his tummy is full and he's just letting go and nodding off. He's feeling heavier and heavier and heavier ... In his mind, he's imagining going on a journey down ten steps into a very special garden, through the back entrance of his house. There he goes, he's on the tenth step, going down; nine, eight, seven, six, five, four, three, two, one [long pauses between each] and now he's entering this very special magical place. Share with him all the things that he can see ... the beautiful colours ... what he can hear ... peaceful sounds, as all the others are asleep ... He can smell the freshness of the place and he can touch the velvety, smooth, soft surfaces ... He lies down, next to the river and now he waves his magic wand and he makes one wish. A very special wish and that is that a very special girl from South Africa can come and visit him and share in his adventure. This special girl's name is Katherine. Now Katherine is 9 years old and lives in a house in Johannesburg. Tin Tin waves his magic wand again and ... oops, here comes a very warm sleepy Katherine through the air and wrapped up in a warm cocoon made out of a very special sleeping bag. Now, Katherine sees Tin Tin, but she is feeling so relaxed, that she keeps quite still and quiet. Lying next to Tin Tin is Snowy and Snowy is almost asleep. Everything is very quiet and very still. Katherine is so happy to be visiting Tin Tin and Snowy but she knows that if she

wakes up, she will find herself back in her own warm, safe bed. So she watches Tin Tin and Snowy. Their eyes are closing again ... Katherine is lying very still. She starts to feel so sleepy too ... Her eyes begin to close and off she goes to sleep, into a deep, deep sleep. Nothing will wake her ... especially now that Tin Tin is here with her. Now Katherine discovers a very important secret. She finds out, that if she keeps very still, she can reach Tin Tin in his thoughts and can join him on his adventures ... she feels so happy now that she, Tin Tin and Snowy can have fun together, so long as both of them are deeply relaxed ... so deeply relaxed. Now Tin Tin will take Katherine on an adventure with him and Snowy. There will be many times she may feel scared and anxious, but each time she will push her finger and thumb together, just like she does in therapy and she will remember that she is quite safe with Tin Tin and Snowy and she will just let go and relax. Katherine's adventure is starting now ... when it's finished she will show me by lifting her yes finger, without waking up. When she wakes up just now, she will tell me all about it ...

[Pause until Yes finger lifted].

Now your adventure is finished ... just let yourself relax very deeply and go into your **safe place** ... that's right ... deeper and deeper ... Now I want to help you learn to relax all on your own so that when you are not with me, you can just let go whenever you need to, anytime you need to relax. Let your eyes open ... that's right ... Now just breathe out ... a nice deep breath - yes, that's right ... just letting go ... Your eyes closing and you count yourself down from five to one. Yes that's right, your eyes are closing ... five ... four ... three ... two ... one and now you are entering your own **safe place** ... Now when you open your eyes again, you will feel much safer ... much more relaxed and calm, much less fearful ... much less worried.

Katherine was told that the therapist would click her fingers and that she would wake up and then the therapist would count with her down from five to one and that Katherine would let herself go back to her **safe place** and that when she was ready, she would just open her eyes, feeling relaxed, peaceful and happy.

The therapist clicked her fingers loudly and Katherine 'woke up' with a start. Then, she and the therapist counted down from five to one and Katherine spontaneously let herself go back into a trance. A few minutes later, she opened her eyes, having brought herself out of the trance. [Gardner (1981:308) maintains that it is important for the child first to experience coming out of hypnosis on his own before putting himself into a trance. She believes that this helps the anxious or nervous child to be less fearful of using hypnosis himself]. Katherine was congratulated on being able to help herself relax so deeply and told that she could use this technique whenever she needed to.

Katherine was encouraged to tell the therapist about her adventure with Tin Tin, which she did. She was then encouraged to relax her body as much as possible in the following week and to feel the good feelings when she 'woke up'. Emphasis was therefore on the **waking up** rather than **going into** the trance. She was encouraged to use it in her warm bath or bed each night, or even at school, before a test, and to report at the next session as to how it was working for her.

Katherine then drew pictures. She was encouraged to portray her fear as an animal. She chose the lion and drew a 'big, fierce lion'. This metaphor was then worked with. Lions were discussed and the soft, pussycat side of the playful lion was examined together. It was hoped, in this way, to challenge Katherine to start seeing other aspects of her fears and worries and to give her more flexibility and lateral thinking to enable her to rationalise her fears more effectively. However, she was left with the paradox that she must be scared of some lions, as they can eat people.

Free play was then encouraged and Katherine chose a game of draughts to play with the therapist.

8.7.3 Analysis of Sixth Session

It is felt that spontaneous chatting and good rapport had developed between Katherine and the therapist and that she wanted to include the therapist in her world, e.g. by sharing her new foster brother with the therapist [cf. 8.7.1.1 & 8.7.1.2]. It was furthermore felt that rapport was being built all the time and that Katherine demonstrated a lot of trust in the therapist by the way she followed the therapist's suggestions while in a trance.

Katherine was able to enter a spontaneous trance through the guided fantasy [cf. 8.7.1.4] and identify with the hypnotic hero Tin Tin [cf. 8.7.1.4]. She became aware of her control over her anxiety [cf. 8.7.1.5] when she pushed her thumb and forefinger together and released her anxiety in that way.

She managed to come out of hypnosis easily and without fear [cf. 8.7.1.6]. When she chose to draw the lion as a metaphor for her fear, she was able to deal with it and allow flexibility into her thinking patterns about her fear [cf. 8.7.1.7].

Katherine was able to fully participate in the free play [cf. 8.7.1.8] and to enjoy the game with the therapist.

8.8 SEVENTH SESSION

8.8.1 Goals Set for Seventh Session:

8.8.1.1 to continue to reduce excessively high levels of anxiety by:

8.8.1.1.1 to allow Katherine opportunities to relax her body completely;

- 8.8.1.1.2 to suggest that it is safe to relax her mind and body, whenever possible;
- 8.8.1.1.3 to use metaphors and paradoxes to allow Katherine to make certain cognitive **shifts** which would enable her to become more relaxed generally; and
- 8.8.1.1.4 to challenge Katherine's thinking patterns as to why she needed to be so tense, to worry about things that might never happen and to be fearful of events such as tests, examinations and presenting before the class.
- 8.8.1.2 to continue to expand Katherine's emotional vocabulary by exploring various feelings, colouring in pictures which depicted them and chatting spontaneously about them;
- 8.8.1.3 to continue to prepare Katherine for Ego State therapy by means of exploring her feelings, both positive and negative ones;
- 8.8.1.4 to allow her superego [conscience] to accept that it is healthy to be aware of all the feelings she has, but that she can decide how to **act out** on a feeling. In this way, she will be less fearful of her own id [unconscious] processes, such as drives, impulses and feelings and be more able to develop a sense of humour about her areas of limitation;
- 8.8.1.5 to allow better energy flow between her unconscious and conscious minds by encouraging her to reach deep trances in which she could become more aware of her unconscious feelings and thoughts;
- 8.8.1.6 to explore the root causes of her anxiety whenever possible and to

deal with the symptoms in order to reduce them when appropriate;
and

- 8.8.1.7 to practise self-hypnosis so that she can use the process away from the therapy sessions and therefore use it more extensively.

8.8.2 Summary of Seventh Session

Katherine entered the therapy room with her father. She was quieter and more introverted than usual. She did not offer spontaneous conversation and seemed less inclined to chat about her week. When asked about the new foster baby she had brought to show the therapist the previous week, she appeared less enthusiastic about him, although she volunteered that she did feed and change him and helped her mother to bath him.

Katherine was then helped to get comfortable on the **comfy chair**. She was asked about the **body friends** that had reminded her to relax that week. Three came to mind; **octopus fingers**, **swan-like neck** and **turtle tummy**. She said that when she was writing a test at school, she found her fingers would get really tight and then she would remember **octopus fingers** floating in warm water. This allowed her to spontaneously relax her fingers and **let go**. It was then much easier to her to continue writing.

Katherine reported that she used **swan-like neck** at night before she went to sleep. She found that her neck became tight and while lying in bed, she could consciously let go and allow her neck to become **swan-like**. A suggestion was made to her that next time she became aware of **tight fists** at school, she would also become aware of any tightness that may be in her neck and shoulders and that, as she relaxed her hands and fingers, so would her neck automatically become **swan-like**. She also found that her tummy became **tight** with **butterflies**

fighting to get out when she got scared at school or at home. She then could imagine the turtle swimming in warm water and she could slowly **let go** and relax her stomach muscles.

Katherine was then encouraged to do progressive relaxation. Starting at her toes and working through all her **body friends**, she was encouraged to relax her body fully. A suggestion was made that she would begin to feel heavy, warm and relaxed, all over.

A formal induction was then done to assist Katherine in going into a deep trance. She was shown how to do **finger-lowering**. Her right hand was held up with only the heel and the tip of the little finger touching the cushion and the thumb and three fingers raised off the cushion. Katherine was told:

Only your little finger is gently touching the cushion. The other fingers are all raised. Now, imagine that your fingers are getting heavier and heavier, more and more tired from being held up and they too want to come down and rest on the cushion. I wonder which one will come down first? Perhaps this one [touching one finger gently]. No? Maybe this one [touching another finger gently].

Slowly Katherine's fingers began to lower and gently rest on the cushion. The thumb was the last one to touch down. The therapist continued:

Now, think about your eyelids. They are getting heavier and heavier, more and more tired. Soon they will be so heavy and tired that they will just close ... Good ... just let them close ... That's right, getting so heavy they just have to close. Breathe out ... That's right, just letting go. Now you're on the tenth step, just going down, step by step ... more and more relaxed ... just letting go ... nine ... eight ... seven ... six ... five ... half way down to your own special, **safe place** ... four ... three ... two ... one ... and now you are entering your own **safe place**. You're feeling so very,

very relaxed, warm and safe. Allow yourself to see, hear, feel, smell and maybe even taste the different, magical things in your own beautiful, **safe place**. Become aware of how peaceful it is there and how beautifully warm you feel. Allow yourself to enjoy these feelings that you are having now.

While in a trance, Katherine was then asked about her **safe place**. She said it was in a magical forest, with a waterfall and different animals peacefully eating in the distance.

A deepening technique was then done, to help Katherine deepen her trance so that some of the causes and symptoms of anxiety could be dealt with. She was encouraged to feel a helium balloon tied to her right hand and to feel how it was pulling her hand and arm up, further and further into the air. Katherine identified the balloon as a yellow and red one, but needed a little help to experience the **lifting** of her arm. The therapist **tied the string** around her wrist and gently lifted the arm. Once Katherine felt the arm lift, the therapist took her hand away and Katherine allowed the whole arm and hand to rise to the count of five. Then the balloon was **removed** and Katherine was encouraged to feel how her arm gently came down to rest on the cushion. The suggestion was given that she would relax very deeply as her hand touched the cushion. She noticeably relaxed, breathed out heavily and appeared to **let go**. It was suggested to Katherine that she may feel so light in her mind and she could feel a floating feeling while her body was heavy and asleep. This was done to help her dissociate her body and mind to enable her to reach her unconscious mind more easily.

She was then asked to imagine that she was holding a big ball of light in her hands. She immediately **held** a ball in her hands. She was asked to imagine that this light could let her feel very, very safe ... that the light from the ball could

keep her very safe ... that while the ball was there, it was safe to look around and explore some of her fears or anxious feelings. The ball would keep her warm and safe. She was encouraged to go **inside** herself and look for those things that made her the most scared or fearful.

Katherine took a long time to respond. Her eyes remained closed throughout and she was in a deep trance but did not answer for a long while. She was encouraged to look for the **voices** that made her worried. An attempt was made to allow her to explore the different ego-states she may experience though her anxiety. She eventually volunteered that she was scared the teacher would shout at her. She was then encouraged to feel that fear of the teacher shouting at her; to experience the fear, in order for her to feel she had some control over it. She was encouraged to feel her **butterfly tummy, tight fists and shivering shoulders**. Then she was encouraged to feel the ball she was holding, to feel its warmth ... like a big **glow-worm**. The following extract is taken from this session:

- T: It's letting the warmth go inside of you ... Now what is that warmth doing as it goes inside of you?
- K: It helps me let go.
- T: It's helping you let go ... just feel how nice it feels to let go ... to feel relaxed and warm. All those scary feelings are changing. Suddenly you are relaxing and feeling much more comfortable ... much more peaceful ... The little voice about the teacher shouting is going further and further away. She doesn't often shout at you ... you are usually good in class ... she doesn't need to shout at you ... so it's not really necessary to worry about being shouted at all the time. Now I want you to turn off the button where she is shouting and turn on the button where she says something nice to you. What is she saying that's nice? ...

Katherine took a long time to answer and then said, 'It's very neat writing'. This was repeated to her as well as other possible phrases like, 'Well done,

Katherine', 'Thank you for trying so hard', etc.. Katherine was therefore challenged to start **hearing** and tuning in to the **positives** her teacher may be saying, instead of focusing in on all the **negatives**. She was also encouraged to look at what was happening at home with her homework. She then volunteered that she could **hear** a part of her saying, 'You have to do the homework by yourself. You are silly ... you are silly'. She was encouraged to look at other parts saying, 'I can't do the work alone. I need my mother and my sister to help me'.

Katherine was then asked to go back in time ... to travel back to another time when she was smaller, when she felt she couldn't do something ... maybe even the first time she felt this way ...

She spontaneously regressed to the previous year when she had been drawing a picture, at school, of herself and her pets. She had felt very unhappy about the way her dog had turned out and then the girl behind her had said it was 'ugly' and the girl sitting next to her had said it looked like a 'strange dragon'. This had upset her terribly. These feelings of hers were explored and refelt and when they had been dealt with sufficiently, Katherine was encouraged to push her thumb and forefinger together, very hard, so it hurt ... and then to allow those feelings to pass out of her ... so that she could let go of them ... In this way Katherine was encouraged to deal with her feelings of hurt, pain, embarrassment, etc., and to then let go of them. She was also encouraged to see the funny side of a 'dog-like dragon' and was encouraged to feel free to laugh at her picture that hadn't turned out quite right. It was then suggested that she could return to her present age, while still in trance, and she was reminded of the part of her that was never satisfied with her achievement, that didn't feel good about what she did, that didn't feel she could manage on her own and she was then asked to find a part of Katherine that felt she could manage, that at least she could try it on her own and see how it came out. She was asked to repeat aloud the

following phrases: 'I can manage, I can do it, I will manage, I feel satisfied with it'.

Katherine was then encouraged to feel the warmth of the ball again and to enjoy the safe warm feelings it gave her. In this way, the good feelings about herself were centred and anchored to be used at any time she needed them.

Katherine was then guided in imagery through her magical forest, which she usually chose for her **safe place**. The aim of the metaphor was to allow her to feel safe in the forest, but then to challenge her to meet any obstacles that came her way; to use her own creative and inner resources and overcome **problems** and turn them into challenges. The following extract attempts to demonstrate this method:

- T: Now, we are moving into the forest ... the magical forest where you feel so safe... I think I can hear water running ... Can you? Could it be a waterfall? Listen carefully. Maybe it's a stream. What can you hear?
- K: A waterfall ... a very big one.
- T: What can you see?
- K: A rainbow, a big bright one.
- T: What does that mean?
- K: The rain is over.
- T: Yes, and the sun is out and everyone in the forest is feeling happy ... happy and relaxed ... Now look at the waterfall ... it's leading into a river ... How deep is the river, would you say?
- K: Very deep.
- T: Are there any obstacles in the water which are stopping the water from flowing?
- K: No.
- T: Well, perhaps we could go for a ride down the river on a log. Can you find us a log?
- K: Yes, here's one.
- T: Is it safe ...
- K: Yes.
- T: O.K. Well, we are both on now, but we could fall off.

- Careful, don't lean too far over. What about animals? Can you see any?
- K: Yes.
- T: Are they friendly or dangerous?
- K: Just a little squirrel and a grey and white rabbit.
- T: So we are safe?
- K: Yes.
- T: Is the water murky or clear?
- K: Clear.
- T: How will our adventure end?
- K: We'll just have a picnic in the forest and feed the animals.
- T: O.K. so we are quite safe ... relaxed and warm and able to deal with anything that comes along ... Let's just spend a few minutes unpacking the picnic basket and enjoying the warm sun on our bodies ...

Katherine was then told that she had mastered an important step the previous week, in that she had learnt to come out of the trance on her own and had experienced how easy that had been for her. It was suggested that she would find the next step, entering the trance, very easy and relaxing. She was then encouraged to climb the stairs slowly and all previous suggestions of heavy and light limbs were carefully removed so that her body would feel completely normal, relaxed and warm, when she woke up. She opened her eyes on the count of ten and appeared relaxed, yawned and stretched herself as she woke up.

Self-hypnosis was then practised. Katherine was encouraged to close her eyes and to count herself down from five to one and to enter her **safe place**, her magical forest. Then, when she was ready, she was told she could just open her eyes. This she did and she was asked when would be a good time each day for her to practise. She replied that before she did her homework would be a good time and she volunteered to practise it each day for a week.

Free play was then encouraged and Katherine chose a game of draughts and

enjoyed winning more kings than the therapist in the remaining therapy time.

8.8.3 Analysis of Seventh Session

Katherine was able to identify three **body friends** spontaneously. Her hands, stomach and neck appeared to be areas in which her tension most often presented itself. She was able to **let go** and relax her body completely through progressive relaxation [cf. 8.8.1.1.1].

There were numerous occasions when the therapist could suggest the safety of relaxing her body and mind, both at home and at school. Specific suggestions, i.e. tests and examinations, as well as more general suggestions were made [cf. 8.8.1.1.2].

The metaphor of a **ball of light** was used to allow her to become aware of the healing qualities of light and warmth; that this ball would help her to feel safe and warm [cf. 8.8.1.1.3].

Katherine was challenged cognitively and emotionally as to why she needed to be fearful in the classroom. The **shouting teacher** became the **complimenting teacher**, the **messed up picture** became a **small part of the whole picture looked a little funny**. The idea of laughing at the funny **dog-like dragon** was introduced and the suggestion was given that it was all right to laugh at some of her **mess-ups** [cf. 8.8.1.1.4].

Katherine's vocabulary of emotions was only worked on indirectly as there was no time to colour in more of the **feeling faces** [cf. 8.8.1.2].

Ego State therapy developed spontaneously and Katherine was able to **hear her voices** or self-speech telling her to be scared, to see herself as silly, useless, etc..

These **parts** were worked with and **counter-parts** were introduced so as to integrate the various parts of her ego [cf. 8.8.1.3 and 8.8.1.4].

Katherine's trance was deepened during the session by means of arm levitation. She did not immediately and spontaneously allow her arm to rise up, but once it was lifted so she could feel the **lightness**, it continued to rise up on its own [cf. 8.8.1.5]. It is felt that she did regress to a younger age and had great clarity about the event in which she felt belittled by her peers, with regard to her drawing of her pets [cf. 8.8.1.5]. In this way, some of the causes of her anxiety, although possibly not the initial sensitising event, were explored [cf. 8.8.1.6]. The symptoms of her anxiety were dealt with throughout the session, when she was encouraged to let go and relax and deepen her trance. No further complaints about psychosomatic headaches and stomachaches have been reported by her or her parents.

Another aspect of self-hypnosis was practised and that was the spontaneous going into the trance [cf. 8.8.1.7] and Katherine found this easy and relaxing to do. Her motivation to follow the therapist's instructions and suggestions was extremely high and it would seem that this contributed greatly to her high level of success in using the techniques meaningfully.

8.9 EIGHTH SESSION

8.9.1 Goals Set for Eighth Session:

- 8.9.1.1 to continue to encourage Katherine to relax her body and her mind;
- 8.9.1.2 to allow her to become aware of the energy flow between herself and her environment through breathing;

- 8.9.1.3 to establish a hierarchy of her classroom fears and anxieties so that in a future session systematic desensitisation with hypnosis can be used to desensitise her to anxiety-provoking situations at school;
- 8.9.1.4 to continue to use metaphors and paradoxes whenever applicable to encourage her to relax and become less anxious;
- 8.9.1.5 to encourage growth at a self-concept, self-esteem and body-image level;
- 8.9.1.6 to continue to work with ego states and to strengthen ego integration; and
- 8.9.1.7 to encourage Katherine to practise self-hypnosis on a regular basis in her daily life.

8.9.2 Summary of Eighth Session

Katherine's father brought her in and reported that she would be away for three weeks. She was to have her sinuses scraped on one of the therapy days and was then flying, with her siblings, to the seaside to visit her grandparents.

Spontaneous chatting developed and Katherine was excited because school was 'breaking up' and the children were having fun activities at school, such as general knowledge quizzes and very little work was being done in class.

The **body friends** were then discussed and Katherine again focused on **turtle tummy**, **octopus fingers** and **swan-like neck** as the friends she needed to help her relax and counteract **butterfly tummy**, **fighty fists** and **shivering shoulders**.

Katherine was then asked to become aware of her breathing, to listen to the rhythm of it and to increase and decrease the pace of her breathing. In this way, her energy flow between the internal and external environment was explored. She was asked to close her eyes, which she readily did. She became quite absorbed in the task and appeared to allow a shallow trance to take place. Feelings and images were suggested to her; light like a helium balloon; heavy like a lead ball, to help her to **feel** the changes in her body. The **body friends** were mentioned to help her to relax fully. She was then asked to imagine that her whole body was becoming light, so light that it felt as if she was just floating up into the sky, like a helium balloon. She was resting on soft cottonwool clouds, watching the birds fly by. She was then encouraged to **wake** herself when she was completely relaxed and peaceful. This was done so that she could practise bringing herself out of the self-induced trance. She chatted about how she felt when she opened her eyes, saying that she felt **nice and relaxed** and that her whole body had been able to **let go**.

The **touch, tingle, twitch arm levitation** was then used for a formal induction. Katherine's right arm was held gently by the therapist and she was asked to relax it. She was told that the therapist would gently run her fingers up from the tip of Katherine's fingers to her elbow [which was exposed after her sleeve had been rolled up] and that she would feel a slight tingle and that the tingle would go on after the therapist stopped touching her. This was repeated with the suggestion that she may feel slight movements in her fingers, little twitching movements that were happening without her doing anything. Katherine's fingers twitched very slightly. Then the suggestion was given that the movements would die away and that her hand would return to normal [**undoing** the suggested phenomena is extremely important]. The movements stopped and the therapist, while telling Katherine what she was doing, once again ran her fingers up Katherine's arm, suggesting this time that her whole hand would feel light, so light that it would feel as light as a feather and would begin to float up all on its own into the air,

as the therapist counted to five and that Katherine would sink deeper and deeper into a trance, the lighter her hand became. At this stage, her eyes closed spontaneously.

On the count of two, her hand had not moved, so the therapist gently moved her arm up and down for her to **gain** the feeling of weightlessness. Then her arm began to lift up slowly to the count of five. It was then suggested that when her arm returned to the cushion, she would sigh and breathe the last bit of tension out.

She was then encouraged to walk down the staircase to ten counts [deepening technique] and to enter her own special place. The suggestion was made that she could feel as if she really was there and she could explore it, to see what she could see, hear, touch, etc.. She was then requested to show the therapist, by wiggling her yes finger of her right hand, when she was ready to leave her special place.

She then **journeyed** to her classroom at school. She was still in Std. 1, her teacher's name was mentioned and she was asked to think about all the things in school that worried her or made her scared and anxious. Together, the therapist and Katherine compiled the following list and set it out in a hierarchy, starting from the least threatening to most threatening, according to the severity of these feelings. This was done to pave the way for desensitisation techniques to be used in future sessions, to lessen Katherine's anxiety within the classroom [The order has been reversed and now reflects most threatening to least threatening]:

- (1) the teacher shouting and her getting bad marks [Katherine could not decide between these two, so they were kept at the same level];
- (2) someone laughing at her;

- (3) speaking in front of the class;
- (4) not drawing well;
- (5) not doing as well as Julia and Lauren [two rivals in the class]; and
- (6) leaving a book at home or losing it [Katherine said leaving a book at home was less scary than losing a book, because at least she knew where it was in the first instance].

Katherine was then encouraged to return to her **safe place** and to let go again as she had visibly tensed up when dealing with these anxieties. Her face often grimaced and her body muscles tensed up as well.

Katherine was then asked to imagine that she had a glove, a beautiful red glove and that this glove was magic. There was powder in it, which allowed her hand to go to sleep. She was to slowly pull on the glove, in her mind, as the therapist counted to five. [At this stage Tinkerbelle powder was sprinkled onto her hand and she acted out the pulling of the glove onto her right hand. This exercise was done to deepen her trance].

Katherine was then asked to choose which magical place she wanted to visit that day. She replied, 'To the magical island in a glass-bottom boat'. It was suggested that she could take along a very special friend with her called Moonface. She was handed a soft cuddly toy with long fur. [At no time did her eyes open, but she did reach out her hands to take the toy]. It was suggested that the **ball of light** she had experienced the previous session, could be taken along as well.

Her trance was then deepened by suggesting that she could go further down as she climbed the steps down to the glass-bottom boat. The therapist counted down from five and then suggested that Katherine had reached the boat and that

she could relax deeply and lie in a hammock on the boat, while the boat transported her to the magical island.

It was suggested to Katherine that as she watched the little fish and dolphins through the glass-bottom of the boat, she would feel like joining them and in her mind she could go and swim and dance in the water with them.

She was then asked what she could see, hear, feel, etc., under the water. She described some beautiful, magical flowers that could be eaten.

The therapist then suggested that there was danger ahead; that something in the water was very frightened and Katherine was asked to identify it. She hesitated and then suggested that perhaps it was a small fish. She was asked why it was so frightened and she replied that it was so small that no one could see it and it would get squashed. Katherine was asked how this little fish could be helped and she replied that she could pick it up and take it to safety. It was suggested that if she shared the **magical ball of light** with it, it could become a **glow fish** and then everyone could see it glowing.

In this way, it was suggested to Katherine that even the smallest of creatures could feel the warmth of the light and use it positively and safely. Her self-concept was then compared to a ball inside of her. All her feelings and thoughts about herself were contained in this **ball of self**. She could help it grow and shine if she **fed** it with positives; good things she told herself about herself that she believed in. It would get smaller as she experienced the **knocks** from the **outside world**, but she could help it grow again each time. Here the suggestion was made that she was really in control of her own emotional growth to a large extent and that she could empower herself.

She was then asked to say out aloud one thing that she liked about herself. After

a long pause, she said she couldn't think of a single thing. It was then suggested that Moonface would give her one and that was that she had beautiful golden hair that shone in the sunlight and that each time she looked at herself in the mirror, as she brushed her hair, she would remember what Moonface had said. In this way, it was hoped that her body-image would slowly improve.

Katherine was then **brought back** to the therapy room by the suggestion that she could climb up the staircase, back to the therapist's room, feeling relaxed, warm and comfortable. It was also suggested that she could use this method of relaxation whenever she needed it, even when she wasn't with the therapist.

Free play was then suggested and Katherine chose a game from the cupboard to play with the therapist.

8.9.3 Analysis of Eighth Session

It is felt that Katherine was able to relax her body and mind fully throughout the therapy session [cf. 8.9.1.1] and that she became aware of the rhythm of her breathing and the flow of energy between her body and her environment [cf. 8.9.1.2]. It was felt that the **body friends** also helped her to identify with different areas of her body, in a fun and game-like way.

A hierarchy of her fears and anxieties was established [cf. 8.9.1.3] and it was felt that these could be used to desensitise her systematically in different sessions.

Her self-concept was dealt with and it was very evident that she was not familiar with the idea of **liking** anything about herself. It was suggested that this was necessary for her to grow emotionally. The concept of getting her to accept herself and building herself up, was introduced [cf. 8.9.1.5]. It is felt that to a

lesser extent, Ego State therapy was touched on by dealing directly with her ego [cf. 8.9.1.6] and encouraging her to find positives about herself.

Katherine was encouraged to practise self-hypnosis when she was not with the therapist [cf. 8.9.1.7]. Many metaphors were used throughout the session and Katherine responded in a positive way to them [cf. 8.9.1.4].

8.10 NINTH TO TWELFTH SESSIONS

8.10.1 Goals Set for Ninth to Twelfth Sessions:

- 8.10.1.1 to continue to reduce the level of anxiety;
- 8.10.1.2 to continue to deal with the symptoms of anxiety;
- 8.10.1.3 to continue to desensitise Katherine to the events that contribute to her anxiety;
- 8.10.1.4 to assist Katherine in improving her self-concept, self-esteem and body-image;
- 8.10.1.5 to assist Katherine in expressing her emotions more easily, especially her negative ones, such as anger, hurt, sadness, etc.;
- 8.10.1.6 to help Katherine to integrate all the various ego states more healthily, so that her own inner resources can be tapped and she can reach her full potential emotionally, socially, intellectually, morally and physically; and
- 8.10.1.7 to encourage the use of self-hypnosis in this way so that Katherine

feels more able to cope on her own and to prepare her for the final stage of therapy which is termination.

8.10.2 Summary of Ninth to Twelfth Sessions

Each session began with some form of progressive relaxation, either on the **magic mat** or in the **comfy chair**. In addition, discussions of the **body friends** that were assisting her to relax physically during the week, when she was away from the therapy room as well as her ability to find her **safe place** when she needed it, were regularly held. A variety of formal induction techniques were used, e.g. watching a **face** drawn onto her right index finger, finger lowering, magnets, magic key, etc., as well as informal ones such as metaphors and images told in story-form. In the ninth session, the hierarchy of fears that Katherine had discussed with the therapist in a previous session, was dealt with. Both the causes and initial sensitising events were traced, whenever possible, and the feeling of anxiety/fear was evoked. Katherine was then encouraged to increase the feeling by **turning up a switch**, until it was so intense that she could let go of it through relaxation [pushing her forefinger and thumb tightly together and allowing her body to relax completely, while concentrating on her breathing]. Feelings were discussed at each session, both generally and specifically. Katherine's feelings, which she experienced at school and at home, during the weeks between therapy sessions, were explored.

Katherine completed colouring in the **faces**, depicting certain positive and negative feelings and she expressed her fears about going up to the next standard in 1995. These fears were explored at a conscious and unconscious level. She stated that she was scared of getting a horrible teacher and that she feared not being with her friends again. Once her fears had been dealt with sufficiently, Katherine was encouraged to explore the possible pros of going up to a higher standard, to assist her in focusing on the positive aspects in life, so as to balance

the negative ones.

Direct and indirect suggestions were made to her at all appropriate times, to encourage her to feel better about herself, to relax her mind whenever possible and to set more realistic goals for herself to attain.

Her different **parts** [ego states] were **called up** on several occasions to encourage them to integrate more readily and easily.

The metaphor of a ball of warm light was used to help Katherine to **heal** herself from within. It began to symbolise for her the maternal warmth that she may have been longing for, over a long period of time.

Using Ego State therapy and regression simultaneously, it was possible to get the nine-year-old Katherine to talk to the 'younger' Katherine at a variety of different ages. In this manner, the ego states of her child, her parent and her adult were explored and attempts were made to integrate them.

In the final session of therapy, for research purposes, the STAIC and the RCMAS were administered and Katherine was encouraged to choose the toys or activities that she would like to play with or do.

8.10.3 Analysis of Ninth to Twelfth Sessions

Katherine always walked straight to the **comfy chair** and relaxed spontaneously into it. No resistance was ever demonstrated towards relaxing physically and mentally and it appeared as though she enjoyed this aspect of the therapy. Discussion around her week and her ability to relax herself, both physically and mentally, indicated that she was aware of the **body friends** that made her body tense and the ones that allowed her body to relax, as well as her ability to find

her safe place when she needed it. In this way, it was felt that her levels of tension and anxiety were reduced, not only in the therapy sessions, but also away from them [cf. 8.10.1.1].

Her symptoms of anxiety, such as her physiological complaints of sleep difficulties, pins and needles in her legs, breathlessness, etc., were dealt with whenever appropriate and it was evident that she was either experiencing them less or focusing less on them as the weeks went by [cf. 8.10.1.2].

While in trance, Katherine was encouraged to explore the events, feelings, etc., that contributed to her anxiety and systematic desensitisation was frequently used [cf. 8.10.1.3]. Katherine was able to explore her negative emotions while in a trance, but struggled to chat about them spontaneously. This area appeared to require further therapy as it was still an issue for her [cf. 8.10.1.5].

It was felt that all Katherine's ego states were slowly being integrated more healthily and that this was allowing her to behave in healthier ways, both at home and at school [cf. 8.10.1.6]. The previous compulsive behaviour was lessening, but was not completely removed. She still needed to wash her hair more frequently than most children, but was able to be more flexible in the times that she washed it. [It was, however, evident from a family session the therapist had with her mother, that Katherine's mother set excessively high standards for Katherine to attain and also felt guilty about many aspects of her inability to nurture her child sufficiently. The guilt appears to make her push her daughter further away from her emotionally and become irritated and disapproving of her daughter's behaviour. These aspects would need to be dealt with in a family or individual session with her mother].

Katherine used self-hypnosis regularly and appeared to enjoy the benefits it gave her. She reported, frequently, that she used it before having to make speeches

in front of the class or having to swim in a gala or dive in front of the class. She also used it at home when she felt she wasn't able to do her homework on her own [cf. 8.10.1.7].

It is not known to what extent Katherine's self-concept, self-esteem and body-image improved because these aspects were not individually measured previously. However, it was evident that she presented as more confident generally and she felt she was making progress in this area at school. She also stopped complaining that she was too fat and she appeared to be more comfortable with herself and her abilities, generally [cf. 8.10.1.4].

8.11 ANALYSES OF CASES C AND D:

8.11.1 Synopses of Assessments of Sandra and Rosemary [cf. 7.4]

8.11.1.1 Sandra

Sandra's assessment revealed that she was experiencing high levels of anxiety [A-State: 94%ile; A-Trait: 93%ile; RCMAS: 94%ile; CAEF: 11 out 12]. There was evidence from her projective tests, especially the TAT and ISB, that her levels of anxiety were negatively affecting her overall development, as well as her relationships with herself and significant others. An overanxious disorder was diagnosed, and certain inappropriate fears, phobias and social anxieties were also evident. Sandra also complained frequently of headaches and stomachaches, which resulted in her being absent from school on certain days. The following areas of difficulty were especially noted:

- * feelings of inadequacy and inability to meet perceived expectations of parents and teacher;

- * difficulties relating to significant others in her life;
- * scholastic underachievement according to her superior intelligence quota;
- * concentration, attention and memory affected by her anxiety;
- * a tendency to become rebellious or passive-aggressive;
- * fears of the dark, of being left alone and of strangers; and
- * feelings of social inadequacy.

8.11.1.2 Rosemary

Rosemary's assessment revealed that she was experiencing excessively high levels of anxiety [A-State: 89%ile; A-Trait: 100%ile; RCMAS: 99%ile; CAEF: 12 out of 12]. It was also evident from the projective tests, especially the TAT and the ISB, that her high levels of anxiety were negatively affecting most of her relationships, specifically with her immediate family and her peers. She was diagnosed as having an overanxious disorder as well as a separation anxiety disorder and many accompanying fears, worries and phobias were also revealed. Psychosomatic symptoms were also diagnosed, such as nausea, headaches, stomachaches, enuresis and muscle spasms, which resulted in absenteeism from school on many occasions. The following specific areas of difficulty were noted:

- * unrealistically high standards set for herself and a fear of failure;
- * perfectionistic tendencies;
- * dissatisfaction with the quality of her interpersonal relationships, both with

family members and with peers and fears of her family members being hurt;

- * outbursts of temper at times and a feeling of losing control easily;
- * a need to avoid competition;
- * low self-esteem and feelings of inadequacy and inferiority;
- * a strong sense of mistrust; and
- * signs of depression and passive-aggressive traits.

8.11.2 Format of Therapy Sessions for Sandra and Rosemary

These sessions have, to a large extent, followed the same format, wherever possible, that Katherine's sessions took, in order for the therapist to compare the different responses of the children. Only if the child had other issues to deal with, was the therapy modified in any way and the emphasis of therapy, at all times, was on dealing with the specific difficulties of the particular child. The metaphors and images were therefore designed to assist the individual child specifically.

The main aspects of the different sessions are highlighted below:

*** First Session**

- spontaneous conversation;
- confidentiality between the therapist and the child dealt with;

- regularity and time of weekly therapy session discussed with the child;
- learning to relax and the introduction of **body friends**;
- theraplay activities engaged in, e.g. face painting and/or body massage;
- ideo-motor signals introduced;
- progressive relaxation learned;
- imagination stimulated and explored;
- trance induced by direct and/or indirect methods;
- protection from being hypnotised by unauthorised persons;
- colouring in **feeling faces**; and
- free play.

* **Second Session**

- greeting and spontaneous chatting;
- establishing a list of child's favourites, e.g. food, TV programmes, stories, animals, etc.;
- guessing game; what can be felt, smelt, heard, etc.;
- fun with the viewmaster to encourage forming **pictures** in the mind;

- inductions (formal and informal);
- establishment of a **special place**;
- discussion of feelings/emotions; and
- free play.

* **Third Session**

- initial greeting and spontaneous conversation;
- fun on the magic mat - nurturing activities, e.g. face-painting and relaxation exercises with the help of **body friends**;
- induction - magnets;
- deepening - going down steps/staircase to magical garden, fairyland, etc.;
- administration of the Stanford Hypnotic Clinical Scale for Children: Standard Form [6 - 16 yrs];
- colouring in **feeling faces** - discussion of child's feelings that week; and
- spontaneous and free play.

* **Fourth Session**

- chatting;

- relaxation with the help of **body friends**;
- breathing exercises;
- induction - finger lowering;
- deepening - glove technique;
- guided fantasy metaphors and mutual story telling;
- discussion about feelings, colouring in **feeling faces**; and
- free play.

* **Fifth Session**

- spontaneous chatting;
- practising relaxation with the help of **body friends**;
- formal induction - the secret door;
- deepening - the magic glove;
- centring - feeling of balance within the centre of the body;
- regression - returning to a time when the child was younger;
- metaphors, story-telling and guided fantasy; and

- practising coming out of trance - first step to self-hypnosis.

* **Sixth Session**

- greeting and spontaneous conversation;
- informal induction through guided fantasy;
- anchoring an action to release anxiety, i.e. pushing thumb and forefinger tightly together, to release feelings of anger, upset, anxiety, etc.;
- self-hypnosis - going in and coming out; and
- dealing with emotions through talking, drawing, colouring in and painting.

* **Seventh Session**

- free chatting;
- relaxing physically with the aid of **body friends**;
- induction - finger lowering;
- sharing a **safe place** with therapist;
- deepening - arm levitation and helium balloon;
- images to assist - ball of light;

- dealing with causes of anxiety, if possible;
 - suggestions to lessen anxiety and its symptoms;
 - self-hypnosis practise; and
 - free play.
- * Eighth and any Subsequent Sessions
- free conversation;
 - relaxing with **body friends**;
 - induction - face drawn on finger;
 - deepening - walking down stairs;
 - entering **safe place**;
 - using Ego State therapy when appropriate;
 - working with unconscious material wherever possible;
 - reducing anxiety and its symptoms;
 - dealing with the causes of anxiety;
 - developing a hierarchy of fears/anxieties where appropriate;

- desensitisation of these fears and anxieties;
- dealing with feelings;
- practising self-hypnosis; and
- free play.

8.11.3 Goals Set for Therapy Sessions with Sandra and Rosemary:

8.11.3.1 General goals set for both children:

- 8.11.3.1.1 to develop rapport with each child;
- 8.11.3.1.2 to explore the child's perceptions of therapy and feelings about being in therapy;
- 8.11.3.1.3 to enable the child to distinguish between normal and neurotic anxiety;
- 8.11.3.1.4 to assist the child in learning to relax fully, both in body and mind;
- 8.11.3.1.5 to allow the child to develop a sense of control over her anxiety;
- 8.11.3.1.6 to help the child to develop a sense of awareness of self;
- 8.11.3.1.7 to assist the child in developing her powers of imagination fully and thereby to assist in the process of relaxation and entering a trance more easily;

- 8.11.3.1.8 to work with the unconscious material which may be revealed during trance and thereby reduce the anxiety and its symptoms, as well as deal with the root causes thereof;
 - 8.11.3.1.9 to encourage self-hypnosis whenever it becomes necessary for the child to relax;
 - 8.11.3.1.10 to encourage the child to explore and express her emotions more easily;
 - 8.11.3.1.11 to encourage the child to take part in free play, painting and drawing activities to release the anxiety;
 - 8.11.3.1.12 to protect the child from being hypnotised by unqualified and unauthorised persons; and
 - 8.11.3.1.13 to allow the child's family to understand the possible reasons for the child's high levels of anxiety and to assist the family members to cope with and modify aspects of the child's behaviour where necessary.
- 8.11.3.2 Specific goals set for Sandra:**
- 8.11.3.2.1 to assist her in feeling more adequate and able in all aspects of her life;
 - 8.11.3.2.2 to help her to relate better to others and to feel more socially adequate;
 - 8.11.3.2.3 to improve her powers of concentration and attention generally;

- 8.11.3.2.4 to encourage her to explore her feelings of aggression and rebellion and to enable her to assert herself more effectively;
 - 8.11.3.2.5 to help her deal with the irrational fears of the dark, strangers, and of being on her own; and
 - 8.11.3.2.6 to enable her to free herself of her anxieties, so that she would be more able to reach her superior intellectual potential in the future.
- 8.11.3.3 Specific goals set for Rosemary:**
- 8.11.3.3.1 to help her to gain more self-knowledge and thereby accept her limitations while respecting her strengths;
 - 8.11.3.3.2 to assist her in setting more realistic standards for herself, which she would then be able to attain and thereby feel challenged by success;
 - 8.11.3.3.3 to help her to improve her interpersonal relationships generally;
 - 8.11.3.3.4 to allow her to feel a certain amount of control over her impulses by means of systematic desensitisation and progressive relaxation;
 - 8.11.3.3.5 to build up her self-concept, self-esteem and confidence generally;
 - 8.11.3.3.6 to encourage her to become more assertive, less dependent on her family and to be able to explore her negative emotions more readily and easily; and
 - 8.11.3.3.7 to explore her feelings of depression with her in a non-threatening

manner.

8.11.4 Summary of Therapy Sessions

8.11.4.1 Sandra's Sessions

Sandra seemed comfortable with the idea of being in therapy and said she was there to 'improve her mind'. She was introduced to the different **body friends**, in the same way that Katherine had been and she appeared to relate to them and was interested in learning about them. She participated actively throughout the sessions, demonstrating at all times her superior intellect and high level of creativity. She was able to enter a trance easily and quickly and when she reached her own special place, she described it in the following way:

There are lots of sequins, sequins catching the light and beams of sunlight making the colours shine. There's a blue river made of sequins and a big green meadow and all the flowers are made of different coloured sequins sparkling in the light.

Each time she relaxed and entered a trance she found herself in this special and magical place. She was able to use the relaxation technique away from the therapy sessions and reported that once, when her sister was given a new porcelain doll for her birthday, she experienced terrible pangs of jealousy. She was able to count herself down from ten and breathe out the feelings and in this way, she was able to deal with her feelings. She was then able to reason with herself that she could get new clothes for her porcelain doll and that would make her feel better within herself. She found that balloon breathing and **turtle tummy** were the two **body friends** that helped her the most. She was able to learn self-hypnosis easily and appeared to enjoy being able to exercise it during the session and away from the therapy room. She proved to be an excellent hypnotic subject and her scores on the Stanford Hypnotic Clinical Scale for Children, are reported in Figure 8.2.

FIGURE 8.2

STANFORD HYPNOTIC CLINICAL SCALE FOR CHILDREN

STANDARD FORM [AGES 6 - 16]

Scoring Form

NAME: Sandra DATE: August 1994 TOTAL SCORE: 7
 AGE : 10 yrs 9 mths HYPNOTHERAPIST: The Researcher

SUMMARY OF SCORES

		Score (+ or -)
1.	Hand Lowering	(1) <u>+</u>
2.	Arm Rigidity	(2) <u>+</u>
3.	TV - Visual	(3) <u>+</u>
4.	TV - Auditory	(4) <u>+</u>
5.	Dream	(5) <u>+</u>
6.	Age Regression	(6) <u>+</u>
7.	Posthypnotic Response	(7) <u>+</u>
TOTAL SCORE		<u>7</u>

Comments:

Sandra was able to use her excellent powers of imagination and her very high levels of creativity during these activities. She was able to enter a very deep trance and her altered state of consciousness was evident. She was able to use the ideomotor signals well and to share with the therapist everything she was experiencing internally. No resistance at any stage was evident and she reported that she **felt** smaller when she regressed to the age of three and it seemed as if she was really **there** at the Christmas tree, unwrapping her rag doll.

She responded to the post-hypnotic suggestion by closing her eyes when the therapist clapped and opening them again when the therapist clicked her fingers.

Sandra regressed many times during the therapy sessions; once to the age of eight, when she fell off a slide and had to have stitches in hospital. Another time she regressed to the age of three and found herself with her grandparents at the Christmas tree where she was given an enormous ragdoll that made her feel very special. [She brought the ragdoll the next week to show the therapist.] During another regression, she became aware that her mother had left the house at night, to visit a neighbour and she lay awake worrying in case something terrible had happened to her. All of her fears and difficulties were explored with her and ways of reducing her anxiety were explored. Her fears of the dark and of burglars breaking in, were revealed and worked through.

Her fears of getting bad marks at school were revealed and the perceived nastiness of her teacher, was explored. Positive aspects of herself were explored and three aspects of her personality, which she liked, were explored and reinforced; Sandra, the writer; Sandra, the artist and Sandra, the creator. Her own levels of creativity were a source of strength to her and she could relate strongly to them. Her intense feelings of jealousy and anger towards her younger sister were explored and worked through on several occasions and the release of these feelings appeared to calm her and have a cathartic effect on her.

Sandra was also encouraged to explore in therapy and in trance, how she related to others, her friends, peers, cousins, etc., and in this way, her ability to relate to others was explored and she was able to express her deeper feelings and insecurities which she felt within these relationships.

8.11.4.2 Rosemary's sessions

Rosemary was initially very anxious and withdrawn. She was most concerned about all the work she had to cope with at school and all the extra-mural activities she was involved in and felt that she would have liked to play some team sports, but could not find the time for them. She also mentioned that she had a lot of difficulty getting along with her peers and her friends. She often felt deserted by them after **terrible fights** that kept erupting.

She seemed to understand why she was in therapy and felt that she would like to work on some of the issues that worried her. Confidentiality was dealt with and progressive relaxation was explored with her, as well as ideo-motor signals. She found her stomach and arms to be the areas which **held** most of her tension. She appeared to relate well to the **body friends** and remembered them easily and used them in therapy sessions and between sessions, while at home or at school.

Rosemary could relate well to the deepening technique of walking down the staircase and described it in the following way:

I walked down the stairs, I was going very slowly. I could only see my feet and I had shoes on with black heels and the staircase had a Persian carpet on it, with all the different colours and designs ... At the bottom, I walked through an open door and I heard a crunch under my feet and I saw grass that was made of peppermint crisp ...

In the second session, her difficulties with her friends were explored while she was in a deep trance. Her own feelings of inadequacy were revealed and a way to deal with her anger, that exploded to cause the **huge fights**, was found. She was taught to feel the anger rising up in her and by means of autogenic feedback, to push her thumb and forefinger together very hard and, at that time, to breathe

out the anger and to let go of it.

Ego State therapy was done and Rosemary was encouraged to explore all the different **parts** of herself. She was asked to examine the parts that she liked and in this way she was encouraged to feel more positive about herself. The guessing game and viewmaster pictures were not done with her, as they were deemed too immature and babyish for her to respond well to.

Between the third and fourth sessions, Rosemary asked her mother to speak to the therapist about the tape recorder that was being used to record the sessions. It became apparent that she felt very uncomfortable about being taped. Although these issues had been discussed with both her and her parents initially, it became evident that it had not been sufficient to deal with the issue of confidentiality in the first session only. This issue was then explored with her and she reported that she was concerned that perhaps her parents could be given the tape to listen to. She did not seem to react in the same way to the video camera, but as it was less visible than the tape recorder, being suspended from the ceiling, she may have forgotten about it over the weeks. She was reassured that the recording was for the therapist's use only and that her parents would not be permitted to listen to or view any of the tapes made during the sessions with her. She appeared relieved about this and the therapist realised that, perhaps for some anxious children, the issue of confidentiality may need to be dealt with on more than one occasion.

Each time a difficulty arose for Rosemary, she would ask her mother to speak to the therapist about it. The therapist gently explained to her mother that Rosemary would need to deal with these issues herself in therapy. Rosemary was reluctant to come to therapy in the holidays, as she said it was 'boring'. Further exploration with Rosemary revealed that she found it threatening to talk about her feelings and to deal with her problems, but she liked the relaxation and

she felt that this part of the therapy really helped her.

Although she had initiated the need to deal with study methods and organising her time more constructively, Rosemary was very reluctant to actually get down and do anything about it. Gentle encouragement to tackle this very issue allowed her to express that, just talking about it, made her feel more anxious and worried and she experienced a strong need to move away from the issues. With guidance she was encouraged to tackle the problem in small sections and then she became much more motivated and far less anxious about 'not being able to fit everything in'. Sessions were spent planning the work she needed to do for her final Std. 5 examinations, drawing up a timetable to study and working out mind-maps using colour, drawings, key words, etc..

Rosemary was able to reach fairly deep levels of trance, but she clearly struggled to trust the situation and had difficulty letting go. The following figure, [Figure 8.3], records the scores she obtained on the Stanford Hypnotic Clinical Scale for Children.

FIGURE 8.3

**STANFORD HYPNOTIC CLINICAL SCALE FOR CHILDREN
STANDARD FORM [AGES 6 - 16]**

Scoring Form

NAME: Rosemary **DATE:** August 1994 **TOTAL SCORE:** 6
AGE : 12 yrs 11 mths **HYPNOTHERAPIST:** The Researcher

SUMMARY OF SCORES

		Score (+ or -)
1.	Hand Lowering	(1) <u>+</u>
2.	Arm Rigidity	(2) <u>-</u>
3.	TV - Visual	(3) <u>+</u>
4.	TV - Auditory	(4) <u>+</u>
5.	Dream	(5) <u>+</u>
6.	Age Regression	(6) <u>+</u>
7.	Posthypnotic Response	(7) <u>+</u>
<hr/>		
	TOTAL SCORE	<u>6</u>

Comments:

Although Rosemary clearly had difficulty trusting the process, she was nevertheless a good hypnotic subject once she had been able to relax and **let go**. She had difficulty imagining her arm could not bend and tended to let it bend relatively easily, without any counter-reaction. However, her ability to see and hear while in a trance, was good and

she experienced vivid imagery. She **dreamt** about a horse which she was riding across a meadow and again appeared to be intensely involved in the process. She regressed to the age of nine years and could see her first house that she had lived in and also how she was dressed. She responded well to the post-hypnotic suggestions.

8.11.5 Analysis of Therapy Sessions

8.11.5.1 Sandra's sessions

It is felt that Sandra is beginning to feel more adequate in all aspects of her life [cf. 8.11.3.2.1]. She is beginning to speak more freely about her feelings, not only to the therapist, but also to her teacher.

She had to deal with her best friend emigrating to America, while she was in therapy and she was able to express her feelings in this regard. She has made new friends and while she is still experiencing some difficulties interpersonally, she appears to be making progress in this area [cf. 8.11.3.2.2].

During the therapy sessions, Sandra was able to concentrate and pay attention far above what is expected of a child her age. It was therefore deduced that the problems she was experiencing at school in this regard, could be related to boredom and frustration, rather than anxiety or neurological factors [cf. 8.11.3.2.3].

Sandra was able to deal with her feelings of anger, jealousy, etc., in therapy as well as in her everyday life. Underneath her anger lay far more feelings of inadequacy than rebellion or hostility [cf. 8.11.3.2.4].

Her fears of the dark, being hurt by strangers and being alone were explored and

ways of coping with these fears were found by Sandra and practised during the therapy sessions [cf. 8.11.3.2.5].

Generally, it was felt that Sandra made good progress during the therapy sessions and that many of her anxieties had been lessened [cf.8.11.3.2.6]. Although she was getting better marks at school, she was still considered to be underachieving, by her teacher. Her parents were assisted in taking some of their pressures off her and her mother entered therapy with the therapist to assist her emotionally. Sandra's therapy was not terminated after the eight sessions as it was felt that she could benefit from further therapy sessions.

8.11.5.2 Rosemary's sessions

Rosemary had many **dips** in her therapy and it was feared, on many occasions, that she would **give up**. However, she managed to persevere and good progress was subsequently made. However, it was felt that many more sessions would be needed to deal with Rosemary's deep sense of insecurity and lack of trust in people, generally. Far less unconscious material was revealed in the initial sessions than in the other two therapy cases. Rosemary also focused on the need for structured help in studying, which was time-consuming and more directive than was necessary in the other therapeutic interventions.

However, it was felt that Rosemary gained self-knowledge and was beginning to feel less threatened and more able to accept her areas of limitation [cf. 8.11.3.3.1].

She had great difficulty in being more realistic about her need for high marks. It is felt that only when her feelings of her self-worth improve, will she be free to set more realistic standards for herself [cf. 8.11.3.3.2].

Although Rosemary discussed her **fits** with her friends, it was felt that her ability to relate better with her peers would only occur when far more therapy was done with Rosemary at an intra-psychic level. She was far too vulnerable and sensitive to be able to explore others' feelings and needs in order to find a balance between hers and theirs [cf. 8.11.3.3.3].

Some systematic desensitisation was done with Rosemary, but needed to be repeated frequently. She did learn to relax more deeply with each session [cf. 8.11.3.3.4].

It was felt that her enthusiasm, generally, and her level of motivation improved, but that more therapy was needed before her self-concept, self-esteem and general levels of confidence would improve [cf. 8.11.3.3.5].

Rosemary found it very threatening to talk about her negative feelings and tended to move away from them, whenever possible. However, she demonstrated insight and maturity on several occasions when she revealed that she knew she would not be able to get rid of her problems just by moving schools. She has planned to go away to boarding school next year, against her parent's wishes and feels that she will cope even though it may be difficult for her [cf. 8.11.3.3.6].

Rosemary demonstrated far greater levels of psychic and physical energy after she was encouraged to tackle her problems herself and not to avoid them. It is felt that depression is no longer an issue and that she is far better able to motivate herself and persevere in areas that she has selected as important [cf. 8.11.3.3.7].

8.12 CONCLUSION

It was possible to complete all the sessions proposed for all three children. These sessions took place each week, for an hour at a time. On a few occasions, a week or two were missed if either the therapist was away or if a child was ill or away. No break in therapy of longer than three weeks was recorded for any child.

All three children settled into therapy with relative ease, although one child, Case D, found it more difficult to commit herself to the therapy than the other two children and a great deal of mistrust was highlighted. However, her resistance was dealt with and overcome by her eventually.

All three children responded well to the hypnotherapy aspect of the Hypno-play therapy. They were all good hypnotic subjects and enjoyed the physical and mental aspects of the relaxation. It was felt that the **body friends** helped them considerably to get into touch with their own levels of tension and their ability to relax progressively. One difference between this age group [6 - 12 years of age] and the smaller, pre-school children was the more structured form the therapy took. There appeared to be more of a distinction between when the child was in a trance and when he was awake. With smaller children, this distinction is less noticeable and the child may, for instance, enter a trance while he is playing on the floor with a car or listening to a story [cf. 6.5.2].

It was felt that all three children made good progress in therapy, but it was interesting to note that the expectations of the parents varied considerably in content but were equally high in degree. Case A's parents, her mother more specifically, expected her to be more self-sufficient and less emotionally needy, while Case C's parents, her father more specifically, expected her to obtain exceptionally high marks at school. Case D's parents expected her to **grow up**

and get along with her peers, without fights and yet could not **let go** of her emotionally. The effect the parents' expectations had on each child's therapy was not able to be measured in this study, but could be an important factor to focus on in future studies.

The progress that the three children made in therapy will be compared and reported on in Chapter Nine, as well as the conclusions drawn from the assessments and treatment of anxiety in these primary school children.

CHAPTER NINE

SUMMARY OF RESEARCH FINDINGS

9.1 INTRODUCTION

The aim of this study has been to explore the assessment and treatment of anxiety in primary school children. The need for this research arose from an identified paucity of standardised tests in South Africa, suitable for assessing anxiety, as well as a lack of research on therapeutic methods for treating anxiety in South African primary school children.

Chapter One explores these difficulties and highlights the need for assessing and treating anxiety in South African children of all ages. It is reported by Acuda [1993:54] that 10 - 24% of children in Africa, suffer from mental health problems and anxiety is known to be a major factor contributing towards psychological difficulties. A recent study carried out by St Leger [1994:1] reveals that 30% of South African black matric students suffer from anxiety and abnormal stress, as opposed to 6% of children in the overall South African population sample surveyed.

The aim of this chapter will, therefore, be to evaluate both the assessment battery used in this research and the Hypno-play therapy, with regard to its success or failure, in reducing the levels of anxiety in primary school children.

More specifically, the following questions will be focused on:

- * Has the battery of tests, chosen by the researcher, been able to measure the levels of anxiety in the sample of children assessed and, furthermore, has it been able to differentiate between the different types of anxiety?

- * Has the Hypno-play therapy reduced the levels of anxiety in the sample of children assessed and then treated?

In addition, this chapter will attempt to:

- * relate the information gained from the empirical investigation to the literature study;
- * record the conclusions that were reached by the researcher;
- * make recommendations with regard to future research; and
- * take note of the limitations of this particular research.

9.2 RESEARCH FINDINGS

9.2.1 Literature Study

Important aspects that emerged from the literature study are the following:

- * anxiety affects all children to a greater or lesser extent;
- * anxiety is multidimensional and can be divided into different types, namely state and trait; general and test; free-floating and manifest; overt and covert; normal and neurotic;
- * there is a relationship between anxiety and fear, phobias, depression and stress;

- * there are many varied theories of anxiety, the main ones being Psychoanalytic and Psychodynamic; Learning theory and Existential theory;
- * anxiety is caused by a variety of factors and situations and can develop in children at any stage of their development;
- * anxiety is often the result of children's basic needs not being met;
- * anxiety can cause psychosomatic illness and symptom formation in children and excessive anxiety can lead to childhood disorders in children and adolescents;
- * the different types of anxiety can be measured by a variety of standardised tests, namely questionnaires, inventories, interviews and projective media, such as drawings, stories and completing sentences; and
- * anxiety in children can be treated by means of play therapy, as well as hypnotherapy.

9.2.2 Empirical Findings

It must be emphasised that, due to the fact that this is an idiographic study of limited scope, the research findings reflect only on the research group studied and cannot be generalised to all primary school children suffering from anxiety. With reference to the selection of subjects for this research project, it is interesting to note that all six children were female, even though males were eligible for selection. In the six month period within which the subjects were selected, 49 boys were referred for assessment, compared to 33 girls. It is therefore surprising that none of these boys were eligible for this particular study. It suggests that fewer boys of primary school age present with symptoms of anxiety,

but this assumption would need further investigation.

With regard to the literature study and the hypotheses outlined in Chapter Six, the findings of the empirical research suggest the following.

9.2.2.1 Hypothesis A: Anxiety can be identified in primary school children by means of a psychometric assessment and can be treated by means of psychotherapy [cf. 6.2.1.1].

9.2.2.1.1 Hypothesis B: Anxiety can be identified in primary school children by means of a psychometric assessment. This assessment needs to include a variety of measures of anxiety, namely:

- questionnaires and inventories;
- interviews; and
- projective media, such as drawings, stories and incomplete sentences, in order for all the various types of anxiety to be measured in primary school children, both at a conscious and unconscious level [cf. 6.2.1.1.1].

9.2.2.1.2 Hypothesis C: Primary school children, identified as having high levels of anxiety, can be treated by means of Hypno-play therapy, their anxiety levels can be reduced and the causes and symptoms of the anxiety can be dealt with in therapy [cf. 6.2.1.1.2].

* **The results of the psychometric assessment**

It was evident from this research that the battery of tests used to assess anxiety in primary school children, was able to highlight the anxiety levels in those

children, as well as discriminate between the different types of anxiety in them. In order to assess the different types of anxiety in these children, it was necessary to include a variety of measures of anxiety. These will be briefly discussed below.

* **Questionnaires and Inventories**

[The scores on these tests are only recorded in percentile ranks and the following ranges will correlate with the various scores (cf. 6.4.2.1.2).]

0 - 20	21 - 40	41 - 60	61 - 80	81 - 100
Excessively Low	Moderately Low	Moderate	Moderately High	Excessively High

* **State-Trait Anxiety Inventory for Children [STAIC]**

This inventory was able to distinguish between state anxiety [how the child felt at that particular moment during the assessment] and trait anxiety [how the child generally feels]. The results of the six children assessed are tabled below [Table 9.1].

TABLE 9.1
RESULTS OF THE STATE-TRAIT ANXIETY INVENTORY

	<u>STATE ANXIETY</u>	<u>TRAIT ANXIETY</u>
CASE A	48%ile	99%ile
CASE B	58%ile	95%ile
CASE C	94%ile	93%ile
CASE D	89%ile	100%ile
CASE E	63%ile	62%ile
CASE F	90%ile	34%ile

It is, therefore, evident that **three** of the children perceived themselves as experiencing **excessively high levels of anxiety** whilst being assessed. **One** child [Case E] had a **moderately high level of state anxiety** and **two** children experienced **moderate levels of state anxiety**.

Of the six children assessed, **four** experienced **excessively high levels of trait anxiety**, while **one** child experienced a **moderately high level of trait anxiety** and **one** child perceived herself as experiencing a **moderately low level of trait anxiety**.

It seems important to mention here that the researcher had certain reservations about this inventory as it claimed to assess the child's reaction to situational anxiety which would be of a transitory nature and which would vary in intensity and fluctuate over time. In addition, it would evaluate the characteristics of the child's basic personality, which would remain fairly stable over time and situation. As the STAIC: A-State [Form C-1] only questioned the child as to his feelings at that particular moment, it was felt that it specifically measured his feelings towards being assessed and not towards a variety of different situations which may result in his feeling anxious. In this respect, it seemed that this aspect of the test was too restrictive and narrow. However, the STAIC: A-Trait [Form C-2], appeared to be better able to assess trait anxiety accurately and these results correlated well with the RCMAS, the results of which are recorded in Table 9.3.

* **Revised Children's Manifest Anxiety Scale [RCMAS]**

This test measured the child's awareness of his symptoms of anxiety and was very similar to the STAIC [Form C-2]. In fact, nine of the twenty questions were virtually identical. The following table [Table 9.2] records the results of this test.

TABLE 9.2

RESULTS OF THE REVISED CHILDREN'S MANIFEST ANXIETY SCALE

	CASE A	CASE B	CASE C	CASE D	CASE E	CASE F
TOTAL SCORE	87%ile	92%ile	94%ile	99%ile	63%ile	44%ile
I. Physiological	72%ile	65%ile	92%ile	97%ile	73%ile	57%ile
II. Worry/oversensitivity	99%ile	98%ile	93%ile	98%ile	28%ile	28%ile
III. Social Concerns	55%ile	93%ile	84%ile	97%ile	92%ile	66%ile
IV. Lie Scale	75%ile	70%ile	44%ile	15%ile	84%ile	94%ile

Five of the six children had **Total scores** indicating **high levels of Manifest Anxiety**. **Four** of these children had **excessively high levels**, while **one** child had a **moderate score**.

On the **Physiological Scale**, **two** children's scores fell in the **excessively high range**, while **three** fell in the **moderately high range** and **one** fell in the **moderate range**, indicating that **five** of them had difficulty relaxing physically and that their anxiety displayed itself in physiological symptoms such as **butterflies in the tummy, sweaty palms, difficulty breathing** and others such as **sleep disturbances, nightmares, fatigue and distractibility**.

The **Worry/oversensitivity Scale** indicated that **four** children had **excessively high scores** and **two moderately low ones**. According to Mattison *et al.* [1988:147], a high score on this scale suggests the likelihood of an anxiety disorder. This aspect will be explored further, under the heading of Anxiety Disorders.

Four of the children had **excessively high scores** on the **Social Concerns Scale**, indicating difficulties at an interpersonal level and feelings of inferiority, loneliness and unhappiness. Of the remaining two, **one** had a **moderately high score** and **one** a **moderate score**.

On the **Lie Scale** **two** children had **moderately high scores**, **one** a **moderate score** and **one** child had an **excessively low score**, indicating that she viewed herself realistically, but fairly harshly and critically. The **Lie Scale** [Reynolds & Richmond 1992:10] is able to detect when the child has a strong need for social acceptance and approval and/or when he is deliberately faking responses. The manual warns that when the **Lie scaled score** is greater than **13** and the **Total T-Score** is greater than **60**, caution should be given to interpreting the results of the test, as they may not be accurate. Although no child fell into this group, it was noted that **two** children had **excessively high scores** on this scale, indicating that they had an idealised view of themselves. This may have been due to the strong need for social acceptance, defensiveness or due to unrealistically high standards they may have set for themselves or had set for them by their parents. A **high Lie** score can also relate to feelings of social isolation and rejection on the part of the child.

The manual states, further, that a **high Lie** score is a good indicator of **emotional difficulties** in the child. In Cases E and F, **both** children scored at the **28%ile** on **Worry/oversensitivity [II]** and in the **excessively high range** on the **Lie scale**. This appears to indicate that they may not have answered the questions on the second scale accurately or honestly and/or may be suppressing and denying their own feelings of anxiety. It is therefore, in these cases vital to assess such children on projective media, where they are less able to manipulate the scores consciously, so as to obtain an accurate assessment of their anxiety and then to assist them in confronting their difficulties in therapy.

There is a strong correlation between the STAIC [A-Trait] and RCMAS Total scores of

the six primary school children assessed. Reynolds [1980:775] also found this correlation in a much larger sample of children and advocated that the two scales could be used as alternative forms of measurement. These results are reported in Table 9.3.

TABLE 9.3
CORRELATION OF STAIC [A-TRAIT] AND RCMAS RESULTS

	STAIC [A-Trait]	RCMAS [Total Score]
CASE A	99 %ile	87 %ile
CASE B	95 %ile	92 %ile
CASE C	93 %ile	94 %ile
CASE D	100 %ile	99 %ile
CASE E	62 %ile	63 %ile
CASE F	34 %ile	44 %ile

*** Interview**

- Children's Anxiety Evaluation Form [CAEF]

This form served to obtain a clinically meaningful assessment of anxiety in primary school children. It highlighted the child's clinical history, his symptoms and his signs of anxiety and proved to be most useful in the older children. It was found that the two youngest children were not able to respond as well as the older children, to the very specific and detailed questioning of the form. It allowed the older children to converse spontaneously about themselves and in this way, much information was elicited, which would not otherwise have been made available. The following table [Table 9.4] records the findings of this test.

TABLE 9.4
RESULTS OF THE CHILDREN'S ANXIETY EVALUATION FORM [CAEF]

	<u>SCORE OUT OF 12</u>
CASE A	12
CASE B	9
CASE C	11
CASE D	12
CASE E	9
CASE F	9

The scores of this test range from 0 - 12 and have been divided into the four ranges listed below.

0 - 3	4 - 6	7 - 9	10 - 12
Excessively Low	Moderately Low	Moderately High	Excessively High

Three children obtained **Total scores** that fell in the **excessively high range** and indicated anxiety levels that were **severe, continuous and dominating** all aspects of their lives. The other **three** children's **Total scores** fell in the **moderately high range**, indicating that their levels of anxiety were **negatively** affecting many aspects of their lives.

* **Projective media**

- **Drawings: Draw-A-Person and Kinetic Family Drawing**

(a) **Draw-A-Person [DAP]**

It is believed that the human figure drawn by the child relates directly and intimately to

the impulses, anxieties, conflicts and compensations characteristic of that child [Machover 1978:35]. In this way, it has been hypothesised that certain indices on the drawing will indicate the child's level of anxiety. The indices that have been included in this research are listed below in Table 9.5, together with the code names of the children who used them.

TABLE 9.5
INDICES OF ANXIETY IN DRAW-A-PERSON
OF CASES A-F

	CASE A	CASE B	CASE C	CASE D	CASE E	CASE F	TTL NO. OF EACH INDEX
excessive detailing	X	X	X	X	X		5
excessive erasing	X	X	X	X			4
inclusion of shadows, dark clouds, darkened sun							0
inclusion of monsters/ grotesque figures					X	X	2
size of drawing [small]			X		X	X	3
omission of body parts/ legs pressed together		X	X	X		X	4
cross-hatching							0
weak foundations			X			X	2
feint, hesitant lines			X	X		X	3
others: jagged lines, excessive pressure, features of face drawn last	X			X	X		3
Child's Total Score	3	3	6	5	4	5	26

(b) Kinetic Family Drawing [KFD]

Because the Kinetic Family Drawing requests that the child draws his family 'doing

something' an added dimension of movement is brought into the drawing. It is, therefore, important to view this drawing as to the actions, styles and symbols that the child includes in it.

Certain indices indicate the possibility of anxiety, insecurity and/or tension and these have been tabled, together with the children's code names, in Table 9.6.

TABLE 9.6
INDICES OF ANXIETY IN THE KINETIC FAMILY DRAWING
OF CASES A-F

	CASE A	CASE B	CASE C	CASE D	CASE E	CASE F	TOTAL NO. OF EACH INDEX
erasures	X	X	X	X			4
barriers/folding paper	X			X		X	3
omissions of self/body parts	X		X	X	X	X	5
shading of figures				X			1
inclusion of base							0
lining at top	X						1
underlining figures							0
hanging precariously/use of ladders				X			1
scribbling/use of X							0
others: irrelevant /excessive detail reluctance to complete drawing, encapsulation, use of symbols, omissions, dependency, feint, hesitant lines	X X	X	X	X	X	X	7
position child drew self	2	4	3	2	0	1	
Child's Total Score	6	2	3	6	2	3	22

It is evident from both the DAP and KFD that certain signs of anxiety can be detected in the children's drawings. Excessive erasing and detailing, omissions, small size of drawing and feint, hesitant lines were significant indices on the DAP. On the KFD, omission of self and/or body parts, erasures as well as barriers, were common in the children's drawings. Many children used feint, hesitant lines as well as symbols and actions to denote their anxiety. Excessive detailing was also evident. There appeared to be no pattern to the position in which each child drew herself.

Although the drawings proved to be invaluable in giving more insight into each child within his life-world and his interpersonal relationships generally, it is felt that the other projective tests were better able to highlight specific areas of anxiety in the children.

* **Incomplete Sentences Blank [ISB]**

It is Rotter and Raffarty's [1950:3] belief that the ISB allows the child to reflect his own wishes, desires, fears and anxieties into the sentences he completes. The criteria on which the children were assessed as to their levels of anxiety, are tabled on the following page, together with the children's code names.

TABLE 9.7
INDICES OF ANXIETY DEMONSTRATED BY THE INCOMPLETE
SENTENCES BLANK

	CASE A	CASE B	CASE C	CASE D	CASE E	CASE F	TOTAL NO OF INDICES
specific anxiety/fear	X	X	X	X	X	X	6
free-floating or covert anxiety	X	X	X	X	X	X	6
anxiety within relationship with:							
self	X	X	X	X	X	X	6
mother	X	X	X	X	X	X	6
father					X	X	2
siblings		X	X	X	X	X	5
peers		X	X		X	X	4
teachers		X	X	X		X	4
signs of aggression			X	X			2
unrealistic thoughts/signs of retreating from reality/escape into fantasy	X				X		2
Child's Total Score	5	7	8	7	8	8	43

It is evident from Table 9.7 that the ISB is a good measure of children's anxieties. Their sentences revealed both overt and covert anxiety and also allowed the assessor insight into the relationships of each child which were affected by anxiety. It is interesting to note that all six children suffered from a specific fear or anxiety, as well as free-floating or suppressed anxiety. In addition, all six children demonstrated anxiety within their relationships with themselves as well as with their mothers. Five of the six children demonstrated anxiety in their relationships with their sibling(s) and four with their teachers and four within their peer relationships. Only two demonstrated anxiety within

their relationships with their fathers. Two of the children appeared to use fantasy as a means of escaping from the anxiety and reality and two demonstrated signs of aggression.

* **Thematic Apperception Test [TAT] / Children's Apperception Test [CAT]**

The TAT and CAT have been described as revealing some of the dominant drives, emotions, sentiments and complexes of the personality. The children's responses tend to allow the assessor a view of the underlying, inhibited aspects and anxieties of each individual, of which the individual may not be consciously aware, or to which he may not want to admit. The child interprets the ambiguous human or animal situations, depicted in the cards, in terms of his personal, past experiences and present needs. Table 9.8 summarises the scores of each child, indicating the total number of indices of anxiety, highlighted by the cards selected. It also records the themes of anxiety that were assessed.

It is evident from the results that the TAT and CAT can both be used to measure anxiety in primary school children. Emerging from the themes of this sample of children were the following needs; the need for defence mechanisms, a high level of passivity, strong content and intensive conflict, the inability to find solutions or resolutions and themes of physical accidents and psychic trauma within their stories. There was a tendency towards hostility and aggression. This tends to suggest that anxious children are not able to deal with their negative emotions and strong drives and feel helpless and vulnerable in their environments. This then tends to activate their feelings of anger and hostility. The themes of orality, obsession, compulsivity in fantasy and activity levels, inability to identify strongly with figures and emotional guardedness and defensiveness [other than the specific defence mechanisms previously recorded] were not revealed, to any large extent.

TABLE 9.8
INDICES OF ANXIETY AS DEMONSTRATED BY THE TAT/CAT

	TAT				CAT		TOTAL
	A	B	C	D	E	F	
Total number of Indices of Anxiety	13	13	17	19	13	9	83
<u>Themes</u>							
defence mechanisms	X	X	X	X	X		5
passivity	X	X	X	X	X	X	6
aggression		X	X	X	X		4
orality							0
obsession				X		X	2
strong content and intensive conflict		X	X	X	X	X	5
compulsivity in fantasy and activity levels							0
inability to identify strongly with figures		X					1
lack of resolutions	X	X	X	X	X	X	6
emotional guardedness and defensiveness	X	X					2
physical accidents and psychic trauma		X	X	X	X	X	5
Total Number of Themes	4	8	6	7	6	5	36

*** Anxiety Disorders**

The term, neurosis, has been replaced largely by the term, disorder, and the anxiety disorders of infancy, childhood and adolescence, which are listed in the DSM III and mentioned in Chapter Three and again in Chapter Seven, are:

- overanxious disorder;

- separation Anxiety disorder; and
- avoidant disorder.

Table 9.9 records the findings of the assessment of the six primary school children with regard to anxiety disorders.

TABLE 9.9
ANXIETY DISORDERS

	CASE A	CASE B	CASE C	CASE D	CASE E	CASE F	TOTAL NO OF DIS- ORDERS
Position in Family	2	1	2	2	1	1	
Overanxious Disorder	X		X	X	X	X	5
Separation Anxiety Disorder		X		X	X	2 of 3 criteria	3
Avoidant Disorder							0
Child's Total Number of Disorders	1	1	1	2	2	1	8

It is obvious from Table 9.9 that the largest number of children [5] could be identified as having an **overanxious disorder**. However, Wicks-Nelson and Israel's [1984:150] research, which demonstrated that this disorder affects the **first born** child more often, is not fully reflected in this small sample of children. **Three** of the six were **first-born** and **three** were **born second**. However, in accordance with what they found, all these families were from a **higher socio-economic** group where there was an **unusual concern** about the level of performance reached and/or the high expectations, academically, of the child and his parents.

Three of the children were suffering from a **separation anxiety disorder** and none from an **avoidant disorder**. **Two** children were diagnosed as suffering from both an **overanxious**, as well as a **separation anxiety disorder** and this is recorded by Kaplan and Sadock [1989:1848] as being fairly common. As mentioned previously, Mattison *et al.* [1988:147] has found that the **second scale [Worry/oversensitivity]** of the RCMAS, has correlated well, in his studies, with **anxiety disorders**. He maintains that a **high score** on the **RCMAS' Scale II** indicates that the child can be diagnosed as suffering from an **anxiety disorder**.

The following table [Table 9.10] compares the scores of this scale with the anxiety disorders as described by the DSM III. The first two rows indicate the RCMAS Scales [II & Lie], while the next four rows record the various anxiety disorders that the children were diagnosed as having. The last two rows indicate whether there was a positive or negative correlation between the two measures [RCMAS: Scale II & DSM III Anxiety Disorders].

TABLE 9.10
COMPARISON BETWEEN THE RESULTS OF THE RCMAS [SCALE II] AND
DSM III ANXIETY DISORDERS

	CASE A	CASE B	CASE C	CASE D	CASE E	CASE F
RCMAS Scale II	99%ile	98%ile	93%ile	98%ile	28%ile	28%ile
RCMAS Lie Scale	75%ile	70%ile	44%ile	15%ile	84%ile	94%ile
DSM III Anxiety Disorders						
Overanxious	X		X	X	X	X
Separation Anxiety		X		X	X	
Avoidant						
Positive correlation	+	+	+	+		
Negative correlation					-	-

It is evident from these results that, in **four** cases, the **excessively high** scores on the **RCMAS [Scale II]** were indicative of **one**, or even **two**, **anxiety disorders**. The **moderately low** score of Case E did not, however, indicate that she was suffering from **two anxiety disorders**. Case F's **moderately low** score, also did not indicate that she could be suffering from an **anxiety disorder**. It would seem that the **RCMAS Scale II** scores can be manipulated by the children to hide or camouflage their true levels of anxiety. However, if the **Lie Scale** scores are taken into account, **high** scores on this scale will show which children are manipulating their scores, consciously or unconsciously.

It is therefore, with caution, that the assumption should be made that a **low RCMAS Scale II** score indicates the **absence** of an **anxiety disorder**. However, if the **Lie Scale** scores are taken into account, **high** scores on this scale can alert the researcher to be cautious in interpreting these scores. This fact also highlights

the necessity of using a variety of different tests in order to be sure that the child is being viewed from all aspects and that a thorough investigation into his anxiety is being made.

* **SYNTHESIS**

The battery of tests used to assess the six primary school children, was able to assess the levels of anxiety successfully and in addition, the combination of tests allowed the researcher to differentiate between the different types of anxiety that were being assessed. Many tests overlapped in the areas that they assessed, but this was felt to be valuable to the researcher in terms of correlating and substantiating the information adequately. The singularly most useful inventory appeared to be the **Revised Children's Manifest Anxiety Scale [RCMAS]**, while the **Children's Anxiety Evaluation Form [CAEF]** was particularly useful for the older children and highlighted areas that the other tests did not. All the projective tests proved valuable, especially the **Incomplete Sentences Blank [ISB]** and the **Thematic and Children's Apperception Tests [TAT & CAT]**. Although the drawings gave valuable information about the child generally, and about his relationships more specifically, they did not always highlight and pinpoint the anxiety as fully as the other projective media.

* **Results of the Hypno-play Therapy**

It is evident that the children who received Hypno-play therapy, benefited greatly from it with regard to their levels of anxiety being lowered [where appropriate].

* **An Analysis of the Results of the Hypno-play therapy**

Case A: Katherine

On the State-Trait Anxiety Scale Katherine's state anxiety increased by 9%ile ranks, but still remained within acceptable limits. Her trait anxiety level was reduced by 37%ile ranks and was brought within a more acceptable range. Her overall manifest anxiety on the Revised Children's Manifest Scale was reduced by 18%ile ranks and also brought within normal limits. Her Physiological reaction to anxiety was reduced dramatically by 46%ile ranks and it was felt that this may have been the result of introducing progressive relaxation, by means of body friends, to each therapy. Her Worry/oversensitivity Scale was reduced by 3%ile ranks and it was felt that further therapy is needed in this regard. Katherine's social concerns appear not to have been reduced by the therapy but remain within acceptable limits. Her score on the Lie Scale has been reduced by 11%ile ranks, indicating that her need for social approval has reduced significantly. However, this score falls in the moderately high range and further therapy may assist her in dealing with her defensiveness and need to project herself as socially acceptable which, in turn, will possibly allow her to accept her true self more readily.

Case C: Sandra

On the State-Trait Anxiety Scale Sandra's state anxiety decreased by 53%ile ranks indicating that she felt much more relaxed and at ease about being assessed the second time. Her trait anxiety level decreased considerably, by 49%ile ranks and was brought within a moderate range, from originally falling in an excessively high range. Her Total score on the Revised Children's Manifest Anxiety Scale [RCMAS] was reduced by 41%ile ranks and was also brought within a moderate range from an excessively high one. Sandra's physiological anxiety was reduced by 52%ile ranks while her Worry/oversensitivity Scale was reduced by 23%ile ranks but still falls in a moderately high range. It is felt that further therapy is needed to attend to this aspect of her anxiety. Her social concerns were reduced by 43%ile ranks and her Lie Scale was increased

by **11%ile ranks**, indicating less need to be self-punishing and self-critical and more ability to seek approval from others. This aspect indicated that Sandra had matured emotionally and was able to deal with her difficulties more realistically.

Case D: Rosemary

Rosemary's **state anxiety increased by 6%ile ranks** and remains in an **excessively high range**. As was stated before, Rosemary was not able to relax easily in the therapy sessions and her resistance was difficult to break through. Her lack of trust became an issue and, at one stage, it seemed as if she would terminate therapy prematurely. She was also insistent on working on study methods and time-tables and this need of hers was respected, but left little time during each session for progressive relaxation and the more formal aspects of Hypno-play therapy. More indirect methods were used, by means of indirect suggestions and metaphors, but it was felt that the therapy would need to continue, even after the research project had been completed. Her **trait anxiety was reduced by 2%ile ranks**, but remains at an **excessively high level**. Of interest, is her **manifest anxiety level**, which was significantly **reduced by 32%ile ranks** and now falls in a **moderately high range**. Her **Physiological reaction to anxiety was reduced by 40%ile ranks** and this appears to indicate that she perceives herself as more relaxed physically. Her **Worry/oversensitivity Scale** appears to have been **reduced dramatically by 37%ile ranks** and this augers well for a reduction in criteria indicating **anxiety disorders**. Her **social concerns** have also been **reduced by 16%ile ranks**, but remain in an **excessively high range** and further therapy will need to focus on this area in the future. Encouragingly, Rosemary's **Lie Scale** has **increased by 27%ile ranks**, indicating that she is less critical of herself and is now better able to seek approval from others in a realistic and healthy way. It currently falls in the **moderate range** instead of the **excessively low range**. It must also be mentioned that the possibility exists that Rosemary tends to exaggerate her difficulties when

answering questionnaires of this nature. She became quite caught-up in and excited by the questions and enjoyed both assessments. It is felt that the use of questionnaires and inventories alone, due to lack of space and time, could have given a less accurate measure of Rosemary's progress, than if the full assessment had been repeated.

The following table [Table 9.11] documents the results of the pre- and post-testing in the sample of the six primary school children.

TABLE 9.11

RESULTS OF EIGHTH TO TWELFTH SESSIONS OF HYPNO-PLAY THERAPY ON THE CHILDREN'S ANXIETY LEVELS

	CASE A			CASE C			CASE D		
	Before therapy	After therapy	+/-	Before therapy	After therapy	+/-	Before therapy	After therapy	+/-
		[12 Sess]	ranks		[8 Sess]	ranks		[8 Sess]	ranks
STAIC A [State]	48%ile	57%ile	+9	94%ile	41%ile	-53	89%ile	95%ile	+ 6
STAIC A [Trait]	99%ile	62%ile	-37	93%ile	44%ile	-49	100%ile	98%ile	- 2
RCMAS Total Score	87%ile	69%ile	-18	94%ile	53%ile	-41	99%ile	67%ile	-32
I. Physiological	72%ile	26%ile	-46	92%ile	40%ile	-52	97%ile	57%ile	-40
II. Worry/oversensitivity	99%ile	96%ile	- 3	93%ile	70%ile	-23	98%ile	61 %ile	-37
III. Social Concerns	55%ile	55%ile	0	84%ile	41%ile	-43	97%ile	81%ile	-16
L. Lie Scale	75%ile	64%ile	-11	44%ile	55%ile	+11	15%ile	42%ile	+27

* **Causes and symptoms of the children's anxiety that were dealt with in Hypno-play Therapy**

Hypno-play therapy was designed to deal with both the causes and symptoms of anxiety. The possible reasons for the children's anxieties were often explored during the initial history, taken from the parents, and certain assumptions were then explored during the assessment and again in therapy. Often the children's perceptions of the causes of anxiety were revealed by regressing the children in trance and allowing the unconscious mind to reveal the initiating events that led to anxiety in the children. Ego State therapy also allowed the therapist to activate the different 'parts' of the children and in this way reveal conflicts, drives, needs and suppressed emotions that could allow the children to feel anxious.

The following table [Table 9.12] indicates how the Hypno-play therapy revealed, influenced and/or decreased the causes and symptoms of the children's anxiety and Table 9.13 evaluates their therapies on a number of different points.

TABLE 9.12

CAUSES AND SYMPTOMS OF THE CHILDREN'S ANXIETY

	CASE A		CASE C		CASE D	
	<u>Before</u>	<u>After</u>	<u>Before</u>	<u>After</u>	<u>Before</u>	<u>After</u>
Investigation and address of the causes of anxiety	Feelings of being unprotected; needing to be self-sufficient; lack of emotional nurturing; unmet dependency needs.	Katherine began to feel stronger within her self and self-nurturing became more evident. She was also able to make her needs known to her family to a greater extent.	Feelings of inadequacy; high parental expectations, especially from her father; strained interpersonal relationships.	Sandra was able to set goals for herself that she felt she could and wanted to achieve. Parental and teacher pressures were dramatically reduced.	A strong sense of mistrust of others; feels victimised; inability to feel 'close' in relationships; difficulties with father.	Rosemary's therapy concentrated on the need to build trust; her relationships were improving at home; but peer relations were still problematic.
Symptoms of anxiety	'Butterflies in tummy'; fears of bad things happening; sighing; vomiting; need to urinate often.	All physiological symptoms of anxiety were reduced and Katherine complained far less about feeling tense and fearing 'things' as much	Headaches and stomachaches; passive aggression.	Sandra's attendance at school improved and fewer physiological complaints were made; She also became far less passive-aggressive and more active in her approach.	Headaches and stomachaches; repeatedly at doctor; nausea, etc; outbursts of temper; need to avoid competition; fear of failure.	Rosemary's psychosomatic complaints reduced dramatically. She was far less often absent from school. She was able to compete more easily. Her fear of failure was still evident but it was reduced in intensity.
Obsessive-compulsive tendencies and perfectionistic behaviour	Needing to wash her hair every morning before school; refusal to do her homework tasks herself, as 'they were not good enough' if she did them.	Katherine began to wash her hair less frequently. She was also able to draw her own pictures and complete her own homework tasks and to take pride in doing them herself.	Obsessive jealousy reported; phobias reported; scared of aliens, the dark, bolted windows each night; nightmares.	Sandra was able to deal with her jealousy of her sister, in therapy and this was reduced significantly. Irrational fears were also reduced.	Need to tidy her room excessively; need for order; need to focus on time and routine.	She was less obsessive-compulsive and was more able to settle down and tackle projects without the high level of anxiety as before. She was able to set a timetable for exams and work consistently through it.

TABLE 9.13
HYPNO-PLAY THERAPY EVALUATED

	YES/NO	CASE A	YES/NO	CASE C	YES/NO	CASE D
Ego states activated	Yes	<ul style="list-style-type: none"> * Parent, child and adult; * 'Inferior one' who was teased and criticised at school; and * 'Naughty one' who would get into trouble. 	Yes	<ul style="list-style-type: none"> * 'Creative' one; * 'Jealous' one; * 'Hurt' eight-year-old; and * Three-year-old at grandparents receiving well-loved rag doll. 	Yes	<ul style="list-style-type: none"> * Angry part; * Victimised part; * Distrustful part; * Timid part; and * Bored part.
Work with irrational/worry perceptions of child	Yes	<ul style="list-style-type: none"> * Fear of school & tests, etc.; * Teacher would shout at her, get cross with her, etc.; and * She was helpless, could not do her own work, could not draw. 	Yes	<ul style="list-style-type: none"> * Fear of bad marks; * Burglars stealing her; and * Teachers disliking her. 	Yes	<ul style="list-style-type: none"> * 'No one likes me'; * 'Others are mean to me'; and * 'I'm always nice to everyone'.
Sense of control over anxiety	Yes	<ul style="list-style-type: none"> * Ball of light to 'warm' her; * Pushing thumb & forefinger together to allow feelings of anxiety out; and * Turning 'switch' up or down. 	Yes	<ul style="list-style-type: none"> * Switching anxiety switch down or up; and * Breathing out to count of three. 	Yes	<ul style="list-style-type: none"> * Less depressed; * Allowing her anger out through her thumb and forefinger; and * Breathing out anger and/or anxiety.
Physical and mental relaxation achieved	Yes	A very high level of both physical and mental relaxation achieved.	Yes	Relaxed deeply, both physically and mentally - very creative in mental images used.	Yes	Systematic desensitisation used often. Able to enter deep trance.
Use of self-hypnosis	Yes	Enjoyed using it and practised frequently in therapy sessions and at home.	Yes	Used her own creative mind to help her find different and interesting safe places .	Yes	To a larger extent at a physical rather than mental level; [progressive relaxation].
Ability to express thoughts and feelings more easily	Yes	Yes, especially at home to mother.	Yes	In therapy and to teacher.	Yes	In therapy and at home; and Difficulties still at school.

9.3 CONCLUSIONS

It is evident, from this research, that anxiety can be assessed in primary school children by means of a battery of tests. Furthermore, different types of anxiety can be identified by using a variety of tests, such as questionnaires, inventories, interviews and projective media, i.e. stories, drawings and completing sentences. The results of the assessment have highlighted the need to assess both conscious and unconscious aspects of the child's anxiety, so as to obtain an overall and balanced view of how high the anxiety levels are and how the anxiety is affecting the child within his life-world.

Certain tests proved to be more useful than others, in certain circumstances. The Revised Children's Manifest Anxiety Scale correlated well with the other tests and the Thematic and Children's Apperception Tests, the Incomplete Sentences Blank and the Children's Anxiety Evaluation Form [especially with the older children], all gave valuable insight into how each child's anxiety affected his social development [his relationships with himself and significant others], as well as how it affected him emotionally, sexually, cognitively and morally.

The Lie Scale of the RCMAS proved to be most helpful in identifying children with strong needs for social acceptance and approval, as well as those who faked their responses consciously or unconsciously. The Worry/oversensitivity Scale [II] of the RCMAS helped to identify children with anxiety disorders, although it was not able to detect those children who attempted to minimise their high anxiety levels or who consciously or unconsciously faked their responses. In this event, the Lie Scale scores which were moderately high or excessively high, were successful in alerting the researcher to this possibility.

The Hypno-play therapy has proved to be successful at significantly reducing most levels of anxiety in the primary school children who were assessed and then treated. It has also been demonstrated that this form of therapy is able to deal with both the causes and the symptoms of the child's anxiety.

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9.4 RECOMMENDATIONS

In the light of this empirical study, the following recommendations can be made:

- 9.4.1** Further research is needed to explore whether anxiety affects South African primary school boys in a similar manner to the way it affects girls [cf. 9.2.2].
- 9.4.2** Further research is recommended, to explore in greater depth, the relationships the anxious female child has with herself, her mother and her sibling(s) as this study highlighted a pattern of problematic relationships in these areas.
- 9.4.3** As all six primary school girls had both a specific anxiety or fear, as well as free-floating or covert anxiety, it appears essential to include in any battery of tests for the assessment of anxiety, both self-inventory questionnaires as well as projective media, in order to assess both these

areas adequately.

- 9.4.4** Self-inventory questionnaires need to be used with great caution when conducting nomothetic research with anxious children in the light of their strong need for social approval and acceptance and their tendency [as highlighted by this research] to suppress their anxiety.
- 9.4.5** The projective media used with this sample of children, reflected a tendency in these anxious children towards defensiveness, the need for defence mechanisms, passivity, intra-psychic conflict and the inability to find solutions to their problems. It is recommended that these aspects be more closely examined to ascertain whether they could be the cause of the child's anxiety or whether they result from the child's high levels of anxiety.
- 9.4.6** According to the DSM III classification criteria, all six children could be identified as having one or more anxiety disorders. Further research on a nomothetic level is needed to ascertain whether the statistics of South African primary school children suffering from anxiety disorders is in keeping with those of the rest of the world [2 - 3% of the population (cf. 3.7.2)].
- 9.4.7** None of the children assessed could be classified as suffering from an avoidant disorder, and again research of a far larger group of primary school children is needed to ascertain whether South African children tend to suffer more frequently from overanxious and separation anxiety disorders than from an avoidant disorder [Kaplan & Sadock (1989:1851) suggest that an avoidant disorder is fairly uncommon].
- 9.4.8** The effectiveness of Hypno-play therapy would need to be researched

more thoroughly with a larger sample of children for any meaningful conclusions to be drawn. It would also be beneficial to research three groups of children simultaneously; Group A who receive Hypno-play therapy, Group B who receive traditional forms of play therapy and Group C who receive no therapy at all.

9.4.9 In order to assess the effectiveness of Hypno-play therapy, a full reassessment is recommended. Although the questionnaires and inventories of the State-Trait Anxiety Inventory for Children and Revised Children's Manifest Scale assisted in evaluating the reduction or increase in anxiety levels in the children who received therapy, it is felt that a full reassessment would have proved more thorough and meaningful, if time and financial implications had made it possible.

9.4.10 This research into the treatment of anxiety by means of Hypno-play therapy, revealed the strong influence that the parents and home environment had on the success of the therapy. Research into this aspect of the child's therapy may prove beneficial and may result in a reduction of the number of sessions needed with each child. The possibility of using metaphors and direct and indirect suggestions, as well as paradoxes, with the families in family therapy, may need to be explored.

9.5 IMPLICATIONS

The implications of the above recommendations are that:

- * a larger sample of children, of all ages, suffering from anxiety, would need to be assessed by the battery of tests used in this research and then treated by means of Hypno-play therapy in order for these results to be generalised

to all children suffering from anxiety.

Areas that need further exploration are:

- * the extent to which anxiety affects boys and girls;
- * the specific relationships that are affected by anxiety in the child or which increase the anxiety levels of the child;
- * the highly anxious child's tendency/ability to manipulate inventories and questionnaires;
- * the high levels of defensiveness, the need for defence mechanisms, passivity, conflict and the inability to find solutions that plague the highly anxious child;
- * the prevalence of anxiety disorders in South African children generally, and in primary school children specifically;
- * the effectiveness of Hypno-play therapy compared to other forms of play therapy and compared to no therapy at all; and
- * the possible use of aspects of Hypno-play therapy with the families of the highly anxious children.

9.6 LIMITATIONS OF THIS STUDY

As mentioned earlier in the chapter [cf. 9.2.2], this study has been of limited scope and the findings cannot be generalised to all primary school children suffering from anxiety. Further research, on a far greater scale, would be needed

in order to achieve this. Research of a nomothetic nature may be needed to verify these results of the assessment of anxiety, within the context of the broader South African population. Further research of a bigger sample of children is needed to verify the results of the Hypno-play therapy and comparisons with other forms of therapy are recommended.

9.7 FINAL WORD

This researcher became aware, during the course of the research, of the debilitating effect anxiety had on all aspects of the lives of the primary school children assessed. Especially noticeable was the negative effect it had on the child's social and emotional development. It is hoped, for this reason, that this study will create an awareness of:

- * firstly, the effect anxiety has on the general development of the child; and
- * secondly, the necessity to assess and treat anxiety in children of all ages.

Valuable information about the children's anxiety was obtained during the assessments and this was used in the planning and execution of the therapy. The therapy sessions resulted in an exciting time for both therapist and child and the Hypno-play therapy created a structured framework within which to work, but left space for the availability of using many other forms of therapy as well.

Finally, it is hoped that the advisability of using Hypno-play therapy to treat anxiety, both its causes and its symptoms, in all children will be recognised.

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APPENDIX A

HOW-I-FEEL QUESTIONNAIRE

Developed by C. D. Spielberger, C. D. Edwards, J. Montuori and R. Lushene
STAIC FORM C-1

NAME _____ AGE _____ DATE _____

DIRECTIONS: A number of statements which boys and girls use to describe themselves are given below. Read each statement carefully and decide how you feel *right now*. Then put an X in the box in front of the word or phrase which best describes how you feel. There are no right or wrong answers. Do not spend too much time on any one statement. Remember, find the word or phrase which best describes how you feel right now, *at this very moment*.

- | | | | | | | | |
|-----|------------------|--------------------------|-----------------|--------------------------|------------|--------------------------|----------------|
| 1. | I feel | <input type="checkbox"/> | very calm | <input type="checkbox"/> | calm | <input type="checkbox"/> | not calm |
| 2. | I feel | <input type="checkbox"/> | very upset | <input type="checkbox"/> | upset | <input type="checkbox"/> | not upset |
| 3. | I feel | <input type="checkbox"/> | very pleasant | <input type="checkbox"/> | pleasant | <input type="checkbox"/> | not pleasant |
| 4. | I feel | <input type="checkbox"/> | very nervous | <input type="checkbox"/> | nervous | <input type="checkbox"/> | not nervous |
| 5. | I feel | <input type="checkbox"/> | very jittery | <input type="checkbox"/> | jittery | <input type="checkbox"/> | not jittery |
| 6. | I feel | <input type="checkbox"/> | very rested | <input type="checkbox"/> | rested | <input type="checkbox"/> | not rested |
| 7. | I feel | <input type="checkbox"/> | very scared | <input type="checkbox"/> | scared | <input type="checkbox"/> | not scared |
| 8. | I feel | <input type="checkbox"/> | very relaxed | <input type="checkbox"/> | relaxed | <input type="checkbox"/> | not relaxed |
| 9. | I feel | <input type="checkbox"/> | very worried | <input type="checkbox"/> | worried | <input type="checkbox"/> | not worried |
| 10. | I feel | <input type="checkbox"/> | very satisfied | <input type="checkbox"/> | satisfied | <input type="checkbox"/> | not satisfied |
| 11. | I feel | <input type="checkbox"/> | very frightened | <input type="checkbox"/> | frightened | <input type="checkbox"/> | not frightened |
| 12. | I feel | <input type="checkbox"/> | very happy | <input type="checkbox"/> | happy | <input type="checkbox"/> | not happy |
| 13. | I feel | <input type="checkbox"/> | very sure | <input type="checkbox"/> | sure | <input type="checkbox"/> | not sure |
| 14. | I feel | <input type="checkbox"/> | very good | <input type="checkbox"/> | good | <input type="checkbox"/> | not good |
| 15. | I feel | <input type="checkbox"/> | very troubled | <input type="checkbox"/> | troubled | <input type="checkbox"/> | not troubled |
| 16. | I feel | <input type="checkbox"/> | very bothered | <input type="checkbox"/> | bothered | <input type="checkbox"/> | not bothered |
| 17. | I feel | <input type="checkbox"/> | very nice | <input type="checkbox"/> | nice | <input type="checkbox"/> | not nice |
| 18. | I feel | <input type="checkbox"/> | very terrified | <input type="checkbox"/> | terrified | <input type="checkbox"/> | not terrified |
| 19. | I feel | <input type="checkbox"/> | very mixed-up | <input type="checkbox"/> | mixed-up | <input type="checkbox"/> | not mixed-up |
| 20. | I feel | <input type="checkbox"/> | very cheerful | <input type="checkbox"/> | cheerful | <input type="checkbox"/> | not cheerful |

HOW-I-FEEL QUESTIONNAIRE

STAIC FORM C-2

NAME _____

AGE _____

DATE _____

DIRECTIONS: A number of statements which boys and girls use to describe themselves are given below. Read each statement and decide if it is *hardly-ever*, or *sometimes*, or *often* true for you. Then for each statement, put an X in the box in front of the word that seems to describe you best. There are no right or wrong answers. Do not spend too much time on any one statement. Remember, choose the word which seems to describe how you usually feel.

- | | | | | |
|-----|------------------------------------------------------------------|--------------------------------------|------------------------------------|--------------------------------|
| 1. | I worry about making mistakes | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 2. | I feel like crying | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 3. | I feel unhappy | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 4. | I have trouble making up my mind | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 5. | It is difficult for me to face my problems | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 6. | I worry too much | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 7. | I get upset at home | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 8. | I am shy | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 9. | I feel troubled | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 10. | Unimportant thoughts run through my mind and bother me | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 11. | I worry about school | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 12. | I have trouble deciding what to do | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 13. | I notice my heart beats fast | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 14. | I am secretly afraid | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 15. | I worry about my parents | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 16. | My hands get sweaty | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 17. | I worry about things that may happen | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 18. | It is hard for me to fall asleep at night | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 19. | I get a funny feeling in my stomach | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |
| 20. | I worry about what others think of me | <input type="checkbox"/> hardly-ever | <input type="checkbox"/> sometimes | <input type="checkbox"/> often |

APPENDIX B

'WHAT I THINK AND FEEL'

[RCMAS]

Cecil R. Reynolds, Ph.D and Bert O. Richmond, Ed.D.

NAME: _____ DATE: _____

AGE: _____ SEX [circle one]: Girl Boy GRADE: _____

SCHOOL: _____ TEACHERS: _____

DIRECTIONS

Here are some sentences that tell how some people think and feel about themselves. Read each sentence carefully. Circle the word 'Yes' if you think it is true about you. Circle the word 'No' if you think it is **not** true about you. Answer every question even if some are hard to decide. Do not circle both 'Yes' and 'No' for the same sentence. There are no right or wrong answers. Only you can tell us how you think and feel about yourself. Remember, after you read each sentence, ask yourself 'Is it true about me?' If it is, circle 'Yes'. If it is not, circle 'No'.

	Raw Score	Percentile	T-Score or Scaled Score
Total:			
I:	_____	_____	_____
II:	_____	_____	_____
III:	_____	_____	_____
L:	_____	_____	_____

- | | | |
|-----|-------------------------------------------------------------------|--------|
| 1. | I have trouble making up my mind | Yes No |
| 2. | I get nervous when things do not go the right way
for me | Yes No |
| 3. | Others seem to do things easier than I can | Yes No |
| 4. | I like everyone I know | Yes No |
| 5. | Often I have trouble getting my breath | Yes No |
| 6. | I worry a lot of the time | Yes No |
| 7. | I am afraid of a lot of things | Yes No |
| 8. | I am always kind | Yes No |
| 9. | I get mad easily | Yes No |
| 10. | I worry about what my parents will say to me | Yes No |
| 11. | I feel that others do not like the way I do things | Yes No |
| 12. | I always have good manners | Yes No |
| 13. | It is hard for me to get to sleep at night | Yes No |
| 14. | I worry about what other people think about me | Yes No |
| 15. | I feel alone even when there are people with me | Yes No |
| 16. | I am always good | Yes No |
| 17. | Often I feel sick in my stomach | Yes No |
| 18. | My feelings get hurt easily | Yes No |
| 19. | My hands feel sweaty | Yes No |
| 20. | I am always nice to people | Yes No |
| 21. | I am tired a lot | Yes No |
| 22. | I worry about what is going to happen | Yes No |
| 23. | Other people are happier than I | Yes No |
| 24. | I tell the truth every single time | Yes No |
| 25. | I have bad dreams | Yes No |
| 26. | My feelings get hurt easily when I am fussed at | Yes No |
| 27. | I feel someone will tell me I do things the wrong way | Yes No |
| 28. | I never get angry | Yes No |
| 29. | I wake up scared some of the time | Yes No |
| 30. | I worry when I go to bed at night | Yes No |
| 31. | It is hard for me to keep my mind on my schoolwork | Yes No |
| 32. | I never say things I shouldn't | Yes No |
| 33. | I wiggle in my seat a lot | Yes No |
| 34. | I am nervous | Yes No |
| 35. | A lot of people are against me | Yes No |
| 36. | I never lie | Yes No |
| 37. | I often worry about something bad happening to me | Yes No |

APPENDIX C

INCOMPLETE SENTENCES BLANK FOR YOUNGER CHILDREN

NAME: AGE: DATE:

INSTRUCTIONS

I am going to start a sentence for you and I'd like you to finish it, without thinking about it too long. Just say the first thoughts that come into your mind. There is no right or wrong answers. Be sure to give your real, true feelings.

1. My daddy is
2. When I can't do what I want to I.....
3. The thing I want to do most of all is.....
4. When I grow up I.....
5. If I were the boss around her, I'd
6. My teacher is.....
7. I know it's silly, but I'm afraid of
8. My best friend is.....
9. I likebest because.....

10. When I was a baby
11. I think most girls are
12. When I see mother and daddy [father] together I
13. My family is the
14. At school I get along best with
15. My mother
16. I would do anything to forget the time that I
17. I sure wish my father would
18. The thing I can do best is
19. I'd really be happy if
20. When I grow up and get a job, I
21. I wish I could lose the fear of
22. I like my father but
23. What I want to happen the most is.....
24. In school, my teachers

25. Most of my friends don't know that I'm afraid of
26. I don't like people who
27. I think most boys
28. When I grow up and get married
29. My family treats me like
30. The other kids in school are
31. My mother and I.....
32. My biggest mistake was
33. When I get sick, I.....
34. My fears sometimes force me to.....
35. When I see the teacher coming
36. The worst thing about me is
37. The kids I like best are
38. When I think about my body
39. I think that most mothers

40. The thing that makes girls different from boys is
-
41. When I am older
-
42. I like my mother but
-
43. I feel anxious when
-
44. When I get worried, I
-
45. The worst thing I ever did
-
46. When I'm feeling unhappy
-
47. What I want more than anything is
-
48. When my parents tell me to do something, I
-
49. When I'm not around, the other kids
-
50. When I get mad, I
-
51. The things I dream about most are.....
-
52. If I would have three wishes come true, I'd like
-

APPENDIX D

INCOMPLETE SENTENCES BLANK FOR OLDER CHILDREN

NAME: **AGE:** **DATE:**

DIRECTIONS:

These sentences are all about you. Please finish them with the very first thought that comes into your mind. There are no right or wrong answers. Try to express your own true feelings.

1. All my life I.....
.....
2. If I were bigger.....
.....
3. If I were smaller
4. If I were a boy [girl].....
.....
5. I'm afraid of.....
.....
6. When I'm afraid, I.....
.....
7. My mother thinks I
8. I often wonder
9. Other children
10. I get mad when

11. Nobody knows
12. My father thinks I
13. I can't understand why
14. When I get mad, I
15. I often wish
16. My friends think I
17. I like to
18. When I eat, I
19. I want to be like
20. In bed at night, I
21. I feel best when
22. When I'm alone, I
23. My hands.....
24. I feel dirty
25. My brother always

- 26. I wish I could lose the fear of
-
- 27. My sister always
-
- 28. I get sick when
-
- 29. My father expects me to
-
- 30. Some day I'll
-
- 31. I feel terrible when
-
- 32. My mother wants me to
-
- 33. I like to pretend to be a
-
- 34. When I feel bad, I.....
-
- 35. My fears sometimes force me to
-
- 36. Mothers don't
-
- 37. Too many times I
-
- 38. I hate to hear people say
-
- 39. I can never
-
- 40. I'd like to know
-

41. In school, I
42. I feel ashamed when
43. Things would be better if
44. I worry when
45. Before my brother [sister] was born
46. I feel disappointed when
47. When something is hard for me, I
48. I can't stand.....
49. When I break something, I
50. I am best at
51. I feel anxious when
52. When I am punished
53. I don't know why
54. When I try hard, I
55. When someone fights with me, I

- 56. When I see myself in the mirror
.....
- 57. My teacher thinks I
.....
- 58. When other children are playing, I
.....

APPENDIX E

MODIFIED CHILDREN'S ANXIETY EVALUATION FORM [CAEF] (abbreviated)

[Scoring: 0= not present; 1= mild, occurs irregularly and for short periods; 2= moderate, occurs more constantly and of longer duration; 3= severe, continuous and dominates child's life; 4= very severe, incapacitating]

		<u>ONSET</u>	<u>DURATION</u>	<u>COURSE</u>	<u>STRESSORS</u>
I	History Suggestive of Anxiety [check presence or absence]				
i.	Fears and worries				
ii.	Sleep disturbance				
iii.	Complaints of nervousness and unhappiness				
iv.	Appetite disturbance				
v.	Somatic complaints				
vi.	Anxiety equivalent symptoms [enuresis, encopresis, stuttering, etc]				
Global Rating I: (0-4) _____					

II	Child's Subjective Assessment	<u>G / S</u>	<u>SEVERITY</u> <u>0 - 4</u>
A.	Target anxiety symptoms. a) What makes you: i. nervous/anxious ii. upset iii. frightened iv. worried v. tense b) How can you tell that you are: i. nervous/anxious ii. upset iii. frightened iv. worried v. tense		
GLOBAL RATING II A. (0-4) _____			

		<u>CIRCUMSTANCE</u>	<u>G / S</u>	<u>SEVERITY</u> <u>0 - 4</u>
B.	Other Anxiety Symptoms			
i.	Anxious mood: anticipation of the worst, fearful anticipation.			
ii.	Tension: feelings of tension, inability to relax, feelings of restlessness.			
iii	Fears: darkness, stranger, being left alone, closed space, of crowds, animals, school, speaking in front of others, etc.			
iv.	Intellectual: difficulty with concentration, poor memory.			
v.	Depressed mood: loss of interest, lack of pleasure, unhappiness, early awakening, daily mood swings.			
vi.	Sleep difficulties.			
vii	Somatic: tinnitus, blurred vision, hot/cold flushes, feelings of weakness, prickling sensation.			
viii	Cardiovascular: palpitation, pain in chest, throbbing, a fainting feeling and missing beats.			
ix	Respiratory: pressure in chest, choking sensation, dyspnoea, sighing.			

		<u>CIRCUMSTANCE</u>	<u>G / S</u>	<u>SEVERITY</u> <u>0 - 4</u>
x	Gastro-intestinal: swallowing, wind, appetite changes, nausea, vomiting, looseness of bowels, constipation.			
xi	Genito-urinary: frequency or urgency of urination, menstrual or sexual problems.			
xii	Autonomic symptoms: dry mouth, flushing, pallor, tendency to sweat, tension headaches.			
GLOBAL RATING II B. (0-4) _____				
C.	Types of Anxiety		<u>YES</u>	<u>NO</u>
	Generalised Anxiety:			
	Do you feel upset and worried and just can't relax most of the time? How long do these feelings last during the day?			
	Social Anxiety: Do you feel particularly anxious when you meet strangers? Boys? Girls? In a new school? New neighborhood? Join a group of people you don't know very well? Are the feelings of nervousness so strong that you avoid these situations?			

	<u>YES</u>	<u>NO</u>
<p>Performance Anxiety:</p> <p>Do you feel particularly anxious when you are expected to do a task that you hope to do well in and that you are not certain of yourself such as:</p> <p>taking tests,</p> <p>doing projects,</p> <p>answering a question in class,</p> <p>writing a composition,</p> <p>speaking in front of the class?</p> <p>Phobias</p> <p>Do you feel scared of the following:</p> <p>darkness</p> <p>strangers</p> <p>being left alone</p> <p>closed spaces</p> <p>crowds</p>		

	<p>Panic Attacks:</p> <p>Have you ever had sudden attacks of feeling very frightened, so that you may feel your heart pounding, have difficulty breathing, feel numb and tingling in your fingers, perspire, feel dizzy and weak? Did it come on suddenly for no particular reason, or was it related to an upsetting or frightening experience? Were you using drugs at the time? Were you physically ill at the time? How frequently do they occur? How many times has it happened?</p>	<u>YES</u>	<u>NO</u>
--	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------	------------------

Global Rating II A+B (0-4) _____

		<u>SEVERITY</u> 0 - 4
III	Observations at Interview by psychologists:	
i.	Tenseness	
ii.	Strained or embarrassed look	
iii.	Close to tears	
iv.	Motionless & speechless with anxiety	
v.	Overly eager to please	
vi.	Too much joking	
vii.	Thinking becoming disorganised	

		<u>SEVERITY</u> 0 - 4
viii	Tremulousness	
ix.	Restlessness/fidgetiness	
x.	Excessive activity	
xi.	Tics	
xii	Nail biting	
xiii	Stuttering	
xiv	Swallowing	
xv	Sweating [wet palms]	
xvi	Dilated pupils	
xvii	Rapid respiration/sighing	
xviii	Others	
Global Rating III: (0-4) _____		

Global Ratings I _____

II _____

III _____

TOTAL SCORE OF GLOBAL RATINGS _____

TOTAL SCORE AVG I, II & III

$$\frac{\quad}{3} = \underline{\quad}$$

APPENDIX F

**STANFORD HYPNOTIC CLINICAL SCALE FOR CHILDREN
STANDARD FORM [AGES 6 - 16]**

Scoring Form

NAME: _____ DATE: _____ TOTAL SCORE: ____

AGE : _____ HYPNOTHERAPIST: _____

SUMMARY OF SCORES

		Score (+ or -)
1.	Hand Lowering	(1) _____
2.	Arm Rigidity	(2) _____
3.	TV - Visual	(3) _____
4.	TV - Auditory	(4) _____
5.	Dream	(5) _____
6.	Age Regression	(6) _____
7.	Posthypnotic Response	(7) _____

TOTAL SCORE _____

Comments:

1. Hand Lowering

Describe movement

Score + if arm and hand lowers at least
6 inches by end of 10 seconds

(1) _____

2. Arm Rigidity

Describe movement:

Score + if arm bends less than 2 inches
by end of 10 seconds

(2) _____

3 & 4. Visual & Auditory Hallucination [TV]

Programme preferred:

(3) Visual

Do you see it?

Is picture clear?

Is it black and white or colour?

What's happening? [detail of action]

Score + if child reports seeing a picture
comparable to actual viewing.

(3) _____

(4) Auditory

Can you hear it?

Is it loud enough?

Sound reported [words, sound effects,
music, etc]:Score + if child reports hearing some sound
clearly.

(4) _____

5. Dream

Verbatim account of dream:

Score + if child has an experience comparable
to a dream, with some action. This does not
include vague, fleeting thoughts or feelings
without accompanying imagery

(5) _____

6. Age Regression

Target event:

Where are you?

What are you doing?

How old are you?

Look at yourself and tell me what you're wearing.

How did it seem to be back there?

Was it like being there, or did you just think about it?

Did you feel smaller?

Other:

Score + if child gives appropriate responses and reports some experience of being there. (6) _____

7. Posthypnotic Response

Response to handclap:

Did child close eyes?

Appear to relax?

Do you feel relaxed?

As relaxed as before?

Discussion of specific items:

Response to handclap after suggestion removed:

Score + if child closed eyes and relaxed at initial handclap. (7) _____

TOTAL SCORE _____

APPENDIX G
AN EXAMPLE OF A GUIDED FANTASY
TO BE USED FOR SLEEP DISTURBANCES, ETC.

_____ this is a special tape for you. I have made up a story for you to listen to. How about letting your whole body relax, breathing deeply and letting all the tightness out? Snuggle up in bed, maybe let your eyes close and feel how very warm and still you have become. Now with your eyes closed, think of your very special friend the _____ that we'll call _____. _____ is also feeling very warm and comfortable and very, very tired, after playing all day in that special _____ called _____. He has put down his _____ and he's snuggling up on some warm leaves in a warm _____. He has his magic wand close to him and he's allowed one special wish. He has eaten his supper of _____ and all kinds of different _____ that he found in the _____. His tummy is full and he's just letting go and nodding off. His feeling heavier and heavier and heavier ... In his mind, he's imagining going on a journey down ten steps into a very special garden, through the back entrance of the _____. There _____ goes, _____ on the tenth step, going down; nine, eight, seven, six, five, four, three, two, one [long pauses between each] and how _____ entering this very special magical _____. Share with him all the things _____ can see ... the beautiful colours of the _____ ... what _____ can hear ... peaceful sounds, as all the other animals are asleep ... _____ can smell the freshness of the _____ and _____ can touch the velvety smooth soft _____ ... _____ lies down, next to the _____ and now _____ waves _____ magic wand and _____ makes one wish. A very special wish and that is that a _____ from South Africa can come and visit _____ and share in _____ adventure. _____ special name is _____. Now _____ is _____ years old and lives in a beautiful _____ in _____ waves _____ magic wand again and ... Oops, here comes a very warm sleepy _____ though the air and wrapped up in a warm cocoon made out of a very special sleeping bag. Now _____ sees _____, but _____ is relaxed; lying next to the _____ and _____ almost asleep. _____ keeps very quiet and very still. _____ so happy to be visiting _____ and _____ knows that if _____

_ wakes up, _____ will find _____ back in his warm, safe bed. So _
 _____ watches _____ eyes closing ... _____ lying very still. _____
 _ starts to feel sleepy too ... _____ eyes close _____ and off _____
 _ goes to sleep, into a deep, deep sleep. Nothing will wake _____ ... especially
 now that _____ is here with _____. Now _____ discovers a very
 important secret. _____ finds out that if _____ keeps very still _____
 _____ can reach _____ in _____ thoughts _____ can join _____
 _ in _____ dreams ... _____ feels so happy now that _____ and _
 _____ can have fun together so long as both of them are deeply asleep ... so deeply
 asleep that they will only wake up in the morning ... _____ magic wand is there
 to keep them safe till its time to get up in the morning. Then they will both wake up
 feeling very rested and really happy and _____ will be back in _____ bed in
 _____ and _____ will be in _____ in _____.

Now let yourself drift off into a very deep sleep, thinking about all the things we have
 talked about and tomorrow you will wake up feeling rested, relaxed and very refreshed.

APPENDIX H**SECOND EXAMPLE OF A GUIDED FANTASY**

Now we are moving into the forest and I think I hear water running. Could it be a waterfall? - Listen carefully - Maybe its a stream? What do you see? How big is it? What can you smell, hear, feel? Are there any things blocking the water? Can we help to unblock it? How deep is the water? Perhaps we could go for a ride down the steam on a log. Can you find us a log? We're off! Are we safe? Any animals around? Are they dangerous or friendly? How is our adventure ending? Let's find a safe place to spend a few minutes, just relaxing and feeling warm, safe and happy.