

**THE UTILISATION OF GESTALT PLAY THERAPY IN OCCUPATIONAL  
THERAPY INTERVENTION WITH TRAUMATISED CHILDREN**

**by**

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## Declaration

I declare that '**The Utilisation of Gestalt Play Therapy in Occupational Therapy Intervention with Traumatized Children**' is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

*M. Maree*

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**M. Maree**

**12 November 2007**

**Date**

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## **SUMMARY**

### **THE UTILISATION OF GESTALT PLAY THERAPY IN OCCUPATIONAL THERAPY INTERVENTION WITH TRAUMATISED CHILDREN**

The aim of the qualitative study was to explore and describe the utilisation of Gestalt Play Therapy in Occupational Therapy intervention with traumatised children. An applied study was conducted and the case study strategy was used with a flexible design. Objectives for the study included conducting literature reviews regarding the profile of the traumatised child and Occupational Therapy and Gestalt Play Therapy intervention with the traumatised child. The empirical study included data collection and analysis, with data gathered through semi-structured interviews. The gathered data was analysed with the use of Creswell's Data Analysis Spiral.

The empirical data showed that Occupational Therapists do utilise Gestalt Play Therapy in their intervention with traumatised children by drawing on their combined knowledge base of Gestalt Play Therapy and Occupational Therapy. Occupational Therapists then conduct a holistic assessment and treatment aims are set according to the assessment with a focus on providing holistic intervention.

#### **Key Concepts**

Gestalt Play Therapy, Occupational Therapy, Traumatized Children.

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## **CHAPTER ONE**

### **INTRODUCTION TO THE STUDY**

#### **1.1 INTRODUCTION**

A traumatic incident, according to Yule (1999:36), is global in its effects – those who are victim to it are injured physically, psychologically and socially. He states that, no matter at what age they are acquired, traumatic stress injuries are the puncture wounds of the psyche. Leaving little outward sign, they are in reality deep and devastating and long after they appear to have healed they may still be festering, producing effects that can be far removed from the original injury.

Many young children experience trauma resulting from psychological, physical and environmental events. Oaklander (1988:247), Yule (1999:36) and Dwivedi (2000:8) provide examples of the types of events that can cause emotional trauma in children, including divorce, serious illness, death, abuse, crime, molestation or natural disasters. They emphasise though, that it is not the seriousness of the event that can cause lasting wounds in the child, but the child's perception of the traumatic incident. Compounding such events, the child does not have the developmental coping mechanisms of adults and they often lack adequate familial support to comfort them.

According to Yule (1999:37) these early traumatic reactions in young children disrupt their functioning and it may interfere with the mastery of important developmental goals. He emphasises that children are also at a high risk of developing psychopathology following the experience of a traumatic incident. Dwivedi (2000:8) agrees with this and also states the treatment of the traumatised child and the principles of the trauma treatment may apply to child therapy more broadly than just the treatment of post-traumatic stress disorder.

Gestalt Play Therapy, as supported by Oaklander (1988:248), has been effectively engaged in the treatment of the traumatised child. She approaches the traumatic experience directly in the therapeutic setting and brings it out into the open, enhancing the child's awareness. She provides the child with the opportunity to talk about the experience and to possibly re-enact it symbolically. Geldard and Geldard (2002:35) stress that within Gestalt Play Therapy the therapist should not focus on the child's past experiences, but the child's current experiences, which is called the here and now. The therapist should therefore make the client aware of his sensory modalities and sensory experiences in the present moment. This will increase the child's awareness of himself and his environment. The child is then allowed to experiment with new behaviour and to integrate his new experiences. They explain that through this process the child is assisted to work through his 'unfinished business' and to complete the contact cycle. Ultimately it allows the child to expel the emotional baggage that he carries and to integrate the traumatic experience into this life.

The researcher has found that in Paediatric Occupational Therapy intervention with the traumatised child, the severe emotional problems of the child are often not the main focus of intervention. The main focus of Paediatric Occupational Therapy intervention is the developmental delays and functional difficulties of the child and also developing the child's independent participation in his activities of daily living (Hong & Howard, 2002:33; Stein & Cutler, 1998:85). The Occupational Therapist, in other words, is skilled in formulating rehabilitation programmes for the child to assist him in maximising his functional abilities including sensory-motor functioning, emotions, cognition and motivation. Models of intervention most frequently used, according to Howard (2000:13), include Sensory Integration, the Bobath Concept and the Biomechanical Model. Life skills and social skills can play a key role in this intervention and the child is assisted to relate effectively with his environment. However, the researcher has found that Occupational Therapists do not have the skill to effectively assist the traumatised child with emotional problems affecting his life spheres and functioning.

As the Occupational Therapist has a holistic approach to the child, this lack of skill could limit effective intervention. The researcher has found that Occupational Therapists are partaking in further training to address this lack of skill. Towards 2006 six Occupational Therapists have completed the Gestalt Play Therapy masters degree at the Huguenot College. More Occupational Therapists are currently studying for this degree. The researcher is of the opinion that the reason for this could be similarities between Occupational Therapy and Gestalt Play Therapy intervention. Some of these similarities include that the Gestalt Play Therapist works holistically with the child and his environment, as does the Occupational Therapist. The Occupational Therapist specialises in the use of purposeful activity during the treatment session which is similar to the projection activity that is used in the Gestalt Play Therapy intervention.

The researcher therefore wanted to explore and describe how Gestalt Play Therapy can be utilised in Occupational Therapy intervention with traumatised children. For the purpose of this study and to limit the discussions the researcher will refer to the child in the male form only, from this point on.

## **1.2 PROBLEM AND RATIONAL FOR THE STUDY**

The Paediatric Occupational Therapist works holistically within a child-centred (client-centred) approach. The therapist aims to maximise the child's functioning in all his life spheres by addressing all his presenting needs. According to Yule (1999:27) the traumatised child shows regressive behaviour, antisocial and destructive behaviour amongst a variation of other emotional and physical 'symptoms'. He emphasises the importance of resolving the emotional hurts at the core of the problems instead of merely addressing the secondary 'symptoms'. This requires the Occupational Therapist to conduct a proper assessment of the traumatised child's presenting problems and to prioritise the main presenting problems to be addressed in intervention.

### **1.2.1 Motivation for the Choice of Topic**

As an Occupational Therapist the researcher found it challenging to address the complex emotional trauma as the main presenting problem of the traumatised child. Occupational Therapy models, like sensory integration, neurological or biomechanical models, do not provide the therapist with the necessary tools to address these complex emotional needs. In order to work more holistically with the traumatised child, the Occupational Therapy profession needs to be able to effectively address the complex emotional needs of the child. Services for children are limited, especially for the family with limited finances. The researcher is of the opinion that it is imperative for the profession to gain the resources required for holistic intervention with the traumatised child. The fact that some Occupational Therapists are training in Gestalt Play Therapy has motivated the researcher to investigate how Gestalt Play Therapy could be utilised in Occupational Therapy intervention with the traumatised child.

The researcher has discussed the viability of such a study with two Paediatric Occupational Therapists who have experience in dealing with traumatised children namely Kingsley (2006) and Terrer-Perez (2006). Both have voiced their frustrations with not being able to effectively provide intervention to the traumatised child due to limited knowledge of how to effectively address the severe emotional difficulties of the traumatised child. These therapists have a basic, limited understanding of Gestalt Play Therapy. They were very interested in the proposed study and stated that they considered such a study as essential to increase Occupational Therapists' awareness of Gestalt Play Therapy.

In order to investigate the utilisation of Gestalt Play Therapy in Occupational Therapy intervention with the traumatised child, the researcher explored literature to build a foundation of the available literature regarding the profile of the traumatised child, the Occupational Therapy intervention and Gestalt Play Therapy intervention with traumatised children. The literature included

books, articles and journals which covers the fields of Occupational Therapy, Psychology and Counselling.

The literature study, according to Delport and Fouché (2005:263), should familiarise the researcher with the current state of knowledge regarding the research problem and identify deficiencies in the area of research. The researcher found that there is limited literature regarding the utilisation of Gestalt Play Therapy within Occupational Therapy intervention with the traumatised child.

### **1.2.2 Problem Formulation**

A research project begins with a single focus. Creswell (1998:21) explains this by stating that the study starts with a single idea that the researcher wishes to investigate. As the researcher begins to build on the idea, the problem formulation provides the reader with a general idea of what the study will consist of and what it will exclude. Fouché (2005:116) agrees with this by saying that the problem formulation should provide the reader with an overview of the subject for investigation. He explains that the problem formulation should demonstrate that the researcher has an established foundation in the area of the study and that the research selection flows from a well developed rationale based on theory and empirical research. The researcher identified the following problem statements to commence this study.

Alers and Ancer (2005:309) suggest that there is a trend in Paediatric Occupational Therapy towards early intervention and the prevention of developmental delay. However, there is a significant lack of Occupational Therapists remediating and preventing developmental delay in child trauma survivors by addressing the underlying emotional trauma of the child. In this regard Stein and Cutler (1998:78) state that although the Occupational Therapist works from a holistic approach, the Occupational Therapist often does not have the skill, and thus the confidence, to address the severe emotional needs of the traumatised child. This results in the Occupational

Therapist not being able to address the holistic needs of the traumatised child. It seems as if Occupational Therapists are therefore training in Gestalt Play Therapy in order to address their lack of skill in assisting with the emotional needs of traumatised children. The researcher consulted databases of UNISA and the National Research Foundation and found that there is a lack of literature and research regarding the utilisation of Gestalt Play Therapy in Occupational Therapy intervention with the traumatised child. The researcher summarised her findings in the following sub problems:

- Occupational Therapists have limited skills in addressing the severe emotional difficulties of the traumatised child within the holistic intervention approach.
- Occupational Therapists have limited knowledge of the use of Gestalt Play Therapy within Occupational Therapy intervention with the traumatised child.
- Limited literature is available regarding the utilisation of Gestalt Play Therapy in Occupational Therapy intervention with the traumatised child.

Fouché (2005:116) states that the research question is the guiding tool that is used to generate questions and to search for patterns within a research study. Considering the above findings of the researcher, this study was guided by the following research question:

How can Gestalt Play Therapy be utilised within Occupational Therapy intervention with the traumatised child?

In order to purposefully commence the research study the researcher formulated aims and objectives which will be described in the following section.

### **1.2.3 Aim and Objectives**

Fouché and De Vos (2005:104) explain that the aim and the objectives of a research study can be differentiated as follows: *The aim* can be defined as the end goal of the study; what the researcher hopes will be accomplished by the research study. The researcher formulated the following aim: To explore and describe the utilisation of Gestalt Play Therapy in Occupational Therapy intervention with traumatised children. *The objectives* are defined as the succession of steps that needs to be followed and completed, within a certain time scale, in order to reach the goal or to accomplish the aim of the study. For the purpose of this study the objectives involved the following:

- A literature review regarding the profile of the traumatised child.
- A literature review regarding Occupational Therapy intervention with the traumatised child.
- A literature review regarding Gestalt Play Therapy intervention with the traumatised child.
- The empirical research, conducted via semi-structured interviews with Occupational Therapists that have completed training in Gestalt Play Therapy, in order to collate and analyse data regarding the utilisation of Gestalt Play Therapy in intervention with traumatised children
- Conclusions drawn and recommendations made for Occupational Therapist on how to utilise Gestalt Play Therapy in their intervention with traumatised children, in order to complement Occupational Therapy practise.

## **1.3 RESEARCH APPROACH**

### **1.3.1 Qualitative Research**

Creswell (1998:15) defines qualitative research as an inquiry process of understanding based on different methodological traditions of inquiry that explore a specific social or human problem. He states that in qualitative

research the researcher aims to build a complex, holistic picture, analyses words, reports detailed views of informants and conducts the study in a natural setting. Fouché (2005:116) elaborates by stating that qualitative research methods are used to discover important questions, processes and relationships and not to test them.

For the purpose of this study the researcher conducted qualitative research. The researcher followed an inquiry process to increase understanding and knowledge of utilising Gestalt Play Therapy in Occupational Therapy intervention with traumatised children. The researcher made use of a specific methodology to explore, to describe and to build a holistic picture from the empirical information gathered from the respondents in the study. The study included a selection of Occupational Therapists that had been trained in Gestalt Play Therapy and are combining their training to provide intervention to traumatised children. The researcher aimed to explore and to describe a detailed view of their method of working.

### **1.3.2 Type of Research**

Fouché and De Vos (2005:105) explain that applied research is aimed at solving specific problems in practice and helping practitioners accomplish tasks. However, they also state that applied research can have implications for knowledge development. Within this study the researcher conducted applied research with an explorative and descriptive approach. The researcher aimed to develop further knowledge to assist Occupational Therapists to review and hopefully improve their holistic treatment approach and intervention including the complex emotional problems of the traumatised child.

Fouché and De Vos (2005:106) state that explorative research is conducted to gain insight into a phenomenon and that the need for the study could arise out of a new area of interest. The researcher makes use of qualitative data. Gestalt Play Therapy is a new interest of Occupational Therapists, including those working with traumatised children. The researcher wished to explore the

utilisation of Gestalt Play Therapy by respondents within Occupational Therapy intervention with the traumatised child.

According to Fouché and De Vos (2005:106) descriptive research presents a picture of the specific details of a phenomenon, social setting or relationships. They elaborate by stating that the research begins with a well-defined subject and the researcher aims to describe it accurately. For the purpose of this study the researcher described the utilisation of Gestalt Play Therapy by the respondents in their intervention with traumatised children.

### **1.3.3 Research Strategy**

The researcher conducted a case study. Creswell (1998:61) defines a case study as an exploration of a bounded system or a case over time through detailed, in-depth data collection involving multiple sources of information rich in context. The bounded system is bounded by time and place, and it is the case being studied. For the purpose of this study the bounded system was Occupational Therapists trained in Gestalt Play Therapy who are providing intervention to traumatised children.

Fouché (2005:272) explains that an instrumental case study is used to elaborate on a theory or to gain a better understanding of an issue. The case merely serves the purpose of facilitating the researcher to gain knowledge about the issue. The issue that was explored and described in this research project was the utilisation of Gestalt Play Therapy in Occupational Therapy intervention with traumatised children. The strategy was flexible and was allowed to evolve through the research process according to the findings of the researcher. This correlates with Creswell's (1998:17) explanation that the qualitative research is complicated by the fact that it does not have firm guidelines or specific procedures and that it evolves and changes constantly.

## **1.4 WORK PROCEDURE AND RESEARCH METHODOLOGY**

For the purpose of this study the methodology used was the qualitative research approach and the case study strategy. As previously mentioned, the researcher started with an in-depth literature review. During the literature review the researcher also made use of books older than ten years as these books are considered to be classic resources in regards to the information that they hold. These included:

- Oaklander, V. 1988. *Windows to our Children*. United States of America: The Gestalt Journal Press.
- Schoeman, J.P. & Van Der Merwe, M. 1996. *Entering the Child's World – a Play Therapy Approach*. Pretoria: Kagiso Publishers.
- Webb, N.B. 1991. *Play Therapy with Children in Crisis*. United States of America: The Guildford Press.

Following the literature review the researcher conducted the interviews. The researcher described the data gathered in the empirical research and lastly summarised the information to make recommendations.

### **1.4.1 Data Collection**

Greeff (2005:287) states that the purpose of the study must guide the researcher to choose the most effective method of data collection and that interviewing is the predominant method of data collection in qualitative research. According to Greeff (2005:292), semi-structured interviews are defined as those interviews organised around certain areas of interest, while still allowing considerable flexibility in scope and depth. Greeff (2005:296) further explains that semi-structured interviews are used to obtain a detailed view of the respondents' beliefs and perceptions about a particular topic. According to Robson (2005:270), semi-structured interviews have predetermined questions but the order can be modified during the interview

based on what seems most appropriate. He also states that semi-structured interviews are widely used in flexible, qualitative designs.

The researcher made use of semi-structured interviews to collate the data from Occupational Therapists trained in Gestalt Play Therapy. The semi-structured interviews were used to explore the Occupational Therapists' perceptions of how they utilise Gestalt Play Therapy during their intervention with traumatised children.

The researcher made use of an interview schedule to conduct the interviews in order to reach the aims of the study (refer to Appendix 1). Greeff (2005:296) defines an interview schedule as a questionnaire formulated to guide the interview. He further explains that the researcher using an interview schedule will be guided by the schedule rather than being dictated by it.

Before the semi-structured interviews were conducted with the respondents, the researcher conducted a semi-structured interview as a pilot study. This was conducted with an Occupational Therapist that has just completed her studies in Gestalt Play Therapy and thus had knowledge of the subject. This ensured that the interview schedule thoroughly covered the topic of the study and that the schedule would be accurate for gathering the information required for the purpose of this study. It was also done to ensure that the chosen questions were clear and understandable for the respondents.

As the researcher was confident that the interview schedule fulfilled the purpose for the study, the semi-structured interviews were conducted with the respondents. The semi-structured interviews were conducted over the telephone and recorded with the use of a dictation machine. The interview schedule allowed flexibility in scope and depth during the interviews. Field notes were taken during the interview in addition to the recordings. Greeff (2005:298) explains that field notes are used to minimise the loss of data and that the researcher use the notes to record information about his experience during the interview.

### 1.4.2 Data Analysis and Representation

Greeff (2005:299) states the researcher must transcribe and analyse the interviews while they are fresh. She further explains that by employing qualitative analysis the researcher is able to capture the richness of themes emerging from the interview. For the purpose of this study the researcher transcribed and analysed the interviews to give a detailed description of the data collated from the respondents. The researcher was attentive to the themes and categories that emerged.

Creswell's Data Analysis Spiral was used to analyse the collected data. When using this approach to data analysis the researcher, according to Creswell (1998:142), engages in the process of moving in analytic circles rather than using a fixed linear approach. This Data Analysis Spiral was applied as follows for the purpose of this study:

- Managing the data: Creswell (1998:143) states that the beginning of the process is organising the data collated. The researcher transcribed the semi-structured interviews and organised the field notes as the information collated in this study.
- Analysing the data: Creswell (1998:143) explains that the researcher continues analysis by getting a sense of the whole database. For the purpose of this study the researcher read and re-read the entire volume of data collected until the researcher gained a general impression and sense of the whole database.
- Describing, classifying and interpreting: Creswell (1998:144) describes that that during this phase the researcher:
  - describes in detail
  - develops themes or dimensions through some classification system and
  - provides an interpretation in light of their own views or views of perspectives in literature.

For the purpose of this study the researcher described the data collected in detail as identified by the interviews. Following this the researcher identified categories, themes or dimensions of information and attempted to narrow them down to a manageable number of categories. From the categories the researcher made sense of the data by interpreting the issues identified.

- Presenting the data: Creswell (1998:145) states that this is the final phase of the spiral. For the purpose of this study the researcher presented the findings of the study in written format.

#### **1.4.3 Description of the Universe, Sampling and Sampling Techniques**

Strydom (2005:197) refers to a differentiation between the terms 'universe' and 'population'. The universe would be all the potential subjects who have the attributes in which the researcher is interested. He defines the population as a term that sets boundaries on the study units. The population refers to individuals in the universe who possess the specific qualities sought for the study.

For the purpose of this study the universe was all Occupational Therapists. The population was Occupational Therapists who have completed training in Gestalt Play Therapy and are providing intervention to traumatised children.

According to Strydom (2005:201) purposive sampling falls into the category of non-probability sampling. For the purpose of this study the researcher made use of purposive sampling as the researcher identified that six Occupational Therapists completed their training in Gestalt Play Therapy from the Huguenot College. All of these were approached for the study.

In relation to this, Creswell (1998:118) states that the purposeful selection of participants represents a key decision point in qualitative research and that the researcher should have clear criteria in mind for the identification of participants. For the purpose of this study the researcher used a purposeful sampling strategy to select the respondents to be approached to participate in

the study. The criteria that were used for the identifying of the respondents were Occupational Therapists that received training in Gestalt Play Therapy and are providing intervention with traumatised children. Occupational Therapists were interviewed in either English or Afrikaans depending on their preference as the researcher is bilingual.

## **1.5 ETHICAL ASPECTS**

Strydom (2005:57) defines ethics as a group of moral principles that is recommended by a group or an individual and is widely accepted. It offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents and all other persons involved in the research. The researcher addressed the following areas to maximise the quality of the data and to deal with issues of access and ethics.

- **Avoidance of harm**

Strydom (2005:58) explains that harm in social sciences is mostly emotional and that there is an ethical obligation on the researcher to avoid any physical or emotional discomfort that may be a result of the study. Due to the nature of this research study, the researcher did not expose the respondents to any harm that could be foreseen. The researcher only interviewed the respondents regarding their work with traumatised children. Therefore the researcher is confident that no harm came to the participants in the research study.

- **Informed consent**

Strydom (2005:59) explains that the researcher must provide adequate information to the respondents in a study regarding goals, work procedures and possible dangers that the respondent might be exposed to during the study. This is essential for the respondent to be able to make an informed decision on whether they wish to participate in the study. For the purpose of this study the researcher ensured that

the respondents were fully informed in writing regarding the goals and procedures of the study prior to committing to participate in the study.

The researcher sent possible respondents a form with all relevant information regarding the study and their rights as a respondent for the study to sign and return to the researcher (refer to Appendix 2). By being transparent about the study the respondents were able to make a voluntary and thoroughly reasoned decision about their possible participation.

- **Deception of subjects**

Strydom (2005:61) states that no form of deception should ever be inflicted on respondents and if this occurs unplanned it should be rectified immediately. For the purpose of this study deception of the respondents were avoided by providing the respondents full access to the process and possible outcomes of the research study. The researcher also revealed the goal and process to the respondents.

- **Violation of privacy/anonymity/confidentiality**

Strydom (2005:62) states that the responsibility of confidentiality rests with the researcher whether the client has requested it or not. Within this study the researcher regarded confidentiality as a priority and undertook the following steps to ensure it:

- The identity of the respondents is not recorded in the study.
- All information gathered was discussed with the researcher's study leader only and confidentiality issues were also clarified with the study leader.
- Information gathered for the purpose of this study that contains personal information regarding the respondents' clients was not in any way shared with a third party, apart from the study leader.
- All collated data was kept in a secure and locked office.

- No concealed media was used to gather data without the knowledge of the respondents.

- **Actions and the Competence of the Researcher**

Strydom (2005:63) states that a researcher is ethically obliged to ensure that they are competent and adequately skilled to undertake the research. This research project was done as partial requirement for the degree and the researcher received supervision from a study leader at the Huguenot College. The researcher completed research modules as required for the study course.

The researcher ensured that all procedures followed during the course of the study complied with the ethical code. Ethically correct actions and attitudes were monitored by the study leader to correspond with the stated ethical code and requirements.

- **Release or Publications of the Findings**

Strydom (2005:65) states that the researcher should compile the report as accurately and objectively as possible. He further states that the researcher has the obligation to ensure at all times that the investigation proceeds correctly and that no deception will take place in publication. For the purpose of this study the researcher provide a written report of the research project to be critiqued. The report was compiled under the guidance of the study leader in accordance to scientific acceptable norms, procedures, standards and ethical considerations for publication.

- **Debriefing of the Respondents**

Strydom (2005:66) explains that after completion of the research study the researcher has to rectify any misperceptions that may have arisen in the minds of the participants. He also states the research study must be a learning process of both the researcher and the participants. During this study the researcher did not explore personal matters or

emotional issues with the respondents and therefore no debriefing was required.

## **1.6 DEFINITIONS OF KEY CONCEPTS**

In order to ensure that the researcher and the reader have the same connotation and perception of the main concepts in the project, the following definitions are provided:

### **1.6.1 Occupational Therapy**

According to the British Association of Occupational Therapists (2006), Occupational Therapy enables people to achieve health, well-being and life satisfaction through participation in occupation. Occupational Therapists work with a range of people including those who are disadvantaged by physical, mental and/or social problems, either from birth or as the result of accident, illness or ageing. They are aware of the impact of illness on people's lifestyles and their ability to participate in society. Occupational Therapists will consider the importance of how a person's physical, mental and social needs will impact on their recovery process and help them to achieve their life goals and the aspirations that are most important to them. Their focus will also be on working with people to reduce avoidable dependency.

According to The Royal College of Psychiatrists (2006), Occupational Therapy uses purposeful activity and meaningful occupation to help people with mental health problems and play a key role in helping people overcome problems and gain confidence in themselves.

The researcher agrees with the above statements and defines Occupational Therapy in relation to the child as a therapy provided by an Occupational Therapist to the child, family and significant members of the child's environment. The Occupational Therapist has a holistic approach to the child and the researcher is of the opinion that this is essential within the intervention. The Occupational Therapist understands how difficulties

experienced in one sphere of living or health can influence the whole individual and participation in activities. Occupational Therapy helps develop adaptive or physical skills that will aid in daily living and improve interactions with a person's physical and social world. It focuses on developing functional skills related to sensory-motor integration; coordination of movement; fine motor skills; self-help skills (dressing, self-feeding, etc.); adaptive devices/equipment; and emotional difficulties that are preventing the child to achieve maximum functioning, independence and health.

### **1.6.2 Gestalt Play Therapy**

According to the Wikipedia (2006), Gestalt Play Therapy is based on the Gestalt Approach, a psychotherapy based on the experiential ideal of "here and now" and relationships with others and the world. It was co-founded by Fritz Perls, Laura Perls and Paul Goodman in the 1940s-1950s. At the centre of Gestalt Therapy lies the promotion of "awareness". The patient is encouraged to become aware of their own feelings and behaviours, and the patient's effect upon their environment. The way in which a patient interrupts or seeks to avoid contact with their environment is considered to be a substantive factor when recovering from psychological disturbances. By focusing on the patient's awareness of themselves as part of reality, new insights can be made into the patient's behaviour, and the patient can engage in self-healing.

Joyce and Sills (2001:1) explain that the characteristics of Gestalt Therapy is the focussing on the here and now emerging experiences, through awareness, phenomenology and the paradoxical theory of change. The therapist establishes a dialogical relationship and works towards holism.

Coon (2006:534) explains that Gestalt Therapy is based on the idea that perception, or awareness, is disjointed and incomplete in maladjusted people. Gestalt Therapy helps persons rebuild thinking, feeling and acting into connected wholes. This is achieved by expanding personal awareness, by

accepting responsibility for one's thoughts, feelings and actions, and by filling in gaps in experience.

The researcher agrees with these definitions and views Gestalt Play Therapy as a therapy that assists the child to function as a whole. By increasing the child's awareness in the here and now the child is able to integrate all fragmented parts of him self into a whole. The child is made aware of his unfinished business and is allowed the opportunity to experiment with new behaviour. Only by becoming what the person truly is can the person fully function and achieve his potential. The researcher emphasises the goal of Gestalt Play Therapy as allowing the child to develop and maximise his potential of effective participation in his relationships by maintaining his internal regulation mechanisms. This will allow the child to function effectively within his life spheres.

### **1.6.3 Traumatized Child**

According to James and Gilliland (2005:129) the traumatized child could have experienced the trauma either as one sudden, distinct traumatic experience or as a long-standing pattern of repeated traumatic ordeals. The traumatized child can experience damage that can carry into adulthood in a variety of ways. Character problems that can affect the traumatized child includes anxiety disorders, dissociation, eating disorders, increased risk of violence by others and by oneself, suicidal ideation and behaviour, drug abuse, self-mutilation and disastrous interpersonal relationships.

According to Rose and Philpot (2005:65) the child can be traumatized by a multitude of incidents, but it is the child's reaction to the incident that traumatizes the child. The child who is abused physically, sexually, emotionally or the child that suffers neglect can be traumatized.

According to Breire (1997:24) the traumatized child suffers emotional discomfort and stress that arises from an experience that threatens the child with the possibility of death or threatens the physical integrity of the child.

Regardless of the type of incident that was experienced by the child, the child will be traumatised by the child's reaction to the occurrence if it includes intense feelings of fear, helplessness and dread.

The researcher is of the opinion that the child experiences many different situations in his life including traumatic incidents. Some of these traumatic incidents will have such a negative impact on the child that the child is left vulnerable with feelings of helplessness and intense fear. These feelings traumatises the child as he has not reached a developmental level where he can make sense of what has happened to him or have the emotional and cognitive ability to integrate the experience. This child is then left with emotions that has not been expressed and that he might not even understand. This confusion and unexpressed emotions will influence all parts of the child's life and will be presented as secondary problems. The researcher is of the opinion that these secondary problems can often be misinterpreted by adults that are not aware of the past of the traumatised child.

## **1.7 SUMMARY**

This chapter demonstrates the research methodology utilised by the researcher to conduct the study. Following the problem formulation for the study the researcher identified the aim and the objectives for the study. The researcher conducted qualitative research and followed an enquiry process to increase knowledge and understanding of utilising Gestalt Play Therapy in Occupational Therapy intervention with the traumatised child. The case study strategy was used and the design was flexible and was allowed to evolve through the process of the study.

For the purpose of this study the data was collected through semi-structured interviews and the use of an interview schedule. Interviews were conducted with Occupational Therapists who met the criteria set. The gathered data was analysed with the use of Creswell's Data Analysis Spiral. This chapter also

explains the ethical aspects that were adhered to throughout the process of this study and during the interaction with respondents in the study.

In the following chapter the profile of the traumatised child is described.

## CHAPTER TWO

### THE PROFILE OF THE TRAUMATISED CHILD

#### 2.1 INTRODUCTION

Trauma has a significant impact on growth and development in children. Unfortunately, this impact is often overlooked at the risk of increasing numbers of adults with depression, eating disorders, anxiety disorders, substance abuse, personality disorders, self-endangering behaviours and disrupted interpersonal relationships (Cairns, 2002:43; Hirst, 2005:33; Hyter, Atchison, Henry, Sloane & Black-Pond, 2001:117). This risk clearly indicates the need for traumatised children to be identified and provided with adequate support to reduce the residual mental health problems. Greenwald (2005:122) states that the awareness of the signs (those behaviours one observes a child doing) and symptoms (those things of which children complain) of the traumatised child gives the therapist an opportunity to help these traumatised children to manage their symptoms and begin the recovery process.

In this chapter the researcher will describe the profile of the traumatised child. The researcher will describe how children instinctively react to a traumatic experience, also called their instinctive drives. Following this the researcher will include a description of post-traumatic stress disorder (referred to as PTSD in this study), as this could develop in the child victim of trauma. Kjorstad, O'Hare, Soseman, Spellman and Thomas (2005:40) say that the signs and symptoms of PTSD may be manifested in symptomatic behaviours associated with PTSD even if the child does not meet the criteria for the formal diagnosis of PTSD. The researcher will explain the developmental effects of trauma and PTSD and how they manifest in different developmental stages of the child including the pre-school child, the school-aged child and adolescents.

Before the effects of a traumatic event on the child can be described, it is important to define trauma itself. The *Diagnostic and Statistical Manual of*

*Mental Disorders* (in Kaplan & Sadock, 1998:617) defines a traumatic event as follows:

... an event that involves actual or threatened death or serious injury, or other threat as to one's physical integrity; or witnessing an event that involves death, injury, or a physical threat to the physical integrity of another person; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.

Gil (2006:6) and Kjorstad *et al.* (2005:40) further describe these types of traumatic events as natural disasters, random events like accidents, terrorist acts, politically motivated violence, war, invasive or traumatic medical procedures and interpersonal acts of assault and injury between strangers, familiar people and family members. In the life of the child this also includes events like domestic violence, abuse and neglect and, among others, the loss of a parent or sibling or even grandparents or a favourite pet (Greenwald, 2005:21; Parkinson, 1997:54).

In relation to this Alers and Ancer (2005:310) include that trauma can be classified in different ways according to how the trauma is experienced. They explain that trauma can be single, multiple or complex in nature. A single trauma is a single event that is sudden, un-expected and over after the incident, for example an accident. Further, a multiple trauma happens when an individual is exposed to more than one trauma over a period of time, for example a teenager whose parents divorce and then witnesses a robbery. Complex trauma is defined as a prolonged repeated traumatic event, like abuse or domestic violence. They explain that in addition to these types of traumas there are also types of trauma victims that can be identified. This includes the primary victim who is directly involved in the traumatic event and the secondary victim, who is a witness to the traumatic event. Alers and Ancer (2005:310) thus emphasise that whether the child is a primary or a secondary victim of trauma, the impact of trauma on the child remains significant.

## 2.2 TRAUMA NEGOTIATIONS: CHILDREN'S INSTINCTIVE DRIVES

Kjorstad *et al.* (2005:40) note that the experience of traumatic events in childhood negatively influences children's development and social behaviour. These significant developmental delays can include behavioural, communication, educational, emotional, physical and psychological domains (Ainscough & Toon, 2002:36; Hyter *et al.*, 2001:114; Levey & Olans, 1998:75). Ryan and Walker (2007:6) further explain that it is mainly the child's reaction to the traumatic event, whatever this event may be, that predisposes the long term effects on the child.

The child's reaction to trauma and the emotional injuries as a result of trauma depend on the complex functioning of internal and external environmental variables in the child's life. Gil (2006:7) describes the following environmental variables:

- *predisposition factors*, such as initial neurobiology, parental attachments, social variables, cultural influences and perceptions of self
- *characteristics of the trauma(s)*, including the type, number, duration, and the age of onset to trauma exposure and
- *post-traumatic variables*, such as level of familial and social support, the child's capacity for emotional expression, relative safety and whether appropriate psychosocial treatment is available.

Kaplan and Sadock (1998:618) expand on this by stating that clinicians must consider the impact of these individual pre-existing biological and psychosocial factors, as well as events that happen after the traumatic event on the emotional injury of the child. They report that when trauma occurs in childhood, an arrest of emotional development frequently results. The child survivor cannot use internal emotional states as signals, may experience psychosomatic symptoms and they are unable to sooth themselves during stress. The researcher is of the opinion that knowledge of the recovery

process is imperative for the therapist providing intervention to understand the functioning of the child and the extent of the child's emotional injuries.

Alers and Ancer (2005:310) explain that there are three phases of trauma recovery and that recovery will often not be linear but will rather be characterised by progress and setbacks. During these phases the child will experience functional difficulties in all their life spheres. The three phases exist of the impact phase, the recoil phase and the reorganisation/recovery phase. During the impact phase the child's protective mechanisms shut down emotional, intellectual and physical awareness to protect the individual from becoming overwhelmed. The recoil phase is marked by the realisation of what has happened. The child will show feelings of intense sadness, anger and guilt and post-traumatic stress signs begin to show (Hirst, 2005:64; Levey & Olans, 1998:252). The child may start to remember more facts than in the previous phase. In the final stage of recovery the child begins to accept what has happened and integrates it into his life. Normal function will resume in all the spheres of life. The progress through these phases might be hindered by a variety of internal and external factors, as previously discussed, and will determine whether the injuries will heal and when.

Van Der Kolk (2005:403) explains that the severity of injuries relies heavily on the debilitating loss of control that individuals, especially children, experience as a result of the traumatic event. When distress is overwhelming, children are unable to modulate their arousal. This causes a collapse in children's ability to process, integrate, and categorise what is happening. Saari and Silver (2005:138) further explain that at the core of traumatic stress is a breakdown in the capacity to regulate internal stress. If the distress does not ease, the relevant sensations, affects and cognitions cannot be associated – they are dissociated into sensory fragments – and as a result, these children cannot comprehend what is happening or devise and execute appropriate plans of action.

The child's behaviour or plans of action following the traumatic event is guided by utilising either or both of two basic drives. Gil (2006:8) defines the first

drive as mastering what is painful or confusing and restoring a sense of control and mastery. These children make efforts to seek understanding about their situations, and they seek out opportunities to overcome feelings of confusion, helplessness or despair. The second drive is defined as avoiding painful emotions, thereby also eluding attempts to engage in therapeutic work. Children can do this in a variety of ways: they can refuse to think about or talk about the event, they can avoid all stimuli reminiscent of the event, and they can withdraw from interactions with others (Ainscough & Toon, 2002:96; Cooper, 2000:271; Gil, 2006:8; Kaplan & Sadock, 1998:617).

According to Gil (2006:9) problems can arise if children develop rigid patterns of avoidance. In these cases suppression is occurring without any processing of difficult, painful memories and thoughts. Kaplan and Sadock (1998:618) explain that avoidance requires sustained efforts to maintain. Children will therefore not gain the understanding and mastery they require to achieve closure, focus on the present and restore normal functioning. If normal functioning is not restored, the child is at risk of developing PTSD or display PTSD symptoms, even if PTSD is not diagnosed. Parkinson (1997:113) is concerned that the psychological consequences for children who witness or participate in traumatic events are frequently overlooked and psychological help is often not available to them. Parents, teachers and health care professionals may not be aware of the symptoms of post-traumatic stress and may attribute behaviour and symptoms to other causes and diagnoses.

### **2.3 POST-TRAUMATIC STRESS DISORDER IN CHILDREN**

The *Diagnostic Manual of Mental Disorder* (DSM-IV) (in Kaplan & Sadock, 1998:617) defines PTSD as a set of typical symptoms that develops after a person sees, is involved in or hears of an extreme traumatic stressor. The person reacts to the traumatic event with fear and helplessness, persistently relives the event and tries to avoid being reminded of the event at all costs. This relates to the main clinical features of PTSD which, according to Kaplan and Sadock (1998:619) is a pattern of avoidance and emotional numbing, fairly constant hyperarousal and the very painful re-experiencing of the event.

To be diagnosed with PTSD the symptoms must last for more than a month and must significantly affect important areas of life such as family and work. The diagnosis of children with PTSD is also based on the above criteria and the specific signs and symptoms displayed in children will be discussed in the following section.

### **2.3.1 Signs and Symptoms**

Research findings have shown that children may experience the effects of traumatic stress through cognitive disturbances, unregulated affect, behavioural problems, sensory and motor problems and psychosomatic symptoms (Hyter *et al.*, 2001:117; Kjorstad *et al.*, 2005:42). The researcher will now describe some of these signs and symptoms and include a discussion on the signs and symptoms that relate to child abuse and neglect. In this regard, Hyter *et al.* (2001:116) report trauma such as abuse or neglect negatively impacts children in a myriad of complex ways. It is important however to understand that the signs and symptoms mentioned on their own do not necessarily indicate that a child is traumatised. The signs and symptoms include the following:

- Cognitive disturbances that children may experience, according to James and Gilliland (2005:219), include time distortions or inability to recall details of the event in sequence, also called narrative coherence. The child may also experience impairments of memory and attention, which combined with the above, have significant consequences for the child who is required to engage in legal proceedings following the traumatic event. Harrington (2001:213) suggests that the child may also suffer from the painful re-experience of the event in the form of disturbing and repetitive images and frightening dreams without recognisable content. He explains that this painful re-experience of the event can traumatise the child anew. Further, cognitive testing may even reveal that psychosis, illusions and hallucinations might be present in the severely traumatised child.

- Affective symptoms that the child may experience following trauma usually manifests in anxiety related symptoms. This includes fear of re-traumatisation, generalised phobias, tension, excessive worry, limited emotions, inability to express emotions and avoidance of pleasurable activities (James & Gilliland, 2005:219; Kjorstad *et al.*, 2005:42). Further, the child can experience sleep disorders, panic attacks and even dissociative states. Signs of dissociation are described as periods in which the children are amnesic, feel no pain or feel that they are somewhere else. James and Gilliland (2005:230) claim that PTSD and dissociative disorders are common in adults who have been abused as children. Children who have been sexually abused reportedly have an increased frequency of poor self-esteem, depression, dissociative disorders and substance abuse (Anderson, 2005:75; Kaplan & Sadock, 1998:850). Ainscough and Toon (2002:101) state that the depressive feelings usually combined with shame, guilt, rejection, humiliation and a sense of permanent damage is commonly reported among children who have been sexually abused.
- Behavioural symptoms found in children, as explained by Kjorstad *et al.* (2005:42), include repetitive traumatic play, regressive behaviours, retelling the event with decreased affect, poor concentration, self-endangering behaviours and hyperactivity. Kaplan and Sadock (1998:847) further specify that children traumatised through physical or sexual abused exhibit many psychiatric disturbances including aggressive behaviour, paranoid ideation, PTSD, depressive disorders and an increased risk of suicidal behaviour. They warn that suicidal behaviour should never be taken lightly by professionals, even with children. Children, who are chronically neglected, on the other hand, can be indiscriminately affectionate, even with strangers or socially unresponsive, even in familiar circumstances (Kaplan & Sadock, 1998:851). Kaplan and Sadock are of the opinion that behavioural

problems are often secondary problems and the underlying emotional issues needs to be resolved to adapt the behavioural problems.

- Hyter *et al.* (2001:117) include sensory and motor problems as symptoms of traumatised children. This includes overactive or reduced reflexes, poor coordination or motor control, limited visual or auditory orientation to stimuli and limited abilities to regulate one's states. According to Anderson (2005:75) children who have been neglected may show overt failure to thrive. These children's physical and emotional development is drastically impaired; they may be physically small and unable to display appropriate social interaction. In relation to this she emphasises that motor and sensory problems in children make up a large percentage of Occupational Therapy referrals. The researcher if the opinion that, as seen above, some of these referrals might be for secondary problems related to severe emotional trauma.
- Psychosomatic symptoms, according to Kjorstad *et al.* (2005:42), include hyperarousal, low stress tolerance, startle response to reminder stimuli, sleep disorders and fatigue. Children may often complain of aches and pains as their way of relating emotional injuries.

Kaplan and Sadock (1998:622) state that, commonly, the child has more difficulty with the resolution of traumatic events and this could be because young children do not yet have adequate coping mechanisms to deal with the physical and emotional insults of the trauma. The problems that the child experiences following trauma should therefore also be considered in the contexts of his development.

## **2.4 REACTIONS ACCORDING TO AGE**

Gil (2006:16) states that early stress in the form of childhood trauma produces a cascade of neurobiological events that have the potential to cause enduring changes in brain development. Harrington (2001:221) corroborates by saying

that if the child is unsupported through the recovery process, the underlying biological structures responsible for emotional regulation may be incapacitated. In the case of prolonged or extreme stress, hormones increase to dysfunctional levels. According to Saari and Silver (2005:67), this unbalance can cause confusion, inability to concentrate, loss of memory and even amnesia. Through the literature study the researcher investigated how this can functionally influence the child at the following three prime developmental stages, delineated as pre-school, school age and adolescents.

#### **2.4.1 Pre-school Children**

According to Hirst (2005:57) it is a common misperception that very young children will rapidly recover from a traumatic event and that due to immature cognition they will not remember the event. The researcher has found that literature clearly describes the possible lasting impact of trauma on the pre-school child. The most common indication of trauma in the life of the young child, according to Greenwald (2005:133) is the loss of previously acquired developmental milestones. This means that pre-school children will often regress developmentally and exhibit behaviours like thumb-sucking or bedwetting. This child's anxiety can also manifest in nightmares and other sleep disorders, obsessions, restlessness and aggressive behaviour (Kjorstad *et al.*, 2005:43; Levey & Olans, 1998:242). Hirst (2005:78) further states that the traumatised child is also likely to have difficulties in his relationships with significant others.

Whiting (2001:83) explains this by stating that studies have found that children who have been traumatised by maltreatment at a young age is at risk of developing problems in forming secure attachment relationships. This influences the achievement of autonomous self, independent exploration and establishing effective peer relationships. According to Cooper (2000:266), warning signals for these include a variety of behaviours including becoming over-dependent, clinging to caregivers or, on the other hand, becoming withdrawn and unresponsive.

These early attachment difficulties, according to Cairns (2002:84), are likely to impact on how the child explores and responds to the human and non-human factors in any play environment as well. According to Santrock (1998:518), play is considered one of the most important occupations in the life of a child and that feeling safe is the most basic prerequisite for a child to play. Thus, if a child does not feel safe the child will not play. It therefore seems clear that traumatic events have many detrimental effects on the occupation of play and traumatised children are likely to show delayed play development (Hyter *et al.*, 2001:118; Kjorstad *et al.*, 2005:41-42).

Cooper (2000:270) reports that studies have found that traumatised children can have decreased pretence and symbolic content in play. These children will introduce fewer dramatic or imaginative play elements and are restricted in the extent and variety of fantasy character roles. She further explains that the intrinsic motivation of traumatised children is lacking in energy with a marked inhibition of activity and aimless in quality with little sustained interest in toys. Hyper vigilance or heightened awareness which is frequently observed in traumatised children, not only absorbs their play attention but also dampens their curiosity, as they are constantly monitoring the verbal and non-verbal cues in their immediate environment.

Smith, Cowie and Blades (2004:269) claim that these behaviours isolate the child and the natural peer relationships formed during play and the subsequent learning of social skills are negatively influenced. Kjorstad *et al.* (2005:45) support this by stating that some children who have experienced traumatic events exhibit decreased social skill development and are less likely to participate in interactive play situations. As this child enters the school-aged phase he will have a significant disadvantage in skills to integrate into the school environment.

### **2.4.2 School-Aged Children**

All children who enter school bring with them a wide range of behaviours. Hyter *et al.* (2001:118) state that for children who have been traumatised the behaviours that they may bring are often difficult to manage or understand in the educational setting. Teachers are often unprepared for children with these types of histories and experiences, who often do not respond to typical educational strategies or teaching methods. Therefore, teachers or informal caregivers may see the behaviour of these children as wilfully disobedient rather than an inability to regulate one's own state. Barnes, Beck, Vogel, Grice and Murphy (2003:338) warn that this can unfortunately cause the child to experience even further rejection as they do not perform academically as expected or in correlation with their peers.

Barnes *et al.* (2003:333) discuss that traumatised children's academic performance can be poor due to a variety of reasons. They state that poor motivation and decreased concentration manifests in difficulties with performing school occupations such as focusing attention on daily tasks, following directions, completing written work, communicating, engaging in group activities, regulating behaviour and having difficulty in organisational, interpersonal, coping and learning skills.

Whiting (2001:83) also reports that a review of research on the long-term effects of the traumatised child's functioning suggests that some of these children exhibit impairments in a number of domains. These include cognitive, linguistic and socio-emotional development. She reports that the combination of these problems leaves the child at risk of behaviour problems in school as well as vulnerable for future development of psychopathology in adolescence.

### **2.4.3 Adolescents**

Greenwald (2005:229) explains that the main problem with trauma for adolescents lies in the difficulty of assigning meaning to the event. Smith *et al.* (2004:289) further explain that adolescents are increasingly able to think

about abstract issues and hypothetical situations as they enter the period of formal-operational thought. This means that the adolescent can contemplate his role in the traumatic event as he attempts to make sense of what happened. Greenwald (2005:230) also warns that the adolescents may experience guilt and shame over not being able to help others during the event. These feelings of guilt and not being able to attach meaning to the traumatic event may result in reckless or inconsistent behaviour. The adolescent may become obsessed with inner plans of action and they may even fantasise about retribution.

These confusing thoughts and feelings of the traumatised adolescent searching for meaning in life may also manifest in self-destructive and suicidal behaviour. According to Ainscough and Toon (2002:67), adolescents who have undergone sexual abuse are at high risk of poor impulse control and even suicidal behaviour. The types and descriptions of behaviours exhibited by the adolescent exposed to trauma could be summarised as follows (Hyter *et al.*, 2001:117; Santrock, 1998:455):

- Anxiety/depression: The adolescent feels unloved, he feels others are out to get him, he feels worthless or inferior, nervous, tense, sad and anxious.
- Social problems: He acts too young for his age, does not get along with peers and gets teased a lot. This results in poor relationship and social skill development.
- Thought problems: The adolescent, as mentioned before, cannot get his mind off certain thoughts regarding the trauma. This may present in strange behaviours like repeating certain actions over and over again, staring and strange ideas and behaviours.
- Attention: The adolescent cannot concentrate for long, cannot sit, he is restless, confused, daydreams and is impulsive; this has a negative impact on his school work. Negative feedback from teacher can then reinforce poor self esteem.

- Delinquent problems: The adolescent may feel no guilt after misbehaving, lies or cheats, prefers older kids, steals and hangs around with other teens that get into trouble.
- Aggressive problems: argues a lot, demands attention, destroy his own things or things of others, disobedient at home and school, sudden changes in mood, unusually loud, tantrums, self-harming behaviour and suicidal thoughts.

Smith *et al.* (2004:310) emphasise that cultural beliefs and attitudes also influences the difficulties that the traumatised adolescent may experience. The expectations for transition into adulthood are high and the risk of pathology in adult life again puts the traumatised adolescent at a disadvantage, if it is not dealt with appropriately.

## **2.5 SUMMARY**

This chapter clearly demonstrates the potentially devastating effects trauma can have on the child in all his life spheres. Unfortunately there is a high risk that as the significant adults in the child's life attempt to calm the aftermath of trauma, the child's emotional needs might be overlooked. Knowledge of the detrimental effects of trauma even on the very young child is essential for all persons involved in the lives of children. The lack of this knowledge and appropriate intervention will result in adults facing their future with the injuries of childhood trauma.

The impact of trauma on the child's life depends on a variety of factors including predisposition factors, characteristics of the trauma itself and post-traumatic variables. The experience of trauma overwhelms the child and his further emotional development is at risk. The recovery process of trauma is slow and the child will face functional difficulties during the process. Often the child is not able to integrate the traumatic incident without help as he does not have the coping skills required due to his developmental level. This child is at risk of developing PTSD.

PTSD is identified by specific signs and symptoms that must last for more than a month and must significantly impact on all important areas of the child's life. The child will demonstrate signs and symptoms that can be categorised as cognitive disturbances, affective symptoms, behavioural symptoms, sensory and motor problems and psychosomatic symptoms. The development of the child is significantly at risk as the child attempts to negotiate his injuries and participate in his life spheres without appropriate support.

It is important to understand and have knowledge regarding the impact of trauma on the child according to his age. The pre-school child is likely to present with the loss of previously acquired developmental milestones. The child will regress to behaviours like thumb-sucking, bedwetting and sleeping disorders. The young child is at risk of developing attachment disorders and difficulties with forming secure relationships. Further the young child's main occupation of play will be affected, which will further influence his skill acquisition and social development. The school-aged child might exhibit a wide range of behavioural problems and adapting to the school environment. His performance in his school tasks will be negatively affected and his social development will be affected.

The adolescent who experience trauma will find it difficult to integrate the experience and assign meaning to the event. He will contemplate his role in the event and replay the event as he tries to make sense of what happened. The adolescent is plagued with feelings of guilt and shame and this may result in behavioural problems. The traumatised adolescent will find it very difficult to transition into adulthood and he is at risk of serious pathology.

The researcher is of the opinion that there are many more aspects that can be considered in the life of the traumatised child. As every child is unique, so is that child's experience of the traumatic event and the injuries obtained. Therefore the researcher finds it necessary to emphasise that the professionals involved with the traumatised child should never generalise the

signs and symptoms that the child may experience. As the profile of the traumatised child has been described through this chapter, the researcher will now describe Occupational Therapy intervention with the traumatised child.

## **CHAPTER THREE**

### **OCCUPATIONAL THERAPY INTERVENTION WITH TRAUMATISED CHILDREN**

#### **3.1 INTRODUCTION**

Occupational Therapy philosophy, according to Alers (2005:77), states that the Occupational Therapist must always work holistically with the client. Alers and Ancer (2005:308) allude to the fact that Occupational Therapists often treat a child's perceptual problems but overlook emotional problems and their sources or treat an adolescent's drug addiction without addressing his sexual abuse. They question whether Occupational Therapists truly are working holistically and addressing the underlying core issues when rehabilitating the trauma survivor.

The researcher agrees with the above statements and is of the opinion that if Occupational Therapists discount the imposing emotional problems of trauma on the child and only focus on the presenting functional problems of the child, they are not following the holistic philosophy. Alers and Ancer (2005:308) make it very clear that Occupational Therapists have the opportunity to develop a therapeutic relationship with the traumatised child that allows the establishment of a new, meaningful, self-affirming experience for the child that is stable and allows safety and containment. This experience allows the child the opportunity to reintegrate into his environment and optimally participate in his activities in the course of daily living. They are adamant that Occupational Therapy does have a role to play in the rehabilitation of the traumatised child.

In this chapter the researcher will describe Occupational Therapy intervention with the traumatised child. An explanation of the holistic approach of Occupational Therapy philosophy will be given. Following this the role of Occupational Therapy in intervention with the traumatised child and Occupational Therapy intervention will be discussed. The researcher will

describe how different intervention strategies are used, including individual therapy, group therapy, play and psycho-education.

### **3.2 THE HOLISTIC APPROACH OF OCCUPATIONAL THERAPY**

Creek (2002:298) explains that the occupational science philosophy is based on the concept that every person, from birth to death, is an occupational being. Occupations range from personal care and domestic daily living skills to work or its substitutes – play in the child’s case - and to the multitude of leisure activities in which the child participates. Dunbar (2007:29) explains that throughout its history the profession of Occupational Therapy, in the field of mental health, has undertaken activity analysis to understand the therapeutic use of purposeful activity and the intrinsic qualities that give the activity its therapeutic value.

Barnes *et al.* (2003:337) explain that Occupational Therapy incorporates psychosocial dimensions into holistic approaches for intervention across all age groups. Occupational Therapists thus consider how psychosocial factors, among others, contribute and influence the child’s occupations. They state, however, that Occupational Therapy literature is insufficient in addressing issues related to children with emotional disturbances such as trauma. They further claim that there is an anxiety under Occupational Therapists to address the emotional needs of the traumatised child and a preference to focus intervention on the developmental and functional needs of the child.

This, according to Whiting (2001:85), could be explained on account of Occupational Therapy intervention historically tending towards the medical model of attempting to ‘cure’ the child. This emphasis has contributed to the continuous focus today on intervention for physical developmental disabilities, often leaving out the psychosocial concerns. Barnes *et al.* (2003:337) and Whiting (2001:85) agree that the profession’s claim to work holistically with the child will erode if the mental health issues are continuously not addressed and if the focus remains only on functional abilities like sensory awareness-processing, gross and fine motor skills, and perceptual skills.

In research done by Barnes *et al.* (2003:340) a variety of reasons have been found why Occupational Therapists tend to avoid providing intervention for the emotional needs of children. They report that some of these included that therapists have a perceived lack of skill and felt that they were not appropriately trained in addressing the emotional needs of traumatised children.

Whiting (2001:86), however, is of the opinion that Occupational Therapists are trained in understanding both physical and psychological issues and that they are capable of assessing both of these. The author further states that if the assessment do not include the psychosocial dimensions as well, holistic intervention will not be possible. The researcher agree with these authors that although the psychosocial dimensions of the child's health are included in Occupational Therapy training, therapists do not have the skill or the confidence in addressing the severe emotional needs of the traumatised child as part of their intervention plan. It is further important to consider the Occupational Therapist's role when providing intervention to the traumatised child.

### **3.3 THE ROLE OF OCCUPATIONAL THERAPY**

Crouch and Alers (2005b:271) state that Occupational Therapists are usually part of the multidisciplinary team, including teachers, psychiatrists, psychologists, speech and language therapists, social workers and the psychiatric nurses. Referrals to Occupational Therapy come from the multidisciplinary team as appropriate or even directly from the family of the child. The reasons for referrals vary, but the main focus is to address the functional abilities of the child or the developmental delays of the child.

According to Crouch (1997:143) the main focus of the Occupational Therapist in the field of child mental health services is to assist the child to structure opportunities for more satisfying relationships, to assist in releasing and sublimating emotional drives, to treat specific problems and to aid in

diagnosis. These objectives can be met as the Occupational Therapist's knowledge base includes expertise on human development throughout the life cycle, the use of purposeful activity, theoretical frameworks to guide intervention and knowledge of the functional impact of psychopathology (Davis, 1999:127; Whiting, 2001:86). Crouch (1997:143) further explains that, equipped with a clearly defined frame of reference and an understanding of appropriate general principles, an Occupational Therapist should be able to exercise flexibility, variation and imagination when designing and implementing therapeutic intervention. During intervention the therapist is guided by clinical reasoning.

According to Creek (2002:79), clinical reasoning is the thinking process that the Occupational Therapist follows in order to make decisions about what to do at each stage of the therapy process. She further states that clinical reasoning acts as an internal guide or structure by which the therapist selects from all the available data and uses it to understand the patient and make treatment decisions. She defines three types of clinical reasoning that can be utilised for working through different types of problems or stages of the intervention:

- **Procedural reasoning:** This is used when considering the client's disability and how to remediate it. It involves identifying problems, setting goals and planning treatment.
- **Interactive reasoning:** This type occurs when the therapist is working face-to-face with the client, building a relationship and trying to understand his experiences.
- **Conditional reasoning:** This is used when the therapist is thinking broadly about the client in his temporal and 'life-world' contexts and about the consequences of possible interventions. The therapist builds an image of the client's past, present and future in order to make predictions about what will work best.

In relation to this Alers and Ancer (2005:323) suggest that by utilising clinical reasoning combined with the Occupational Therapists' knowledge about

assessment, observation and integration of information it could lead to a truly holistic treatment plan. Before the treatment plan can be executed the Occupational Therapist needs to establish a therapeutic relationship with the traumatised child, which will be discussed in the following section.

### **3.4 THE THERAPEUTIC RELATIONSHIP**

Before assessment of the traumatised child can take place the Occupational Therapist, according to Crouch (1997:144), must establish a non-threatening, supportive relationship with the child. She explains the importance of familiarising the traumatised child with the Occupational Therapy room and devoting the first few sessions, if time allows, in building the therapeutic relationship. This can be done by giving the child time for free play and exploration, neutral activities can be suggested and verbal and nonverbal communication with the child must be developed throughout.

According to Lewin and Reed (1998:324) the therapeutic relationship must first and foremost be built on trust and emotional safety as often in a traumatic situation the safety of the child is compromised. Alers and Ancer (2005:323) include that the Occupational Therapist must make the child feel safe and be aware of the child's needs. They emphasise that trauma survivors must know that their needs matter, their boundaries are respected and that their boundaries will not be violated or invalidated. The child must not be made to feel trapped or constraint in any way. They explain that setting boundaries creates structure and allows for a safe situation in which independence can be developed. Further, external structure can also be provided by adapting the therapeutic environment and this can help the child to develop inner structure and will enhance the therapeutic relationship. Alers and Ancer (2005:323) stress that some trauma survivors often do not respect or acknowledge boundaries. Therefore boundaries need to be modelled by the Occupational Therapist. The child must be made aware of what behaviour is acceptable and unacceptable in any given situation and in the therapeutic session. The Occupational Therapist must communicate to the traumatised child that he is accepted unconditionally.

Alers and Ancer (2005:334) further explain that the therapeutic relationship must be open, transparent and supportive. The reason is that the abused child is often familiar with relationships defined by secrecy, intimidation and isolation. They emphasise that this has a significantly impact on the therapeutic relationship. Dunn (2000:62) further encourages the therapist to ensure that active and open communication is established with the abused child. The therapist must ensure that the child understands the therapist's use of language and he must never talk down to the child. She states that the therapy session must be client-centred especially with regards to physical distance and touch. Honesty and integrity is of the utmost importance when working with abused children.

Ingram (2003:97) is also of the opinion that a safe environment for the child is paramount to the building of a therapeutic relationship. She explains the issue of permission given by the child and the therapist, as well as from the larger system for therapy to take place. The parents or the carers of the child should endorse the therapy as far as this is possible. Once the child is more secure in the therapeutic relationship the future plan of the therapy can be discussed with the child.

### **3.5 OCCUPATIONAL THERAPY INTERVENTION**

Occupational Therapy intervention is a process in the sense that intervention and change take place over time. In many cases, according to Creek (2002:79), the process of carrying out a programme of purposeful activity is more important than the goal of the programme. Dunbar (2007:54) explains that the Occupational Therapist's actions follow a recognisable sequence through the three main stages of intervention, namely assessment and observation, treatment and evaluation. This is furthermore a circular process which means that when certain issues are dealt with, new aims and objectives can emerge during the evaluation stage. In the following sections the researcher will discuss and explain Occupational Therapy intervention with

the traumatised child. This includes the three main stages which involve assessment and observation, treatment and evaluation.

### **3.5.1 Assessment and Observation**

According to Crouch and Alers (2005b:273) the holistic assessment is complemented by consideration of the following issues:

- the child's psychological development
- the child's ability to express emotion and general behaviour of the child
- the child's living environment and permanence of the living environment
- level of cooperation and support of the carers.

They emphasise that assessment and observation starts at the moment of referral of the traumatised child and happens throughout the development of the therapeutic relationship. According to Creek (2002:79) assessment is the basis for all intervention and must be both thorough and valid in order to ensure that the treatment is appropriate and holistic. She states that observation, on the other hand, is a systematic and disciplined activity. In order for the Occupational Therapist to make considered decisions based on observations of behaviour, the Occupational Therapist must become an expert in observation (Crouch, 1997:144). In relation to this Ingram (2003:187) advises that no interpretations based on past experiences, expectations or assumptions may be made.

Alers and Ancer (2005:324) state that adequate time for assessment must be allowed for the trauma survivor. They suggest that an impact assessment can be done to ascertain how the traumatic event has affected the child's functioning in all his life spheres. Pre-trauma and post-trauma activity charts can be used to gather information about the child's actual performance in all the occupational performance areas. Creek (2002:80) emphasises the need for a detailed assessment of the traumatised child to be carried out in order to determine the child's needs, strengths, interests and goals for treatment.

A further aspect, according to Crouch and Alers (2005b:273), which needs to be kept in mind during the assessment phase, is the fact that the Occupational Therapist should have an understanding of the local child protection systems when considering intervention with the traumatised child. In this regard the researcher is of the opinion that the Occupational Therapist should acknowledge any legal proceedings taking place around the child and consult with the team around the child regarding this before treatment commence.

Upon comparison of lists of assessment and observation aspects that need to be kept in mind when working with the traumatised child, the researcher found that among Crouch (1997:145), Whiting (2001:86) and Crouch and Alers (2005b:278) the last named had the most holistic list. Their assessment and observation lists for the traumatised child include the following:

- Behaviour: The child' response to new situations, the presence of symptoms of stress and anxiety such as fears, phobias, separation anxiety, poor self-esteem, tics, self-destructive or attention-seeking behaviour, psychosomatic symptoms, tactile defensiveness and hyper vigilance.
- Conduct: Does the child lie, steal, fight, bully, disobey instructions, act aggressively, start fires, destroy toys and articles? What is the child's response to teasing?
- Motor behaviour: Is the child hyperactive or under-active? Does the child display involuntary movements, poor coordination, poor posture and tone?
- Attention span: Level of concentration, distractibility, preoccupation present. Is there daydreaming? Is there dissociation? Does the child listen and carry out tasks?
- Play: What type of play does the child prefer? Is the play constructive or destructive? Choice of toys, materials and people.

- Language: Content and appropriateness of speech. Are there stuttering, articulation errors or pressure of speech? Is the receptive and expressive input and output intact?
- Activities: How does the child participate in creative activities and drawing activities? Does the child complete activities? Is there frustration tolerance? Is there a consolidated task concept? Is there apathy, withdrawal, negativism towards self or impulsiveness?
- Habitual manipulations: Are there habits such as nail-biting, body rocking, head banging and hair pulling present? Is there any self-injurious behaviour?
- Sexual behaviour: Are any of the following present: seductiveness, masturbation, homosexual tendencies or conflict about sexual identity, inappropriate sexual behaviour towards others?
- Mood of the child: Is the child anxious, depressed, elated, hostile or displaying feelings of guilt? Does the child have mood swings?
- Relationships with children: Is the child demonstrative and affectionate? Is his behaviour appropriate? Is the child aware of peers and who is the choice of playmate? Is the child liked by peers and does the child show leadership? Is the child selfish and does the child display solitary play? Does he spoil others' play?
- Relationships with others: When in the presence of adults does the child show a preference for certain adults and choose a particular adult for a particular need? Does he avoid talking to, or interact with, an adult? Is the child cooperative, compliant, indifferent, dependent or independent?

These observations are part of a continuous assessment throughout intervention with the child. Crouch and Alers (2005b:278) include other more formal assessments that can be part of the holistic assessment namely: gross and fine motor skills, perceptual motor skills and sensory-integrative function according to the developmental level of the child. They warn, however, that there is a tendency with Occupational Therapists to carry out only these physical assessments, when the focus of attention should actually be on the

psychological problems. The intervention for the child as a result of such an assessment would be inadequate and would not contribute to the multidisciplinary diagnosis and intervention plan.

As seen above, thorough assessment is essential for the traumatised child to enable effective goal setting for treatment. Creek (2002:80), however, notes that there may be no clear division between assessment and treatment in Occupational Therapy, where clients are often being observed participating in activities that also have therapeutic value.

### **3.5.2 Treatment and Treatment Aims**

According to Crouch (1997:146) it is very important for the Occupational Therapist, when part of a multidisciplinary team for the traumatised child, to ensure that the frame of reference complements the therapeutic approach and treatment plan for the traumatised child. Intervention must thus be compatible and have similar aims as the intervention of the rest of the team. Occupational Therapy intervention, according to Creek (2002:80), occurs in three stages which may be repeated as necessary, depending on the progress of the child:

- formulation of the treatment plan
- treatment implementation
- treatment review.

The author explains that the preliminary treatment plan should be formulated by the therapist and child together, if the child is capable of making such a contribution. Other significant people in the child's environment may also be involved in this stage, including the parents or primary caregivers. The plan will furthermore include the goals or outcomes of treatment, methods to be used and an individual treatment programme.

Anderson (2005:77) reports that effective assessments will lead directly to setting measurable goals or defining expected outcomes of intervention and

to the choice of appropriate treatment methods. She states that the focus of the Occupational Therapist working with the traumatised child needs to be more on the child's emotional needs than on their developmental skill acquisition. She explains that the emotional legacy of the trauma requires a flexible approach to therapy in order to assist the child to enhance their coping resources. This means that the Occupational Therapist may need to sacrifice some of the developmental performance elements of the goals set for the traumatised child. In relation to this, the therapist needs to consider that the traumatised child who is prone to anxiety is likely to be negatively impacted by tasks that demand achievement and performance. Davis (1999:136) therefore is of the opinion that the aims that the Occupational Therapist would set for the traumatised child, would be to acquire functional skills that enhances the ability to recognise feelings, eliminate cognitive distortions about the event, problem-solve and identify more rational options for coping.

Alers and Ancer (2005:335), however, focus more on setting goals for self-esteem and self-image for the child traumatised by abuse. They report that these goals will assist the child to improve his body image. They emphasise that the child also needs to be assisted to experience positive interactions with adults and to learn to trust adults. The child's emotions further need to be acknowledged and accepted and appropriate emotional responses need to be encouraged. These children need to be taught communication skills and how to have their needs and feelings met appropriately. Lewin and Reed (1998:312) explain that problems regarding socialisation affect the child's functioning in all spheres of life and coping, as well as anger management, needs to be taught. The child's environment can further be adapted by reducing unnecessary stimuli and distractions and increasing predictability in the environment. Therefore restoring habits and engaging the child in meaningful occupations will help to restore predictability in the aftermath of trauma. As treatment must value holistic working, the frame of reference used must provide nurturance, predictability and physical and emotional support.

The process of Occupational Therapy according to Creek (2002:81) clearly has a purpose, which is to achieve a desired outcome. She explains that the

outcome of treatment should be measurable according to the objectives of the treatment.

### **3.5.3 Evaluation**

According to Creek (2002:81) the process of Occupational Therapy is completed by evaluation of the treatment. She explains that evaluation involves the outcomes of the set aims and the objectives of the treatment. Further, an objective is a precise statement of the desired change in terms of measurable behaviour. The treatment implementation involves putting the plan into action and continually monitoring the client's progress. The treatment evaluation is done to review what progress has been made and to judge the success of the programme. It allows for minor adjustments to be made according to any new information or changes in circumstances in the life of the traumatised child. She emphasises that assessing the outcomes of therapy also provides the opportunity for the client and the therapist to make decisions regarding discharge or referral to other agencies (Creek, 2002:81). Davis (1999:137) emphasises that for the traumatised child, intervention should be evaluated in terms of nurturance that the child received, predictability of the therapeutic setting for the child and the physical and emotional support that the child received.

Creek (2002:81) further states that as the child is as far as possible included in setting the aims for treatment, the child should also be included in the evaluation of the treatment. This allows the traumatised child to gain perspective and to see the progress that he has made. The child and the therapist can compare the present state of the child with the child's position before intervention so that the progress is obvious and the termination of treatment can be seen as positive. This is empowering for the traumatised child, as well as his primary caregivers, and instils hope for the future.

## **3.6 METHODS OF INTERVENTION**

De Witt (2005:3) explains the philosophy of Occupational Therapy as actively engaging a client in meaningful activity in order to improve or maintain occupational performance and quality of life. Correctly applied and selected activities can aid the child to reach his utmost physical, mental (emotional and intellectual), social and educational potential. These skills of activity selection and the presentation of the activity are essential to Occupational Therapy. Therapy is provided in individual session or group session. As the activity most appropriate for the child is considered play, this will also be discussed as a medium of intervention. Lastly, considering the primary caregivers of the child, psycho-education will be briefly discussed.

### **3.6.1 Individual Therapy and Group Therapy**

Therapy can be provided in individual sessions or in group sessions. Crouch (1997:147) states that the Occupational Therapist makes use of individual therapy for the child who has special problems such as perceptual-motor disorders, concentration problems and might require additional time to build the therapeutic relationship with the traumatised child. The Occupational Therapist furthermore must consider the child's age, stage of development, therapeutic needs, abilities, interests and social and cultural background in the choice of activity (Crouch, 1997:146).

Crouch (1997:147) also explains the benefits of group therapy for the traumatised child. She states that within the accepting atmosphere of a closed group the traumatised child can be allowed to present his problems. Furthermore, non-threatening exploration could happen and insight could be gained and there is also opportunity for modelling of behaviour within the group.

Alers and Ancer (2005:328) state that within the chosen group it is very important to instil hope, cohesion and existential factors to get the desired

outcomes for the trauma survivor. Crouch (1997:147) considers the following aspects when selecting a group:

- Developmental age of the members, to encourage age-appropriate identification and activity.
- Children with dissimilar problems to provide a variety of models, complementary behaviour and to reduce the reinforcement of maladaptive behaviours.
- Do not include children with widely different abilities in the same group.
- Mixed groups before the age of six and one-sex groups over the age of six, comply with normal grouping patterns.

The author explains that when these factors are taken into consideration when the group is formed, the group offers support, understanding and a positive growth environment for the traumatised child.

### **3.6.2 Play as Traditional Method of Intervention**

According to Crouch (1997:146) Occupational Therapy treatment of children with psychiatric disorders is usually through the medium of play. The play activity that is chosen would depend on the treatment aim set by the Occupational Therapist. The activity must remain meaningful to adhere to Occupational Therapy philosophy.

According to Creek (2002:296), play has many purposes in the Occupational Therapy session. It is used to establish a therapeutic relationship with a child by providing a neutral, shared experience. Therefore the Occupational Therapy setting should provide a normal play environment for the child.

Crouch (1997:146) explains that as play is the main medium of treatment, there must be provision for developmental play, imaginative and imitative play, social play, and creative and expressive play. She further differentiates between play that can be controlled or situational play and free or

spontaneous play. In controlled or situational play the Occupational Therapist, who is familiar with the child's problems, sets up a specific play scene which relates to the problem of the child. This method is particularly helpful where there are specific problems and symptoms of short duration. In free or spontaneous play the child is allowed to choose the play activity. This is more appropriate for the anxious child and the child with long-standing, deeply emotional problems (Crouch, 1997:146).

Alers and Ancer (2005:335) emphasise the importance for the Occupational Therapist to consider the emotional level of the child's developmental age and not the false emotional maturity that the child might portray, when choosing play activities. According to Cooper (2000:262) the Occupational Therapist should carefully consider the activities used with traumatised children according to their specific behaviours and suggests the following:

- For the child that exhibits behavioural and conduct problems, the Occupational Therapist will include a wide range of motor activity; the activities will be short term and interesting; they should be flop-proof and encourage a good end-product and encourage task-concept.
- For the over-anxious child the activities will be clearly demonstrated and step-by-step instructions will be given and assistance will be given if asked for.
- For the child with psychotic symptoms, establishing contact with others and communication are a priority. The activities should not be isolating in any way, they should be simple and promote the use of the senses. The end result of the task is of little significance.

The traumatised child cannot be treated in isolation and his environment and his significant others must be involved and educated to allow the child to re-integrate successfully into his life.

### **3.6.3 Psycho-Education**

Davis (1999:138) stresses the importance of the child and his family being taught the expected signs and symptoms that can be experienced following a traumatic experience. She emphasises that it should be communicated to the family and the child that these signs and symptoms are normal reactions to abnormal situations. She believes further that to gain mastery over intense feelings is empowering and helps the family members to develop supportive skills that facilitate recovery. The caregivers are especially important to the child in the aftermath of trauma, as they play a key role in helping the child adjust to trauma. If the caregiver is calm and responsive to the child's needs, the child has a better chance of avoiding post-traumatic stress disorder. Coaching families on how to relax, talk about feelings, eat a balanced diet, maintain exercise, stay involved with others, develop spiritual resources, get professional help and make use of leisure time, protects against the ravages of trauma.

### **3.7 SUMMARY**

Trauma and abuse affects the very core of the emotional and functional being of the individual. Occupational Therapy, however, has a significant role to play in the treatment of the traumatised child as the Occupational Therapist has a unique perspective on the impact of trauma on all the child's occupations and activities of daily living.

Because recovering from trauma can only occur in the context of relationships, it is essential for the Occupational Therapist to be aware of the impact of the therapeutic use of child's self. The establishment of a secure therapeutic relationship allows for the traumatised child to feel safe and contained in the therapeutic session. This allows the child to explore his situation and to begin recovery.

Assessment and observation ensures that a holistic picture of the child's situation and problems are clear. The Occupational Therapist makes use of

the Occupational Therapy process and clinical reasoning to guide her intervention. The child is included in the planning of therapy wherever possible to do so. Evaluation of the intervention can demonstrate to the child that he has progressed and that the traumatic event can be integrated into his life story. In order to ensure a smooth transition into adulthood it is important to validate and normalise reactions to traumatic events.

Although in theory, Occupational Therapists have the knowledge of both the physical and psychological impacts of trauma on the child, Occupational Therapists are not confident regarding their skills in addressing the significant emotional needs of the traumatised child. In the following chapter the researcher will describe Gestalt Play Therapy intervention with the traumatised child. Gestalt Play Therapy has effectively been used as intervention for traumatised children.

## **CHAPTER FOUR**

### **GESTALT PLAY THERAPY INTERVENTION WITH TRAUMATISED CHILDREN**

#### **4.1 INTRODUCTION**

According to Norton and Norton (2006:32) to be is to play. They describe how play is the child's introduction into the world and that nothing expresses his being more than play. Play is the language that the child uses and he expresses himself through his toys. Thus to the Gestalt Play Therapist, toys are the medium through which the child expresses his experiences. Ferreira and Read (2006:183) state that it is important to remember that children experience the same emotions as adults, but that children have not developed the language skill to verbalise the emotions, nor are they cognitively able to understand, identify and process traumatic material. Children will rather express their emotions through play and non-verbal behaviour, and feel the emotional pain physically as they are not able to verbalise their emotions.

Ferreira and Read (2006:181) also warn that although children have a natural ability to recover from traumatic experiences the possibility exists, however, that these children can be overwhelmed by the traumatic experience. They state that Gestalt Play Therapy can assist the traumatised child to express his feelings and experiences and enable him to come into contact with himself and his environments, as these aspects are often destroyed in trauma situations. Bauer and Toman (2003:60) elaborate on this by stating that:

...in the process of experiencing life, each child has a range of high and low polarities between which they oscillate in reaction to life events. The boundaries of that zone is shattered the moment trauma strikes. This expanded range encourages shifts in the figure/ground perception. Especially sensory perceptions

that once have been ground might become figural after a traumatic experience.

Ferreira and Read (2006:185) claim that post-trauma intervention through the use of Gestalt Play Therapy should take place as soon as possible after the traumatic incident to allow the child the opportunity to identify, verbalise and express his emotions in an age-appropriate way. They explain that Gestalt Play Therapy intervention can assist the traumatised child to work through the unfinished business of the trauma and reduce the risk of the child developing PTSD.

The researcher will focus this chapter on the Gestalt approach to Play Therapy intervention with traumatised children. The researcher also investigated how the play of the traumatised child is affected by trauma as this, according to Gil (2006:150), can have a significant influence on the Gestalt Play Therapy session.

#### **4.2 POST TRAUMATIC PLAY: THE IMPORTANCE OF PLAY IN TRAUMA RESOLUTION**

Post-traumatic play, according to Gil (2006:151), is noticed with children who have been exposed to a traumatic experience that has not been resolved in other ways. She defines post-traumatic play as a unique type of play that is characterised as being literal, repetitive, highly structured, self-absorbed and joyless. In agreement with this Webb (1991:30) further states that post-traumatic play occurs when the traumatic experience is too large and difficult for the child to assimilate immediately and the child uses this form of play to experience and re-experience the event.

Gil (2006:157) describes that by utilising this distinctive type of play, the child externalises the feared or traumatic event that he may otherwise avoid by not thinking or speaking about it. It is, however, interesting to note that while the child makes a conscious decision to avoid direct confrontation with the traumatic material, he seems compelled to replay the suppressed events by

utilising symbols that may provide the safe distance so that the traumatic material can be approached. This type of play is a natural form of self-imposed 'gradual exposure' also called desensitisation (Gil, 2006:157; Oaklander, 1988:248; Webb, 1991:30). Gil (2006:157) further explains that the child's ability to externalise and narrate his stories through action allows for gradual integration of feared affect or cognition. As the child recreates and concludes the play sequence while maintaining a sense of mastery, control and safety, the child may experience a sense of restoration. Norton and Norton (2006:49) include that while the child is exposed to the frightening memories the event is not happening to him as he constructs the scene of trauma. Gil (2006:157) calls this dynamic post-traumatic play.

However, Gil (2006:157) warns that post-traumatic play can be both liberating and dangerous. She explains that in some cases of post-traumatic play, difficult emotions may persist because the play fails to relieve anxiety or release energy through expression. The child can become re-traumatised through the play, experiencing feelings of vulnerability, and increased helplessness. When this happens, according to Webb (1991:30), the child can have the actual physical and emotional experience of the event – thus reliving the traumatic event. This seems to occur when the required emotional distance usually afforded through the use of symbols is not achieved and this play then does not serve the purpose of mastery. Gil (2006:158) calls this stagnant post-traumatic play as the child is hindered from recovery and gets 'stuck' in this play.

Gil (2006:160) explains that the outcomes of dynamic and stagnant play directly impacts on the healing of the child. In dynamic play the child is able to change elements of the play, producing a sense of mastery and control. According to Norton and Norton (2006:36), when the child changes elements in the play he takes an active role on his own behalf and he goes from being a victim to an active change agent. When the child nurture, protects or values his protected self, he is able to engage in attempts of restoration. Gil (2006:160) agrees and further states that when hurtful objects are held accountable or punished, the child can be restored. In stagnant play the child

are left incapacitated and overwhelmed by the trauma and his inability to defend himself against it. Thus the therapist must closely monitor the play and be ready to design and implement interventions designed to re-direct, shape or transform the play from stagnant to dynamic.

#### **4.3 THE USE OF GESTALT PLAY THERAPY WITH THE TRAUMATISED CHILD**

Ferreira and Read (2006:192) emphasise the need to look at the holistic impact of trauma on the child in his specific developmental phase. They explain that the traumatised child finds it difficult to express his feelings meaningfully and is often not given a chance to do so by society. Further, as the significant others of the child are most likely dealing with their own experience of the trauma they are often not able to assist the child effectively through his trauma reactions, even though they might be willing to do so. Oaklander (1988:247) suggests that the traumatised child requires support to help him integrate overwhelming feelings because, if these feelings are not dealt with, they may be repressed and cause secondary problems for the child.

The researcher will describe the Gestalt Play Therapy approach to addressing the needs of the traumatised child from the view point of establishing the therapeutic relationship, the role of the sensory modalities, trauma and the contact cycle, contact boundary disturbances and lastly the therapeutic process used for the traumatised child.

##### **4.3.1 Establishing the Therapeutic Relationship**

Kelly and Odenwalt (2006:191) claim that the immediate priority for the traumatised child is safety and security. Ambridge (2001:168) further states that it would be unrealistic and cruel to expect a traumatised child to engage in therapy if the child is not safe from the trauma. These authors agree that once the child's safety and security has been established the child can be

introduce to the therapeutic process. The first step of this process would be establishing the therapeutic relationship with the traumatised child.

Kelly and Odenwalt (2006:196) propose that in Gestalt Play Therapy the therapeutic relationship has long been considered a major change agent with the traumatised child. They explain that often the traumatised child suffers psychological bruising from interpersonal relationships related to the trauma experienced in his life. Gil (2006:61) agrees and further describes that healing is gained through the opportunity of being in a safe and supportive interpersonal relationship with the trustworthy therapist. Rasmussen (2001:16) believes that as the therapeutic relationship develops and the child gains confidence in the Gestalt Play Therapist's competence to help him, the traumatised child will commit to therapy and to the healing process. In relation to this Harris and Landreth (2001:31) elaborate by stating that this healing process through a therapeutic relationship provides the traumatised child with a more positive experience of interpersonal relationships. The relationship allows the child to develop a more positive perception of others, particularly adults, and improved expectations of relationships with others.

It seems as if there are numerous characteristics of the therapeutic relationship that would allow the traumatised child to experience healing as described above. Geldard and Geldard (2002:9) give a comprehensive list of attributes of the child-therapist relationship and these attributes will now be discussed:

- A connection between the child's world and the therapist: Through the relationship, according to Landreth (2002:77), the Gestalt Play Therapist is able to view the child's world from the child's own perspective and experience. This connection is established if the therapist goes in confluence with the child and seeks to understand the child's experience in the here and now moment. He further describes how confluence means that the therapist follows the lead of the child and, in fact, flows with the child. The therapist thus stays with the child in his experiences and only works with the present moment, called the here and now.

- Exclusive: Geldard and Geldard (2002:13) explain that the traumatised child needs to experience that he has an exclusive relationship with the therapist. The child needs to experience mutual trust and respect and experience that he is fully accepted by the therapist for who he is and with the experiences that he brings into the therapeutic session.
- Safe: In addition to being safe from his trauma as mentioned above, the child needs to experience a safe relationship with the Gestalt Play Therapist. According to Landreth (2002:85) this means that the child has the opportunity to share and disclose the trauma that he experienced with a therapist that will not judge him because of it. The child must feel free to act out and express his emotions in the therapeutic session without disrupting the therapeutic relationship.
- Authentic: Landreth (2002:70) emphasise that the therapeutic relationship must be genuine and the Play Therapist must make her real self known to the child. This will allow the traumatised child to give up his pretence and share his inner self. The child and the Gestalt Play Therapist must engage naturally and spontaneously in their play.
- Confidential within limits: Geldard and Geldard (2002:14) give very clear advice on how confidentiality should be explained to the child. The therapist should be honest with the child from the start of therapy that certain information must be shared and give the child some control and choice on how this will be done. With regards to the session, the child must know that what he shares will be kept confidential unless he chooses to share his experiences.
- Non-intrusive: The therapeutic relationship, according to Geldard and Geldard (2002:14) should serve to empower the traumatised child and the therapist thus needs to respect the boundaries of the child. The traumatised child must be allowed to join in the relationship in a way that is comfortable and at his own pace.
- Purposeful: Geldard and Geldard (2002:15) explain that the reason for engaging in therapy should be discussed with the child in the

presence of his parents. This allows the child to know what to expect of the sessions and he can prepare himself for the sessions.

In addition to this list, Blom (2006:54) describes the development of an I-Thou relationship with the traumatised child. She explains that the I-Thou relationship means that the child and the therapist meets each other on an equal level. The Gestalt Play Therapist must go in congruence with the child and be led by the child. Oaklander (1997: 303) further describes the I-Thou relationship as meaning that the therapist accepts the child as he is and will attempt to join the child in his experience by being present and 'contactful'. In relation to this Gil (2006:62), states it is very important to go in congruence with the traumatised child at his own pace as establishing the therapeutic relationship with the traumatised child can take time.

Schoeman and Van Der Merwe (1996:29), however, caution that within the therapeutic context it is highly unlikely that the child will be able to build a relationship and participate in the therapeutic process if the child is not sensory intact.

#### **4.3.2 The Role of Sensory Modalities in Awareness for the Traumatized Child**

Sensory awareness, according to Blom (2006:90) fulfils an important part in the life of the traumatised child as it has a direct influence on the child's ability to make contact with his environment. She describes how a traumatic event can result in a child desensitising himself by inhibiting his sensory awareness and sensitivity in his body in order to protect himself against further hurt. According to Oaklander (1988:109), the result of the child being out of touch with his senses is that the child becomes out of touch with his feelings and he blocks his expressions.

In relation to this Norton and Norton (2006:49) further explain that trauma is largely a somatic experience and that the trauma memory is a somatic memory. This means that for the traumatised child the use of body and

movement is crucial in playing out the event in the therapeutic session. The child needs to become aware of his senses and use them within the session to facilitate his contact-making skills. Also, since trauma is a flight, fright or freeze response, the child must confront his modality of response in order to regain his sense of dignity, empowerment and control. The researcher agrees that the Gestalt Play Therapist must enable the child to use his senses in the session to facilitate and increase his awareness of his experience. Norton and Norton (2006:49) further state that in trauma resolution, the Gestalt Play Therapy process should focus on sensory responses and somatic experiences in order to allow emotional discharge and ultimately empowerment for the traumatised child.

Blom (2006:89) further explains that to assist the traumatised child to regain his sensory awareness will improve his ability for self-support and emotional expression. She suggests that sensory and bodily contact-making can be addressed by means of various Gestalt Play Therapy techniques and activities during the therapeutic process. An important aim in Gestalt Play Therapy would therefore be to provide the child with the opportunity to make contact with his environment through his senses.

#### **4.3.3 The Contact Cycle and Figure/Ground**

Ferreira and Read (2006:195) claim that within the Gestalt Play Therapy process the main aim is to make contact. They explain that making contact means that the traumatised child is able to use his environment for the satisfaction of his needs. The child's needs will be satisfied when the child is fully functioning in all facets of his life. This can only be done if the traumatised child is assisted in becoming fully present and aware in himself and can contact the environment appropriately. Blom (2006:25), however, highlights the fact that young children will only be able to gain a limited awareness of their needs according to their developmental level. She further explains that the needs that the child experiences at a specific point in time, the here and now, will relate to his development and to environmental influences.

Blom (2006:26) explains that a child must be able to identify his most significant need at a given moment, this is called the figure, while the background of the child's experience at that specific moment is called the ground. Ferreira and Read (2006:195) further explain that the child's environmental field is differentiated by boundaries and both intrapersonal contact (contact between the child and aspects of himself) and interpersonal contact (contact between the child and the environment) are considered important. They explain that as the child makes contact with his environment to meet a specific need, the figure disappears and becomes part of the background as a gestalt is formed. Following this a new figure can appear in the foreground. Thus healthy functioning of the child implies that the child is capable of making contact with his environment to meet a foreground need and then withdraw once the need is met and the gestalt is formed.

In relation to this Norton and Norton (2006:49) state that for the traumatised child the foreground need would be to integrate the traumatic experience as well as the emotions related to the traumatic experience. They caution that the traumatised child might need to replay the traumatic event for several episodes in the process of Gestalt Play Therapy. Bauer and Toman (2003:64) explain that when the gestalt is formed withdrawal takes place. The withdrawal from contact stage can take years for the traumatised child as withdrawal could be delayed; it can even remain unfinished business for a lifetime, without intervention. They further suggest that post-traumatic stress symptoms are indicators of unfinished business that emerge, in part, from efforts to assimilate an experience which is inassimilable, as well as repeated and unsuccessful efforts to complete the cycle of experience. In order to incorporate a traumatic event and its aftermath into the child's life story, the story changes and a new gestalt forms. This completion of the contact cycle allows the child to continue to meet his needs in a more effective way – which is part of the objectives of Gestalt Play Therapy.

They further explain that when the child is not given the chance or is not able to express and verbalise his intense feelings, contact boundary disturbances

might surface in order to protect the child. In the Gestalt approach this can be explained as what restricts the child's ability to meet his needs and what causes imbalance for the child. The researcher is of the opinion that Gestalt Play Therapy can therefore assist the child through this difficult time, but it is important for the Gestalt Play Therapist to understand the process of trauma and how this relates to contact boundary disturbances

#### **4.3.4 Contact Boundary Disturbances**

Ferreira and Read (2006:195) explain that contact boundary disturbances need to be treated and resolved to enable the child to process the trauma and return to optimal functioning of contact-making and meeting his needs. Corey (2001:200) explains that from a Gestalt perspective contact boundary disturbances can be called resistance and it refers to defences that the traumatised child develop as a result of his emotional pain. This concept of resistance means that the child interrupts his contact with his environment to protect himself, which then prevents him from experiencing the present in a full and authentic way.

Clarkson (2003:101) further suggests that the Gestalt Play Therapist sees resistance as something that is accepted and respected in therapy. Every traumatised child will initially come to therapy with some form of resistance, and it is the role of the Gestalt Play Therapist to understand the resistance and to help the child become more aware of resistance for contact to eventually take place.

Blom (2006:31) gives a comprehensive list of contact boundary disturbances, which she describes as follows:

- **Introjections:** She states that introjections occur when the child takes in contents from his environment without criticism and awareness. The child thus sacrifices his own opinion and beliefs and accepts the point of view of others without questioning it.

- Projections: According to Blom (2006:33) projections occur when the child disowns attributes of the self that are inconsistent with his self-image and assigns it to others in his environment. The child makes others responsible for feelings and attitudes that is actually part of himself.
- Confluence: Confluence occurs when the child has a poor sense of self. The child has no boundaries between himself and the outer world. Blom (2006:35) states that the child who is in confluence finds it very difficult to make choices during Gestalt Play Therapy and would expect the therapist to choose for him.
- Retroflection: Retroflection is described by Clarkson (2003:103) as a process where the child does things to himself that he would like to do to others. This can be seen in self-harming situations where the child cannot express his negative emotions and then turns on himself.
- Deflection: Deflection according to Corey (2001:200) is the redirecting of attention on others or objects rather than on the self. The child would blame the trauma or outside forces for his own feelings and deny his responsibility for his own feelings.
- Desensitisation: Blom (2006:37) describes this contact boundary disturbance as the process whereby the child would exclude himself from sensory input and physical experience related to the traumatic incident such as pain and discomfort. The sensory experiences are therefore not appreciated and kept from being a figure on the child's foreground.
- Egotism: Egotism, according to Blom (2006:39) implies that the child has objective, rational awareness of their own experience but not subjective or emotional awareness of their experience. This child is thus not in contact with himself and attempts to control the uncontrollable and surprising aspects in his life at the expense of emotional contact.

Blom (2006:31) summarises that the role of the Gestalt Play Therapist would be to use the therapeutic process to increase self-awareness for the traumatised child and facilitate making contact with the environment to meet the foreground need of the child. The researcher will now describe the therapeutic process used with the traumatised child by the Gestalt Play Therapist.

#### **4.3.5 The Therapeutic Process used with the Traumatized Child**

The therapeutic process, according to Ferreira and Read (2006:194), is the most important aid to use during Gestalt Play Therapy. They explain that emotional expression is the focus of the therapeutic process for the traumatised child. The child is offered the opportunity to recognise, to own and to express his emotions so that his unfinished business can be accomplished.

According to Cattanaach (2003:44) integration occurs when the child is able to accept himself in total and function as a whole. To be able to function as a whole the child needs to accept his abilities, restrictions and experiences and integrate all of these. If this is done the child can accept responsibility for himself and he can use his strengths to meet his needs, this is called self-support. She also states that although a therapeutic process is used for addressing the needs of the traumatised child, the focus must remain on the process of the child.

Norton and Norton (2006:38) explain the Gestalt Play Therapy process according to the following stages:

- **The exploratory stage:** These are the first sessions and are used to build the therapeutic relationship with the child. The child explores his new environment as well as his relationship with the therapist. The therapist on the other hand has the opportunity to experience the child's process. The therapist conveys acceptance of the child and his situation.

- **Building the therapeutic relationship:** During this stage it is critical for the therapist to attend to the child's needs for expression rather than strive for control of the experience. By doing this, the child will realise that the therapist cares for his activities and expressions. Because the child knows that the experiences stored in his memories are unsettling and disturbing, he needs to also know that the therapist will not be distracted by the content of his memories but will stay focussed on his expression at all cost, even if he enters the depth of his internal pain.
- **The dependence stage:** The child is now free to express the emotional pressure that results from the trauma that disturbs his sense of well-being. This stage is the beginning of the healing journey. The child develops theme play as externalisation of the inner pain that he carries. He invites the therapist to join in his games. This is important as the child needs this relationship to provide security and protection as he confronts aspects of the trauma. As the child deals with these disturbing thoughts and feelings his play intensity will start to diminish to a more normalised level.
- **The therapeutic stage – the integration of self:** Once the child has confronted and resolved most of his issues, he will notice a void in his life as most of his energy previously has gone into the traumatic event and coping. He now no longer has to think about protecting himself. The child can now begin to re-experience his identity and develop a new capacity to experience and integrate his surroundings. The child is given the opportunity to experiment and explore his strengths and weaknesses and develop them into a functioning whole as he creates his new self-concept. As he develops his self-concept the child will be able to make the transition to finally developing self-support.
- **The termination stage:** The therapist will start to introduce the question of termination. Termination is a process in itself and the child might even feel a loss of this relationship. Therefore the therapist must work towards closure.

During these stages different techniques and media can be used to facilitate the process. The researcher will now discuss Gestalt Play Therapy techniques and choice of media.

#### **4.4 PLAY THERAPY TECHNIQUES AND CHOICE OF MEDIA**

Geldard and Geldard (2002:133) explain that techniques and media are used as a way to help the child to tell his story. They emphasise the need to remember that each child is unique as are his life experiences. Also, each of the techniques and media available has different and particular properties. The Gestalt Play Therapist needs to match the media and techniques with the individual traumatised child and his experiences. They name factors of importance when making the choice of activity as the developmental age of the child, individual or group therapy and the current therapy goals of the child. Ferreira and Read (2006:196-202) give a comprehensive list of treatment activities that can be used with the traumatised child. The list which will be discussed next, are divided into groups and include relaxation play and sensory contact-making, assessment play, biblio-play, dramatised play and creative play.

##### **4.4.1 Relaxation Play and Sensory Contact-making**

Ferreira and Read (2006:196) explain that relaxation play is used to build the therapeutic relationship between the traumatised child and the Gestalt Play Therapist and that it facilitates an atmosphere for therapy. These fun activities help the child to relax through the process of physical contact-making and sensory exploration. Oaklander (1988:124) describes how the traumatised child can experience the physical symptoms of anxiety and stress in aches and pains. These relaxation activities can help the traumatised child to become comfortable and to reduce his anxiety. The child can be assisted to physically relax his body and become aware of his needs through various activities. Relaxation techniques and free-play activities include stretching and breathing exercises through body movement, relaxation techniques, music activities and relaxed accompanied fantasy trips.

The researcher is of the opinion that it is important to remember that the traumatised child can be hyper vigilant and could find relaxation to be anxiety provoking. Special consideration should be given to requests such as closing his eyes as the child might not be comfortable with this. Once the child is more trusting and feels safe within the therapeutic relationship further activities can be explored.

#### **4.4.2 Assessment Play**

Ferreira and Read (2006:197) emphasise that assessment should never be the aim of therapy or to get specific information from the child. They claim that assessment in the Gestalt Play Therapy setting should be based on the three objectives namely: awareness, self-support and integration. They explain that assessment play can be used to observe the child's perceptual, cognitive, emotional and cultural background, behaviour and motivation. In addition to this Geldard and Geldard (2002:89) give a comprehensive list of observations to be made in the early stages of therapy, including the child's general appearance, mood, behaviour, intellectual functioning and thinking processes, speech and language skills, motor skills, play and relationship with the therapist. This information is used as a guide to assist the therapist in deciding how to proceed with therapy (Ferreira & Read, 2006:197; Geldard & Geldard, 2002:89).

Ferreira and Read (2006:197) further explain that the Gestalt Play Therapist should start where the traumatised child is and aim to understand the child's perspective and experience of his situation and problems. In this regard Geldard and Geldard (2002:92) stress the need for the therapist to monitor his own behaviour and to stand back when making observations and to ensure that he refrains from making judgements and interpretations about the child's presentation. Activities that are useful for assessment play include animal cards, family portrayal, the rosebush technique and the safe place fantasy. Assessment play can also be useful to direct the therapeutic process and the choice of further activities to be explored with the child.

#### **4.4.3 Biblio-Play**

According to Geldard and Geldard (2002:136) books and stories can be used in Gestalt Play Therapy to help the traumatised child gain mastery over issues and events that happened in his life. It will also allow the child to develop insight into his own behaviour and experiences as he learns from the situation of the characters in the stories. In relation to this Webb (1991:34) further explains that as storytelling involves distancing, identification and projection, it allows the child to consider alternative solutions to problem situations. This will help the child to develop problem-solving and decision-making skills and to transfer these skills to his own life.

In relation to this Ferreira and Read (2006:198) are of the opinion that stories offer the opportunity to convey, in a child-friendly way, a message to children that will answer their questions and that will reassure them with regards to the trauma that they have experienced. Biblio-play can also be used to determine themes on the child's foreground or unfinished business that the child might have. It then offers the Gestalt Play Therapist the chance to enter and explore the child's world. Oaklander (1988:85) describes activities in biblio-play as including the use of books, diaries, cards, letters, poems and audio-visual material.

#### **4.4.4 Dramatised Play**

Ferreira and Read (2006:198) state that dramatised play is very useful in the change-orientated phase, as it gives the child the opportunity to play out threatening situations in a safe environment. The traumatised child is able to relive traumatic experiences and gain control over them. They further explain that the focus of these activities should be on unconscious fears and feelings. Norton and Norton (2006:36) explain that in the fantasy of the drama, the traumatised child can gain power and control over the villain in his story. This allows a defence for the traumatised child against the overwhelming power that the world has over him. The dramatised activity brings reality into the

here and now and feelings are projected, new roles and skills are learnt, problems are solved and decisions are made. For the traumatised child it is less painful to project painful feelings through dramatised play and it is easier to gain narrative information.

Further to this Webb (1991:32) includes that dolls or puppets allow the child to re-enact events that he has witnessed, especially in his own family. The child can identify with the toy and project the feelings and conflicts that he repressed onto the dolls. This allows for the safety net of not having to own the feelings if the child is not ready to do this. Another benefit of dramatised play is that the child can repeat the traumatic experience and various outcomes of the event over and over again. Geldard and Geldard (2006:136) explain that this allows the child to gain mastery over the traumatic event and can empower the child. Activities for dramatised play include role-play, hand puppets, paper dolls and masks.

#### **4.4.5 Creative Play**

Creative play activities according to Ferreira and Read (2006:200) include art therapy, drawing, painting, clay, monster, empty chair, sand, clay and sand work. These activities are used to make projections in a non-threatening way, and can be used as a metaphor for the child, like drawing an emotion. However, the therapist should never use the projection for interpretation but it should be explored with the child (Geldard & Geldard, 2002:93).

Ferreira and Read (2006:200) further state that these projections can easily be used to work through the model of Gestalt Play Therapy as it allows the child to explore his inner world and he can gain insight into his own experience, complete unfinished business and restore balance. Through creative play the polarities that cause conflict for the traumatised child are exposed and can also be dealt with in the therapeutic session. Further to this, Webb (1991:32) and Geldard and Geldard (2002:136) state the child's creative art work of an event illustrates visual portrayals of feelings that the child could not adequately verbally express. Allowing the child to talk about

his creation permits the feelings to gradually enter into conscious awareness and the child is relieved of the pressure to continually repress them. Regarding the expression of pent-up emotions, Landreth (2002:140) emphasises that play materials should include the experience of being able to destroy something in order to give outlet to these aggressive feelings. Clay, for instance, provides a safe outlet of aggressive feelings as the clay requires some amount of pounding, poking and squeezing to achieve the desired form.

Geldard and Geldard (2002:136) explain that the traumatised child feels empowered when he is able to influence his environment. The child feels powerful through physical expression. They further explain that in a traumatic event the child's self-concept and self-esteem are adversely affected. In order to build self-esteem the therapist needs to select activities that will promote self-fulfilment and independence in the child.

#### **4.5 SUMMARY**

The traumatised child uses post-traumatic play in an attempt to integrate the overwhelming experience of trauma. This means that the child will play out the traumatic experience again and again in an attempt to assimilate the traumatic material from a safe distance created by his play. It often happens though that the traumatic experience is too large and difficult for the child to integrate, and he is stuck with the emotions and the experience that he cannot deal with on his own. Gestalt Play Therapy intervention is well suited to allow the child, in a supportive and non-threatening way, to deal with his traumatic experience.

Once the child has been secured from the traumatic experience and he is safe, he is brought into the therapeutic setting. The Gestalt Play Therapist's initial main aim would be to build the therapeutic relationship with the traumatised child. The therapeutic relationship offers the traumatised child the opportunity to experience a more positive experience of relationships with others. The therapeutic relationship can be healing as the child experiences acceptance and understanding in the safety of an I-Thou relationship where

he is equal with the therapist. Through the I-Thou relationship the Gestalt Play Therapist goes in confluence with the traumatised child and shares his experiences in the here and now. The Gestalt Play Therapist allows the child to express his built-up emotions and to gain mastery and control over his situation without judgement, thus allowing the child to be who he is. It will be difficult though for the child to engage in this process if he is not sensory intact, which is very likely in the case of the traumatised child.

The experience of a traumatic event can cause the child to inhibit his sensory awareness and sensitivity in his body as he desensitises himself. The traumatised child does this in an attempt to protect himself from further hurt and pain. Unfortunately this has the result that the child's contact functions are being inhibited or distorted as well. The traumatised child with poor sensory awareness and poor contact skills has difficulty to recognise his foreground needs and to make contact with his environment to meet those needs. This child has developed contact boundary disturbances which interrupt his contact functions. The Gestalt Play Therapist would then aim to increase the child's awareness of himself and his environment in order to improve his contact functions through the therapeutic process. This therapeutic process will allow the traumatised child to express his emotions and be empowered as he is able to improve his self-concept.

Different techniques and media can be used to facilitate the Gestalt Play Therapy process. The media and techniques assist the child in telling his story. Each of the techniques and media has different and particular properties and they need to be matched to the particular child and his experiences. Through the use of these media and the Gestalt Play Therapy process the child can heal from his trauma by integrating it into his life and improving his self-support.

## **CHAPTER FIVE**

### **RESULTS OF THE EMPIRICAL STUDY**

#### **5.1 INTRODUCTION**

The aim of the research study was to explore the utilisation of Gestalt Play Therapy in Occupational Therapy intervention with the traumatised child. The empirical data was collected through conducting semi-structured interviews with Occupational Therapists who met the criteria for the study. Six Occupational Therapists were identified to be included in the study. Five of these were interviewed and one Occupational Therapist did not wish to participate in the study. The researcher however found that after the fifth interview, a point of saturation had been reached. If this was not the case the researcher would have continued to identify more respondents until this point of saturation had been reached. The semi-structured interviews were conducted via the telephone. The conversations were recorded with the telephone on loudspeaker mode and recorded with the use of a dictation machine. The researcher also made field notes during the interviews which were then used in addition to the recordings in the analysis of the data.

The empirical findings will now be presented within the context of a literature control. As previously mentioned (refer to 1.2.2) there is limited literature available on the utilisation of Gestalt Play Therapy in Occupational Therapy intervention with traumatised children. The information gathered from the study has resulted in a number of key themes being identified by the researcher. The researcher will present each of these themes individually and incorporate the literature control in the discussions.

The major themes that will be discussed are as follows: The role of the Occupational Therapist providing intervention to the traumatised child, methods of utilising Gestalt Play Therapy in Occupational Therapy intervention with the traumatised child and Gestalt Play Therapy concepts utilised in Occupational Therapy intervention with the traumatised child.

The researcher has provided a flow diagram which illustrates the identified themes.

**THEME 1: The Role of the Occupational Therapist trained in Gestalt Play Therapy in Intervention with the Traumatized Child**

**Sub-themes:**

- 1.1 The Utilisation of the Knowledge Base Consisting of Gestalt Play Therapy and Occupational Therapy
- 1.2 Holistic Intervention Provided for the Traumatized Child

**THEME 2: Methods of Utilising Gestalt Play Therapy in Occupational Therapy Intervention with the Traumatized Child**

**Sub-themes:**

- 2.1 Referral Scenarios to the Occupational Therapist
- 2.2 Assessment of the Traumatized Child
- 2.3 Setting Treatment Aims and Treatment Implementation

**THEME 3: Gestalt Play Therapy Concepts Utilised in Occupational Therapy in Intervention with the Traumatized Child**

**Sub-themes:**

- 3.1 Establishing the Therapeutic Relationship
- 3.2 Choice, Control and Contact Boundary Disturbances
- 3.3 Sensory Modalities and Awareness
- 3.4 Use of Activity and Media

**Table 5.1** DEFINING THREE MAJOR THEMES AND NINE SUB-THEMES TO BE PRESENTED IN THE EMPIRICAL FINDINGS

## **5.2 THEME ONE: THE ROLE OF THE OCCUPATIONAL THERAPIST TRAINED IN GESTALT PLAY THERAPY IN INTERVENTION WITH THE TRAUMATISED CHILD**

The empirical research demonstrated that when an Occupational Therapist works with children, it is very likely that he will come across a child that has been traumatised in his practice. One respondent reported that currently in South Africa most of the traumatised children on her caseload had been traumatised by either social problems in the family or by the violence and crime that plagues the society. Even schools are reportedly not safe from crime and intimidation and the child sometimes faces these traumatic experiences in the school environment. It therefore seems important that the Occupational Therapist must be equipped to identify and treat the traumatised child effectively.

In this regard Crouch and Alers (2005b:272) describe the Occupational Therapist's role, which includes a complete assessment of the physical and psychosocial aspects of the child, in detail. This would include assisting the family in developing a plan of intervention for the child and evaluating the adaptive and social interactive functioning of the child. The Occupational Therapist further structures opportunities for development of more satisfying relationships via emotional expression and treating problems such as concentration, memory and perception, as required.

In addition, Blunden (2001:68) suggests that the knowledge base of the Occupational Therapist provides a good foundation for the development of Gestalt Play Therapy skills. This knowledge base includes, among others, creative thought, careful observations and combined knowledge of anatomy, physiology and psychology. However, she suggests that the Occupational Therapist utilising Gestalt Play Therapy will need to acquire a good knowledge of the different theories used in Gestalt Play Therapy and if possible undertake some postgraduate training. Further she emphasises the need for the Occupational Therapist to have work experience and knowledge

of children and families in different settings before undertaking further training in Gestalt Play Therapy.

It can therefore be concluded that the Occupational Therapist experienced in working with children and families must have a holistic approach and a particular foundation of knowledge on which their intervention is based. Consequently, the holistic intervention and the utilisation of a combined knowledge base in the treatment of the traumatised child as identified by the empirical findings will now be discussed. The researcher will describe the sub-themes pertaining to the role of the Occupational Therapist utilising Gestalt Play Therapy in intervention with traumatised children as identified by the study.

### **5.2.1 The Utilisation of the Knowledge Base Consisting of Gestalt Play Therapy and Occupational Therapy**

The empirical findings reveal that respondents greatly value their current knowledge base consisting of Occupational Therapy training and Gestalt Play Therapy training in terms of their intervention with the traumatised child. One respondent explains this by stating that: *"...die arbeidsterapeut kyk alreeds holisties na die kind, maar as die spel terapie-agtergrond ook by kom, maak dit die terapeut net nog meer sensitief vir die getraumatiseerde kind se situasie"*.

Before being trained in Gestalt Play Therapy, most of the respondents reported they did not view their knowledge or skills as being adequate to address the holistic difficulties, particularly the emotional difficulties of the traumatised child. A truly holistic approach to intervention with the traumatised child was not possible and the therapeutic process lacked this component. As one respondent put it: *"Ek glo dat voor ek Gestalt Spel terapie gedoen het, het ek nie besef wat dit beteken om werklik holisties met die kind te werk nie"*. This respondent is of the opinion that there is a void in Occupational Therapy training with regards to dealing with the severe emotional difficulties of the traumatised child.

The researcher agrees from personal experience that Occupational Therapists have the knowledge to know the importance of a holistic approach to helping the traumatised child. However, a defined knowledge and skill of how to address the severe emotional needs of the traumatised child is lacking. Consequently, Occupational Therapists are seeking to equip themselves with an additional tool to address the needs of the traumatised child and therefore expand on their skills by completing training in Gestalt Play Therapy. One respondent mentioned that when working with children, emotional trauma is always involved and that having the tool of Gestalt Play Therapy to work with brought immense value to her career.

Respondents clearly indicate that the knowledge base of the Occupational Therapist consisting of thorough training in both the physical and psychological functioning of the child, combined with Gestalt Play Therapy theory, is invaluable to their intervention with the traumatised child. Creek (2002:304) confirms that the Occupational Therapists planning for holistic intervention with traumatised children will be influenced by the combination of their education and training, knowledge, skills and experience. Creek (2002:34) therefore identifies the following as the main areas of Occupational Therapy's theoretical foundations:

- Theories of Occupation
- Biological Sciences
- Developmental Theory
- Physical Medicine
- Psychiatry
- Psychology
- Sociology

The researcher found that with this combined knowledge base of Gestalt Play Therapy and Occupational Therapy training, the respondents remained focused on Occupational Therapy philosophy as their main frame of reference for assisting traumatised children. The focus of this philosophy is on

occupation and purposeful activity. The profession of Occupational Therapy, according to Hagedorn (2000:20), was founded on the belief that people can influence their own health by being proficient in occupations which allows them to explore and interact with their environment in an adaptive way. The child's main occupation is play, and play is considered a purposeful activity for the child by assisting to explore and influence his environment (Ingram, 2003:185; Goggin, Hong & Howard, 2002:115). Therefore by using play in Occupational Therapy intervention the child is assisted to influence his own health and well-being.

One respondent explained this concept by stating that she starts her intervention with the traumatised child by assessing his occupations. She asks herself how the experience of a traumatic incident prevents the child from effectively participating in his daily occupations. She focuses on the play of the child by stating that: "The child's occupation is to play. If a child is prevented from play through his circumstances or through trauma, my personal understanding of occupational therapy is that the child is then prevented from being". Case-Smith (1998:192) elaborates by explaining that play as an occupation means that the child can experience feelings associated with productivity, satisfactory quality of life, meaningfulness and value. Therefore it is essential that the child is able to play.

This respondent is therefore of the opinion that her main treatment aim would be to enable the child to fully participate in his main occupations, including play. Further, the respondents discussed the holistic impact of trauma on all the life spheres of the child and his subsequent development.

### **5.2.2 Holistic Intervention Provided for the Traumatized Child**

The need for a holistic intervention approach for the traumatised child has been mentioned and highlighted by all respondents in the study. The Occupational Therapist needs to incorporate intervention specifically with the focus on the severe emotional difficulties of the traumatised child in order to have a holistic intervention plan. One respondent described how the natural

emotional development of the child is spontaneous but that this development can be severely disrupted by trauma. As a result of the disrupted emotional development the child can display inappropriate behaviour influencing all aspects of his life, including his development of social, physical and scholastic skills. Respondents therefore agree that when the traumatised child is assessed in a holistic way it is very likely that a number of secondary problems can be identified in terms of his functioning. This aspect has been highlighted in Chapter 2 (refer to 2.3.1) where it was described that the problems of the traumatised child are far reaching and influence many aspects of the child's life.

The researcher is of the opinion that the secondary problems of the traumatised child are often the reason for the referral to the Occupational Therapist and not necessarily the primary emotional difficulties of the child. Anderson (2005:75) describes this notion in a case study. In this case study a child who suffered abuse was referred to an Occupational Therapist for intervention regarding his developmental delays and hence a treatment plan was devised for the developmental delays. This treatment plan did not incorporate intervention for the emotional difficulties of this child. Following the course of development, focussed Occupational Therapy intervention and initial progress made by the child, the improvements were short lived. Anderson is of the opinion that this is the result of an intervention plan not formulated around a holistic approach including the emotional difficulties of the traumatised child. As the child's emotional difficulties were not dealt with, the intervention for the secondary functional difficulties was not successful.

Empirical data also reflected this concept and identified the risk that the Occupational Therapist who lacks the skill of addressing the emotional difficulties of the traumatised child will only focus on the functional and physical difficulties of the traumatised child. The result of this is that the holistic needs of the traumatised child will not be met. The Occupational Therapist specialising in, for example, Sensory Integration or Neuro-Developmental Techniques, can according to Case-Smith (1998:192), use these skills as valuable tools to assist the child through his developmental

delay or physical disability due to trauma. The emotional difficulties of the child, however, will be neglected as it cannot be addressed via these methods.

All the respondents also emphasised the need to consider the developmental phase of the traumatised child in intervention. This should include an understanding of the child's physical, cognitive and emotional development as this is a key factor in the successful treatment of the traumatised child. Crouch and Alers (2005b:268) agree with this and also add that as the trauma impacts on the child's ability to function at his full potential in his psychosocial environment, the Occupational Therapist with an understanding of the child's emotional development will be able to assess to what degree the child's functioning is impaired. The Occupational Therapist who therefore considers the holistic development of the traumatised child will be able to view the child as a whole throughout the entire process of intervention.

One respondent emphasised that this holistic approach ensures that important factors such as developmental level, functional abilities and subsequent activity choice are considered in all sessions with the traumatised child. In addition to this, the respondents also stressed the importance of considering the child's age and developmental milestones in the assessment of the traumatised child. This corresponds with Webb (1991:15) advising to consider the relation between the cognitive development of the child and the impact of trauma, especially related to the possibility that thought distortions can occur in relation to the cognitive development of the child. Respondents agreed that their combined and integrated knowledge of the developmental theories of, for example Erikson and Piaget, equips them to better understand the traumatised child's situation and can direct their assessment and goal setting. According to respondents they are confident that with Gestalt Play Therapy knowledge they can meet the holistic needs of the traumatised child.

### **5.3 THEME TWO: METHODS OF UTILISING GESTALT PLAY THERAPY IN OCCUPATIONAL THERAPY INTERVENTION WITH THE TRAUMATISED CHILD**

The researcher found similarities and variations in the methods that the respondents use to integrate Gestalt Play Therapy into their Occupational Therapy intervention. Respondents reported that their methods of implementing Gestalt Play Therapy techniques are largely shaped by their own experience, peer supervision and discussions. Some respondents reported that they present discussion groups and training events to other Occupational Therapists on how to integrate Gestalt Play Therapy into Occupational Therapy intervention based on their own experience. This was initiated after they identified a need under Paediatric Occupational Therapists with regards to a lack of skill and knowledge base to address the emotional difficulties of the traumatised child. These respondents reported that these events are greatly valued by attendees that have not been trained in Gestalt Play Therapy. It provides them with a place where they can learn about the importance of addressing the emotional difficulties of children seen in their practice and how to implement the skills.

Other respondents identified that they have shaped their intervention methods according to their experience in the field. One respondent reported how their service have accustomed their initial process of interviewing parents before intervention starts according to information gained from the Gestalt Play Therapy training. However, overall it can be summarised that due to limited evidence based research and literature on the subject, there are few guidelines for the implementation of Gestalt Play Therapy intervention in Occupational Therapy intervention with traumatised children.

The researcher will now discuss the referral scenarios to the Occupational Therapist, assessment of the traumatised child, setting treatment aims and treatment implementation for the traumatised child.

### **5.3.1 Referral Scenarios to the Occupational Therapist**

The study again demonstrated that referrals to Occupational Therapy for the traumatised child are rarely directly related to the trauma itself. Referrals are rather for assistance with the secondary and functional problems related to the traumatic incident as mentioned above. The reasons for this, according to respondents, could be that parents face financial constraints and cannot take the child to more than one professional. Or, that the parents might be traumatised as well, depending on the incident and could therefore not cope with having to take the child to another therapist. Davis (1999:127) agrees with this by stating that parents, teachers and some health professionals often overlook the emotional needs of traumatised children due to a variety of reasons, including their own psychological trauma or lack of knowledge regarding the impact of trauma on the child. She further explains that it is only after the secondary problems related to the trauma surface that the child will be referred to the Occupational Therapist. From the empirical data it was evident that the referral scenarios for the traumatised child to the Occupational Therapist could be summarised as follows:

- Firstly, through a direct referral for Gestalt Play Therapy intervention as it is known that the Occupational Therapist is trained in Gestalt Play Therapy. One respondent reported that as she was known to be a qualified Play Therapist she received many direct referrals for Gestalt Play Therapy intervention. She recalled a scenario where a parent actually told her that she preferred to bring the traumatised child to her as an Occupational Therapist rather than to take the child to a psychologist. The respondent assumed that this could be because of the stigma attached to receiving psychological intervention. In this situation the expectation of the parent was for the respondent to address the emotional needs of the child related to the traumatic incident. Respondents were in agreement that in scenarios like this, the intervention would likely be pure Gestalt Play Therapy sessions and integration with Occupational Therapy would be limited unless developmental or functional needs of the child are also identified. The

aim of these sessions would be the expression of emotional difficulties that the child experiences relating to the trauma and the impact of this on the child's contact functions.

- Secondly, but more frequently, respondents report that a child seen for Occupational Therapy treatment of physical or functional difficulties either discloses a previous traumatic incident or experience a traumatic incident in their life whilst they are in therapy. Respondents reported that as the therapeutic relationship formed through the Occupational Therapy intervention is so secure, the child might place his trust in the therapist and disclose his traumatic experience. However, when the child discloses the traumatic experience the therapist is now in the position where she must recognise the foreground need of the child (refer to 4.3.3), act appropriately and provide the intervention that the child requires. One respondent states, "*Indien die kind in terapie inkom en die terapeut vertel wat op sy voorgrond is en die terapeut kan dit nie hanteer nie, maar sy gaan net voort met die funksionele take, gaan die sessie amper waardeloos wees vir die kind*".

The researcher agrees with the respondents that if the Occupational Therapist is not able to deal with such a situation appropriately it will have devastating effects on the therapeutic relationship he is building with the child. Respondents report that as they are trained in Gestalt Play Therapy, they are now able to recognise the foreground needs of the child and make it a priority to address these foreground needs in the session with the child. It is at this point that the Occupational Therapist, according to the respondents, will integrate Gestalt Play Therapy in the Occupational Therapy intervention.

The researcher will now describe the information gathered through the empirical research relating to the intervention methods and treatment goal setting pertaining to these scenarios.

### **5.3.2 Assessment of the Traumatized Child**

One respondent emphasized that before assessment and planning strategies for treatment commence it is imperative to ensure that the traumatized child's basic needs, especially in terms of safety and security, have been met. In this regard she states, "Only once the child is stabilized and safe, the next natural drive to reaching his potential would be to be able to engage in his world". The researcher agrees that the therapist must first ensure that attention is given to the safety of the child. Kelly and Odenwalt (2006:185) also stress this point by stating that, when assisting the traumatized child, there is no point in attempting to provide intervention to a child that does not have safety and security. The reason for this, according to Gil (2006:12), is that if the basic needs of the child, in particular safety, are not met the child will not be motivated for therapy and realizing his potential.

Respondents reported that the combination of Occupational Therapy and Gestalt Play Therapy knowledge provide them with a solid foundation to perform a holistic and thorough assessment of the traumatized child. This complete assessment is not done necessarily as separate from the treatment session but will continue throughout the treatment sessions as well. Respondents are of the opinion that this approach to assessment enables the Occupational Therapist to really focus on the here and now of the child and where he is in the moment. In this regard Blom (2006:66) specifically states that although background information may be required to understand the holistic situation of the child, assessment can only be done in the here and now according to Gestalt Play Therapy. The researcher is of the opinion that this integration of knowledge whilst assessing the traumatized child would give a true perspective of child's experience of the traumatic incident and the experience of the child in the therapy session. The researcher is further of the opinion that if the Occupational Therapist is able to identify the needs of the traumatized child in the here and now, only then can effective aims be set for the therapy session with the traumatized child.

Most of the respondents reported that they also make use of some functional and physical developmental Occupational Therapy assessments before they plan the treatment for the child. The reason that they give for this is twofold. They find it necessary to establish the abilities and the skills of the child as a whole, including his functional performance, in order to be aware of any developmental delays that the child might have. These assist them to make a decision in activity choices and what challenges and expectations to present the child with. It also prevents a situation, for example, where the therapist asks the child to draw a projection but the child does not have the body concept of drawing a figure or perhaps the fine motor skills required for drawing. Also it assists in establishing any developmental delays that the child might have secondary to the trauma and for intervention planning.

One respondent further described a case study of a child who recently lost his mother and had to cope with a new and abusive step-mother. This child was developmentally assessed by an Occupational Therapist and the assessment showed severe developmental delays. A referral for intervention was made to the respondent trained in Gestalt Play Therapy. As the emotional difficulties of the child were recognised in the therapy sessions, he subsequently received appropriate intervention regarding his emotional trauma from the respondent. As the emotional difficulties were resolved and integrated, the child was re-assessed regarding the developmental delays. However, this assessment demonstrated very few developmental delays. The respondent is convinced that the first developmental assessment was inaccurate because of the child's poor contact functions and emotional trauma. The respondent therefore emphasised the importance of a holistic assessment including the emotional difficulties of the traumatised child. The complete assessment of the traumatised child will guide the Occupational Therapist to set goals for intervention with the traumatised child (Blom, 2006:86; Blunden, 2001:82).

### **5.3.3 Setting Treatment Aims and Treatment Implementation**

The empirical data demonstrates that respondents are faced with the challenge of integrating the Occupational Therapy model of structured

treatment aims (refer to 3.5.2) with the non-directive approach of Gestalt Play Therapy (refer to 4.3.5). Respondents reported different working methods of how to deal with setting treatment aims and following a treatment plan. Most of the respondents are of the opinion that the therapist can use Gestalt Play Therapy and Occupational Therapy principles within one session with the traumatised child. One respondent, however, is of the opinion that Occupational Therapy sessions and Gestalt Play Therapy sessions should be kept separate.

Although respondents have different views regarding the above they agree that setting the treatment aims for the traumatised child is complex and that it is important to be able to adapt to the needs of the child throughout the session. According to the respondents working from a Gestalt Play Therapy perspective, setting treatment aims present difficulties as the priority of the foreground needs of the child must be balanced with the presenting functional problems of the child. In addition, the expectations of the parents for intervention must be considered. Treatment aims in Occupational Therapy, according to Crouch and Alers (2005b:280), are traditionally set post-assessment and in consultation with the parents of the child. The sessions will then be structured and planned in some detail to lead the child through the session to meet the treatment goals that have been set out for the child. Hong and Howard (2002:8) explain that Occupational Therapy objectives are formulated to make sure that the goals are met within the session and a purposeful activity is chosen as the medium of intervention. The Occupational Therapist takes care to work client-centred through the Occupational Therapy process but the aim is focussed on meeting the treatment goals.

Respondents agree that the Occupational Therapy sessions will be planned and structured in terms of the functional or developmental treatment aims that have been set for the child, but this would be flexible and should be adapted as the need arises. The main consensus is that whatever the goal for the session was, it is important to recognise when a foreground need is expressed by the child as this is considered a priority. In situations like these the Occupational Therapist then needs to make the decision of how to

address that foreground need. In relation to this, one respondent described a case study of a nine-year-old child seen in therapy for visual perception and coordination difficulties and subsequently engaged in a treatment programme for these difficulties. However, it was suspected that this child suffered physical abuse from his stepfather and that he experienced emotional trauma. The respondent engaged the child in an Occupational Therapy treatment program to allow time for the therapeutic relationship to develop and for trust to be established. Once the child was more secure the respondent allowed the child to make projections in the session when the need was identified. The respondent would then spend more time on the child's emotional needs than on the functional needs in the session until this child was emotionally more stable.

Based on the above, the researcher came to the conclusion that the action the respondents would take depend on at what stage during the session the child starts to express a need. If the session is at a stage where it can be interrupted and steered towards Gestalt Play Therapy techniques it would be done, for example following sensory integration activities. However, if the child is in the middle of a specifically structured activity, for example a visual perception activity, the respondent might decide to first complete this and then to come back to the expressed need following completion of the activity.

This aspect is further explained by respondents in that they report that the Occupational Therapy intervention that they would provide is often complementary to the Gestalt Play Therapy intervention and could even be structured in this way. Occupational Therapy uses purposeful activity as method of intervention including sensory focussed activities and sensory integration techniques. Respondents report that these activities can directly serve to prepare the sensory modalities of the child for Gestalt Play Therapy. Other activities used for functional goals can, however, also be used as a possible projection later in the session. One respondent gives the example that not only can a drawing activity be used to perhaps improve the visual perception of the child, but this activity can later be used as the projection of

the child where he can make up a story around the activity that has been done.

Although this will be discussed in sub-theme 5.4.3, the researcher finds it important to mention that the Occupational Therapist is able to ensure that the sensory input provided for the child is accurate in relation to the sensory needs of the child. The researcher is of the opinion that if the incorrect level of sensory input is provided it can actually influence the ability of the child to focus on the projection and his awareness. This conclusion is drawn from literature regarding sensory integration, including Case-Smith (1998:230) commenting on the use of sensory integration techniques to modulate the sensory systems of the child and to enable the child to focus on the task at hand.

As mentioned earlier, one respondent was of the opinion that Occupational Therapy sessions and Gestalt Play Therapy sessions should be kept separate. According to this respondent she would refer the traumatised child to one of her colleagues for Gestalt Play Therapy intervention if the child appeared to need this, due to the emotional difficulties associated with the traumatic event. She explained that as her Occupational Therapy sessions are goal orientated and very structured she will find it difficult to have specific expectations of the child in one half of the session and then go in confluence with the child and follow his lead in the next half of the session. The researcher can comprehend the view of this respondent in terms of possibly causing confusion for the child with regards to expectations in the relationship and how to act. The researcher is of the opinion that if the child has very specific developmental functions that need to be improved in order to establish the emotional well-being of the child, this scenario might therefore be more appropriate.

#### **5.4 THEME THREE: GESTALT PLAY THERAPY CONCEPTS UTILISED IN OCCUPATIONAL THERAPY INTERVENTION WITH THE TRAUMATISED CHILD**

The researcher explored with respondents which Gestalt Play Therapy concepts they considered valuable to integrate into their intervention with the traumatised child. Respondents explained how some of these concepts are part of both Occupational Therapy and Gestalt Play therapy intervention with the traumatised child, although usually from different perspectives. The empirical data further demonstrated how these concepts, when integrated into intervention with the traumatised child can complement each other to the benefit of the traumatised child.

The concepts which were highlighted by the respondents which include the therapeutic relationship, choice, control and contact boundary disturbances, sensory modalities, awareness and the use of activities will be discussed in the following section. According to respondents, they use these concepts to enable the traumatised child to express his emotions and improve his contact-making. One respondent stated that, "I use Gestalt Play Therapy to enable the child to engage with his environment and the objects in his environment – people".

##### **5.4.1 Establishing the Therapeutic Relationship**

Respondents described the importance of establishing a therapeutic relationship with the child as the base for intervention. This relationship characterised by mutual respect and trust, according to respondents, will allow the traumatised child to experience the safety necessary to share his life experiences. The researcher agrees with the statement of one respondent saying that, "...to expect a child to share his hurts and fears, without establishing an authentic relationship is cruel..." Literature confirms that the traumatised child must experience that he is respected and valued in an authentic relationship in order to feel safe enough to share his experiences (Landreth, 2002:174; Geldard & Geldard, 2002:66).

Respondents reported feeling a strong sense of responsibility regarding being able to address the emotional needs of the child when the child brings his foreground needs into the therapy session. One respondent verbalised that she feels that she must be "...able to come through for the child when he needs you and you have established a trusting relationship with a child". Respondents explained that when the traumatised child trusts the Occupational Therapist, the child might attempt to share his experiences with the therapist.

This trusting relationship, according to respondents, can be complex and time consuming to establish with the traumatised child. They report that the intensity and the type of trauma that the child experienced can have a significant influence on the time it takes to develop a deep trusting therapeutic relationship with the child. This child, according to Gil (2006:62), might test the therapist or be unwilling to trust as his past experiences with significant adults in his life have taught him that it is just not worth it to engage in a trusting relationship. In this situation the respondents reported that their Occupational Therapy knowledge of activities greatly benefits the relationship-building phase. They have access to a multitude of equipment and activities that the child can engage in, in order to allow the traumatised child the time that he needs to become comfortable in the therapeutic environment.

Respondents also placed emphasis on being able to recognise the child's needs in the here and now when in the process of building a therapeutic relationship. They stated that the therapist must be observant and be able to identify cues that the child gives in order to support the child and make him feel secure. Respondents also reported that the therapist must demonstrate a genuine interest in the world of the child and some respondents reported that they would, for example, even visit the child in school. They will see where he sits in class, look at his books and meet his teacher. According to the respondents this might even be more than what the child's parents might do and the child's confidence will grow as he sees the therapist's interest in his world. The researcher is of the opinion that the Occupational Therapist

engages in the child's world as part of the assessment of the child in different environments. The researcher is further of the opinion that this is beneficial to the building of the therapeutic relationship between the traumatised child and the therapist. Jenkins, Ahmad and Hyde (2002:56) agree that the Occupational Therapist should seek to observe the child in different environments as this can assist the child to trust that the Occupational Therapist will help him. The researcher is of the opinion that establishing this relationship is essential to start the therapeutic process and for the child to, according to Cattanach (2003:103), share his experiences with the therapist.

#### **5.4.2 Control, Choice and Contact Boundary Disturbances**

The empirical findings revealed that respondents considered choice, control and contact boundary disturbances as important Gestalt Play Therapy concepts that they would utilise as objectives in their intervention with traumatised children. As far as the concept of choice and control is concerned, Gil (2006:63) is of the opinion that the traumatised child needs to experience that he is in control of some aspects in his life and that he can take responsibility and influence his environment post-trauma. She further explains the importance of allowing the traumatised child to make choices because it will help to strengthen his self-concept. As the child is given the opportunity to make choices, the child is allowed to experience being in control of a situation and shaping his environment around his needs.

All of the respondents reported that they will give the traumatised child choices in every session that they have with the child, although the application of this varied between respondents. Most of the respondents will give the child choices but structure the environment according to the child's assessed needs. Choices will be given, such as whether the child wants the door of the room opened or closed, does he want the lights on or off, would he like to take his shoes off or not?

The empirical research demonstrated that the Occupational Therapist will face challenges in terms of her approach to presenting the traumatised child with

choices. Particularly when the Occupational Therapist has certain treatment goals that needs to be addressed in the session. For example, if the child is referred for specific difficulties in scholastic skills it is likely that the child will avoid activities chosen to enhance these skills. Or, if the child has difficulty with fine motor skills it is likely that he will avoid fine motor activities and might prefer participation in gross motor activities that does not require fine motor skills. This means that the Occupational Therapist might consider limiting the choices that are given to the child in terms of activities to be completed in the session as she wants to engage the child in activities that will address the skill that needs to be developed. One respondent reported that if the Occupational Therapist has certain goals that need to be met in the session, the choices given will be limited, but then it is important to be honest with the child and explain the expectations that will be put to him. Rodger and Zivani (2006:113) explain that as the Occupational Therapist works child-centred the child always has the choice of participation in activities and the therapist needs to communicate this to the child.

These choices, according to Silverman and Treffers (2001:368) can initially be very difficult for the traumatised child to cope with. One respondent explains the importance of choice and control for the traumatised child as follows, "*Wanneer 'n kind getraumatiseer word, gaan dit oor die verlies van kontrole*". Regarding children that have been traumatised by their parents' divorce, another stated that, "The child never got to make the choice whether his parents should stay together or get divorced". The respondent further explained how the concepts of choices and control are very important within Gestalt Play Therapy and that this aspect should be integrated into intervention with the traumatised child. As the child is given the opportunity and is supported through initial decision making skills, the child's awareness will increase and he will start to make contact with his environment.

One respondent further mentioned that the severely traumatised child might not even be able to make the simplest of choices. She reported that when this happens, it is very likely that the child has such severe contact boundary disturbances (refer to 4.3.1) and has such poor self awareness that he is not

able to make these decisions. She reports that a child in this position might not be ready for therapy and mentions that she will continue focussing on sensory modalities and building the relationship with this child until he is more self-aware and can make better contact with his environment. Blom (2006:89) agrees that when the child restricts his senses and body, his contact-making and emotional expression will be poor. The traumatised child needs to be assisted to make contact within the therapeutic environment as a prerequisite for therapy.

The researcher is of the opinion that the contact functions is one of the key Gestalt Play Therapy concepts that the Occupational Therapist will need to deal with in her intervention with the traumatised child. Literature demonstrates that the traumatised child can have a number of contact boundary disturbances. Oaklander (1997:144) explains that the significance of contact boundary disturbances for the traumatised child as follows:

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

As the child then starts to make contact with his environment post-trauma, according to Cattnach (2003:31), the child needs to experience a world where he is a powerful presence and has mastery over what he is doing.

Although traumatised children should be given the opportunity to make choices, respondents were of the opinion that the child also needs to take certain responsibilities within the session. One respondent specifically stated that she views this as a priority with the traumatised child. She gave the example that if a child drops something whilst he is on a ladder she would expect him to come down and pick up whatever was dropped. The respondent further stated that the child is also responsible within her sessions

for cleaning and clearing the play room before he leaves and ensuring that toys are packed away. She feels that is essential for the child to develop this awareness of his environment and taking responsibility for his part in it. Blom (2006:108) explains that control and responsibility within the session is not the same as power gained during a struggle for power, but it is the interaction between the therapist and the child that can lead to growth. When the child is able to make choices and take responsibility it should be seen as contact-making and positive growth.

#### **5.4.3 Sensory Modalities and Awareness**

Respondents reported that they find the knowledge base of the Occupational Therapist in terms of the sensory systems and modalities very beneficial to their work with traumatised children. Respondents explained that this knowledge complements the intervention model of Gestalt Play Therapy in terms of the sensory modalities of the child and facilitates sensory awareness for the traumatised child.

Respondents emphasised that they considered it important for sensory awareness to be created through a purposeful activity chosen to meet the sensory needs of the traumatised child. This is supported by Crouch and Alers (2005b:339) when they explain that as every person has a unique sensory profile, the sensory activities chosen must focus on the individual needs of the traumatised child. One respondent also stressed the need to give the correct quantity of sensory input for the child according to the assessed sensory needs of the child. She reported that she would use different sensory loads to get different responses from the traumatised child. Respondents agreed that it is useful to engage the entire sensory spectrum and mentioned that the chosen activities are usually guided by knowledge of the child's sensory profile. Chara, Chara and Berns (2004:212) explain the importance of knowing the sensory needs of the child and what sensory systems to focus on for the individual. They emphasise the need to present the sensory activities at the right level for the individual child, to allow him in order to modulate and focus.

One respondent explained that every person uses one or two sensory systems more than others to modulate their experience and function. The traumatised child is also likely to use specific sensory systems to modulate his functioning and to calm him. The child that is always chewing, for example, might do this to calm and modulate his behaviour rather than being purely anxious. Respondents claim that the Occupational Therapist knows this and can use the sensory systems that the traumatised child favours to help calm the child and bring him to awareness in the session. Activities are specifically chosen that engage these sensory systems that the child favours. The researcher is of the opinion that as the child is modulated through the sensory system that calms him, he will become more relaxed and focused in the session. In this regard Cattanach (2003:127) states that as the child's awareness increases he will be ready for the therapy to commence.

Respondents emphasised the need for a functional component in the chosen sensory activity as this will increase the child's motivation to participate in the activity. Examples of sensory activities were given by respondents, such as using little model cars and putting them through a carwash by using water and shaving foam. The child is engaged in the story of washing the car and sensory input is gained from all the different textures from the water, foam, sponges and cloths used on the little car. The researcher agrees that by using such a play activity the child receives sensory input through different sensory systems and this assists him to become more focused and aware in the here and now of the session.

Respondents reported that movement can also be used very effectively to increase awareness for the traumatised child. They pointed out that the Occupational Therapist with the facilities in her practice, such as swings and hammocks can use this to great benefit of the traumatised child. One respondent reported that the sensory input received from the hammock can even influence the amount of eye contact that the child will make during the session and improve his communication during the session. With the

traumatised child this is even more important as traumatic memory is stored as a sensory memory (Gil, 2006:9).

Respondents agreed that to create awareness with the traumatised child, the sensory activity should be a calculated and specific activity. This will assist the child to become aware of his inner self and experiences. When this is achieved the child will be ready to make a projection, express his emotions and make contact in the therapeutic session.

#### **5.4.4 The Use of Activities and Media**

Respondents report that their skill in activity selection allows them to choose activities that is, as one respondent calls it, "...the just right challenge..." to engage the child in. The child, according to Rodger and Zivani (2006:116), can experience mastery and control and be empowered through activities that challenge him at the right level.

Bylsma (2005:358) emphasises that Occupational Therapists are experts in purposeful activity. She explains that the choice of media and a purposeful activity is used as the tool of treatment to enable the client to improve his participation in his occupations. Occupational Therapists are therefore skilled in the selection and adaptation of these activities to suite the individual client.

Respondents agree that the Occupational Therapist is able to pitch the activity at a level that is just right for the child. This means, according to Bylsma (2005:348), that the challenge that is set before the child is at the precise right level where he can master the activity but that it is also a developmental challenge for the child. The purpose of the challenges that are set for the traumatised child is to motivate the child for participation. Care should therefore be given that the challenge is not too high, as this can discourage the child from participation and could have an adverse effect for the emotionally unstable traumatised child.

One respondent suggests that when the 'just right' challenge is set for the traumatised child, it could be viewed as going in confluence with the child. When this occurs the challenge can be met and the child will be motivated for participation. This means that the child would have the abilities to master the media offered and complete the activity proposed to him. The respondent claims that this can strengthen the relationship between the Occupational Therapist and the child as the child feels safe within the challenges set by the Occupational Therapist in the treatment session. In a situation like this the child feels secure that he will not be expected to perform something that he is not able to and he feels valued in the challenge that is set for him. The respondent explained that within this safe situation the child will be more willing to make his projection and use the media that the therapist makes available to him. Geldard and Geldard (2002:133) advise that the choice of media is important as each child is an individual with his own preference, interests and frame of reference. They stress that the activity therefore needs to be matched to the child's needs and abilities as well as his developmental age and the counselling goals for the child. When these factors are considered the activity should be suitable to engage the child in.

One respondent emphasised that the choice of activity is guided by proper assessment and getting to know the child in terms of his skills, abilities and level of motivation. She reported that as the child feels confident that the therapist understands him and his abilities his trust will grow and the child will be more willing to share his experience with the therapist.

#### **5.4 SUMMARY**

The empirical research demonstrated that respondents greatly benefit from utilising Gestalt Play Therapy in their Occupational Therapy intervention with the traumatised child. The respondents revealed how Gestalt Play Therapy can be used as a tool to complement their intervention with the traumatised child. These respondents, previously lacking the knowledge and skill, now have confidence to address the severe emotional difficulties of the traumatised child. Therefore it allows the respondents to adhere to both

Occupational Therapy and Gestalt Play Therapy philosophy of having a truly holistic approach in their intervention with the traumatised child.

The researcher was able to identify three themes and nine sub-themes that emerged through the empirical data collected. These themes demonstrated how respondents view their role as Occupational Therapists trained in Gestalt Play Therapy and the methods they would use to integrate Gestalt Play Therapy in their intervention with the traumatised child. The respondents highlighted specific concepts from Gestalt Play Therapy that are also found in Occupational Therapy and that can be integrated as important objectives when providing treatment to the traumatised child from a holistic perspective.

It seems clear that the respondents, while remaining focused on the child's ability to participate in his occupations of daily living can now, with the knowledge of Gestalt Play Therapy, identify the emotional needs of the traumatised child as well. The respondent can assess the developmental delays and the functional and physical abilities of the child with their Occupational Therapy skills. This can then be integrated with their Gestalt Play Therapy knowledge with regards to the emotional experience of the child in the here and now. This allows respondents to gain a true perspective of the child's experience of the traumatic experience and his experience in the session. As play is the child's main occupation, the respondents will assess how the traumatic experience will influence the child's ability to play and to participate in his other occupations, like school. Thus, respondents who might have received referrals to address the secondary problems related to the traumatic incident, can now address the emotional difficulties that might still be present as well.

Following the holistic assessment of the child and the treatment aims set for the traumatised child; the respondents identified the challenge of integrating the Gestalt concepts into their intervention. The empirical research showed that respondents largely agree that Gestalt Play Therapy can be utilised in the Occupational Therapy session when the need is identified by the respondent. One respondent, however, reported that the integration into one session is a

difficult concept that she would not do within her practise. This respondent considers it more appropriate to keep the intervention separate.

Gestalt concepts identified as the therapeutic relationship, choice, control and contact boundary disturbances, sensory modalities and sensory awareness and the use of activities are important to consider in the intervention with the traumatised child. The researcher is of the opinion that utilising these Gestalt Play Therapy concepts complements the Occupational Therapy intervention and vice versa. Occupational Therapy activities and intervention can provide the child with a safe environment where he can take time to settle and build a trusting relationship with the therapist. The Occupational Therapist's knowledge of the sensory systems allows the therapist to present the child with sensory activities that will facilitate optimal functioning in the session and improve the child's awareness. Once the child's awareness increases and the child starts to experiment with choices and control, positive change can occur in the child and he can improve the contact he makes with his environment. The researcher is of the opinion that this aspect of sensory awareness can be done properly by the Occupational Therapist with this combined knowledge base, to the benefit of the traumatised child. The empirical data has demonstrated the importance of the Occupational Therapist being able to present the traumatised child with suitable possible activities to engage in. These activities can be used for the purpose of making a projection if the child presents a foreground need in the session. As the therapist is trained in Gestalt Play Therapy she can then assist this child, who is sensory aware, through the Gestalt Play Therapy process.

Respondents again identified the problem of a lack of literature and evidence-based research on the process of integrating Gestalt Play Therapy in Occupational Therapy intervention. Respondents reported how they would use their own experience and peer supervision to guide their intervention. Some respondents have engaged in presenting training events to help build knowledge on this process and to allow Occupational Therapists with a venue to problem solve. The lack of literature thus remains and further evidence-based research are required to create a guideline for Occupational Therapists

on how to integrate Gestalt Play Therapy in their Occupational Therapy intervention with traumatised children.

## **CHAPTER SIX**

### **CONCLUSIONS AND RECOMMENDATIONS**

#### **6.1 INTRODUCTION**

From the research results described in Chapter five, it can be seen how Gestalt Play Therapy is used within Occupational Therapy intervention with traumatised children. The aim of this chapter is to demonstrate to what extent the aims and objectives of the study have been met to resolve the research question. A summary will be given, conclusions will be drawn and recommendation will be made as resulted from the research project.

#### **6.2 AIM OF THE STUDY**

The aim of the study was:

- To explore and describe the utilisation of Gestalt Play Therapy in Occupational Therapy intervention with traumatised children.

This aim was met as follows: From the literature study conducted and from consultation with experts, a knowledge base was created from where the researcher formulated questions to be used for an interview schedule. The interview schedule was used to conduct semi-structured interviews with the respondents identified to participate in the study. Five semi-structured interviews were conducted to obtain qualitative data in order to establish the utilisation of Gestalt Play Therapy intervention with traumatised children.

#### **6.3 OBJECTIVES OF THE STUDY**

The researcher formulated objectives, as discussed in 1.2.3, to direct the study. The objectives of the study will be discussed individually:

- To conduct a literature review regarding the profile of the traumatised child, Occupational Therapy intervention with the traumatised child, and Gestalt Play Therapy intervention with the traumatised child.

This objective was met as the researcher gathered information and built a theoretical knowledge base regarding the above-named subjects through a thorough literature study. This information is discussed in Chapters 2, 3 and 4 of the dissertation.

- To conduct the empirical research via semi-structured interviews with Occupational Therapists who have completed training in Gestalt Play Therapy, in order to collate and analyse data regarding the utilisation of Gestalt Play Therapy intervention with traumatised children.

Semi-structured interviews were used as the data collection method to explore how the respondents utilise Gestalt Play Therapy in their Occupational Therapy intervention with traumatised children. The semi-structured interviews were conducted through the use of an interview schedule. The following aspects were covered in the interview schedule:

- how respondents view their role as occupational therapists working with traumatised children
- examples of case studies where Gestalt Play Therapy has been utilised in their Occupational Therapy intervention with traumatised children
- what Gestalt Play Therapy concepts the respondents view as important when working with the traumatised child
- the benefits of utilising Gestalt Play Therapy in Occupational Therapy intervention with traumatised children.

Six respondents were identified who met the criteria for participation in the study. Five of these were interviewed after which a point of saturation was reached. The respondents were all Occupational Therapists who currently

provide intervention to traumatised children and use Gestalt Play Therapy in the intervention. This objective has been met as the empirical information collected and analysed covered the aspects of this objective.

- To draw conclusions and make recommendations for Occupational Therapists on how to utilise Gestalt Play Therapy in intervention with traumatised children, in order to complement Occupational Therapy practise.

Conclusions and recommendations with regards to this objective will be made within this chapter. This can then be used as a guideline for future research to be conducted.

Both the aim and the objectives of this study have been met through the research project.

#### **6.4 RESEARCH QUESTION**

As this study was conducted within a qualitative research design, the following research question was formulated:

How can Gestalt Play Therapy be utilised within Occupational Therapy intervention with the traumatised child?

This question was answered via the data gathered in the empirical research. Respondents reported that they use Gestalt Play Therapy as a tool within existing Occupational Therapy intervention to enable them to have a truly holistic approach to intervention with the traumatised child. Respondents' training in Gestalt Play Therapy reportedly complements their Occupational Therapy intervention model with the traumatised child. As trained Occupational Therapists, respondents are able to assess and address the developmental, functional and physical difficulties of the traumatised child. With their Gestalt Play Therapy knowledge, respondents are now able to address the emotional difficulties of the traumatised child as well.

By applying Gestalt Play Therapy knowledge in Occupational Therapy intervention, respondents are able to identify the foreground need and the emotional difficulties of the traumatised child. Respondents reported that, previously, they might not have been able to identify the expression of a foreground need and the opportunity to address that need would have been lost. Respondents are now able to act appropriately when the child expresses a foreground need by allowing the child the opportunity to engage in the Gestalt Play Therapy process. The respondent will, for instance, allow the traumatised child to make a projection in the Occupational Therapy session. It will depend on the session itself when the projection will be made, but respondents identified that projections are often made following the Occupational Therapy activity, especially after sensory work has been done. However, it can also be done separately towards the end of the session if this is more appropriate. The traumatised child is thus given the opportunity to express his emotions in the here and now in the Occupational Therapy session.

For the traumatised child this means that he has the opportunity to re-enact his traumatic experience in a safe and supportive environment. Through enacting the experience the child can integrate the overwhelming emotions with the support of the Occupational Therapist. The traumatised child is allowed the opportunity to express his emotions without being judged or stopped. The child is also further allowed to experiment with alternative solutions for his problems and can gain mastery and control over his situation through this experience. The child is given the opportunity to see how his contact boundary disturbances influence his functioning and development tasks. Through this the child can gain some insight into his current situation and experiment with alternatives to improve his contact functions.

Furthermore, certain concepts from Occupational Therapy and Gestalt Play Therapy can be integrated during the Occupational Therapy session to the benefit of the traumatised child. The respondents described how the Occupational Therapy sensory activities that are used, facilitates the child's

sensory awareness and prepares the child for the therapeutic session. As the method of intervention in Occupational Therapy is via purposeful activity, the activity used in the session could lend itself to making a projection as well. The respondents identified the complexity around when to allow the child to make a projection and go in confluence with the child's emotional expression and the structured Occupational Therapy goals set for the session. Most respondents were of the opinion that this does not need to be a problem as the therapist would view the traumatised child's emotional needs as a priority in the session. Thus, by bringing the Gestalt Play Therapy knowledge into the therapeutic session, the Gestalt Play Therapy skills and techniques can be used when the therapist identifies the foreground need expressed.

## **6.5 CONCLUSIONS AND RECOMMENDATIONS**

### **6.5.1 Conclusions Drawn from the Research Results**

The researcher is of the opinion that the research question has been answered as the respondents who participated in the study shared their methods of utilising Gestalt Play Therapy in intervention with traumatised children. The research results were verified within a literature control even though the researcher identified that there is very limited literature on utilising Gestalt Play Therapy in Occupational Therapy intervention with traumatised children. The results of the empirical study can be summarised in the following themes:

- The role of the Occupational Therapist trained in Gestalt Play Therapy in intervention with the traumatised child
- Methods of utilising Gestalt Play Therapy in Occupational Therapy intervention with the traumatised Child.
- Gestalt Play Therapy concepts utilised in Occupational Therapy intervention with the traumatised Child.

The conclusions reach within these themes will now be discussed.

- *The Role of the Occupational Therapist trained in Gestalt Play Therapy in Intervention with the Traumatized Child*

The empirical findings again demonstrated that the respondents previously experienced difficulties meeting the holistic needs of the traumatized child as they did not have the knowledge or the skill to address the child's emotional needs. Following their training in Gestalt Play Therapy they are now confident that they can meet the holistic needs of the traumatized child as they are able to use Gestalt Play Therapy in their intervention with the traumatized child. Respondents reported that they need to have the skills to assist the traumatized child as these children often do not have access to debriefing opportunities and parents might not have the insight or the financial means to provide this for their children. The respondents are of the opinion that their combined knowledge base consisting of Occupational Therapy and Gestalt Play Therapy ensures that the assessment and the treatment plan for the traumatized child is more accurate and would meet the child's needs in the here and now.

- *Methods of Utilising Gestalt Play Therapy in Occupational Therapy Intervention with the Traumatized Child*

The empirical research showed that respondents receive referrals to assist the traumatized child either directly because of the trauma or, more often, for the secondary developmental or functional difficulties that the child might have. When conducting the assessment of the traumatized child the respondents utilise the combined knowledge base of Gestalt Play Therapy and Occupational Therapy. This knowledge base includes considering the developmental theories in relation to the child's developmental level and functioning in terms of his emotional, physical and cognitive development. By completing Occupational Therapy assessments the developmental and functional difficulties of the child can be established and with the Gestalt Play Therapy knowledge the emotional impact of the trauma on the child can be established. The researcher is therefore of the opinion that the respondents

can effectively establish the effect of the trauma on the whole life of the child and how his participation in his occupations is affected.

As the respondents are now in the position to integrate this specific knowledge base into their assessment, they can gain a truly holistic approach in their treatment plan for the traumatised child. The research data however demonstrated that the setting of treatment aims and the implementation of these aims are complicated. This could be due to the fact that according to respondents there is a lack of literature on how to implement the Gestalt Play Therapy techniques into the Occupational Therapy session. When setting treatment aims, respondents are faced with the complexity of balancing the needs of the traumatised child in the here and now with the functional treatment aims set initially. As treatment aims are likely to be set in consultation with parents as well as the child, this raises expectations of what will be focussed on in the sessions.

By setting aims to improve the child's independent functioning in activities of daily living, the functional abilities or lack of abilities is included in the treatment aims. In order to improve and develop the child's functional abilities the respondents would utilise structured activities with set aims and objectives for the therapeutic session. However, if a foreground need surfaces during the session the respondents would go in confluence with the child according to Gestalt Play Therapy techniques. Respondents agree that the foreground needs of the traumatised child in the here and now are always the priority in the session. This means that the Gestalt Play Therapy can be brought into the Occupational Therapy session and used when it is required.

Respondents reported different methods of integrating Gestalt Play Therapy into the session. Most of the respondents reported that a projection can be made following an activity that has been used for a specific treatment aim as the activity might lend itself to making a projection. Other respondents would allow time following the completion of the Occupational Therapy treatment for a separate projection to be made. One respondent, however, reported that she does not view it as feasible to use Gestalt Play Therapy within the

Occupational Therapy session as her working methods in Occupational Therapy are too structured and this may cause confusion for the child. The researcher found that most of the respondents viewed it as feasible to integrate the treatment into one session as the traumatised child expresses a foreground need.

- *Important Gestalt Concepts to be Utilised when Providing Intervention to the Traumatized Child*

The respondents identified important Gestalt concepts utilised with the traumatised child that are also pertinent in Occupational Therapy intervention. The researcher explored how these concepts are used by respondents and how they can be integrated to the benefit of the traumatised child. These included the therapeutic relationship, choice, control and contact boundary disturbances, sensory modalities and the use of purposeful activities.

Respondents emphasised the need for the therapeutic relationship, characterised by mutual respect, trust and authenticity, among others, to be established before therapy can commence. For the traumatised child forming trusting relationships is often a serious difficulty and the traumatised child is likely to need time and patience to form this therapeutic relationship. Respondents highlighted the need to allow the traumatised child the opportunity to make choices and have control in the therapeutic environment. For the traumatised child this concept is very important as he needs to experience being in control of a situation by having choices and influencing the environment. This will enable the child to make contact with his environment and to master his environment. Respondents allow the child plenty of freedom and choices in the therapeutic session. The researcher is of the opinion that integrating the Gestalt Play Therapy concept of following the lead of the child and working client-centred in Occupational Therapy can be of great benefit to the traumatised child.

The value of being able to engage the child in the Occupational Therapy intervention and purposeful activities allows the child to interact with the

respondent in a less threatening way and allows for time to be spent together. Respondents reported that as they are able to engage the child in activities aimed at his specific developmental level and abilities whilst still allowing for the child to be challenged, the child experiences that the therapist understands him. Respondents call this the 'just right' challenge for the child as well as going in confluence with the child where he is in the here and now. Respondents reported that as the therapeutic relationship is established, the child might feel safe to disclose some of his unfinished business. It would be at this point that Gestalt Play Therapy would be brought into the session in order to address the child's emotional needs.

The researcher found that the sensory activities used by the respondents also assist in preparing the child for Gestalt Play Therapy. The empirical data showed that respondents understand the need for engaging the sensory modalities and creating sensory awareness specifically for the traumatised child. As traumatic memory is stored in sensory memory, engaging the traumatised child in the correct sensory activities is essential. Respondents reported being able to assess the sensory needs of the traumatised child and provide the correct quantity of sensory input to focus the child in the here and now to enhance his participation. The researcher is of the opinion that the sensory activities used to commence the Occupational Therapy session prepares the way for the Gestalt Play Therapy techniques due to the engagement of the specific sensory modalities as required by the traumatised child.

The empirical data demonstrated that most of the integration that takes place of Gestalt Play Therapy into the Occupational Therapy session is done on a trial and error basis by respondents. The researcher is of the opinion that this is due to the lack of literature available of how Gestalt Play Therapy intervention can be integrated into Occupational Therapy intervention with the traumatised child. However, the empirical data demonstrated there is a wealth of knowledge in the field as individual Occupational Therapists trained in Gestalt Play Therapy have become experts in the integration of Gestalt Play Therapy in Occupational Therapy intervention with traumatised children.

These respondents share their knowledge and expertise in discussion and training groups to other Occupational Therapists. The researcher is of the opinion that this sharing of information and problem-solving opportunities should be used to build literature for the benefit of Occupational Therapists and traumatised children.

### **6.5.2 Recommendations**

The researcher makes the following recommendations in terms of the role of Paediatric Occupational Therapists:

- Paediatric Occupational Therapists need to recognise the significant role that they have to play in the emotional well-being of the traumatised child on their caseload. Therapists should never assume that the child has received any debriefing intervention formally or informally or that the child has the familial support to assist him. It can also never be assumed that the child will have access to counselling outside the Occupational Therapy sessions, as in many cases it is likely that the child will not be seen by another professional. Paediatric Occupational Therapists therefore need to consider their skills and knowledge and whether they can meet the holistic needs of the traumatised child.
- Paediatric Occupational Therapists should never become desensitised to the trauma that the child experiences in his life. Occupational Therapists need to be able to recognise the impact of traumatic situations on a child's life and never assume that the child has the inner resources to cope with what is happening in his life. In a society plagued by crime and social problems including domestic violence and divorce, the therapist needs to be aware of the possible impacts of these on the child.

- Paediatric Occupational Therapists need to ensure that they are able to recognise and clearly identify the holistic needs of the traumatised child that they might provide intervention to. They need to realise the significance of the child's emotional problems in relation to the child's functional difficulties in the here and now. The Occupational Therapist who has built a trusting relationship with a child has a responsibility to be able to understand what the child is trying to communicate and to act appropriately to this information. The therapist should not be distracted by their treatment aims for the session and then not focus on the child in the here and now.

The researcher would like to make the following recommendations regarding expanding the current knowledge base and research done:

- Occupational Therapists should make use of discussion groups and reflective practise groups in order to build their knowledge base on how to utilise Gestalt Play Therapy in Occupational Therapy intervention with traumatised children. Limited training groups are available as some Occupational Therapists have recognised the need to share knowledge and expertise in this area. The researcher is of the opinion that this is of great value and that the example should be followed to create more such groups.
- There is, further to this, a significant lack of literature on the subject of utilising Gestalt Play Therapy in Occupational Therapy intervention with the traumatised child. The researcher is of the opinion that further research should be done in terms of integrating Occupational Therapy and Gestalt Play Therapy concepts for the maximum benefit of the traumatised child. Sensory activities and the use of sensory profiling for example is a field that can be very valuable for the traumatised child as seen from the empirical data.

- The researcher would like to see further research done in possibly formulating a model that can be used by Occupational Therapist to utilise Gestalt Play Therapy in Occupational Therapy intervention with traumatised children. A model will give therapists a clear direction of how to approach and implement their treatment plans for the traumatised child.

A hypothesis that could be formulated in relation to this recommendation for further research could be the following: If a model of intervention could be created for the utilisation of Gestalt Play Therapy in Occupational Therapy intervention with the traumatised child, this would lead to a more holistic intervention plan for traumatised children.

## **6.6 FINAL THOUGHTS**

The researcher is of the opinion that the needs of the traumatised child in South Africa is a responsibility of all those involved with the child, including caregivers, family, school and professionals. Paediatric Occupational Therapists have access to many children through their practise and must recognise the significant role that they can play in the healing process of these children. Hopefully the cycle of inflicted trauma can be broken if children are given the opportunity to heal their wounds and successfully integrate to make a positive contribution to their societies.

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## **APPENDICES**

### **Appendix 1: Interview Schedule**

<b>INTERVIEW SCHEDULE</b>
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**Project: The Utilisation of Gestalt Play Therapy in Occupational Therapy Intervention with Traumatized Children.**

Time of interview:

Date:

Interviewer: Mariese Maree

Interviewee:

Position of interviewee:

#### **Questions:**

- 1. Please tell me how you view your role as an OT working with traumatised children.**
- 2. Can you please tell me about a case study where you provided intervention to a traumatised child and you utilised Gestalt Play Therapy.**
- 3. What Gestalt Play Therapy concepts do you find important to use within your approach to the traumatised child as an OT?**
- 4. What do you think the benefits are of utilising Gestalt Play Therapy intervention within the OT intervention with the traumatised child?**
- 5. Is there anything else that you feel you want to mention regarding the utilisation of Gestalt Play Therapy within OT?**

## Appendix 2: Consent Form

**40 Tranton Rd  
Bermondsey  
London  
SE16 4SB  
United Kingdom**

**2007**

Dear Respondent

**Re: Informed Consent Form:**

**The utilisation of Gestalt Play Therapy in Occupational Therapy intervention with traumatised children.**

My name is Mariese Maree and I am currently doing my dissertation as partial fulfilment for the degree of MDIAC in the subject of Play Therapy at the University of South Africa. I am a qualified Occupational Therapist and completed my studies at the University of the Free State.

I would like for you to participate as a respondent in my study as an Occupational Therapist who have completed this degree previously. Please see the attached consent form, also explaining your rights as a respondent. If you kindly agree to participate in this study please read the attached forms and email your consent to participate in the study to me.

If you have any further questions regarding the study please do not hesitate to contact me by phone or be email and I would be happy to clarify any issues. I thank you for your time in considering this request and look forward to your response.

Yours sincerely

Mariese Maree

**Tel: 0944 (0)77 9666 2856  
mariesemaree@hotmail.com**

**Title:**

The utilisation of Gestalt Play Therapy in Occupational Therapy intervention with traumatised children.

**Objectives of the study:**

1. To do a literature review regarding the profile of the traumatised child.
2. To do a literature study regarding Occupational Therapy intervention with the traumatised child.
3. To do a literature study regarding Gestalt Play Therapy intervention with the traumatised child.
4. To conduct semi-structured interviews with Occupational Therapists that have completed their training in Gestalt Play Therapy and are providing intervention to traumatised children.
5. To draw conclusions on the study and to make appropriate recommendations.

**Work procedures:**

Semi-structured interviews will be conducted to gather data for the study. The maximum duration of the interview will be one hour. The researcher will make use of an interview schedule to conduct the interviews and will have some predetermined questions and themes that will be covered in the interview. The researcher will record and transcribe the interviews.

The researcher will make use of the Data Analysis Spiral of Creswell to manage and analyse the data collated. The researcher will describe in detail the data identified in the interviews. Following the researcher will look for categories, themes and dimensions of information and attempt to narrow them down to a manageable number of categories. From the categories the researcher will attempt to make use of the data by interpreting the issues identified. The findings will be represented in written format as a dissertation and the respondents can view this when completed.

The researcher will be receiving supervision from a study leader at the Huguenot College. Ethically correct actions and attitudes will be monitored by the study leader to correspond with the stated ethical code and requirements.

**Confidentiality:**

The identity of the respondents will not be recorded in the study. All transcriptions of the interviews will be destroyed after the research study. All information gathered will only be discussed with the researcher's study leader and confidentiality issues will also be clarified with the study leader. All collated data will be kept in a secure and locked office. No concealed media will be used to gather data for the purpose of the study without the knowledge of the respondents. Information gathered for the purpose of this study that contains personal information regarding the respondents' clients will not be shared with a third party for whatsoever reason.

**Rights of respondents:**

Participation of the respondents in the study is by own free will. The respondents can withdraw from the study at any stage. The respondents will receive no payment for their participation in this study.

I AGREE TO PARTICIPATE IN THE STUDY AS EXPLAINED TO ME ABOVE AND UNDERSTAND THAT I WILL NOT RECEIVE PAYMENT FOR MY PARTICIPATION.

I UNDERSTAND THAT I CAN WITHDRAW FROM THE STUDY AT ANY STAGE THAT I WOULD WISH TO DO SO.

I UNDERSTAND ISSUES OF CONFIDENTIALITY AS EXPLAINED TO ME.

Name of Respondent: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please return this form to me at your earliest convenience by email.