

THE EFFECT OF GESTALT PLAY THERAPY ON FEELINGS OF ANXIETY
EXPERIENCED BY THE HOSPITALIZED ONCOLOGY CHILD

by

MELANY CONSTANTINOU

Submitted in part fulfilment of the requirements for the
degree of

MAGISTER DIACONIOLOGIAE
(In the Subject of Play Therapy)

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR MUNITA DUNN

November 2007

DECLARATION

I hereby declare that “THE EFFECT OF GESTALT PLAY THERAPY ON FEELINGS OF ANXIETY EXPERIENCED BY THE HOSPITALIZED ONCOLOGY CHILD” is my own work and that all the sources I have used or quoted have been indicated and acknowledged by means of complete reference.

MELANY CONSTANTINO

DATE

ACKNOWLEDGEMENTS

I Would Like To Express My Gratitude To:

- ◆ My supervisor Dr Munita Dunn for guiding me through this process.
- ◆ The people at the hospital who welcomed my working with the children; Specifically Dr Janet Poole, Alta Benz, Sister Brenda and the doctors of Ward 286.
- ◆ The children who gave of themselves even through their difficult times.
- ◆ My mother who is my light and has supported me throughout this Journey.
- ◆ My brother Michael who often put up with my long absences and has always been the light side of my life.
- ◆ My brother Dino who has always been my inspiration.
- ◆ My father, who has never given up on me.
- ◆ Colleen Potgieter for always believing that I could do this.
- ◆ Annelien Nieman who got me here in the first place and helped me to understand my purpose in this journey.

ABSTRACT

A child diagnosed with a life-threatening illness such as cancer, and is hospitalized for extensive periods of time, is faced with innumerable stressful and traumatic circumstances. This emotionally challenging life situation can bring on much emotional distress such as anxiety. Thus, it has become imperative that the oncology child is assisted and supported, in his individual struggle to cope with the harshness of his strained reality. In this study the hospitalized oncology child was provided with a means of support and intervention through the use of Gestalt play therapy. Gestalt play therapy was conducted to assist the child to express and work through feelings of anxiety and related emotional distress associated with his present life experience. Gestalt play therapy was presented with six case studies. The researcher explored and described the experiences of each case study from which, the researcher drew conclusions and made recommendations.

KEY WORDS

child, chronic illness, oncology, cancer, anxiety (medical), distress, Gestalt, Gestalt play therapy, diagnosis, treatment

DECLARATION OF TERMS

In order to avoid confusion and to eliminate long-windedness the masculine form of the pronoun will be used in this study to refer to both sexes. However where reference is made to the research participant in Case Study B, the feminine form of the pronoun will be used.

TABLE OF CONTENTS

CHAPTER 1: ORIENTATION OF THE STUDY

1.1	INTRODUCTION _____	1
1.2	MOTIVATION AND PROBLEM FORMULATION _____	3
1.3	GOALS AND OBJECTIVES _____	7
1.4	PARADIGMATIC PERSPECTIVE _____	8
1.5	RESEARCH DESIGN _____	10
1.5.1	The Framework For Research Design: A Qualitative Approach _____	10
1.5.2	Selection Of Research Participants _____	11
1.5.3	Sample Size _____	12
1.5.4	Data Analysis _____	13
1.6	RESEARCH METHODS _____	13
1.7	ETHICAL ASPECTS _____	14
1.7.1	Informed Consent And Participant Assent _____	14
1.7.2	Well-Being Of Research Respondents _____	15
1.7.3	Research To Be Sensitive To Needs Of Respondents _____	15
1.7.4	Anonymity/Confidentiality _____	15
1.7.5	Necessity Of Referral To Other Professionals _____	16
1.7.6	Cultural Sensitivity _____	16
1.7.7	Voluntary Participation _____	16
1.7.8	Risks Of The Study _____	17
1.7.9	Benefits _____	17
1.7.10	Ethical Approval _____	17
1.8	CLARIFICATION OF CONCEPTS _____	17
1.8.1	The Child _____	18
1.8.2	Chronic Illness _____	18
1.8.3	Oncology/Cancer _____	18
1.8.4	Paediatric Oncology Unit _____	19
1.8.5	Anxiety In A Medical Setting _____	19
1.8.6	Gestalt _____	20
1.8.7	Gestalt Therapy _____	20

1.8.8	Play Therapy	20
1.8.9	Gestalt Play Therapy	21
1.9	APPARENT OBSTACLES OF THE RESEARCH STUDY	21
1.10	RESEARCH PROGRAMME	22

CHAPTER 2. LITERATURE REVIEW

2.1	INTRODUCTION	23
2.2	STATISTICS OF PAEDIATRIC CANCER IN SOUTH AFRICA	23
2.3	RESOURCES CONCERNING THE ONCOLOGY CHILD	24
2.3.1	Understanding Psychosocial Aspects Of Childhood Cancer	25
2.3.2	Alternative Views Concerning The Effects Of Diagnosis And Treatment Of Paediatric Cancer	28
2.4	ANXIETY IN A MEDICAL CONTEXT	30
2.5	HOSPITALIZATION AS A TIME OF CRISIS	32
2.5.1	Reactions To A Chronic Illness	32
2.5.2	Need For Intervention Measures	34
2.6	PLAY AS AN INTERVENTION STRATEGY	36
2.7	THE GESTALT THERAPEUTIC PLAY PROCESS	40
2.7.1	Therapeutic Play As An Intervention Measure	41
2.7.2	Gestalt Play Therapy And Its Intentions	41
2.7.2.1	Awareness	42
2.7.2.2	The Therapeutic Relationship	43
2.7.2.3	Strengthening The Self	43
2.7.2.4	Integration	44
2.7.3	Play Therapy With Children In Crisis: The Hospitalized Oncology Child	45
2.8	SUMMARY AND CONCLUSIONS	46

CHAPTER 3. RESEARCH DESIGN AND METHODOLOGY

3.1	INTRODUCTION	48
3.2	RESEARCH DESIGN	48
3.2.1	The Framework For Research Design: A Qualitative Approach	48
3.2.2	Strategies Of Inquiry: Case Study	50
3.2.3	Data – Collection And Analyses	50
3.2.3.1	Setting	51
3.2.3.2	Selection Of Research Participants	51
3.2.3.3	Length Of The Study And Number Of Participants	52
3.2.3.4	Diagnosis And Treatment Of Participants	53
3.3	DATA COLLECTION METHODS AND FIELDWORK PRACTICE	54
3.3.1	One-On-One Semi-Structured Interviews	54
3.3.2	Questionnaires	54
3.3.3	Observation	55
3.3.4	The Gestalt Play Therapy Process	55
3.3.4.1	Procedure And Practice Of Gestalt Play Therapy Sessions	56
3.3.5	Analysis Of Findings	63
3.4	CONCLUSION	64

CHAPTER 4. DATA COLLECTION METHODS AND FIELDWORK PRACTICE

4.1	INTRODUCTION	65
4.2	DESCRIPTION AND EVALUATION OF CASE STUDIES	65
4.2.1	Case Study 1	66
4.2.1.1	Background Information Of B	66
4.2.1.2	Responses Of B To Interview	66
4.2.1.3	How I Feel In Hospital Questionnaire	67
4.2.1.4	Play Therapy Sessions	68
4.2.2	Case Study 2	74
4.2.2.1	Background Information	74

4.2.2.2	Responses of M's Parent/Guardian to Interview _____	75
4.2.2.3	Responses of M To Interview _____	75
4.2.2.4	How I Feel In Hospital Questionnaire _____	76
4.2.2.5	Play Therapy Sessions _____	76
4.2.3	Case Study 3 _____	84
4.2.3.1	Background Information _____	84
4.2.3.2	Responses of L's Parent/Guardian To Interview _____	84
4.2.3.3	Responses of L To Interview _____	85
4.2.3.4	"How I Feel In Hospital Questionnaire" _____	85
4.2.3.5	Play Therapy Sessions _____	86
4.2.4	Case Study 4 _____	91
4.2.4.1	Background Details _____	91
4.2.4.2	Responses of A's Parent/Guardian To Interview _____	91
4.2.4.3	Responses of A To Interview _____	92
4.2.4.4	"How I Feel In Hospital Questionnaire" _____	92
4.2.4.5	Play Therapy Sessions _____	93
4.2.5	Case Study 5 _____	98
4.2.5.1	Background Information _____	98
4.2.5.2	Responses of S's Parent/Guardian To Interview _____	98
4.2.5.3	Responses of S To interview _____	98
4.2.5.4	"How I Feel In Hospital Questionnaire" _____	99
4.2.5.5	Play Therapy Sessions _____	99
4.2.6	Case Study 6 _____	104
4.2.6.1	Background Details Of D: _____	104
4.2.6.2	Responses of D's Parent Guardian To Interview _____	105
4.2.6.3	Responses of D To Interview _____	105
4.2.6.4	"How I Feel In Hospital Questionnaire" _____	105
4.3	SUMMARY _____	111

CHAPTER 5. CONCLUSIONS, RECOMMENDATIONS, POSSIBLE SHORTCOMINGS AND FINAL REMARKS OF THE RESEARCH PROCESS

5.1	INTRODUCTION _____	112
5.2	GOAL AND OBJECTIVES REVISITED _____	113
5.3	SUMMARY OF FINDINGS AND LITERATURE CONNECTIONS _____	114
5.4	POSSIBLE SHORTCOMINGS _____	117
5.5	RECOMMENDATIONS _____	118
5.6	FINAL REMARKS _____	119
	BIBLIOGRAPHY _____	143

APPENDICES

Appendix 1.	Ethics Committee Approval Document _____	121
Appendix 2.	Parent/Guardian Informed Consent _____	122
Appendix 3.	Parent Interview _____	128
Appendix 4.	Child Participant Assent Form _____	132
Appendix 5.	Child Interview _____	134
Appendix 6.	Child's Drawing - Diagnosis _____	135
Appendix 7.	How I Feel In Hospital Questionnaire _____	136
Appendix 8.	Feeling Faces _____	137
Appendix 9.	All About Me Questionnaire _____	138
Appendix 10.	Incomplete Sentences _____	139
Appendix 11.	Meditation - The Ally Within/Safe Place _____	140
Appendix 12.	Healing Cells Meditation _____	141
Appendix 13.	Questionnaire For Termination Of Play Therapy _____	142

LIST OF FIGURES

Figure 2.1.	A Literature Map _____	26
Figure 4.1.	Case Study B - Free Drawing _____	69
Figure 4.2.	Case Study B - Diagnostic Drawing _____	69
Figure 4.3.	Case Study B - Safe Place _____	69
Figure 4.4.	Case Study B - Collage _____	69
Figure 4.5.	Case Study B - Cancer Out Of Play Dough _____	69
Figure 4.6.	Case Study B - Mandala _____	69
Figure 4.7.	Case Study M - Free Drawing 1 _____	79
Figure 4.8.	Case Study M - Free Drawing 2 _____	79
Figure 4.9.	Case Study M - Diagnostic Drawing _____	79
Figure 4.10.	Case Study M - Safe Place 1 _____	79
Figure 4.11.	Case Study M - Mandala 1 _____	79
Figure 4.12.	Case Study M - Safe Place 2 _____	79
Figure 4.13.	Case Study M - Collage _____	79
Figure 4.14.	Case Study M - Cancer Out Of Play Dough _____	79
Figure 4.15.	Case Study M - Drawing Of Illness _____	79
Figure 4.16.	Case Study M - Mandala 2 _____	79
Figure 4.17.	Case Study L - Free Drawing _____	88
Figure 4.18.	Case Study L - Diagnostic Drawing _____	88
Figure 4.19.	Case Study L - Collage _____	88
Figure 4.20.	Case Study L - Cancer Out Of Play Dough _____	88
Figure 4.21.	Case Study L - Cancer Out Of Play Dough _____	88
Figure 4.22.	Case Study L - Mandala _____	88
Figure 4.23.	Case Study A - Diagnostic Drawing _____	95
Figure 4.24.	Case Study A - Free Drawing _____	95
Figure 4.25.	Case Study A - Safe Place _____	95
Figure 4.26.	Case Study A - Collage _____	95
Figure 4.27.	Case Study A - Cancer Out Of Play Dough 1 _____	95
Figure 4.28.	Case Study A - Cancer Out Of Play Dough 2 _____	95
Figure 4.29.	Case Study S - Diagnostic Drawing _____	102
Figure 4.30.	Case Study S - Free Drawing _____	102

Figure 4.31. Case Study S - Safe Place _____	102
Figure 4.32. Case Study S - Collage _____	102
Figure 4.33. Case Study S - Cancer Out Of Play Dough _____	102
Figure 4.34. Case Study S - Mandala _____	102
Figure 4.35. Case Study D - Free Drawing _____	108
Figure 4.36. Case Study D - Collage _____	108
Figure 4.37. Case Study D - Cancer Out Of Play Dough _____	108
Figure 4.38. Case Study D - Mandala 1 _____	108
Figure 4.39. Case Study D - Mandala 2 _____	108

LIST OF TABLES

TABLE 4.1 Case Study B - How I Feel In Hospital Questionnaire _____	67
TABLE 4.2 Case Study B - Incomplete Sentences _____	73
TABLE 4.3 Case Study M - How I Feel In Hospital Questionnaire _____	76
TABLE 4.4 Case Study M - Incomplete Sentences _____	83
TABLE 4.5 Case Study L - How I Feel In Hospital Questionnaire _____	85
TABLE 4.6 Case Study L - Incomplete Sentences _____	90
TABLE 4.7 Case Study A - How I Feel In Hospital Questionnaire _____	92
TABLE 4.8 Case Study A - Incomplete Sentences _____	97
TABLE 4.9 Case Study S - How I Feel In Hospital Questionnaire _____	99
TABLE 4.10 Case Study S - Incomplete Sentences _____	103
TABLE 4.11 Case Study D - How I Feel In Hospital Questionnaire _____	106
TABLE 4.12 Case Study D - Incomplete Sentences _____	110

CHAPTER 1

ORIENTATION OF THE STUDY

1.1 INTRODUCTION

The diagnosis of a life threatening illness such as paediatric cancer, can define a moment of crisis for the oncology child. The young patient faces such complexities as being diagnosed with a life threatening illness, experiencing a potentially long course of treatment and going through numerous and sometimes prolonged hospitalizations (Adams cited in Webb, 1995: 54; Di Gallo, 2003: 490; Gariépy & Howe, 2003: 523). Thus, the diagnosis, hospitalization and the treatment process of paediatric cancer can impose multiple stressors on the child patient that may result in excessive feelings of anxiety and other emotional distress.

The hospitalized oncology child is not only separated from his family and friends, but he is exposed to a somewhat hostile and threatening environment (Barrera, Rykov, & Doyle, 2002: 379; Papaikonomou & Nieuwoudt, 2004: 283). The multi-modal approach to cancer treatment incorporates a number of very invasive medical treatment procedures that take place within the hospital environment (Papaikonomou & Nieuwoudt, 2004: 283). Consequently, the subsequent effects of such experiences may manifest in a variety of short and long-term negative outcomes. These could include such symptoms as: regression; slowed development; eating and sleeping disorders; the appearance of sympathy-evoking habits and imaginative fears; over dependency; aggressiveness; apathy; negativism; and the onset of anxieties and post-traumatic stress symptoms (Matthews, Bar-Mor, & Kayes, cited in Haiat, Bar Mor, & Shochat, 2003: 210; Taïeb, Moro, Baubet, Revah-Lévy, & Flament, 2003). The researcher thus maintains that if a child remains unable to organise the experiences of this illness and release his feelings into the external world, then it is inevitable that his illness can become a source of internal, silent turmoil.

A number of theoretical and empirical arguments have advocated that therapeutic play may provide a significant means in alleviating anxiety and in assisting in the process of increasing the adjustment of the hospitalized child (Adams, 1976; Erikson, 1981; Gariépy & Howe, 2003; Rae, *et. al.*, 1989). Margaret Adams (1976) was one of the first researchers who conducted a study recognizing that children that are hospitalized with a life threatening illness may

experience emotional stress, and that play can be used to facilitate the expression of feelings, and enhance a sense of mastery. Many authors who have done subsequent studies often refer to this study, and the researcher thus finds it significant to refer to Adams's work in this context.

In this study, the ideas that have been procured by previous studies of play therapy with the hospitalized child, as mentioned above, that suggest that play therapy with the hospitalized child can help reduce or prevent a child's emotional distress, such as levels of anxiety, are supported by the researcher. Furthermore, in this study, some of their ideas will be integrated with the principles of Gestalt play therapy, and utilized with the hospitalized oncology child.

It is the researcher's opinion that Gestalt play therapy is a powerful means of helping children to work through traumatic experiences as suggested by the works of Oaklander (2000; 1999; 1998; 1997; 1993), Lampert (2003), Blom (2004), as well as Schoeman and Van der Merwe (1996). Furthermore, the researcher believes that the usefulness of Gestalt play therapy can be applied in the context of the hospitalized oncology child. The researcher was unable to locate studies that incorporated the use of Gestalt play therapy with the hospitalized oncology child. This motivated the implementation of the present study.

Thus, the present study builds on the ideas of previous studies mentioned above that have utilised play therapy with the hospitalized child. It also fundamentally incorporates the critical ideas of Gestalt play therapy and applies them to the context of the hospitalized oncology child. The researcher bases the study on the idea that a study using the Gestalt therapy process with the hospitalized oncology child would be invaluable to the field of the psychosocial care of these children.

Gestalt play therapy acknowledges that play is a powerful and effective tool that can be used to reduce tension, anger, frustration, conflict and anxiety, which, for the oncology child, may be accompanied by the loss of control and self-esteem (Haiat, *et al.*, 2003: 210). In Gestalt play therapy the child is seen to naturally express feelings about self and experiences through play (Axline, 1993: 16; Landreth, 1991: 14; Oaklander, 1988: 160). Playing is seen as the means in which the child tries out and learns about his world. Play can become a language for the child that may be used in the place of words (Oaklander, 1988: 160). The reasoning behind this view is that the child experiences much in life that cannot be expressed in words, and so he uses play to formulate and assimilate what he experiences (Oaklander, 1988: 160).

Applying the Gestalt play therapy process to hospitalized oncology children may assist them to cope better and master their stressful experiences (Chambers, 1993: 352). Because feelings of loss of control, fear, anxiety and anger can be difficult for children to verbalize, therapeutic play becomes imperative. Play therapy for the hospitalized child appears to facilitate the release of feelings and enables the child to communicate with significant others information that would otherwise not be verbalised (Lingnell & Lori, 1999: 160). Gestalt play therapy acknowledges that in play, the child has the opportunity to develop his ability to reason, to think and to problem-solve. Thus, play may offer the child a way to gradually assimilate the anxiety being experienced, which would allow the child to gain a better sense of control over his life (Oaklander, 1988: 160).

1.2 MOTIVATION AND PROBLEM FORMULATION

The diagnosis of a life threatening illness such as paediatric cancer, and the resulting hospitalization can be stressful and traumatic and can lead to the emanation of feelings of anxiety and distress, if a child is not adequately prepared and supported through his experiences (Bowmer, 2002; Chambers, 1993; Doherty, 1992; Haiat, *et al.*, 2003; Lizasoain & Polaino, 1995; Noll, Maclean, Witt, Kaleita, Stehens Waskerwitz, Ruymann & Hammond, 1997; Rennick, *et al.*, 2004). Further studies have shown that the continual anxieties related with being diagnosed with a life threatening illness and being hospitalised as a consequence, may have negative repercussions on the child's psychological and social well-being (Gariépy & Howe, 2003: 524; Manner & Miller, 1998; Massimo, Zarri & Caprino, 2005: 389; Meijer *et al.*, 2000: 309; Mitchell, Clarke & Sloper, 2006: 805; Patenaude & Kupst, 2005: 14). It also needs to be acknowledged that a child's fears and fantasies during a traumatic illness, may not only influence the intensity of the illness but may also have some impact on the actual course that the illness may take and may thus, also influence the child's recovery process (Adams, 1976: 416; Ellis, 2000: 33; Jones, 2001: 274).

It is the researcher's experience that when children are diagnosed with a life threatening illness such as paediatric cancer and are hospitalized, what often occurs is that their physical needs are of primary importance, and their emotional needs are sometimes, left un-addressed or minimally acknowledged. Various studies have reported the same findings (Adams & Deveau, 1984; Barraclough, 1999; Lizasoain & Polaino, 1995; May & Sparks, 1983; Patenaude & Kupst, 2005; Petrillo & Sanger, 1980). Optimal care of sick children involves more than merely

meeting children's physical or medical needs (Barraclough, 1999: 199; Petrillo & Sanger, 1980: 2; Thompson & Stanford, 1981: 9). Psychosocial and emotional needs of the child also need to be addressed as numerous studies have noted (Adams, 1976; Eiser, 1990; Favara-Scacco, Smirne, Schilirò & Cataldo, 2001; Manne & Miller, 1998; Meijer, *et al.*, 2000; Noll, *et al.*, 1997; Patenaude & Kupst, 2005; Rennick, *et al.*, 2004; Vitulano, 2003).

The oncology child is under constant stress and feelings of emotional stress can be experienced at different levels, depending on his day-to-day circumstance. His life circumstance, from the time of diagnosis includes experiences such as: treatment-related pain, recurrent nausea and vomiting, visible side effects such as hair loss, weight loss or weight gain, mouth ulcers, severe headaches, multiple hospitalizations and clinic visits and repeated absences from school and peers (Cohen & Walco, 1999: 35; Gariépy & Howe 2003: 524; Winfree, Williams & Powell, 2002: 28). These can be severely traumatic experiences.

A child is often unable to express his fears or communicate his emotions appropriately (Savins, 2002). Furthermore, the researcher is aware that a child may have difficulty understanding why he needs to be subjected to such trauma. It can be that a child does not know how to deal with his experiences. Significant caregivers, being themselves under undue stress (due to having their child diagnosed with a life-threatening illness), may be unable to adequately support their child.

A more holistic manner of supporting the oncology child through his treatment and recovery that goes beyond meeting his physical needs is being increasingly acknowledged as an essential necessity for a child's overall healthy prognosis and rapid recovery (Barraclough, 1999; Bowmer, 2002; Doerty, 1992; Gariépy & Howe, 2003; Mitchell, *et al.*, 2006). A holistic model maintains that all aspects of the self, including body, emotions, mind, and spirit, are equally important. In the healthy state, these aspects exist in harmony together, forming 'a whole which is more than the sum of its parts' (Barraclough, 1999: 198). This idea is supported in Gestalt therapy theory, as is argued by the masters of Gestalt therapy, Perls, Hefferline and Goodman who noted that within the Gestalt approach lies the very insight that the whole actually determines the parts (1951: xi). Furthermore, nature or existence is seen as a unified whole. People are thus perceived as undivided and greater than the sum of their descriptions (Brownell, 2003). Gestalt therapy is holistic in the sense that it views the entire biopsychosocial field, including the organism and environment as relevant and important (Yontef, 1993: 87). In

Gestalt therapy, it is acknowledged that people live organismically in a number of inseparable and interpenetrating dimensions, that is, they live bodily, cognitively, emotionally, purposively, aesthetically, spiritually, interpersonally, socially and economically (Crocker cited in Brownell, 2003).

In recent years hospitals have become increasingly aware of the psychosocial, educational, and recreational needs of their paediatric patients (Jones, 2001: 271). However, the researcher believes that in practice, despite this awareness, a hospitalized child's needs are not often holistically addressed, and this specifically refers to the South African context. This perception was supported by a paediatric oncologist, working at a private hospital, and a sister working in the oncology ward at a leading provincial hospital. This reality may be the result of various reasons, one of which may include the fact that medical staff are only able to focus predominantly on the medical and physical needs of the child patient, as there is generally a lack of optimal time and appropriate resources.

If one were to look at the situation in other countries much could be learnt about the holistic health care of children. The researcher is specifically referring to *child life programs* that have been developed in some countries (such as the United States, Canada and the United Kingdom). These programs incorporate a specific approach of using play with hospitalised children, with the intent of both limiting anxiety and promoting growth (Webb, 1995: 52). Child life specialists firmly believe that play is the child's primary modality of communication, expression and healing (Lingnell & Dunn, 1999: 363). A child life worker is responsible for making the hospital and treatment experience less intimidating for the child by coordinating play therapy into their lives, to promote optimal development of children, adolescents and families, and to maintain normal living patterns by minimizing psychological trauma. They provide opportunities for gaining a sense of mastery, for play, for learning, and for self-expression (Bolig, 1984: 337). In South Africa, the emotional well-being of the child patient has become the responsibility of the social worker, and in very rare cases, of the sisters and nurses, and in some very fortunate instances, the play therapist. Limited resources however, and restricted time, and in some cases lack of fundamental knowledge, limits the implementation of psychosocial support on a more extensive, holistic level.

In an environment in which many things are threatening and nearly everything is out of the child's control, helping children achieve and maintain a sense of comfort, safety, and well-being

is a major challenge to the child life specialist (Wojtasik & Sanborn, 1991: 296). It is on this level of intervention, that the implementation of play therapy, in hospitals in South Africa, can have a significant impact in supporting children's psychosocial needs.

A crucial question that thus arose for the researcher was: *What can be done to help the child cope better with excessive feelings of anxiety and emotional distress caused by the diagnosis of a life-threatening illness?* And this led to the emergence of the second question: *How can Gestalt play therapy help to reduce or minimize anxiety and increase positive mood in the hospitalized oncology child?*

The above questions are derived from previous empirical findings, such as Adams (1976), Bowmer (2002), Chambers (1993), Eiser (1990), Gariépy and Howe (2003), Malan (2003), McArdle, (2001), and Patenaude and Kupst (2005), and the conceptual model of Gestalt play therapy proposed by Oaklander (2000; 1999; 1997; 1993; 1988). As Gestalt play therapy has been found to assist distressed children to come to terms with their fears and to master their experiences, it was the researcher's contention that it could be applied to the context of the hospitalized oncology child. The underlying problem that is focused on in this study thus concerns the use of Gestalt play therapy with the hospitalized oncology child, as a coping mechanism that may assist the child to work through any feelings of anxiety and other significant negative emotional effects relating to his experiences of being in hospital, and of being diagnosed with a life threatening illness.

The researcher has taken the above-mentioned questions as a basis for her study, and will attempt, in this study, to explore and describe how therapeutic play that developed within the Gestalt therapy tradition, may be used as a coping mechanism, with the oncology child. It is surmised that therapeutic play may assist the oncology child to cope better with any negative emotional effects that may arise as a consequence of his illness.

1.3 GOALS AND OBJECTIVES

The exact meaning of the terms “goal” and “objective” presents with some confusion. “Goal” has been defined as “an end towards which effort is directed; an aim or objective” (The New Penguin English Dictionary, 2001: 597). The Chambers Dictionary (2000: 686) defines “goal” as “an end or aim to effort or ambition”. “Objective” is defined as “a goal or aim” (The Chambers Dictionary, 2000: 1117); “something towards which efforts are directed; a goal” (The New Penguin English Dictionary, 2001: 963).

It appears that often, the terms “goal”, “purpose” and “aim” are used interchangeably. For the purpose of this study the researcher will use the terms “goal” and “objective” as used by Fouché (2002: 107). That is, seeing the terms such as “goal”, “purpose” or “aim”, as referring to the actual outcome of a process, whereas the term “objective” referring to the actual steps taken gradually and purposefully, within a certain time-span in order to attain the outcome of the process or the intended result of the study.

The aim of this study was to explore and describe the process of Gestalt play therapy as a means of limiting or minimizing feelings of anxiety experienced by the hospitalized oncology child. Following from this primary aim a number of objectives were undertaken in order to accomplish the overall outcome of the study. These include the following:

- ◆ A predominant objective of the study was to perform the Gestalt play therapy process with the hospitalized oncology child in order to explore and describe its significance in assisting the child’s adjustment process. The researcher developed a Gestalt play therapy process that was based on the principles of Gestalt therapy theory. The Gestalt therapy process was based on the following objectives:

- ❖ Establishing a safe and secure therapeutic relationship based on warmth and acceptance was an essential aspect in achieving the process of Gestalt play therapy.
- ❖ The child was presented with the opportunity to work through and assimilate the anxiety he may have been experiencing. This was done through the use of various channels of expression, which included drawing, painting, clay work, and collage.
- ❖ Through the Gestalt play therapy process the child was provided with means of gaining a better sense of control over his life.

- ❖ The attaining of awareness was another objective focused on providing the child with the means of being more in touch with the world and with his own existence.
- ❖ Developing a strong sense of self, strengthening the child's sense of well-being and enhancing his inner strength to express any buried or unexpressed emotions.
- ❖ The accomplishment of integration that provides a feeling of being whole and complete.
- ◆ To gain insight and knowledge of the experience of the research participant by collecting and interpreting data through observations, descriptions and interviews in order to explore and describe the outcome of the Gestalt therapy process of the hospitalized oncology child
- ◆ Once the Gestalt play therapy process was concluded the researcher proceeded to describe the results obtained through identifying relevant themes, feelings etc., and identifying whether significant changes could be seen through analysis of findings and thereafter recommendations were suggested based on the findings of the study.

1.4 PARADIGMATIC PERSPECTIVE

The Chambers Dictionary (2000:1178) defines the term paradigm as “a basic theory; a conceptual framework within which scientific theories are constructed”. In a scientific research study, a paradigm is a fundamental model or frame of reference researchers use to organise their observations and their reasoning (Fouché & Delport, 2003: 266). Qualitative researchers are said to approach their studies, with a certain paradigm or worldview. This involves a basic set of beliefs or assumptions that tend to guide their inquiries (Fouché & Delport, 2003: 266). The paradigmatic perspective upon which this study is based on is the humanistic, process oriented mode of therapy based on the principles of Gestalt therapy theory that is concerned with the healthy, integrated functioning of the total organism (Oaklander, 2003: 143). An underlying perception that thus embodies the purpose of this study is the idea shared by the researcher, that all living things have an inherent tendency to develop all their capabilities to their highest potential; and, thus, all living things should be able to have this opportunity to reach that essential level of being. The researcher further believes that when any living being is found to be within a context that inhibits their fundamental growth and threatens their true ability to reach self-actualization, then all assistance possible should be sought to aid the reversal of the disorder or imbalance and thus promote the re-establishment of homeostasis and balance. This supports the theoretical paradigm of Gestalt therapy. Subsequently, it can be seen that children are born with this inherent ability to develop to their full potential.

However, when they are faced with difficulties that may threaten this natural process of healthy development, they need to be assisted, as best as possible, to reach their true potential.

The researcher believes that one of the most natural means that children utilise to help them to deal with the stressors of life is their unique use of play. It is generally accepted that play is a child's natural medium of expression (Axline, 1993: 16; Landreth, 2002: 16; Oaklander, 1988: 160). Children are generally very concrete thinkers and words tend to be a rather abstract concept for them. Thus, play bridges the gap between abstract thought and concrete experience. Children will thus use play to work through their problems, make sense of their world and develop themselves as they grow and flourish through their lifespan.

It was Erickson who so aptly described the process of play therapy as follows:

You see a child play and it is so close to seeing an artist paint, for in play a child says things without uttering a word. You can see how he solves his problems. You can also see what is wrong. Young children especially have enormous creativity, and whatever is in them rises to the surface in play (cited in Russ, 2004: 8).

With children who are experiencing overt trauma, who are within life crises situations that threaten their overall well-being, and that interrupt their fully functioning potential, they experience fragmentation rather than integrated functioning. Within the Gestalt therapy paradigm, play therapy can be incorporated as a means of assisting such children in dealing with their trauma and so return to the road of healthy development (Oaklander, 2003: 144).

It is the view of Gestalt theory that within a situation of imbalance, it is essential that a state of harmony, or in Gestalt terms, homeostasis and organismic self-regulation be re-instated (Blom, 2004: 11). It was Violet Oaklander (1988; 1993; 1996; 1999; 2000) who significantly expanded and revised the theory and techniques of Gestalt therapy to be used with children. These Gestalt play therapy techniques have provided a monumental contribution to the therapy of children and adolescents. Within the theory of Gestalt therapy, the concepts of homeostasis and organismic self-regulation refer to the idea that a child is continuously experiencing needs of a different nature such as physical, emotional, social, spiritual or intellectual needs (Blom, 2004: 11; Rudolph & Thompson, 1996: 144). Gestalt play therapy aims at assisting children to function systematically and holistically so that they can focus their complete attention on the full satisfaction of their needs (Rudolph & Thompson, 1996: 119). Gestalt therapy is based on an underlying fundamental view that all individuals have the innate ability to achieve integration

(Parsons, 1975: 19). In organismic self-regulation the organism achieves a natural integration of mind and body, thoughts and feelings (Yontef, 1993: 103). These views go in direct confluence with the view supported by the researcher, as described earlier. The researcher thus, has great faith in the Gestalt play therapy process as it addresses the needs of children in a more holistic manner and thus children can be assisted, when experiencing difficulties, to find their inherent potential for living fully.

Thus, from a Gestalt perspective, through play children try out and learn about their world. Thus play becomes essential to their healthy development (Oaklander, 1988: 160). "Play is the child's form of self-therapy, through which confusions, anxieties and conflicts are often worked through" (Oaklander, 1988: 160). It is through the safety of play that the child can try out his own new ways of being. And thus, play provides a vital function for the child. It serves as a language for the child – a symbolism that is used in the place of words. The child experiences a substantial amount in life that he cannot as yet express using language, and so instead, he uses play to formulate and assimilate what he experiences (Oaklander, 1988: 160). Based on the research paradigm of Gestalt therapy, the researcher incorporated the Gestalt play therapy techniques with the hospitalized oncology child, in order to assist the child through his experience. The child was assisted to work through any feelings of anxiety and other significant negative emotional effects relating to his experiences of being in hospital, and of being diagnosed with a life threatening illness.

1.5 RESEARCH DESIGN

1.5.1 The Framework For Research Design: A Qualitative Approach

A research design is defined as a set of guidelines and instructions to be followed on how one intends conducting the research problem (Babbie & Mouton, 2001: 74; Mouton, 1998: 107). Its main function is to enable the researcher to anticipate what the appropriate research decisions should be in order to maximise the validity of the concluding results (Mouton, 1996: 107). It is thus, a plan or blueprint of how one intends conducting the study (Babbie & Mouton, 2001: 74). In this study a qualitative, naturalistic, basic research paradigm was used. Qualitative research allows the researcher to study human action in its natural setting, through the eyes of the actual participants, and places an emphasis on detailed description and understanding of phenomena within the appropriate context (Babbie & Mouton, 2001: 278). This study attempted to explore

and describe the experience of each research participant's play therapy process, and thus the researcher adopted the qualitative, naturalistic research paradigm as the most appropriate research approach for the study. This is also due to the fact that the researcher had worked within the natural setting of the child, that is within the hospital context.

The study adopted a basic research design as it focused on empirical observations. Basic research seeks primarily to understand behaviour and mental processes. It is not interested in "the scientific planning of induced change in a troublesome situation" (Fouché, 2004: 108). Basic research aims at understanding a phenomenon, that is, of determining how "nature" works (Shaughnessy, Zechmeister & Zechmeister, 2003: 323).

Furthermore, the researcher used the case study as the strategy of enquiry in order to gather comprehensive, systematic, and in-depth information about the participants involved in the research study (Patton; 2002: 447). Cases are "specific, unique, bounded systems", they are "units of analysis" (Stake, 2000: 436). Case studies take as their subject one or more selected instances of a social entity, which are studied using a variety of data collection techniques (Hakim, 2000:59). The case study approach to qualitative analysis constitutes a specific way of collecting, organizing and analyzing data (Patton, 2002: 447). The purpose is to gather comprehensive, systematic, and in-depth information about each specific case (Patton, 2002: 447). Thus the case or unit of analysis in this study was the hospitalized oncology child.

In this research study, the case study approach was considered by the researcher to be an ideal methodology for a holistic in-depth investigation. The study focused on the very process of each child participant's experience rather than on the outcome of some event (Newman & Benz, 1998: 65). What was emphasized was the description of the personal meanings that each child participant placed on his play therapy experience.

1.5.2 Selection of Research Participants

When selecting the research participants of a study, a distinction needs to be made between the terms "universe", "population" and "sample". The universe refers to all potential subjects who possess the attributes in which the researcher is interested (Strydom & Venter, 2002: 198). In this research study, the researcher conducted the study within the natural setting of the research participants. The research participants in this study are the hospitalized oncology children, and thus, the natural setting was the hospital ward where the children were receiving

treatment at the time of the research study. The “universe” thus comprised of all the children present in the paediatric oncology ward, at the Johannesburg Hospital, at the time of commencement of the study.

The population is “a set of all cases of interest” (Shaughnessy, *et al.*, 2003: 128). It, however, incorporates certain relevant boundaries on the study units. It refers to individuals in the universe who possess specific characteristics (Strydom & Venter, 2002: 198). A sample comprises of the elements of the population that are considered for the actual inclusion in the study (Arkava & Lane, cited in Strydom & Venter, 2002: 199). The “population” would refer to those children who were selected by the head of oncology as possible candidates for the study. Initially the researcher aimed at using children who were within a specific age group. However, this criterion did not prove feasible as the children available at any given time ranged across various developmental ages. The researcher thus decided to use the “school going child” between the ages of nine to fourteen years. The same selection procedures and intervention procedures were incorporated with all the children selected for the study. (A further description of the term “child” can be found below in paragraph 1.8.1).

The “sample” in the study thus consisted of the paediatric cancer children within the relevant age group, nine to fourteen years of age, that had been selected by the head of paediatric oncology, and who also had the following criteria:

- children who diagnosed with cancer and receiving treatment in the ward
- children who would be present in the ward for at least three or more weeks
- children who were English speaking

1.5.3 Sample Size

A sample refers to the elements of the population that is considered for inclusion in the study (Strydom & Venter, 2004, 197). In this study, the sample size of the population consisted of 6 participants, 5 male participants and 1 female participant. Due to the complexity and intensity of the application of the procedures, and to the limited amount of time available to complete the study, it was not viable for the study to accommodate a larger number of participants. In case studies it is often the case that the sample size of the study is limited in number as this allows the researcher to obtain extensive data about the individual participants (Anastas, 1999: 95).

1.5.4 Data Analysis

Data analysis refers to the process of “bringing order, structure and meaning to the mass of collected data” (De Vos, 2002: 339). The researcher attempted to discover and illustrate the experiences of the research participants by observing and interpreting their experience as it was described by them. Ultimately, the study included an in-depth description and understanding of the experience of Gestalt play therapy by the hospitalized oncology child. Once data was collected, the researcher described and analysed the various data obtained, attempted to obtain relevant themes and then following from this, and deduced relevant conclusions. Thereafter findings were described in response to these findings.

1.6 RESEARCH METHODS

Research methods refer to the research tools and procedures used in the study that guide the research process (Babbie & Mouton, 2001: 75). The specific methods of data collection and analysis that were used in the study included the following:

- ◆ *Interviews:* An interview is a conversation conducted for the purpose of obtaining information from a relevant person (Anastas, 1999: 308). The interviews used in this case were one-to-one semi-structured interviews. With semi-structured interviews, the researcher has a set of predetermined questions on an interview schedule (a questionnaire that is written to guide an interview), where the interview is guided by the schedule rather than dictated by it (Greef, 2002: 302). Semi-structured interviews were conducted with parents at the beginning of the research study.
- ◆ One-on-one semi-structured interviews were conducted with each child participant at the beginning of the research study. Analysis of information obtained from the interviews involved attaining relevant themes, or concerns related to the study. Interviews were also conducted at the end of the study.
- ◆ *Questionnaires:* A questionnaire is a set of written questions that is answered by the person whom the study is meant to describe (Anastas, 1999: 373). Questionnaires were given to children to complete at the beginning of the study in order to establish the presence of anxiety.
- ◆ *Play therapy:* Play therapy included approximately six sessions and were used as an intervention measure to assist children to work through their trauma and to become more self-supportive. The sessions consisted of Gestalt play therapy sessions that were used were based on the works of Oaklander (1988), and Gestalt theory (Yontef, 1993).

- ◆ *Observation.* Observation in research refers to data collected by direct visual experience of the study participants by the researcher (Anastas, 1999: 327). Observations were conducted, wherein the researcher wrote field notes on the behaviour and activities of each child participant during play therapy sessions. The researcher observed children's progress, behaviour and how each child responded with the play therapy sessions.
- ◆ *Analysis of findings:* This was done on a qualitative level, through identifying relevant themes, feelings, for example. Once interviews and questionnaires were re-administered at the end of the study, the researcher attempted to identify whether any significant changes could be seen after the play therapy experience.

1.7 ETHICAL ASPECTS

Ethical issues arise out of our interaction with other people and the environment, and especially where there is potential for, or is, a conflict of interest (Babbie & Mouton, 2001: 520). When conducting research, the researcher has an ethical responsibility to search for knowledge and to strive to improve the quality of life (Shaughnessy, *et al.*, 2003: 45). At no time however, was the well-being of relevant participants jeopardized or compromised. Quality of life always referred to the respect, and the acknowledgment of the well-being of all relevant parties.

The following ethical measures will be considered throughout the progression of this study. They are based on the ethical issues described by Shaughnessy, *et al.* (2003: 45-75) and Strydom (2005: 58-67; 2002, 62-76).

1.7.1 Informed Consent and Participant Assent

Informed consent needs to be obtained by researchers from the various parties involved in the study. In the case where children are involved, (that is children below the age of 18 years), in research as in this study, participant "assent" must be obtained from the child participants themselves. This can be verbal or written. In these cases formal informed consent must also be obtained from the participants' parents or legal guardians (Shaughnessy *et al.*, 2003: 58). Child participants are made fully aware that their parents/guardians knew about the study and that they had/had not provided consent. Participants were provided with appropriate explanations of procedures to be undertaken during the study and all the ethical conditions that applied to them, including voluntary participation, the confidentiality issues, and the right to

withdraw from the study or not participate during specific sessions should they feel unable to in any way.

Children were never confronted with any of the research criteria if they were sedated or not well enough to cope. The child's well-being was always the most importance facet that dominated the research study.

Consent from the hospital where the research study was conducted was obtained prior to any procedures being undertaken in the study. A copy of the research proposal and relevant consent forms (such as parent consent form) was sent to the relevant hospital and to the appropriate persons involved in providing consent for the research study. This was to ensure that all relevant parties had a clear understanding of what the study entailed, and how the study was to be conducted.

1.7.2 Well-Being of Research Participants

This refers to the physical/emotional well-being of research participants and stipulates essentially that research participants will not be exposed to any means of harm, during the course of the study (Babbie & Mouton, 2001: 522; Strydom, 2002: 64).

1.7.3 Research to Be Sensitive to Needs of Participants

The researcher was prepared to change the nature of her research as it was deemed necessary, rather than expose her participants to even the slightest possibility of physical and/or emotional harm of which she may be aware (Babbie & Mouton, 2001: 522).

1.7.4 Anonymity/Confidentiality

The researcher has a primary obligation to take reasonable precautions to protect confidentiality rights of research participants (Shaughnessy, *et al.*, 2003: 57). This specifically refers to the protection of people's identities and those of the research locations.

- ◆ The confidentiality of each child was acknowledged from the very inception of the study to the end. The researcher was able to identify a given person's responses, thus the concept of anonymity was not applied to this study. However, the researcher ensured at all times that the responses or performance of each participant were not revealed publicly at any time.

- ◆ Each participant's identity was disguised by the use of pseudonyms for each subject. The true identity of participants was thus disguised from others in the field, and the field notes used.

All names, and addresses were removed from questionnaires and replaced by identification numbers and pseudonyms. A master identification file was created that linked numbers and pseudonyms to names. This file was only made available to the researcher and was only used for legitimate purposes.

- ◆ The researcher ensured that the participants and their parents/guardians were aware of the difference between anonymity and confidentiality.
- ◆ No information was discussed with any person, except with the researcher's supervisor and supervision group, and was done only if the subject gave consent that such information be shared. At no time was the true identity of subjects revealed. However all measures were taken ensure that responses or performance of each participant would never be revealed publicly.

1.7.5 Necessity of Referral to Other Professionals

The researcher contended that if during the course of the study, it was noticed that any child involved in the study required further clinical attention, and then all efforts were made to refer such children to relevant professionals, such as for instance, a clinical social worker (no further reference was found that referred to the above condition).

1.7.6 Cultural Sensitivity

The researcher also proposed as necessary to consider the issue of cultural sensitivity (no reference could be found that considered this condition). At no time were participants in the study discriminated against as a result of their personal cultural or ethnic domain. All procedures that were used took into account each participant's holistic nature. All children equally received the same intervention and no approach was used that would favour one child against another.

1.7.7 Voluntary Participation

Prior to commencement of the study, both parent/guardian and child were given all possible information concerning the procedures that were to be followed during the study. All efforts were made to provide such information to parents/guardians and children to ensure that they are made aware of all the aspects of the study (Neuman, 2000: 96; Shaughnessy, *et al.*, 2003: 57). Thus, being part of the study was each participant's personal choice. Participants were free to withdraw from the study, at any time during the course of the study, and they were not obliged to give any explanation.

1.7.8 Risks of the Study

At the inception of the study, the researcher did not foresee any risks that a child might experience should they have agreed to participate in the study (Strydom, 2002: 64).

1.7.9 Benefits

The potential benefit from the child's participation in this study was seen to have been that the therapeutic play might have assisted the child to cope better with what he was experiencing due to his illness and being hospitalized as a result. If the child was experiencing any feelings of anxiety, fear or any other signs of distress, play therapy may have helped to alleviate the intensity of such feelings. It is also important to note that should the child have reacted positively to therapeutic play, it may not have been clearly seen immediately after intervention took place. However, this did not necessarily imply that the child had not responded positively to the play intervention. Often, significant benefits may have occurred in an indistinct manner, so they were not immediately seen, and the true effects would only be revealed days, weeks or even months after intervention had taken place.

Furthermore, the child's participation in this study may have contributed to other psychotherapeutic knowledge that may help other children who are going through the same life experiences.

1.7.10 Ethical Approval

This study protocol was submitted to the University of the Witwatersrand, Human Research Ethics Committee (HREC). Approval to conduct the study was granted in January 2006. A copy of the approval document can be found in Appendix 1 on page 121.

1.8 CLARIFICATION OF KEY CONCEPTS

In order to gain a broader understanding of the nature of this research study, it is necessary to describe the key concepts that were focused on within the study. These included the following: the school going child; chronic illness; oncology/cancer; paediatric oncology unit; anxiety; Gestalt; Gestalt therapy; and Gestalt play therapy.

1.8.1 The Child

Research participants within this study included school going children between the ages of nine years to fourteen years of age. This age range constitutes two developmental stages, including middle and late childhood and adolescence. Middle and late childhood is the developmental period that extends from about six to eleven years of age and also corresponds with to the primary school years (Santrock, 1995: 19). Adolescence is the developmental period of transition from childhood to early adulthood, entered approximately at the ages of ten to twelve years and ends at eighteen to twenty-two years of age (Santrock, 1995: 19). For the purpose of the study both the middle childhood (nine to twelve years), and later childhood (thirteen to fourteen years) children were incorporated in the study as the children that were available in the study fell within both periods of development.

1.8.2 Chronic Illness

Chronic illness can be defined as “a disorder with a protracted course that can be fatal or associated with a relatively normal life span despite impaired physical or mental functioning”. Such an illness frequently shows “a period of acute exacerbations requiring intensive medical attention” (Materson, cited in Goodman, 2001). Illnesses such as cancer, AIDS (acute immunodeficiency), asthma, insulin dependent diabetes mellitus, congenital heart disease, juvenile rheumatoid arthritis, sickle cell disease, haemophilia, and cystic fibrosis would fit the above definition of chronic illness (Goodman, 2001). For the purpose of this study chronic illness will refer to the life-threatening illness of paediatric cancer.

1.8.3 Oncology/Cancer

The word ‘oncology’ is a medical term, referring to the study of the physical, chemical and biological properties and features of cancer and malignant tumours (Adams & Deveau, 1988: 271). The term ‘cancer’ involves the abnormal and excessive division of cells (Barracough, 1999: vii). The abnormal cell growth can occur in any tissue of the body. It results from a change in certain cells that allows them to grow and multiply indefinitely, thereby severely interfering with the development and growth of normal tissues (Adams & Deveau, 1988: 265). Cancers occurring in childhood are generally different to those of adults. These cancers most often occur in developing cells, like bone marrow, blood, kidneys and tissues of the nervous system. Cancer is thus, a group of diseases, each with its own name, each requiring its own treatment, and each having its own unique prognosis (Childhood Cancer Foundation – CHOC, [sa]).

In this study, the terms “cancer” and “oncology” will be used interchangeably, and no reference will be made to other types of cancer besides the ones that are common in children.

The children in this study were diagnosed with varying types of paediatric cancer. A brief description of each diagnosis is presented as follows:

- ◆ Acute Myeloblastic Leukaemia: is a cancer that involves an abnormality of blood cells (MedicineNet.com, 2007)
- ◆ Osteosarcoma: A malignant tumour occurring in the bone or cartilage (MedicineNet.com, 2007)
- ◆ B-cell lymphoma: a malignant lymphoma, an abnormal growth in the lymphoid tissue; with HIV: a T-cell leukaemia/lymphoma virus (Wikipedia, 2007)
- ◆ Burkitts Lymphoma : another form of a malignant lymphoma (Online Medical Dictionary, [sa]).

Depending on the type of cancer, treatment consisted of chemotherapy, radiation therapy, surgery or a combination of the three. At times, some of the children received a very aggressive chemotherapy. They were then unable to participate in a play therapy session.

1.8.4 Paediatric Oncology Unit

The paediatric oncology unit refers to the unit within the hospital, designed for the care of children diagnosed with cancer, and any other life threatening blood disorders (Childhood Cancer Foundation of South Africa – CHOC, [sa]). In this study, the pediatric oncology unit refers to the pediatric oncology ward at the Johannesburg Hospital, where the study was conducted.

1.8.5 Anxiety in a Medical Setting

Within this study the terms stress, distress and anxiety will be used interchangeably, that is, as synonyms for one another. In terms of the variable of anxiety, this study will not focus on any childhood anxiety disorders per se, but will investigate the features of anxiety that are prominent in the children of the study. In the medical setting, anxiety is behaviourally defined as: a feeling of uneasiness caused by fear, that can make children feel tense, nervous, or afraid (D’Alessandro & Huth, 2002). It thus refers to fear related responses that originate or are expressed in medical settings (Prins, 1994: 268). For the purpose of this study, anxiety will refer to any feelings of uneasiness, or emotional distress that is brought about due to the experience of being diagnosed with paediatric cancer and being hospitalized as a result.

1.8.6 Gestalt

The word *Gestalt* is a German word that when translated into English refers to number of concepts, which include: a shape, a pattern, a whole form and a configuration (Gilmore, 2002; Kirchner, 2000). The essence of its meaning lies in the word *complete*. It describes the unified nature of a pattern of elements and, in Gestalt therapy practice, refers to our tendency to exist as unified wholes, instead of as functioning as parts. Thus, the concept of Gestalt will be considered as an entity or a whole of which the total is more than its component parts (Blom, 2004: 3). For the purpose of this study, the core of the Gestalt concept will refer to the idea that people are born whole and full of the potential to function optimally.

1.8.7 Gestalt Therapy

Gestalt therapy is a form of psychotherapy that focuses on that which is immediately present, the here and now moment (Blom, 2004: 3). As the term Gestalt refers in essence to “the whole” or the integrity of the whole, in Gestalt therapy the person is never reduced to parts and structural entities but is viewed always as an integrated whole with a deep seeded innate ability to grow and better himself, reaching a level of mature self-expression and self-actualisation (Kirchner, 2000).

In Gestalt therapy people are seen as potentially having all the necessary abilities to solve their problems or face their difficulties. Therefore, a person is viewed as a functional, organismic whole that strives toward higher levels of potentiality, actualisation, and integration within and as part of its organism/environment field (Blom, 2004: 4; Kirchner, 2000). Thus, in this study, Gestalt therapy will refer to the psychotherapeutic approach that is based on Gestalt theory. Gestalt therapy strives for the healthy, integrated functioning of the total organism, and is also concerned with achieving wholeness and integration, that ultimately defines the quality of healthy living.

1.8.8 Play Therapy

Play therapy is a psychotherapeutic method that is intended to help relieve the emotional distress of young children through a variety of imaginative and expressive play materials, such as clay, art materials, dolls, puppets, sand play, board games and miniature objects (Webb, 1991: 27). In play therapy it is assumed that children will express and work through emotional conflicts within the metaphor of play. In this study, this description of play therapy is utilized.

A description by Landreth (2002: 16) fits with the ideas adopted in this study. He defines play therapy as:

A dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures who provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self (feelings, thoughts, experiences, and behaviours) through play, the child's natural medium of communication, for optimal growth and development.

1.8.9 Gestalt Play Therapy

Gestalt play therapy refers to the psychotherapeutic technique that uses the principles and techniques of Gestalt therapy in its use of play therapy with the child (Blom, 2004: 5). By developing a therapeutic relationship and experiencing what Oaklander (2003: 143) described as a "Gestalt therapeutic process", children are given the opportunity to express their feelings, verbally and non-verbally, thus enhancing their sense of self, which is seen as a crucial step toward healthy emotional expression and optimal growth and development (Blom, 2004: 5; Oaklander, 2003: 143).

For the purpose of this study Gestalt play therapy will refer to a Gestalt therapeutic process based on the principles of Gestalt therapy, that are used to assist children to become aware of their process, enhance and confirm their sense of self, verbally and non-verbally, express their thoughts and nurture themselves, thus reaching self integration and wholeness.

1.9 APPARENT OBSTACLES OF THE RESEARCH STUDY

Some of the obstacles that the researcher foresaw include the following:

- ◆ The researcher acknowledges that intervention may or may not present with positive effects that are directly observable with each child participant. It is essential to acknowledge that the oncology child faces many day to day stressors, and thus the uniqueness of each child's life circumstance may indeed underplay any significant aspects that play therapy may bring about. It is for this reason that this study will be interested in essentially observing the uniqueness of each child participant's interplay with the intervention process of play therapy, and will record how each child responds, positively, negatively, or neutrally. Thus, a pattern of change or reaction to the play therapy intervention procedures may not be clearly seen during the time of the research study.

- ◆ The researcher is aware that due to the nature and unpredictability of the oncology child's illness, a child participant was not always feeling well enough to take part in a research programme scheduled for a specific day. The researcher therefore, at all times planned her research programmes in accordance with each child's needs, and adapted her schedule to suit each child as best as was possible.
- ◆ It is also apparent to the researcher that the nature of the oncology child's illness determines the quality of life of the child at any point in his illness. This was the case when a child unexpectedly passed away during the course of the study.
- ◆ Due to the small sample size, heterogeneity of the types of cancer and treatments received, as well as the actual stage at which the illness presents itself at the time of the study, the nature of, and the seriousness of the illness itself, and even the present length of hospitalization and previous hospital experience, may have hindered the generalizability of results obtained.

1.10 RESEARCH REPORT

Chapter 1 was devoted to orientation, an analysis of the problem, aims of the research and the nature and course of the research study.

Chapter 2 entails an extensive literature review that will discuss relevant documents that the researcher obtained on the research topic of this study. It will thus investigate the various studies and ideas presented regarding the relevance of play therapy as a significant intervention measure for assisting the hospitalized child to cope better by reducing anxiety that have been experienced due to the stress and trauma of hospitalization. Special attention will be given to the discussion of how Gestalt play therapy can be used with the hospitalized oncology child to help to reduce feelings of anxiety.

Chapter 3 will contain the empirical qualitative research design and methods of gathering data and the analysis of the data. Chapter 4 will discuss the empirical results of the research study. The findings in this study were integrated with findings reviewed in the literature. The discussion will end with Chapter 5 where, conclusions and recommendations and limitations of the study will be considered.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter a review of the literature concerning the hospitalized oncology child, specifically on psychosocial aspects, and the use of play therapy as a coping mechanism and intervention strategy will be undertaken. A review of the literature generally aims at contributing towards attaining a clearer understanding of the actual nature and meaning of the relevant research problem (Fouché & Delport, 2002: 127). The goals of a literature review and of this chapter entail the following (Neuman, 2000: 446): to demonstrate a familiarity with a body of knowledge and establish trustworthiness; to illustrate the path of research that has been done previously, and how such work is linked to this study; and to integrate and summarize what is known in a specified area

In the following section, the researcher considers the ideas of research that has been conducted concerning the hospitalized oncology child. A specific focus is placed on literature, and studies conducted, concerning the psychosocial aspects of childhood cancer. Thereafter, the discussion leads to a recognition of research focusing on the need for intervention strategies that may be used to assist the child in hospital to deal with the effects of his illness.

2.2 STATISTICS OF PAEDIATRIC CANCER IN SOUTH AFRICA

Prior to discussing the studies that concern the hospitalized oncology child some reference will be made on the actual statistics of childhood cancer in South Africa. According to the Childhood Cancer Foundation (2006) in South Africa, about 700 children are diagnosed with cancer each year. It is estimated that less than 50% of cases are diagnosed early enough, or at all, for effective treatment. If diagnosed early enough, survival rates are in excess of 70%. Thus, more than two-thirds of children and young people with cancer today can be cured (Di Gallo, 2003: 490; Massimo, *et al.*, 2005: 389). Despite the increased chances of survival the effectiveness of various approaches to improving the quality of life, as a patient and as a survivor, is viewed by some researchers, such as Osborn, Democada and Feurstein (2006: 14), as still not being well understood. Various studies have supported the view that quality of life involves a patient's sense of well being and function and can be significantly affected by

such factors as depression, anxiety and pain (Dejon & Frombonne, 2005; Osborne, *et al.*, 2006; Patenaude & Kupst, 2005; Taïeb, *et al.*, 2003; Vitulano, 2003). In acknowledging that this notion holds some truth, then the necessity of providing the oncology patient with at least some intervention and coping resources, such as play therapy, is highlighted. In the following section, the actual resources that concern the hospitalized child and the various studies that support the need for intervention strategies are reviewed.

2.3 RESOURCES CONCERNING THE ONCOLOGY CHILD

An exploration of the literature concerning studies pertaining to the hospitalized oncology child was conducted. It was found that studies had been conducted in three primary areas. These included: (1) the effects of illness and hospitalization on the child with the general view that hospitalization is seen as a time of crisis for the child and his family. This includes the idea that there is a general increase in internalising spectrum disorders such as anxiety, depression, sleep and eating disorders, and excessive fears (Vitulano, 2003: 585); (2) intervention strategies used to assist the oncology child to deal with the effects of his illness. This refers to such resources as social support information that helps the child to better understand his situation, and play therapy that is used as a means that may help the child cope more positively with his experiences (Gariépy & Howe, 2003: 523). It also refers to the need for support to be provided for the child to cope with the following aspects: psychological effects of the disease; bodily changes; how they perceive themselves; relationship with family and friends; returning to school, information regarding the illness and treatment, and preparation and support for treatment procedures (Mitchell, *et al.*, 2006: 805; Winfree, William & Powell, 2002); and related with this strategy, (3) the coping mechanisms used by the child, that helps him to cope with his experiences of having a life-threatening illness and being hospitalized as a result. Coping mechanisms such as finding acceptable outlets for feelings of anxiety, anger, and fear and gaining a sense of mastery over the environment have been identified as important coping tasks among oncology children (Koocher & O'Malley, cited in Goodman, 1991: 314). Play therapy has been seen to play an important role here. The link of play therapy as part of an intervention strategy and as a coping mechanism is illustrated in Figure 2.1 (page 26).

The researcher considers the essential contributions that previous studies have made as summarised in figure 2.1. In this section the researcher generally discusses studies and ideas procured in the three areas of interest. Furthermore, a discussion of the psychosocial aspects

of paediatric oncology will be undertaken, in the view that this may provide greater awareness as to what the child is experiencing, which in turn may allow for the appropriate employment of relevant intervention resources to assist the child through his experiences.

2.3.1 Understanding Psychosocial Aspects of Childhood Cancer

Over the past thirty years the field of paediatric psycho-oncology and psychosocial functioning of the child with cancer and his family has transpired and evolved (Patenaude & Kupst, 2005: 10). Psycho-oncology is concerned with the relationships between cancer and the mind. (Barraclough, 1999: vii). Psychosocial oncology is a similar term with the broader implications that cancer concerns not just individual patients, but their families, friends, and the society in which they live (Barraclough, 1999: vii). Research in the field of paediatric psycho-oncology has attempted to answer the following questions: (1) “how do children and their families deal with the many diverse stressors that are initiated by the diagnosis of paediatric cancer, and the treatment that follows?” and (2) “what can be done to improve adaptation of patients and their families?” (Patenaude & Kupst, 2005: 10).

Gestalt play therapy is relevant in this context as it considers the entire biopsychosocial context of the child as essential, therefore taking into account the child and his relationship to his environment. It also acknowledges the physiological, sociological, cognitive and motivational variables as relevant in understanding how people manifest their distress (Yontef, 1993: 131). No relevant dimension is excluded from understanding the child. So when a child is diagnosed with a life threatening illness, it becomes important to acknowledge that the child brings his total self, that is, all his experiences of living up until this time, to have some influence on his life context. (Barraclough, 1999: 198).

Psychosocial oncology research in paediatric psycho-oncology, began in the 1960's and continued in the early 1970's with studies that were predominantly observational of parents' mourning and their psychological reactions to the death of the child (Patenaude & Kupst, 2005: 11). The research subjects were mainly parents, as children were not routinely informed about the nature of their illnesses. It was not seen as appropriate for children to be closely involved in discussions about their treatment, thus attempts were made to protect them from potentially distressing information (Eiser, 1998: 621; Patenaude & Last, 2001: 281; Taïeb, *et al.*, 2003: 256).

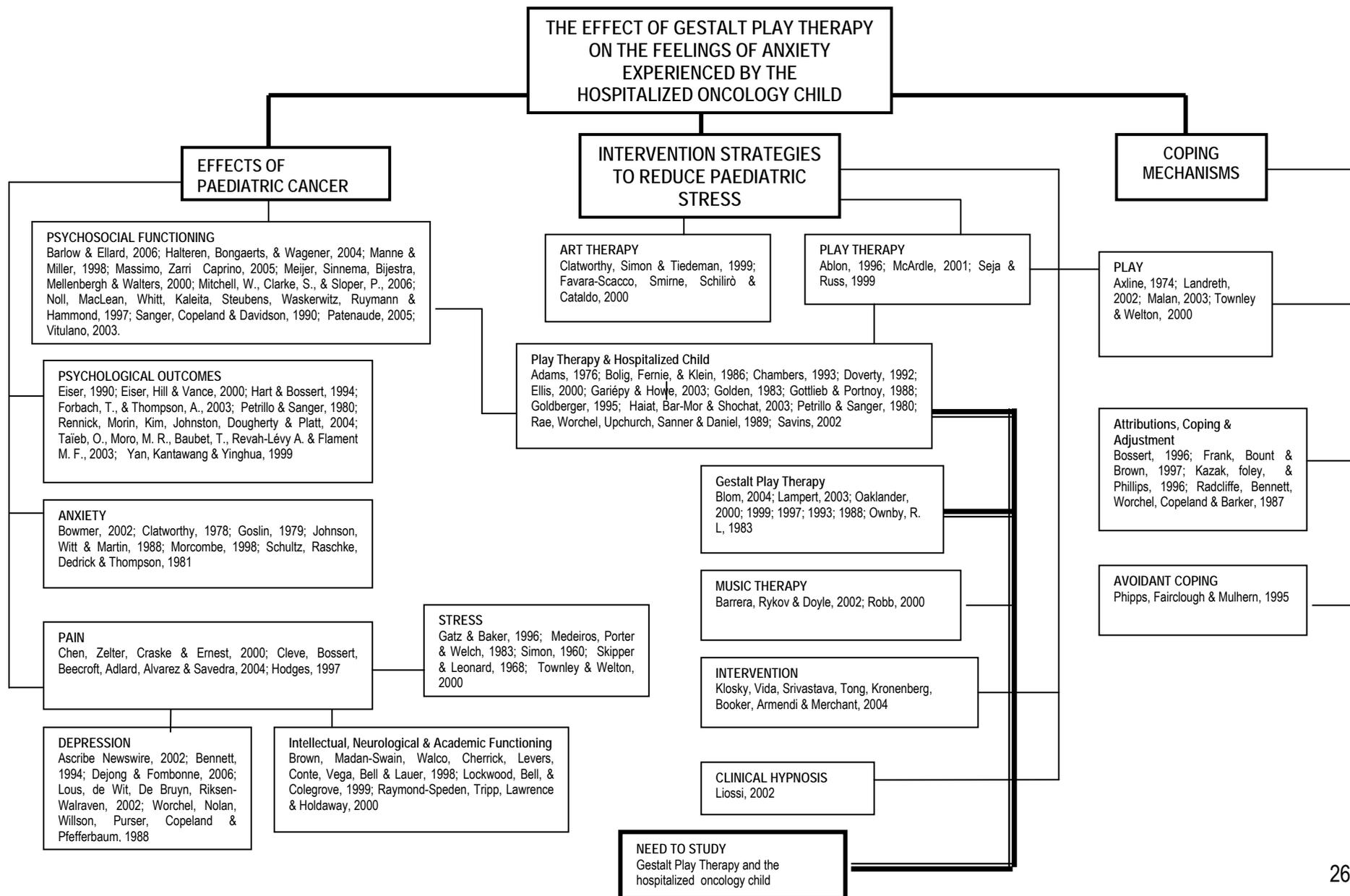


Figure 2.1 A Literature Map (Adapted from Creswell, 2003: 40)

Attitudes toward more open communication about diagnosis and prognosis with paediatric cancer patients have changed markedly in conjunction with the improvement of survival rates (Eiser, 1998: 623; Mitchell, *et al.*, 2005: 805; Patenaude & Kupst, 2005: 11). This may be related to the notion that it is more difficult to discuss a condition that is rapidly fatal than it is to discuss a condition for which treatment exists, hereby providing some hope of long-term survival. Thus, over the years, experience has shown that the child with cancer copes more optimally when he is involved in open, honest discussions about his illness and potential death (Goodman, 1991: 314; Patenaude & Kupst, 2005: 11). Improved treatment modalities in more recent decades have shifted focus of viewing cancer as a primarily acute and fatal illness to seeing it as an illness that is mostly chronic with long-term physical, psychological and social effects (Di Gallo, 2003: 490; Patenaude & Last, 2001: 281).

Subsequently, it has been advocated that the understanding of the psychological aspects of childhood cancer has developed during a period where the advances in medicine has dramatically increased the survival rate of children with cancer (Papaikonomou & Nieuwoudt, 2004: 283; Patenaude & Kupst, 2005: 11). The effects of paediatric cancer on the child's psychosocial experiences following diagnosis and a need to improve the quality of life of these children has therefore received some attention (Barlow & Ellard, 2006; Eiser, *et al.*, 2000; Lingnell & Dunn, 1999; Manne & Miller, 1998; Meijer, *et al.*, 2000; Mitchell, *et al.*, 2005; Patenaude, 2005; Rennick, *et al.*, 2004; Sanger, Copeland & Davidson, 1990; Savins, 2002; Vitulano, 2003; Walker, Wells, Heiney & Hymovich, 2002; Winfree, *et al.*, 2002). In Figure 2.1, the prevalence of these studies is clearly illustrated, as the researcher found that the majority of studies regarding paediatric cancer were related to the effects of the illness on the child patient. Although psychological symptom patterns are not seen as being disease specific, there is a general increase in acknowledging the internalising of such disorders, such as anxiety, depression, sleep and eating disorders, and excessive fears, and presenting with such late effects as social functioning and relationships, academic success, personal and family functioning (Patenaude, 2005: 12; Vitulano & Tebes cited in Vitulano, 2003: 585). As a consequence of the increase in long-term survival of childhood cancer patients, quality of life issues have taken a more prominent role as part of a more comprehensive treatment plan for childhood cancer (Winfree, *et al.*, 2002: 26).

Increased chances of survival have become possible as a result of the use of progressively more effective methods of treatment. Thus, as survival rates have improved, there has

been recognition of the need to assess the quality of life of oncology children (Eiser, 1998: 621; Mitchell, *et al.*, 2006: 805; Vitulano, 2003: 590; Winfree, *et al.*, 2002: 26). The extensive, invasive, and strenuous treatment methods of this very intrusive disease incorporate surgery, chemotherapy and radiation therapy, alone or in combination, in order to ensure the best therapeutic outcome (Eiser, 1998: 622; Gariépy & Howe: 2003: 523; Kuykendall, 1988: 174; Lioffi, 2002: 106; Papaikonomou & Nieuwoudt, 2004: 283; Patenaude, 2001: 281). There is also a greater recognition of how the effect of this treatment process can be painful, disfiguring, frightening and can alter the child's physical and emotional well-being. This has resulted in a shift in psychological emphasis from coping with imminent death to facilitating coping with, and adaptation to a chronic illness (Di Gallo, 2003: 490; Sloper cited in Papaikonomou & Nieuwoudt, 2004: 284; Winfree, *et al.*, 2002: 26).

De Clercq, De Fruyt, Koot and Benoit (2004: 579) note that although numerous studies have examined the psychological aspects of paediatric cancer, they suggest that it still remains uncertain how the illness and its side and late effects have an influence on the child's psychological development and adjustment. In acknowledging this view, the researcher suggests that as a result of this it becomes relevant, to describe the ideas and findings of such research studies that argue that it is generally unclear how paediatric cancer, its diagnosis and treatment, actually impacts on a child's psychological and social adjustment. (2004: 579).

2.3.2 Alternative Views Concerning the Effects of Diagnosis and Treatment of Paediatric Cancer

Despite extensive studies conducted involving the exact effects of diagnosis and treatment of paediatric cancer, the exact processes whereby the diagnosis and treatment of a chronic illness such as cancer, might affect a child's subsequent psychological, social, physical or behavioural functioning has been argued by some researches to be to some extent as unclear and indefinite (Barlow & Ellard, 2006: 20; De Clercq, *et al.*, 2004: 579; Eiser, 1998: 625; Phipps, Larson, Long & Rai, 2006: 299). This is related to the fact that investigations of the psychological and social adjustment of paediatric oncology patients have resulted in mixed findings (Varni & Katz, 1997: 267). Some studies suggest that children with a life threatening illness such as cancer are at increased risk for more serious adjustment and emotional problems (Eiser *et al.*, 2000; Goodman, 2002; Hart & Bossert, 1994; Lioffi, 2002;

Meijer et al., 2000; Petrillo & Sanger, 1980; Rennick, *et al.*, 2004; Yan, Kantawang & Yinghua, 1999). The ages of the participants in these studies ranged from the age of six years to the age of seventeen years.

However, other studies have reported that children and adolescents with cancer exhibit relatively few emotional or behavioural problems and demonstrate normal psychosocial functioning (Kellerman, Zelter & Ellenberg cited in Sanger, *et al.*, 1991). These studies also included children between the ages of six to eighteen years. Furthermore, there have been studies that have concluded a poor performance on measures of intellectual and academic functioning by children diagnosed with cancer between the ages of three to sixteen years (Lockwood, Bell, & Colegrove, 1999; Raymond-Speden, Tripp, Lawrence & Holdaway, 2000). Other studies have, however, shown that many children do recover and are able to perform academically as well as their peers or normal siblings (Eiser, 1998: 625), and that there is no consistent evidence to suggest that oncology children inevitably have certain negative outcomes (Brown *et al.*, cited in Varni & Katz, 1997: 267; Eiser 1998: 625).

The researcher, in reviewing the literature, maintains that it becomes important to recognise that such factors as personality style, social support, family constellation, medical variables, developmental level and the actual stage at which the illness is when research takes place, may influence the child's reactions and responses to study variables.

Thus, although numerous studies have examined the psychological aspects of childhood cancer, it remains unclear how the disease and its side effects affect children's psychological development and adjustment (Barlow & Ellard, 2006; De Clercq, *et al.*, 2004: 479; Massimo, et al., 2005; Phipps, et al., 2006). However, the fact that a number of studies have found some indications of various implications cannot go unnoticed. The researcher thus contends that the need for further research in identifying exactly what implications may actually result after diagnosis of a chronic illness such as paediatric cancer remains an area requiring further investigation.

The notion that the oncology child is exposed to multiple levels of anxiety-laden experiences, which is argued by studies addressing the effects of paediatric cancer, leads to the discussion in the following section. This section describes the nature of anxiety in the medical context, and its effect on the overall psychosocial functioning of the oncology child.

2.4 ANXIETY IN A MEDICAL CONTEXT

The researcher's investigation for resources on the subject of the nature and characteristics of anxiety in the medical setting yielded only one source that described the nature of medical anxiety in a more extensive manner. This refers to an article written by Prins (1994) in the book, "International Handbook of Phobic and Anxiety Disorders in Children and Adolescents". Although this source is outdated, its ideas could still be considered as relevant to the medical context today. Prins (1994: 268) argued that because no clear and accepted diagnostic criteria are available for "normal" anxiety in medical settings at any given developmental stage, a problem arises as to how to distinguish excessive from normal levels. It is also often difficult to distinguish whether medical anxiety is a situation-specific response to a threatening stimulus or whether it reflects a more general and basic type of childhood anxiety, such as separation anxiety, stranger anxiety, or fear of bodily harm (Prins, 1994: 269). The researcher suggests that this is clearly another issue requiring further research attention.

It cannot be denied that anxiety, and particularly within a medical context is undoubtedly not just concerned with irrational fear (Emmanuel, 2001: 5). Various studies have shown that for a child facing a life threatening illness such as cancer, visits to the doctor and hospitalization are stressful experiences (King, Gullone & Ollendick, 1990; Manne & Miller, 1998; Mitchell, *et al.*, 2006; Osborne *et al.*, 2006: 14; Rae *et al.*, 1989; Sanger *et al.*, 1991; Varni & Katz, 1997). He is faced with extensive amounts of adversity to cope with. The stressors associated with invasive medical procedures, recurrent hospitalizations, prolonged separation from family and friends, periodic and unpredictable exacerbation of symptoms, physical discomfort, body disfigurement, negative treatment side effects, and the probability of a shortened life-span must have some significant impact on the overall well-being of an oncology child patient (Gariépy & Howe, 2003: 523; Mitchell, *et al.*, 2006: 805; Varni & Katz, 1997: 267). Thus, conditioned anxiety in response to recurrent diagnostic and treatment procedures has been seen to be a major source of distress for the oncology child (Katz, Kellerman & Siegel, 1980: 356; Winfree, *et al.*, 2002: 28). Such anxiety is often anticipatory (occurring prior to the administration of medical procedures) and manifests in a variety of symptoms such as nausea and vomiting, anorexia, insomnia, nightmares, withdrawal and depression (Katz *et al.*, 1980: 356; Vitulano, 2003: 585).

Research on relevant clinical developmental issues such as separation anxiety and attachment (Garnezy, 1983), mother-child interactions during stressful events (Blount, Davis, Powers & Roberts, 1991; Bush, Melamed, Sheraz & Greenbaum, 1986), the development of fear and coping (Melamed & Siegel, 1985; Peterson, cited in Prins, 1994:267), and pain and anxiety in children (Lander, Hodgins & Fowler-Kerry, 1984) have been undertaken. It appears that research has concentrated on gaining reliable and valid descriptions of anxiety in medical settings and on a variety of variables that are correlated with it. These correlates appear to shed some light on the nature and origin of anxiety in medical settings (Prins, 1994: 268). Extensive reviews of children's reactions to medical procedures, life-threatening conditions and chronic illnesses are also available (Forsbach, & Thompson, 2003; Gross & Drabman, 1990; Jay, 1988; Melamed, 1979; Mitchell, *et al.*, 2005; Patenaude & Last, 2001; Patenaude & Kupst, 2005; Routh 1988; Siegel, 1988; Taïeb, *et al.*, 2003; Vitulano, 2003). These reviews generally conclude that despite medical advances on treatment and survival rates, the diagnosis and treatment of childhood cancer remains a frequently traumatic experience for patients and their families. They also describe how current research in paediatric psycho-oncology focuses on the psychological effects of the disease and on differentiating which factors envisage problematic versus positive outcomes in the adjustment of the child and the family.

A greater awareness has ensued that acknowledges how anxiety as a behaviour is seen to be commonly present in the child diagnosed with cancer, and can be especially destructive for the child's psychological growth and development (Winfrey, *et al.*, 2002: 28).

To conclude, based on the findings of previous studies, what is essential to acknowledge is that anxiety, in the medical context, is a multidimensional construct that manifests in different ways in different individuals (Meijer, *et al.*, 2000: 310; Patenaude, 2005: 13; Prins, 1994: 285; Taïeb, *et al.*, 2003: 256). Stressors have been seen to be related to a number of factors. These include: admission into hospital, the effects of the illness itself and medical procedures, which could include injections, chemotherapy, radiation therapy or surgery and being separated from parents, family and friends (Eiser, 1985: 41; Forsbach & Thompson, 2003: 117; Papaikonomou & Nieuwoudt, 2004: 283; Varni & Katz, 1997: 268).

It is the researcher's view that there is a major stressor for the oncology child that is added over and above all other stressors of being diagnosed with a life-threatening illness that

involves the necessity of being hospitalised, often at multiple instances during the course of the illness. In the following section, the idea of hospitalization as being a very stressful time for a child is discussed, acknowledging that such an invaluable awareness may allay the negative consequences on the oncology child's overall psychological and social well-being.

2.5 HOSPITALIZATION AS A TIME OF CRISIS

Researchers and clinicians became interested in preparing the child for hospitalization and surgery when it became clearer that reports recognized that children presented with emotional and behavioural problems during and after hospitalization (Di Gallo, 2003: 489; Harbeck-Weber & Mckee, 1995: 168). A number of studies have shown that the continual anxieties related with being diagnosed with a life threatening illness and being hospitalised as a result, may have negative repercussions on the child's psychological and social well-being (Di Gallo, 2003; Gariépy & Howe, 2003; Meijer, *et al.*, 2000; Mitchell, 2005; Taieb, *et al.*, 2003; Vitulano, 2003).

The hospitalized oncology child has very little control over his life. Just after diagnosis, tests are undertaken and treatment is started. This represents a challenging task of adaptation for the child and his family. Everyday life becomes increasingly more stressful as the child is more vulnerable physically and the feeling of a "normal" life is altered (Gariépy & Howe, 2003: 523). A child's life is characterised by the presence of strangers, being injected with needles, being placed into machines, and having to eat food that he dislikes when he hardly feels like eating. The child has little autonomy of his body and is in constant pain, and is given medicine that makes him throw up and lose his hair (Amatruda, 1998: 74). How a child reacts to being diagnosed with a life-threatening illness and being hospitalised as a consequence is said to be influenced by a variety of factors. In the following section, studies addressing such factors are discussed.

2.5.1 Reactions to a Chronic Illness

Several studies have found that reactions to hospitalization and illness are influenced by a wide variety of factors (Gottlieb & Portnoy, 1988; Lizasoain & Polaino 1995; Massimo, *et al.*, 2005; Patenaude & Kupst, 2005). These include: the child's age and temperament; his coping style; his personality; the nature and seriousness of the illness itself that has an effect on the child's physical, psychological and social development, implicit in chronic

illness; the length of hospitalisation; the characteristics and organization of the hospital centre; and any previous hospital experience (Gottlieb & Portnoy, 1988: 177; Lizasoain & Polaino 1995: 18; Patenaude, 2005: 14). The following have been cited as being among the principle effects on the lives of the hospitalised oncology child (Lizasoain & Polaino 1995: 17; Patenaude, 2005: 13):

- ◆ Behavioural changes (regression, aggressiveness, uncooperative behaviour, refusal to cooperate with medical treatment, changes in sleeping and eating habits, rejection responses, and muteness)
- ◆ Lack of attention and difficulties in concentration
- ◆ Anxiety, stress and fear
- ◆ Depression, sadness and lack of interest

In addition, some of the most areas of concern for mental health professionals include (Goodman, 2001; Haiat, *et al.*, 2003: 210; Winfree, *et al.*, 2002: 28):

- ◆ internalising problems: anxiety, depression, fear, hopelessness, helplessness, loss of control and frustration
- ◆ externalising problems: aggression, non-compliance, withdrawal
- ◆ somatic complaints: pain and impaired functioning
- ◆ self-concept issues: poor self-image, low self-esteem, changed or negative identity
- ◆ social and educational difficulties: academic and learning problems, decreased or deficient social competence

Some of the effects of the child's responses to hospitalisation also depend on the maturational factors. A very young child (between the ages of one and four years of age) is concerned primarily with physical comfort and maternal security; preschool children with shame, autonomy, the invasion of his body, this growing sense of independence, guilt and fears of mutilation; and the school aged child is concerned largely with his sense of competence and mastery, and is distressed by the loss of function or control and by separation from family and friends (Adams, 1976: 417; Mitchell, *et al.*, 2006: 806).

In addition to the above well-recognised stressors, which accompany hospitalization, there are also problems specifically related to the diagnosis, and treatment of the hospitalised oncology child (Adams, 1976: 417; Gariépy & Howe, 2003: 29; Mitchell, *et al.*, 2006: 805; Papaikononou & Nieuwoudt, 2004: 283). For instance, there is the stress of the diagnosis

of a potentially fatal illness, and an unpredictable and prolonged treatment period, with multiple hospitalizations, and out patient visits. There are also the traumatic effects of anaesthesia, surgery, chemotherapy, and radiation therapy, lumbar punctures (LPs), bone marrow aspirations, intravenous treatments, injections, and of resulting consequences of such treatment, such as nausea, hair loss, weight loss and body disfigurement (Barraclough, 1999: 13; Chen, Zelter, Craske & Katz, 2000: 933; Winfree, *et al.*, 2002: 30).

It has also been found that the child with cancer and other chronic illnesses often adapts to his condition by repressing his emotions, thus covering over feelings of depression and anxiety (Phipps cited in Ascribe Newswire, 2002: 4). It has been unclear whether defensiveness is an adaptation that helps or hinders the child. By seemingly blocking out depression and anxiety symptoms, defensiveness may help the child to better deal with the practical demands of his illness. But the repression of his feelings may also result in the child ignoring important signs of disease progression. Defensiveness has been defined as a tendency to avoid or deny negative thoughts about oneself (Ascribe Newswire, 2002: 4).

2.5.2 Need for Intervention Measures

An increasing awareness has emerged in recent years that acknowledge that there exists a growing need for special attention to be placed on the oncology child, and for measures to be developed and applied that will counteract the adverse psychological effects that may occur (Haiat, *et al.*, 2003: 210; Lizasoain & Polaino, 1995: 18; Mitchell, *et al.*, 2006: 805). It was in the late 1970's and 1980's that an increase in research occurred that focused on helping the child with cancer who was undergoing treatment that involved painful procedures and side effects (Blount *et al.*, 1991; Katz *et al.*, 1980; Mitchell, *et al.*, 2006; Vitulano, 2003; Taieb, *et al.*, 2003). From studies such as these, it was found that children do not necessarily habituate to the stressors they experience and that their coping does not always improve with time (Patenaude & Kupst, 2005: 10). Research has noted that as many children with cancer and survivors experience residual physical, psychological, social and behavioural effects that are associated with the disease or its treatment procedures, and thus considerable implications are brought upon the child patients (De Clercq, *et al.*, 2004: 579; Eiser *et al.*, 2000: 449; Papaikonomou, 2004: 283).

Previous experiences, age and developmental level, level of parental anxiety and distress, level of social support, current coping skills, and perceived control were all found to be

related to the child's pain and distress (Zelter cited in Patenaude & Kupst, 2005: 10). At the present time cure for the oncology child is no longer seen to refer to biological cure alone, but also considers psychological and social aspects of a child's well-being (Di Gallo, 2003: 490; Massimo, *et al.*, 2005: 389). The paediatric oncology patient has been identified, in a number of studies, as a group at risk for developing difficulties in his psychosocial adjustment (Di Gallo, 2003: 490; Ellis, 2000: 32; Eiser, *et al.*, 2000: 449; Forsbach & Thompson, 2003: 124; Massimo, *et al.*, 2005: 389; Mitchell, *et al.*, 2006: 805; Sanger, Copeland & Edwards, 1991; Vitulano, 2003: 585). It is thus of critical importance that the health care for the oncology child should involve intervention procedures that are multi-dimensional in nature so as to holistically meet a hospitalised child's needs and that will help to improve the child's quality of life. The need to assist the hospitalised oncology child in dealing with his emotional distress, has thus led to the development of such measures as therapeutic play, that are becoming common practice in paediatric oncology clinics. As therapeutic play has been shown to be an effective means of reducing stress for the child, it can be incorporated as an intervention strategy with the hospitalized child (Chambers, 1993; Doerty, 1992; Gariépy & Howe, 2003; McArdle, 2001; Webb 1995). It can be used to assist the child through his hospitalization and to help him to work through any feelings of anxiety and other significant negative emotional effects relating to his experiences of being in hospital, and being diagnosed with a life threatening illness.

Programmes are urgently required that will attempt to reduce the anxiety of the hospitalised oncology child, and that will help him to adjust and adapt to the reality of his hospitalisation, and to develop a series of coping skills in the paediatric patient that may prevent the emergence of anxiety symptoms (Lizasoain & Polaino 1995: 18; Mitchell, *et al.*, 2006: 805; Van Halteren, *et al.*, 2004: 824).

In the following section, the discussion proceeds with a discussion describing the studies that support the view that play therapy can be used as an intervention strategy, specifically with the oncology child.

2.6 PLAY AS AN INTERVENTION STRATEGY

The underlying theoretical perspective upon which this study paradigm is formulated is Gestalt therapy. Gestalt therapy, is existential, phenomenological holistic in nature, and emphasises the attaining of awareness in the here and now moment, and also acknowledges the interdependence between people and their environment. (Blom, 2004: 40). The researcher was unable to locate any studies concerning the use of Gestalt play therapy with the hospitalized child. Other studies that support the relevance of play therapy within this context is illustrated in this section.

A review of the literature demonstrates that despite his age and increased mastery, the school-aged child has many anxieties and concerns regarding his illness and hospitalization (Harbeck-Weber & McKee, 1995: 168; May & Sparks, 1983: 119; Massimo, *et al.*, 2005: 389; Winfree, *et al.*, 2002: 29). With admission to the hospital, the child enters a new world, with new people and strange machines, procedures, and routines. The child sees other patients, observes their conditions, and strives to achieve some kind of order out of the surrounding confusion. Hospitalization can thus be a traumatic experience for any child. Experiencing difficult medical procedures and continually meeting new people who do all sorts of uncomfortable things to the child can build up tension and lead to some distress. The young patient may become nervous, anxious, and emotionally distressed. For the hospitalized child, some form of outlet in play becomes essential (Gariépy & Howe, 2003: 524; Haiat, *et al.*, 2003: 210; National Cancer Institute, 1999).

The recent advances in treatment for paediatric cancer have changed the outlook from being life threatening to one where a significant number of children now experience long term survival. Studies have shown that this survival comes at the cost of enduring prolonged and intensive hospital treatments, acknowledging the significance of the seriousness of a chronic illness, anxiety concerning the progression of the disease, and when in remission children can still experience anxiety related to such factors as the chronic uncertainty about relapse and survival (MacGrath & Huff, 2001: 461; Winfree, *et al.*, 2002: 29). Thus, the researcher maintains that it has become imperative that children undergoing such treatments are assisted and supported, in their individual struggle to cope with the harshness of such illness related experiences.

Numerous studies have been conducted that have described the use of play therapy with the hospitalised child, (Bolig, 1984; Bowmer, 2002; Chambers, 1993; Ellis, 2002; Ferni & Klein, 1986; Haiat, *et al.*, 2003; McArdle, 2001; Webb, 1995) and some specifically with the hospitalized oncology child (Gariépy & Howe, 2003; Krietemeyer & Heiney, 1992; Kukendall, 1988). Some studies have specifically found that play therapy during hospitalization can result in the reduction of overt anxieties and fears (Adams, 1976; Bowmer, 2002; Chambers, 1993; Ellis, 2002; Gariépy & Howe, 2003; Haiat, *et al.*, 2003; McArdle, 2001; Webb, 1995).

Thus, it has also been previously recognised that within the hospital context, therapeutic play has been found to be beneficial in helping the child regain control of his life, expressing his feelings of anxiety, gaining information about hospital procedures, preparing for medical events, and transforming the child from being a passive sufferer to being actively involved in his holistic care (Adams, 1976: 418; Chambers, 1993: 350; Gariépy & Howe, 2003: 525; Golden, 1983: 214; Jones, 2001: 274; Rae, *et al.*, 1989: 625; Webb, 1995: 52; Weininger 1983: 67). The most fundamental usefulness of play therapy within the hospital environment is to increase the child's ability to cope effectively with his experiences (Doverty, 1992: 77; Gariépy & Howe, 2003: 525).

In essence, play therapy is a therapeutic technique most often used when working with the child (Ablon, 1996: 545; Axline, 1993: 16; Blom, 2004: 50; Chambers, 1993: 350; Doverty, 1992: 77; Ellis, 2000: 32; Haiat, *et al.*, 2003: 210; Hart, Mather & Slack, 1992: 2; Webb, 1995: 52). While a child may not be developmentally able to articulate his feelings, a therapist can help him to express what's going on through engaging him in play. Through play therapy a child can create a world he can master, practice social skills, overcome frightening feelings and experiences, and symbolically overcome difficult experiences that have threatened his well-being (Haiat, *et al.*, 2003: 210; Landreth & Bratton, 1999).

Play has also been recognised as essential to a child's ability to make sense and cope with his experiences, brought about by his illness and subsequent hospitalisations (Bolig, 1984: 323; Gariépy & Howe, 2003: 535; Haiat, *et al.*, 2003: 210). Such studies suggest that emotional distress emerging with the hospitalized oncology child can be addressed symbolically and directly through play. Piaget has stated that play "allows the ego to assimilate the whole of reality, to integrate it in order to relive it, to dominate it, or to compensate for it" (cited in Adams, 1976: 418).

Findings from previous studies have noted that for a child who has been hospitalized, play can have further benefits (Ellis, 2000; Gariépy & Howe, 2003; Haiat, *et al.*, 2003; Savins, 2002). Play in the hospital may allow the child to rehearse his medical experiences and gain a sense of mastery over procedures, which in turn has the potential to build self-esteem and strengthen the sense of self. Play also gives the child opportunities to make his own choices at a time when so little is in his control. Play opportunities allow the child to exert a sense of mastery and relieve stress, whilst being in an environment where he is likely to feel helpless and somewhat anxious (Haiat, *et al.*, 2003: 210; Webb, 1995: 52). Play may be used to console the child or to help him to cope with the stresses that often accompany injury, illness, or hospitalization (Haiat, *et al.*, 2003: 210). By acting out through play a frightening or traumatic experience or situation symbolically, and perhaps changing or reversing the outcome in play activity, a child can move toward an inner resolution, and then be better able to cope with or adjust to problems (Landreth & Bratton, 1999).

Thus, as a result of previous studies that have shown the usefulness of play therapy with the traumatized and distressed child, the reduction of the child's anxiety that is associated with the reality of physical disease and resulting hospitalization has come to constitute an important clinical and research focus for paediatric professionals. It is evident that efforts to decrease anxiety associated with hospitalization have received considerable attention in the last three decades (Bolig, Fernie & Klein, 1986; Bowmer, 2002; Doverty, 1992; Gaynard, Goldberger & Laidley, 1991; Gariépy & Howe, 2003; Gottlieb & Portney, 1988; Ispa, Barrett & Yanghee, 1988; Hall & Cleary, 1988; McCue, 1988; McGrath & Huff, 2001; Morcombe, 1998; Savins, 2002; Schultz, *et al.*, 1981; Shipton, 1999; Weininger, 1983; Wilson, 1988). Play therapy is becoming an integral part of many childcare programs. This can be clearly seen in Figure 2.1 on page 26. Within the hospital context, therapeutic play provides an outlet for the child to work through many of his fears and anxieties (Ellis, 2000: 32; Gariépy & Howe, 2003: 525; McCandless, 1981: 18).

The researcher supports the view that is held by Webb (1995: 52) that acknowledges that the hospitalized child requires a special person who is trained in child development and play. The hospital play therapist or play specialist should be considered to be an integral member of the paediatric team, as they implement all types of play in order to address the child's total needs. The play therapist examines how the hospital, along with its procedures, threatens the emotional and overall development of the child. The challenge for the

therapist is to create a play setting that makes hospital stress manageable and also allows the child to assimilate the new reality into his life (Kuykendall, 1988: 173; Webb, 1995: 52). Play provides a means that allows a child to express worrying and negative feelings in an acceptable, safe and indirect manner (Webb, 1995: 52). Finding acceptable means of working through feelings of anxiety, anger, and fear and gaining a sense of mastery over the environment have been identified as important coping mechanisms for the seriously ill child (Koocher & O'Malley, cited in Goodman, 1991: 314). Play can strengthen personality, encourage interpersonal relations, further creativity and advance learning (Caplan & Caplan cited in Doverty, 1992: 77). It helps the child to resolve problems and anxiety arising from stressful situations by means of connecting the safety of the dream world with the harsher realities of his real-life predicament (Doverty 1992: 77).

With the incorporation of play into hospitals in order to replicate the child's normal everyday world, has come the recognition of play as a complex activity of child development (Savins, 2002: 14; Hall & Cleary, 1988: 24). Studies are increasingly showing that play in hospital constitutes a scheme for the child to experiment with the external threatening hospital world and through play can further gain a sense of mastery while being prepared for the events of hospitalization (Ablon, 1996: 545; Bowmer, 2002: 15; Ellis, 2000: 32; Kuykendall, 1988: 173; Savins, 2002: 14; Webb, 1995: 54). Thus, play is now seen as a means to assist the child through difficult experiences by providing a means of self-discovery, reassurance against fear and anxiety, and an increase in self-esteem through achievement and mastery (Webb, 1995: 52).

As mentioned at the beginning of this section, this study focuses on the implementation of play therapeutic techniques developed within the Gestalt approach of play therapy. It is said that it was Violet Oaklander (2000; 1997; 1988) who developed a play therapy model for children and adolescents, that was based on Gestalt therapy principles. In the following section a discussion will involve the Gestalt therapeutic process and its relevance to the hospitalized oncology child and to the present study. The discussion that follows will not include a definitive theoretical description of Gestalt therapy. Only some aspects of the theory that relate and are applicable to the context of this research study will be considered.

2.7 THE GESTALT THERAPEUTIC PLAY PROCESS

In the late 1970's Violet Oaklander, developed the Gestalt play therapy approach, which fits within the philosophy, theory and practise of Gestalt therapy, (Oaklander, 2003: 144; 1999: 162; 1997: 292). Oaklander developed a process of therapy that has emerged through the analysis of her work with children and adolescents over a span of thirty-two years (1997: 292). Gestalt play therapy, is based on the principles of Gestalt therapy, that originally was developed by Frederick and Laura Perls, and has at its base principles from psychoanalytic theory, Gestalt psychology, humanistic theories, as well as aspects of phenomenology, existentialism, and Reichian body therapy (Oaklander, 2003: 143). The therapeutic process begins with the warm and friendly foundation of a therapeutic relationship between the client and the therapist. This research study will incorporate the principles of Gestalt play therapy and apply them to the context of the hospitalized oncology child.

The underlying philosophy of previous approaches in play therapy that goes in confluence with the views of Gestalt therapy is that there exists in all human beings a drive for self-realization, which motivates both adults and children. It is also assumed that given the opportunity to express themselves freely, children will play through their conflicts and arrive at solutions to them and will further attempt to find organisation for the affectively powerful aspects of their experience and inner life. This occurs in a setting where there is sometimes minimal verbalisation and interpretation (Ablon, 1996: 546; Wilson, Kendrick & Ryan, 1992: 2). The innate capacity of play for organisation, synthesis, integration and promoting self-regulatory processes forms part of the powerful Gestalt therapeutic process.

The value of play for children in health care settings has been described previously in the literature (Adams, 1976; Chambers, 1993; Gariépy & Howe, 2003; Gaynard, Goldberger & Lardley, 1991; Hart, Mather, Slack & Powell, 1992; Jones, 2001; Petrillo & Sanger, 1981; Weininger 1983). Play has been recognised as one of the most powerful and effective means used within the hospital context to reduce stress, tension, anger, frustration, conflict and anxiety, which are accompanied by the loss of control, and self-esteem (Haiat, Bar-Mor & Shochat, 2003: 210; Petrillo & Sanger, 1981: 161). Based on these ideas, it was the researcher's opinion that the principles of Gestalt play therapy could be applied within the context of the hospitalized oncology child, as a possible coping mechanism to help the child to cope better with his experiences and possibly attain a level of self integration.

2.7.1 Therapeutic Play as an Intervention Measure

Therapeutic play is the use of play as therapy to help the distressed or potentially distressed child to come to terms with his fears and to master his experiences (Chambers, 1993: 350). The Gestalt play therapy process that will be used in this study will consist of Gestalt play therapy sessions based on the works of Oaklander (1988; 1993; 1997; 1999; 2000), and on the ideas of Gestalt therapy theory (Yontef, 1993; Perls, *et al.*, 1994). These sessions will be used primarily to assist the oncology child through his experiences and to help to at least minimize his anxiety and distress that he may be subjected to as a result of his diagnosis and hospitalization. The Gestalt play therapy with the hospitalized oncology child will aim to primarily assist the hospitalized oncology child to function more systematically and holistically, thus increasing his quality of life and thus allowing him to become more self-supportive. The Gestalt therapeutic process will also aim at enhancing the child's awareness of his process. The play therapy sessions carried out in this study followed within the framework of this model of play therapy.

2.7.2 Gestalt Play Therapy and its Intentions

One of the predominant objectives of Gestalt play therapy is to enhance the child's *awareness*, in order to promote his ability to live fully in the here and now. The concept of awareness is further discussed in paragraph 2.7.2.1. Further objectives include teaching the child to be *self-supporting* by taking charge of his own life thus becoming responsible for himself, and also involves facilitating his achievement of personal integration (Blom, 2004: 50; Thompson & Rudolph, 1992: 113). In Gestalt play therapy, these objectives are attained through awareness and dialogue, which allows the child to work through his distress through the medium of play within the context of the therapeutic relationship.

Oaklander described play as the means used by the child to try out and learn about his world, and is thus essential to the child's healthy development (1988: 160). She further noted that it is through play that a child works through confusions, anxieties and conflicts (1988: 160). Play serves as a language for the child; a symbolic means that when verbal expression becomes difficult it can substitute for words. The child experiences much in life that cannot be expressed using language, and so uses play instead of words to formulate and assimilate his experiences (Oaklander, 1988: 160). It is thus important for the child to be provided with opportunities that will enable him to find the power within himself that may

free him from those constraints that inhibit his ability to accept and express his varied emotions and to live according to his true potential (Oaklander, 1997: 306). The healthy, uninterrupted development of a child's senses, body, feelings, and intellect is seen in Gestalt play therapy as the underlying base of the child's sense of self. A strong sense of self allows the child to have good contact with his environment and people in his environment (Oaklander, 1988: 57).

The hospitalized child has a need to express what he is feeling and to work through the challenges he is facing. Play therapy can provide a safe context wherein this becomes possible (Webb, 1995: 57). Play is a normal act for the child – a medium through which he can communicate, develop and master the universe (Chambers, 1993: 352).

2.7.2.1 Awareness

In Gestalt therapy a primary goal is *awareness*. Awareness refers to the manner in which one is in touch with one's own existence and with "what is" (Yontef, 1993: 139). It includes knowing the environment, taking a responsibility for the one's choices, attaining a self-knowledge, self-acceptance and the ability to make contact (Blom, 2004: 52). This process was aptly described by Perls as "the capacity to be in touch with your own existence, to notice what is happening around and inside you, to connect with the environment, other people or yourself; to know what you are feeling or sensing or thinking; how you are reacting at this very moment" (Clarkson & Mackewn, cited in Blom, 2004: 52).

Dialogue refers to the particular contact that arises from the dynamics of the therapeutic relationship. Thus in Gestalt play therapy the therapist guides the child to become aware of and experience his process. The child becomes more aware of himself in the therapy experience, thus discovering who he is, what he feels, what he likes or dislikes, what he needs, what he wants, what he does and how he does it (Oaklander, 1994: 285). It is through this process that the child will discover that he can make choices, choices of expression, for getting his needs met, and for exploring new behaviours (Oaklander, 1994: 285).

2.7.2.2 The therapeutic relationship

An essential component of Gestalt play therapy is the therapeutic relationship that develops between the child and the therapist. Once a relationship has been developed, all further work will take its shape. The play therapist is warm, accepting, genuine, open, and responsive to the child's emotions. In this tradition, it is believed that "nothing can happen without at least a thread of a relationship" (Oaklander, 1997: 293; 2000: 29; 2003: 143).

As in Gestalt play therapy that is implemented in any context, when working with the hospitalized child the relationship the child develops with the therapist lays the foundation of the therapeutic process. This relationship in Gestalt play therapy is referred to as the I/Thou relationship, and is based on the writings of the philosopher, Martin Buber (Oaklander, 1997: 293; Yontef, 1993: 64). The relationship between the therapist and the child is considered in Gestalt play therapy to be the most important aspect for the therapeutic process (Yontef, 1993: 126). The development of trust, rapport, respect, and acceptance assists the child to achieve self-realisation and master fears and anxieties (Bolig, 1984: 323; Golden, 1983: 217; Gottlieb & Portnoy, 1988: 178;). In a relationship characterised by understanding and acceptance, the play process allows the child to consider new possibilities not possible in reality, thus greatly expanding his expression of self (Landreth & Bratton, 1999). Various findings strongly acknowledge the importance of the therapeutic relationship (Landreth & Bratten, 1999; Schoeman, 1996: 29; Webb, 1995: 56). Within the therapeutic context, both the therapist and the child grow by being actively present and engaged both during therapy sessions and in the world in general (Yontef, 1993: 6).

Within this study, the researcher implemented the essential ideals of this therapeutic relationship, with the children involved in the study. Children were helped to feel at ease, safe and secure through the researcher's warmth, acceptance, openness and responsiveness to their emotions and needs.

2.7.2.3 Strengthening the self

A major aspect in assisting the child to develop a strong sense of self through the medium of play therapy involves helping him express buried or difficult emotions, which is also an important step in the healing process (Oaklander, 1997: 298). A child who has experienced trauma tends to block his emotions related to the trauma, and has a limited experience in knowing how to express them. This results in fragmentation that inhibits healthy growth and

integration. Helping the child develop a strong sense of self gives him a sense of well-being and a positive feeling of self as well as the inner strength to express any buried emotions (Oaklander, 2003: 145). The healthy, uninterrupted development of a child's organism, including the senses, body, emotions, and intellect, is the underlying basis for the child's sense of self. A strong sense of self allows a child to be in good contact with his environment (Oaklander, 1994: 283). It allows the child to reach homeostasis and balance and thus also gain new levels of growth and development.

Gestalt play therapy is used in this study with the hospitalized oncology child, as a means of assisting the child through his experience. He is assisted in strengthening his sense of self, thus helping him to work through any feelings of anxiety and other significant negative emotional effects relating to his experiences of being in hospital, and of being diagnosed with a life threatening illness.

2.7.2.4 Integration

The term *integration* derives from the Latin word *integrare*, which in English means *whole, complete* or *uninjured* (Chambers, 2000: 835). Integration, therefore, refers to a process leading to a unification, connection, or standardization (Di Gallo, 2003: 491). Integration does not correspond solely to a synthesis of concepts, but is always connected with their differentiation. An example is the development of the cognitive capacities of the child that is inextricably coupled to the maturation of the brain (Di Gallo: 2003: 491). The pre-existing biological and psychological structures determine how new experiences are received and integrated into the totality of the child's psyche (van der Kolk, cited in Di Gallo, 2003: 491). In the course of development, an increasingly more secure self is constituted, shaped by continuity and coherence (Di Gallo: 2003: 491). In the play of keeping apart (differentiation) and bringing together (integration), brings about a level that allows the evolving person to acknowledge various perspectives and which creates a mutual space for symbolic communication and relationships (Daser cited in Di Gallo, 2003: 491).

Gestalt play therapy is concerned with the child's total existence and integration (Blom, 2004: 53). Integration requires that the child, as a holistic entity, must be helped to integrate his cognitions, emotions, body and senses in order to resolve unfinished business. (Blom, 2004: 53). As Yontef himself noted "an integrated and growthful completion of the psychological situation requires integration" (1993: 28). Successful psychotherapy is said to

achieve integration (Yontef, 1993: 147). Psycho-oncological support of the oncology child and his family has placed a fundamental importance on a process that helps to maintain the experience of continuity and coherence and thus the psychological integration of the very often traumatic experience (Di Gallo: 2003: 491).

2.7.3 Play Therapy With Children In Crisis: The Hospitalized Oncology Child

Erikson viewed play as the child's means of achieving mastery over traumatic experiences (1981: 190). As elaborated previously, the hospitalized child is often confronted with many stressful realities. A child that is diagnosed with a life threatening illness is under continual stress and without adequate support and efficient coping mechanisms, will be confronted with negative repercussions. Within the medical context the child has been seen to benefit from therapeutic play as it helps the distressed, or potentially distressed child come to terms with his fears and master his experiences (Chambers, 1993: 350). Thus within the life circumstance of the hospitalized oncology child, the use of Gestalt play therapy can prove to be essential to assisting the child to adapt and cope better with there experiences. Gestalt therapy starts a process that guides the child to learn to develop the awareness he needs to solve his problems. The child learns to use his internal and external senses fully so that he can become self-responsible and self-supportive (Yontef, 1993: 128).

Play has been increasingly recognised as essential to children's effectively coping with the experience of being constantly exposed to combined physiological and psychological stressors of illness and hospitalization (Bolig, 1984: 323). A number of studies have shown that the child exposed to stressful circumstances, has benefited from therapeutic play as he is able to express his anxiety in a language that is developmentally appropriate for him (Adams, 1976; Amatruda, 1998; Chambers, 1993; Gariépy & Howe, 2003).

To conclude, Gestalt play therapy, with its emphasis on using play as part of the healing process for the oncology child, involves a restoring of wholeness in the individual (Yontef, 1993: 31). It can thus be incorporated as an intervention method to assist the hospitalized child deal with the continual anxieties they experience. A hospitalised child can benefit from Gestalt play therapy in other ways. Play in the hospital allows the child opportunities to rehearse his medical experience and gain a sense of mastery over procedures, which in turn has the potential to build self-esteem and strengthen the self-concept. Play in the hospital gives the child opportunities to make choices at a time in his life when so much

seems beyond his control. Play may be used to console the child or to help him cope with the stresses that often accompany injury, illness, or hospitalization. Through Gestalt play therapy a child can create a world he can master, practice social skills, overcome frightening feelings and experiences, and symbolically overcome traumas that have threatened his well-being.

2.8 SUMMARY AND MAIN CONCLUSIONS

In this chapter studies concerning the psychosocial consequences of paediatric cancer were reviewed. Some studies have supported the view that a chronic illness such as paediatric cancer may have implications on the psychosocial well-being of a child. Conversely, other studies have noted that there are no clear negative psychosocial effects on the child with cancer. The researcher proposes that the fact that some studies have concluded that there may be some negative implications on the hospitalised oncology child, cannot be disregarded.

The chapter further explores the ideas and findings of studies that suggest that play therapy can be used with the hospitalised oncology child to reduce the stress and decrease the anxiety surrounding the cancer experience, and enable the child and his family to cope in a positive manner. The effective use of play as a means of helping a child cope optimally has been acknowledged as significant by a number of studies.

Play is increasingly being recognised as an important component in the holistic care of the hospitalized child. The diagnosis of a life threatening illness and the resultant hospitalization of children will remain a potentially stressful and traumatic experience for children in which their growth and development and overall functioning can be adversely affected. This remains true despite important changes that are occurring, that include a strong concern for emotional as well as primary physical care (Wilson, 1988: 232). Paediatric professionals are recognising the importance of providing normalizing activities such as play within the context of a strange and possibly frightening setting of the hospital.

With the existing evidence and clearer understanding of the psychological morbidity of the oncology child, and the increasingly good medical prognosis for paediatric oncology patients, it still remains disheartening that studies relating to the value of specific psycho-

social interventions are extremely rare and that no clear guidelines exist regarding models of holistic care (Papaikonomou & Nieuwoudt, 2004: 284).

In many health care contexts, there appears to still be a lack in the awareness of the importance of play for the hospitalized child (Chambers, 1993: 350). If holistic care is to be carried out with the hospitalized oncology child, then provision must be made to provide opportunities for therapeutic play for the child. Therapeutic play must thus be recognized as an essential part of the hospitalised oncology child's emotional care, because the contribution made by play to children's recovery, in its broadest sense cannot be overlooked.

In the following chapter the research design and methodology of the present study that explores the idea that Gestalt play therapy can have some effect on reducing feelings of anxiety or emotional distress experienced by the hospitalized oncology child, will be described.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter describes the study's research design and methodology. It describes in detail the means and methods of how the research was conducted and what the specific ways were that helped to gather data in this research study.

3.2. RESEARCH DESIGN

In this study, a qualitative, naturalistic, basic, case study research paradigm was applied. Thus the study emphasized how each research participant described his experience of play therapy, through his personal meanings of the experience. This is in accord with the idea the basic research tends to primarily seek to understand and describe human behaviour and mental processes rather than to changing people's lives for the better, and explaining human behaviour (Babbie & Mouton, 2001: 270; Shaughnessy, *et al.*, 2003: 34). The process of describing people and their experiences, and significant places and events becomes the basis of qualitative research and thus, as in this study, the qualitative researcher generally focuses on descriptions and explanation (Janesick, 2000: 395).

In the following section, the various strategies that were employed in the research study are discussed.

3.2.1 The Framework For Research Design: A Qualitative Approach

The study employed a qualitative research approach. In qualitative research the researcher studies human behaviour within its natural setting, and describes the outcomes through the eyes of the actual participants. An emphasis is thus placed on a detailed description and understanding of phenomena within the appropriate context (Babbie & Mouton, 2001: 278). As this study took place within the oncology child's hospital ward, the researcher decided to adopt a qualitative, naturalistic research paradigm as the most appropriate research approach. According to Babbie and Mouton (2001: 270) qualitative research involves the following: research is conducted in the natural setting of research participants; the focus is on process rather than outcome; the research participant's perspective is emphasized; the

primary aim is in-depth descriptions and understanding of actions and events; the aim is to understand social action in terms of its specific context rather than attempting to generalize to some theoretical population; and, the qualitative researcher, as in the context of this research study, is seen as the main instrument in the research process.

In this research study, the researcher was the main instrument in the research study. Detailed descriptions of each child participants play therapy experience was made. In analysing qualitative data the researcher strives to understand a relevant phenomenon as a whole. Thus, a description and interpretation of a person's social environment, is essential for an overall understanding of what has been observed during fieldwork (Patton, 2002: 59). The holistic approach assumes that the whole is understood as a complex system that is greater than the sum of its parts. The analyst searches for the totality or unifying nature of particular settings – the “Gestalt”. Fritz Perls, a founder of Gestalt therapy, made the term “Gestalt” equivalent with a holistic perspective in psychology (Patton, 2002: 59).

Qualitative inquiry means going into the field. It involves immersing oneself in naturally occurring contexts. The data for qualitative analysis typically come from fieldwork. During fieldwork, the researcher spends time in the setting under study. The researcher directly observes the activities and interactions, and sometimes engages as a participant observer (Patton, 2002: 4). In this study the researcher worked with the child within the hospitalized context.

This research study adopted a basic research design as it sought empirical observations. Basic research seeks primarily to understand human behaviour and mental processes. It was not interested in the process of scientific planning that induces change in any difficult situation (Fouché, 2005: 105). Basic research aims at understanding a phenomenon, that is, of determining how “nature” works (Shaughnessy, *et al.* 2003: 323). In this study the researcher, after allowing the oncology child to experience the Gestalt therapy process, attempted to understand and describe each child participant's experience. A primary objective of the study was to explore and describe the effect of Gestalt play therapy on the feelings of anxiety experienced by the of the hospitalized oncology child.

3.2.2 Strategies Of Inquiry: Case Study

The case study is a design strategy used in qualitative research. A case study is an in-depth study of all the pertinent aspects of that, which is being studied (Bailey, cited in Newman & Benz, 1998: 193). The researcher applied a case study approach as the strategy of enquiry. This was done in order to gather comprehensive, systematic, and in-depth information about the participants involved in the research case study.

Cases are “specific, unique, bounded systems”; they are “units of analysis” (Stake, 2000: 436). Case studies take as their subject one or more selected examples of a social entity, which are studied using a variety of data collection techniques (Hakim, 2000: 59). The case study approach to qualitative analysis constitutes a specific way of collecting, organizing and analyzing data (Patton, 2002: 447). The purpose is to gather comprehensive, systematic, and in-depth information about each specific case (Patton, 2002: 447). The case or unit of analysis in this study is the hospitalized oncology child.

In this research study, the case study approach was considered by the researcher to be an ideal methodology for a holistic in-depth investigation. The study thus focused on the very process of each child participant’s experience rather than on the outcome of a specific occurrence. What was emphasized is the description of the personal meanings that each child participant placed on his play therapy experience.

In the following section the various data collection strategies used in the study, and the means of analysis of accumulated findings and events are described.

3.2.3 Data – Collection And Analyses

Data was collected during the various play therapy sessions, through observations, interviews and questionnaires. These techniques of the collection data, a description of the selected research participants, and a further depiction of the setting, that is, the place wherein the research took place, are described in this section.

3.2.3.1 Setting

The study was conducted in a paediatric oncology unit at the Johannesburg Hospital, a provincial hospital in the Gauteng province. Within the ward there are generally about twenty-one children (maximum). Children's length of stay ranges from just a few days to as long as over one year, depending on their diagnosis. There are four nurses per twelve-hour shift. The paediatric unit is considered to be a very prominent centre for treatment of paediatric oncology care and treatment, in Gauteng. During her work at the ward the researcher saw many children from various parts of Gauteng, surrounding areas and various parts of Africa coming to the centre for treatment.

3.2.3.2 Selection of Research Participants

The research participants in this study were the hospitalized oncology children, who were within the hospital ward and were receiving treatment at the time of the research study. The head of the paediatric oncology unit selected children who were present in the paediatric oncology ward, at the time of commencement of the study randomly. Initially the researcher aimed at using children who were within a specific age group. As the researcher had to work with the children who were in the ward at the time of the study it was difficult to focus the study on children in one specific age group. However, this criterion did not prove feasible as the children available at any given time ranged across various developmental ages. The researcher thus decided to use the "school going child" between the ages of nine and fourteen years. Although this selection includes children that are in the middle childhood (six to eleven years) and adolescent (twelve to eighteen years), developmental levels, the procedures for selection, therapeutic process used in the study, were identical for both groups of children.

Once children were selected as possible candidates, the following criteria had to be considered in order to participate in the study:

- ◆ Children were diagnosed with cancer and were receiving treatment in the ward
- ◆ Children would be present in the ward for at least three or more weeks.
- ◆ Children were English speaking
- ◆ Children were school-going children between the ages of nine and fourteen

As a result of the necessity to run the study for a specific period of time within the hospital context, participants were selected primarily if they were to remain within the ward for that period of time. Participants thus needed to be in the paediatric ward for at least three weeks, so that a minimum number of sessions (at least six sessions) could be undertaken. As a result of this, the child participants were at various stages of their illness, some having been only recently diagnosed, and others having being on treatment for number of months, before commencement of the study.

The head of oncology and doctors of the unit also evaluated children's quality of health. Children who were either in the isolation ward or who were not physically strong enough to be included in the study were not considered as participants for the study.

Once relevant children were identified, the researcher conducted a detailed interview with parents or guardians and with the child. The parent/guardian that was available when the interview was conducted was interviewed. Generally only one parent was available for the interview. The gender of the parent was not considered to be a relevant criterion in the study. The child participants were interviewed in the absence of their parents/guardians. Both child participant and parent/guardian were given all possible information concerning the procedures that would be followed during the study. All efforts were made to provide such information to parents or guardians and their children in order to ensure that all participants knew that they would participate voluntarily in the study. It was specified that participants were free to withdraw from the study, at any time during the course of the study, without an obligation to provide an explanation. No specific demographic (race or gender) criteria were used to select participants. However, at the time of selection all research participants were from the black population. This was purely due to the fact that only these children were available for selection at the commencement of the study. Participants and their parents represented a diverse spread in terms of employment, educational levels and geographic location, ranging from Berea in Gauteng to Angola in Africa.

3.2.3.3 Length of Study and Number of Participants

Gestalt play therapy sessions consisted of between forty-five to sixty minute sessions, twice a week for at least three weeks. However, as each child participant's health and ability to participate fluctuated at each session, in some cases sessions extended into eight or twelve weeks. Initially the sample size of the population included was initially seven participants.

However, one child passed away after the second session. Thus the sample size consisted of six participants. One was female and five were male. The mean age of the children was eleven years. Due to the complexity and intensity of the application of the procedures, and to the limited amount of time available to complete the study, it was not viable for the study to accommodate a larger number of participants. One reason for limiting the number of cases used in a study was to enable the researcher to gather very extensive data about each individual participant of the case study (Anastas, 1999: 95). Qualitative inquiry typically focuses on relatively small samples (Patton, 2002: 46).

3.2.3.4 Data Analysis

The primary goal of data analysis is to determine whether the observations obtained support a claim about a relevant behaviour (Abelson, cited in Shaughnessy, *et. al.*, 2003: 361). Data analysis thus refers to the process of “bringing order, structure and meaning to the mass of collected data” (De Vos, 2005: 333). The analysis of findings was done on a qualitative level through identifying relevant themes. Information obtained from the interviews, questionnaires and observations was analysed and described in detail. The researcher attempted to explore and describe the experiences of the research participants by observing and describing their experiences (Babbie & Mouton, 2001: 270). Ultimately, the study included an in-depth description and understanding of the experience of Gestalt play therapy by the hospitalized oncology child.

The aim of this research was not to generalise the findings to some theoretical population, but rather to understand and describe the experiences of each child participant in terms of his specific experiences, within his unique social and personal contexts. This was based on the ideas described by Hakim (2000:37) that acknowledges that qualitative research tends to be used most heavily in disciplines that emphasize description and explanation rather than on prediction.

3.3 DATA COLLECTION METHODS AND FIELDWORK PRACTICE

Data collection procedures refer to the research tools and procedures used in the study that guide the research process (Babbie & Mouton, 2001: 75). In this section, the researcher will provide details of the data collection process that is, the data collection techniques and procedures used in the research study. The specific methods of data collection and analysis that are used in the study will be described below.

3.3.1 One-On-One Semi-Structured Interviews

The interviews used in this case were one-on-one semi-structured interviews. With semi-structured interviews, the researcher has a set of predetermined questions on an interview schedule (a questionnaire that is written to guide an interview), where the interview is guided by the schedule rather than dictated by it (Greeff, 2005: 292).

These were used to gain a detailed picture of the research participants, by interviewing both parents/guardians and child participants. Parents/Guardians and research participants were interviewed at the beginning of the research study. In these interviews the researcher had an interview schedule (Greeff, 2005: 392). Analysis of information obtained from the interviews involved attaining relevant themes, or concerns related to the study. Interviews were also conducted with the participants at the end of the study. A copy of the research interview protocols appears in Appendices 1, 2, 3 and 4 on pages 122, 128, 132 and 134.

3.3.2 Questionnaires

Questionnaires can be described as “a set of questions, usually on a form, to be asked of a number of people to obtain statistically useful information” (the New English Penguin Dictionary, 2001: 1145). In the study questionnaires were given to children at the beginning of the study to establish the presence and nature of their anxiety. Questionnaires typically entail several questions that have structured response categories (Anastas, 1999: 373). The “*How I feel in Hospital Questionnaire*” was compiled by the researcher as a possible instrument to identify and describe the nature of the child’s anxiety at the time of the study. In this questionnaire the child participant was provided with a range of events and feelings and they needed to choose whether they did or did not experience them. Please refer to Appendix 7 for the Questionnaire (on page 136).

3.3.3 Observation

A major source of qualitative data involves what people say, whether what they say is observed verbally through an interview or in written form through document analysis or survey responses (Patton, 2002: 21). Observation in research refers to data collected by direct visual experience of the study participants by the researcher (Anastas, 1999: 327). Observations in natural settings are basically descriptions of the case being studied (Angrosino & Pérez, 2000: 674). Through the process of participant observation the researcher attempts to gain an in-depth insight into the manifestations of reality (Strydom, 2005: 276). What is focused on with this procedure is the everyday and natural experiences of the participants (Strydom, 2005: 276). Observations were conducted, wherein the researcher took field notes on the behaviour and activities of each child participant during play therapy sessions. Once play therapy sessions were implemented, the researcher observed children's progress, behaviour and overall functioning, during each session; the same procedure of observation was carried out with each individual child and during each individual session. The researcher observed how the child reacts and interacts with the play therapy sessions. Detailed descriptions of the participants' activities, behaviours, actions and the full range of interpersonal and organisational processes were made by the researcher (Patton, 2002:4).

In the following section, the actual Gestalt play therapy process that was implemented during study is described.

3.3.4 The Gestalt Play Therapy Process

The researcher was interested in using Gestalt play therapy sessions with the hospitalized oncology child in order to help to reduce or minimize feelings of anxiety experienced by the child. Play therapy included approximately six sessions and was used to assist children to work through their trauma and to become more self-supportive. The sessions consisted of Gestalt play therapy sessions that were based on the works of Oaklander (1988), and Gestalt theory (Yontef, 1993). Various play therapy tasks were used to provide the child with emotional tools to assist him in his emotional expression and to strengthen his coping skills. Gestalt play therapy was based on the Gestalt theoretical framework. Thus, the following basic goals were promoted (These goals were adapted from Geldard & Geldard, 2004: 6):

- ◆ Gestalt play therapy can enable the child to deal with painful emotional issues
- ◆ Gestalt play therapy can enable the child to achieve a level of congruence relating to his thoughts, emotions and behaviours
- ◆ Gestalt play therapy can self empower the child and assist them to feel good themselves
- ◆ Gestalt play therapy can enable the child to accept his limitations and to acknowledge his strengths
- ◆ Gestalt play therapy can enable the child to change those behaviours and thought processes that have negative consequences
- ◆ Gestalt play therapy can enable the child to function comfortably and adaptively within the external environment (specifically within the stressful environment of the hospital)
- ◆ Gestalt play therapy can maximize the opportunity for the child to reach his true potential in an holistic manner

3.3.4.1 Procedure and Practice of Gestalt Play Therapy Sessions

Various media were used during the process of play therapy. The work children produced during the sessions through various projective media, together with interviews and questionnaires and observations recorded by the researcher were used to provide relevant data for this research study. In the following section, an account is given to the various methods used during the play sessions. Tasks included in the play therapy experience are described below.

◆ Establishing the Child's Mood

The child was presented with a "feeling faces" page to establish his mood at the beginning of each session. They were also asked at the end of the session to describe how they were feeling. This was done in order to ascertain whether there was a change in mood after Gestalt play therapy was carried out. A copy of the feeling faces is in Appendix 8 (on page 137).

◆ Projective Drawings

Drawings were incorporated in the study as one means of projective expression. Projection has been described by as the process through which objective stimuli can be perceived and interpreted according to personal interests, needs, fears, and expectations (Kerlinger, 1986:471; Malchiodi, 2007: 238). This view holds that we all project some part of ourselves into everything we do. Thus, through a projective stimulus it should be possible to

project one's emotions, needs, motives, attitudes or values. Solomon (2005) notes that young children are able too naturally process feelings, trauma, illness and death through their drawings and the stories that spontaneously emerge in their drawings. They are able to mix imagination with real life experiences in a way that can help them start resolving issues. Children are often able to express their feelings more easily through drawings than through words (Solomon, 2005: 63). Violet Oaklander herself noted the usefulness of projective tools as expressive media (1988: 175).

Sometimes drawing and painting provide the child with a medium for expression. Drawings can inform us of the overall feelings concerning the external threats as well as how a child perceives himself in relation to them (Councill, 2003: 213; Kuykendall, 1988: 176). Providing a child with the opportunity to express feelings rather than holding them in allows a child to transform from passive into an active agent of his healing process and also allows the child to sublimate difficult feelings such as anxiety, fear or anger (Councill, 2003: 213; Goodman, 1991: 315). Therapeutic play and art expression help the child to deal with emotional release by offering "rich and significant channels of expression" (Petrillo & Sanger, 1980: 160). It allows for the reorganization and re-experiencing of problems and anxiety. Kübler-Ross (cited in Goodman, 1991: 315) notes the following:

We receive from the child a picture of his world that is often clearer and more direct than what the artist portrays, because a child has little formal knowledge of art. When the child is investing his feelings and ideas in his drawing, the process unfolds without any critical forces to accuse him... It appears that the child's feelings and thoughts... flow freely and directly onto drawing paper

The following drawings were presented to each child participant as a means of expressing his thoughts and feelings.

❖ Free drawing

The child is instructed to draw anything and then tell a story about the drawing. Children would rather prefer to draw or paint whatever they want to rather than be told what to do (Oaklander, 1988: 47). Asking a child to draw anything and then tell a story about what they have drawn, is not only a good self-empowering tool, but it also gives the researcher an idea of what is on the child's foreground. This in itself also provides a good communication tool to assist in strengthening the therapeutic relationship.

❖ Scribble drawing

This technique is another unthreatening method that can be used to help the child express outwardly a part of his inner life (Oaklander, 1988: 37). The task is conducted as follows: Children are instructed to relax their bodies in order to engage in drawing as freely as possible (Malchiodi, 2007: 109). Children are encouraged to draw without conscious planning by making continuous, flowing lines on the paper and keeping the drawing material on the paper. When completing the scribble, they are asked to look at the pattern of lines and try to identify a design, shape, or object, person animal or landscape. The drawing could be turned in different directions if necessary, in order to discover an image, which could then be developed, elaborated or modified (Malchiodi, 2007: 109). Thus in this exercise the child discovers, in a random pattern he creates, personal symbols whose qualities he can compare to his own personality or personal life (Remocker & Storch, 1992: 109). The researcher was interested in the process of spontaneous imagery, and was not interested in finding the unconscious meaning in the images provided.

❖ Diagnostic Drawing

Each child's drawing of his diagnosis was obtained by directing the child to indicate on a given body outline and with colour, what they think is wrong with them (Petrillo & Sanger, 1980, 160). This procedure was used by Anna Freud, (1952) in a study, which graphically demonstrated children's ability to communicate their understanding of themselves during their current illness. Although this study was psychoanalytic in substance, the idea of the child communicating an understanding of his illness onto an illustrated drawing can very substantially be considered relevant in a Gestalt therapy context. The equipment used for the Child Drawing-Diagnosis, included a box of assorted crayons, the human figure outline (as illustrated in 6 on page 135) and a flat surface to draw on. The instructions to each child were as follows: "Here is an outline of a boy (or girl). Please draw for me what is wrong with you. Variable instructions could include: "Draw on the body outline where your illness is"; or "Draw what made it necessary for you to come to hospital".

❖ Drawing of a Safe Place

After experiencing a meditation that attempts to guide a child to a safe place, the child is asked to graphically express his safe place (adapted from Oaklander, 1988: 10). This was aimed at allowing a child to experience as sense of safety and calmness.

◆ Sensory Awareness

Giving the child experiences that will help to bring them back to themselves, include experiences that help to renew and strengthen his awareness of the senses; sight, sound, touch, taste, smell. It is through these modalities that we experience ourselves and make contact with the world (Oaklander, 1988: 109). Within a Gestalt approach, the development of sensory and bodily awareness plays a valuable role in the therapeutic process, as it is seen to greatly contribute in assisting the child to function holistically. This is one of the primary goals of Gestalt play therapy, that is, in assisting the child to function again as a holistic entity that consists of thought, emotions, and body (Blom, 2004: 98). A child may lose his sensory awareness and sensitivity in respect to his body, due to the traumatic events that he may experience (Clarkson cited in Blom, 2004: 98).

◆ All About Me Questionnaire

The therapeutic relationship is enhanced with this task of getting to know the child. The questionnaire is presented in Appendix 9 (page 138). It was adapted from Hart, Mather, Slack and Powell, 1992: 13.

◆ Positive Thoughts Affirmations and Self-Empowerment

At the end of each session the child was given a Can-Can- Kidz card that provided the child with a positive affirmation message. These cards were developed to provide positive self worth and the researcher decided to incorporate them with the children to providing positive self worth and self-empowerment. The primary goal for using these positive affirmations was to assist the child to think thoughts that made them happy and things that make them feel good (Hay, 2006: 102). The children had to simply choose a card from a pack, say the message on the card three times and try to acknowledge it as part of themselves.

◆ Personal Collage

Collage is any design or picture made by pasting or attaching materials of any variety to flat backing, such as cloth or paper. Sometimes a collage is made in conjunction with drawing, painting or some kind of writing (Oaklander, 1988: 80).

The rationale behind using collage with the children in this study was as follows:

- ❖ In order to deepen the rapport between the researcher and the child.
- ❖ To assist the child in his increasing awareness of how he sees himself at present, and how he might like to see himself in the future.
- ❖ To encourage an expression of emotion, and to assist in helping the child gain mastery over his relevant issues and events (Geldard & Geldard, 2004: 136).

The instruction to the child was as follows: The child was asked to divide a large piece of paper in half. On the one half he was asked to make a collage that described how he saw himself and how his life was at the present time, what was going on in his life at present; who were the important people/things in his life in the present time. He was encouraged to place in his picture as many symbols and pictures, of things that make up his life in the present moment. In the other half of the paper, he was to place pictures that would describe what he would like his life to be in the future. He was to place there everything that he would like to have in his life that he may not have in his life at the present time; things he wanted to do and couldn't do in the here and now, and/or places he wanted to go to in the future, etc.

After this process was completed the child was asked to share his view of his collage. Each side of the picture was given a name.

◆ Building the Cancer out of Play Dough

Oaklander has described working with clay as being both tactile and kinaesthetic (1988: 67). She also notes that working with clay encourages the working through of "the most primal and internal processes" (1988: 67). Working with clay assists the child to stay connect with his inner self (Pearson and Nolan, 2004: 84). By interacting with a very The very sensual contact with the malleable clay allows the child to engage his interest and integrate his body and mind together in a way that also promotes the working through of emotional issues Pearson & Nolan, 2004: 84).

This task gave the child the opportunity to create what they believed his cancer/illness looked like and after "taking it out" of his body, symbolically take his power back by destroying it. Instructions were as follows: The child was asked to explore the ply dough, notice the texture, colour, and shape. He was then asked with his eyes closed or open, make his illness; he was presented with the following ideas that may have helped them to create his structure: what shape or shapes it was; maybe it was made of different pieces; what colour was it. He was encouraged to let his hands guide him to make whatever he was making. Finally the form was given a name. The child was then guided through the process of seeing how the cancer was out of his body. He could destroy it, change its form and make it into nothing. Feelings of the process were discussed.

◆ Meditation and Creative Visualisation

This method can help a child to go within and feel his very essence. Meditation is a very soothing, relaxing way of coping with the stress and anxiety of daily life (Garth, 1994: 1). It help a child to get in touch with the spiritual depths of his being, in a place where there is peace and serenity and can also bring stability (Garth, 1994: 4). A child is essentially made up of physical, mental, emotional, and spiritual components and it is thus important to assist a child to take the time to nourish his body, mind, emotions, and the spiritual essence within, his higher self (Garth, 1994: 4). Meditation means going within, listening to the inner or higher self, while visualisation means using pictures in the meditative state to create what you need in your life (Garth, 1994: 11).

Creative visualisation is a form of meditation that helps to promote tranquillity. It involves putting thoughts and images into a more concrete form where a child can actively work on the images. By meditating in this way a child can create a scene or an image within himself with which he can work to benefit his everyday life. A child can close his eyes and see his thoughts transferred into scenes which project his closest desires (Garth, 1994: 10). Creative visualisation is a process of going within, focussing attention on breath and bodily relaxation and moving to deeper levels of consciousness where more images are accessible to the conscious mind. They take the form of a pleasant journey to the beach or mountains, a meeting with an inner figure of wisdom, or visualizing oneself as successful in whatever one believes in (Murdock: 1987: 2). A child thinks in images all the time. He knows things with all of his senses. One can use this natural ability to learn with the sensory images to assist children to find inner peace, self-support and self-actualisation.

The researcher combined meditation with imagination and visualization. The meditations and visualisations used in this study are presented in detail in Appendix 11 and 12 (on pages 140 and 141). They include: meditation and drawing of a safe place, in addition to the healing cells meditation.

◆ Mandala Painting/Drawing

A mandala is a circular design that radiates from the centre outwards. *Mandala* is a Hindi word derived from Sanskrit meaning “sacred circle” or circle or centre (Cox, 2003: 428). They have been used throughout time by many cultures for meditation and healing (Solomon, 2005: 36). The Spiral of the Milky Way, the orbiting of the planets around the sun, and the movement of the moon across the sky appears to echo the constant presence of circular forms (Malchiodi, 2007: 122). Before making the mandalas, children were involved in a discussion where they were asked to look for mandalas in nature, and in human made things. They are also encouraged to look for mandalas in their present surroundings.

Making mandalas has been described to be very calming, and has been done to reduce stress. The circle is a containing shape to work in and can promote a feeling of wholeness (Solomon, 2005: 49). The mandala has been referred to as the reflection of one’s psyche at the moment and a representation of a potential change and transformation (Malchiodi, 2007: 123). Creating mandala images is often associated with a feeling of wholeness, growth, or the birth or emergence of something new, a complete Gestalt. People who are experiencing serious illness or a life crisis may spontaneously create mandala images when they are physically or emotionally healing (Malchiodi, 2007: 123). While a mandala drawing will not magically reduce anxiety or troubling emotions, studies have shown that drawing within a circular format can have calming effects in the body in terms of heart rate and body temperature (Malchiodi, 2007:127). It has been used to assist in providing a container or safe boundary within which chaos could be potentially transformed into order, balance, and wholeness (Cox, 2003: 428).

After identifying circular forms in his world-space, the child was guided through the following process: A child was provided with a circular outline and asked to notice the centre of the circle. He was asked to choose a colour or colours to draw something in the centre. Focusing on what he had drawn in there, they were asked to continue to draw from the centre outwards, filling the whole circle until no white space was left (except if that was part of the painting). The circle could be filled with shapes, colours, lines....whatever came to his mind. The design was placed in the correct position and a small “t” is placed at the top. A name was then given to the painting. Thereafter, an emphasis was placed on what the child has made and a discussion on the process followed.

◆ Incomplete Sentences

The *Incomplete Sentence* exercise is a projective method where the child is given a series of incomplete sentences that they are to complete. The child is provided with the first half of a sentence and he has to complete the sentence with his own meanings. By grouping and evaluating the responses some judgments were made about the child's psychological state of mind. Generally, the opening words, or sentence stems, permits the child to present what is on his foreground. This task is presented towards the end of the six sessions. It was compiled by the researcher. A copy of the sentences appears in Appendix 10 (on page 139).

◆ Final Interview and Termination

The final interview took place in the sixth session. (See in Appendix 13 on page 142).

3.3.5 Analysis of findings

This was done on a qualitative level, through identifying relevant themes, feelings, and observations. Information obtained from the interviews, questionnaires and emotional assessments were analysed and described in detail. The researcher described the very process of each child participant. A major component in the study involved the observation of the various case studies. Observation is a fundamental and critical method in a qualitative inquiry. It entails the systematic noting and recording of events, behaviours and artefacts (objects) in the social setting chosen for study. It can be used to discover complex interactions in natural social settings (Marshall & Rossman, 1995: 80). Through observation the researcher learns about behaviours and the meanings attached to these behaviours. In this method it is assumed that each behaviour carries a purpose and expresses deeper values and beliefs (Marshall & Rossman, 1995: 79).

The primary focus of data collection involves what is happening to individuals in a setting and how individuals are affected by the setting (Patton, 2003: 228). An in-depth exploration and description of the experience of play therapy by each child participant was made. The research was concerned with the individual child's own account of his attitudes, motivations, and behaviour. The researcher will, in the following chapter, provide richly descriptive reports of each child participant's perception, attitude, belief, view and feelings regarding his personal experience of the play therapy process. The qualitative researcher sought to describe and explain, and make understandable the familiar in a contextual, personal and passionate way (Janesick, 2000: 393).

3.4 CONCLUSION

The discussion in the above chapter involved a more detailed account of the research design and methodology of this study. It explained the framework of study that entailed a qualitative, naturalistic, basic, case study research paradigm. The researcher had chosen the above methodology as it tended to suite the nature of this study. The researcher worked within the context of hospitalised child and focused on describing each child participant's personal account of his experiences. Thus, what will be emphasized in this study is the description of the personal meanings that each child participant placed on his play therapy experience.

A detailed account of the techniques used as part of the Gestalt therapy process was provided in this chapter.

In the following chapter, the Gestalt play therapy process utilizing the techniques described in this chapter, paragraph 3.2.4, with each case study, will be portrayed and observations will be discussed.

CHAPTER 4

DATA COLLECTION METHODS AND FIELDWORK PRACTICE

4.1 INTRODUCTION

Data collection defines the application of relevant data collection techniques and procedures utilized in the research study, (Mouton, 1996: 111). Chapter 4 provides a detailed account of the data collection process presented with each child. This was done in order to ascertain what effect the Gestalt Play therapy process had on the hospitalized oncology child. The researcher conducted Gestalt play therapy with six hospitalized oncology children and the process was analysed. The details of each case study, the various data collection techniques and procedures used, and procedural discussions are presented accordingly.

It was the researcher's intention to present all procedures to all the case studies in the same manner. However, it became necessary at times to vary or adapt presented processes. Variables that had to be taken into account included: the health of the child at the time of the play therapy sessions; the treatment procedures which sometimes, took place during the play therapy sessions; and the child's difficulty to complete various tasks. Therefore some aspects were omitted with some of the participants, or adapted to suit each child participant's personal need. One aspect that may have contributed to this included that it was difficult to compare the Gestalt play therapy experiences of each child as some children did not go through the same process. It also made it difficult to establish whether there were any significant influences between Gestalt play therapy and the feelings of anxiety of the oncology child. Should it have been possible to have contained the same process throughout the study, relevant outcomes may have differed.

4.2 DESCRIPTION AND EVALUATION OF CASE STUDIES

In order to provide a comprehensive view of each case study, background information, as well as relevant interviews will be presented prior to discussing the actual Gestalt play therapy process. The procedures used as part of a Gestalt play therapy process included the following: interviews, questionnaires, drawings, painting, collage, clay work, meditation and positive self-empowerment work

4.2.1 Case Study 1

The first child will be referred to as B to ensure the anonymity of the child and her family.

4.2.1.1 Background information of B

B is a 12-year-old girl and is in grade 6. She speaks Zulu and English. She was admitted to the Johannesburg Hospital in August 2005. She was hospitalized when she injured her leg. Further tests were conducted when her leg would not heal. She was diagnosed with osteosarcoma (in August 2005). Osteosarcoma is a malignant (cancerous) tumour that may occur in any bone, but develops most commonly in long bones, particularly near the knee or in the upper arm. Amputation is sometimes necessary to reduce the likelihood of it spreading to other areas of the body (MedicineNet.com, 2007).

Shortly after being diagnosed with osteosarcoma B underwent surgery. Her leg was amputated just above the knee area. At the time of the study (between March and April, 2006) B was receiving chemotherapy and physiotherapy. In February 2006 B began to walk with a prosthetic leg. The research began when B was towards the end of her treatment and was to be going home in the next three to four weeks.

B's parents were not available prior to commencement of the study, as they lived a vast distance from the hospital. When they came to visit it was during times that did not coincide with the time allocated for the research sessions. B's parents gave verbal consent for their child to participate in the study. They were unable to complete the parent interview.

4.2.1.2 Responses of B to Interview

Only responses by B to the conducted interview are noted here (a copy of the interview schedule can be found in Appendix 5 on page 134).

I have never been in hospital before this time. I knew I was going to hospital when I felt sick. Before I went I felt sad and scared. I wanted them to save my leg. I feel better now about being in hospital. I have been here since July 2005. I had cancer in my leg. My parents and the doctors and sisters here all talk to me about what is going on. My mom visits me here when she doesn't have to work. She sleeps here when she can. When she leaves I feel sad.

The following are the feelings B experienced during the time of her illness: angry (sometimes when she couldn't go home); shy (often when new doctors and nurses came); sad (often, when her mom couldn't stay with her); lonely (often, when her mom left); sick (sometimes); anxious (sometimes, when she didn't know what was going on); happy

(often, when her family came; when it was someone's birthday); bored (sometimes when there was nothing to do).

4.2.1.3 How I Feel in Hospital Questionnaire

The responses to the questionnaire are presented in Table 4.1 on page 67. Only the responses that are essentially characterized by anxiety or emotional distress were indicated. A copy of the questionnaire appears in Appendix 7 (on page 136).

Table 4.1. Case Study B - How I Feel In Hospital Questionnaire

<ul style="list-style-type: none"> ▪ I can <i>often</i> talk to people about my illness ▪ I <i>often</i> worry about my illness. ▪ I <i>often</i> worry I might not get better. ▪ Hospital is sometimes a scary place ▪ In hospital I <i>often</i> worry a lot ▪ I <i>sometimes</i> feel different to other children ▪ <i>Often</i> I am afraid that other kids will make fun of me ▪ At night it is <i>sometimes</i> difficult to fall asleep ▪ I <i>sometimes</i> feel tense or uptight ▪ At night I <i>sometimes</i> have bad dreams 	<ul style="list-style-type: none"> ▪ I <i>sometimes</i> feel scared ▪ I <i>very often</i> can't relax when I am in hospital ▪ I sometimes find it hard to make new friends ▪ I <i>very often</i> get scared when my parents leave ▪ I <i>sometimes</i> feel shy when I meet new people ▪ I <i>often</i> worry about what other people think of me ▪ I <i>sometimes</i> have a pain in my chest ▪ I <i>sometimes</i> don't have a good appetite ▪ I <i>sometimes</i> feel anxious when I get my treatment ▪ If I get upset or scared I can <i>often</i> tell someone
---	---

Discussion: "The How I Feel in Hospital Questionnaire" was developed by the researcher, to provide some idea of the nature of the child's anxieties. Responses to the above questionnaire suggest that B was experiencing some anxiety. Some key areas of concern included: a general anxiety concerning her illness; feelings that she may not recover from her illness; having lost her leg; anxiety about how others would react to her when she went back home; when her family had to leave her in the hospital. The complex, multi faceted nature of the oncology child's anxiety can be perceived to some extent in the responses given by B on the above questionnaire. Furthermore, B experienced the hospital as a scary place.

The notion that the presence of anxiety within the medical context is multi dimensional in nature is supported by literature. Previous studies have described how the continual anxieties of childhood cancer involve such factors as treatment, related pain, recurrent nausea and vomiting, visible side effects, hair loss, loss or gain of weight, multiple hospitalisations and visits to the clinic, repeated absences from school and interaction with peers (Forsbach & Thompson, 117; Gariépy & Howe, 2003: 329; Manne & Miller, 1998:121; Papaikonomou & Niewoudt, 2004: 283; Patenaude & Kupst, 2005: 13). It is the researcher's

opinion that emotional distress is inevitable after enduring such experiences. These ideas are strongly supported in this research study.

4.2.1.4 Play Therapy Sessions

At the beginning of each session a child was presented with a “feeling faces” page in order to establish how the child was feeling (The copy of the feeling faces appears in Appendix 8 on page 137). In addition, at the end of some of the sessions a child was given a Can-Can-Kidz self-affirmation card as a means for promoting self-empowerment.

◆ Session One

A sensory awareness exercise was carried out that focused on the sensory experience of sight and sound. Thereafter, various drawings were completed.

The Child’s Process: At this first session, B seemed to be eager to be a part of the study as she said she was excited to perform the tasks that had been described to her in the initial interview. B chose the “very happy” face in this session. She noted that she was glad she could do something different during the session. The researcher then completed a sensory awareness exercise where B was asked to notice the room she was in and become aware of the colours and shapes around her as well as the sounds that were present. A discussion about this experience followed.

B completed a “free drawing” where she was asked to draw a picture of anything and tell a short story. B described the picture as being about herself and her friend. They were walking to school together. She called the picture “nice picture”. The picture appears in Figure 4.1 on page 69. Missing home and school, and being with her friends were the main themes portrayed in her drawings.

◆ Session Two

The “All About Me Questionnaire” (See Appendix 9 on page 138) was completed first. The details of the questionnaire will not be discussed as most of the content is provided in the child’s interview.

An exercise involving the senses of touch, and taste was done by exploring an array of edibles, and then experiencing a variety of textures and forms was then carried out. B then completed the diagnostic drawing. This appears in Figure 4.2 (Also see Appendix 6 on page 135). The final task incorporated the “scribble drawing”. The scribble drawings were all of a very light quality and could not be reproduced. They are thus not illustrated here

The Child’s Process: B chose the very happy face. The scribble exercise was approached with some apprehension. Exercises to loosen up the body and help B relax were performed.

The symbols that B identified in her drawing included the following: *shoes*, a *razor* and a *butternut*: *Shoes*: reminded her of when you run on the stones at school and you must wear them, they protect your feet; *razor*: was used when one did not have a pair of scissors; *butternut*: was food she did not like.

Affirmation message: “The more I love myself the more love I have to share with others”. Personalising the message was promoted by discussing how the message could be made applicable to her life at the present moment. She said that she loved herself and by loving herself she could love others. When asked what she enjoyed about the session she said she loved talking about school and about things she enjoyed doing.

In this session B commented that she felt more relaxed and comfortable with the researcher. B seemed to always try something even though she was unsure of what the task entailed. She was always willing and enthusiastic.

◆ Session Three

The “Safe Place/Ally Within” meditation was carried out (See Appendix 11 on page 140). After the meditation, B drew her “safe place”. Her drawing appears in Figure 4.3 on page 69.

The Child’s Process: B chose the happy and the worried face and commented that she was worried because the doctors had started a new dose of chemotherapy and she had been put back on the drip. This made her sick, and she was unable to eat.

B found it difficult to close her eyes initially to do the meditation. After the breathing and relaxation exercises B was able to close her eyes. B appeared to respond well to the meditation. She seemed more relaxed. The researcher discussed with B how she could take the vision she had of her safe place and use it whenever she needed. Her image was of a house with a garden and a swimming pool. B noted that it wasn't anywhere she had been to before but it was somewhere she would like to be, because it was so beautiful and so quiet.

Affirmation message: "I am powerful and loving". B described its relevance to her life. B described herself as being powerful, which helped her to feel like she could do anything and loving helped her to think about how much she loves her family and her friends and how they love her.

◆ Session Four

Another meditation was done called the "Healing Cells" (see Appendix 12 on page 141). The personal collage was then completed.

The Child's Process: The neutral face was chosen. B noted that she did not feel happy or sad. During the meditation she thought about her illness getting smaller and going away. This gave her a good feeling. After completing the collage exercise, the researcher continued to work with the images B had chosen and discussed their personal meanings. Her collage can be seen in Figure 4.4 on page 69.

The symbols chosen for the present time included: *teddy bear*: it made her feel better while in hospital; a *smiling face*: she liked to feel happy and to smile; a *man resting on a hammock*: he looked relaxed and she wanted to feel like him; a *drum*: she liked the music it made; two *religious pictures*: church was very important to her and she loved going to church. She also knew she was being protected; *two people with a heart*: it meant love and this was also very important to her; *foods*, she liked these; *hospital pictures*: these were all about her life at present. A *butterfly*: it reminded her of being free and being able to be outside and fly where one wanted to. B was asked to think of herself as a butterfly, flying wherever she wanted to be. She was asked where she would like to go to if she could go anywhere and she said she just wanted to go home.

The side of the future and her future dreams included the following: *hospital and doctor*: she wanted to be a doctor when she left school, “to help children like me”; *aeroplane*: she wanted to go in one some day; *hot air balloons*: they are interesting and she thought it would be fun to go up into the sky with one; *ocean and the beach*: she wants to go there when she was better.

B and the researcher discussed in detail the meaning of the symbols and the impact of the future on the present, the importance of the here and now moment. B could see the things she really wanted would come true in the future. She said that one thing that was already happening was that she was going home in the next few days.

Affirmation message: “I never give up”. Discussing the personal meaning of this message in her life at the present moment was highlighted. This also involved describing how the message could be used in her present life. B said she would never give up her fight against the cancer.

◆ Session Five

B was made aware of her surroundings, by focusing on the sounds, the smells and the textures around her. B was then guided through the process of building the cancer out of play dough

The Child’s Process: B chose the happy face. B initially described this task of building the cancer as difficult. However she wanted to go on with the exercise. B explored the clay and by making it into various forms. She played with the play dough for a while. After some time had passed she made it into a round ball, about the size of a golf ball illustrated in Figure 4.5 on page 69. She described it as being a round growth that had been growing in her leg. The researcher led B through the ritual of “taking the cancer out of her body” and “destroying it”, and leaving it formless and without any means of hurting her any more. After this experience B said that she felt better now that “the cancer was now gone”.

In Table 4.2, B’s Incomplete Sentences are presented. (A copy of the incomplete sentences can be found in Appendix 10 on page 139). Some of her responses included the following:

Table 4.2. Case Study B: Incomplete sentences

<ul style="list-style-type: none"> ▪ The people I like best <i>are my friends.</i> ▪ Most of my friends don't know that I am afraid of <i>them seeing me with my cutted leg.</i> ▪ I wish that I could lose the fear of <i>my cutted leg.</i> ▪ Something I don't like to think about is <i>the last/past things.</i> ▪ When I am older <i>I want to be a doctor.</i> ▪ My favourite place to be is <i>school and church.</i> 	<ul style="list-style-type: none"> ▪ I like to be alone <i>when I pray.</i> ▪ Someday I would like to <i>tell my friends about my leg.</i> ▪ Something that really bothers me <i>is what will happen when I am sick</i> ▪ Sometimes I am <i>scared of what's going to happen.</i> ▪ Three wishes: <i>I could be better; I could be a doctor one day; people liked me.</i> ▪ When I need to talk with someone I <i>like to talk to Mama Brenda (a sister in the ward).</i>
---	---

The incomplete sentences present a beginning of a sentence and provide a child with an unlimited variety of responses that describe what remains on his foreground. It can be hypothesized that the above responses reflect the nature of B's anxieties. Naturally having lost her leg is a major source of distress for B. Other concerns included the outcome of her future, and what would happen with her illness in the future.

◆ Session Six

In this final session, B completed her mandala painting. The mandala was symbolic of completion of a process. Thereafter a discussion of the "safe place" that was done in session three was refocused on. This was done to remind B that she could always feel safe and protected no matter where she was. Finally the termination interview was completed.

The Child's Process: B chose the very happy face. She was going home during that next week. B's painting of her mandala was carefully planned. She called her painting "Nice Flower". It appears in Figure 4.6 on page 69. When asked to become the flower and describe herself as the flower she said: "I look nice. I like the colour red. Black and red are around me. Red is like the blood around me; black is like the night. I feel proud of the flower. I feel so happy to be a flower".

B's responses to termination interview were as follows: (A copy appears in Appendix 13 on page 142).

"The play therapy helped me to feel happy. The things that I did were lots of fun. I learnt that I loved to paint and I liked the stories (meditations). They helped me to feel calm and relaxed. I think that the play therapy would help other children to feel happy and to have a bit of fun. I think that the play therapy helped me to feel better and I would have liked to have done more of it. When I first came to the hospital I was very anxious and very worried, but people like some of the doctors and Mama Brenda (a sister in the ward) helped me to

feel better. Some things that worry me now is that when I go home I am worrying about how my friends will be with me because they still don't know what I have been going through with the cancer and losing my leg. What would help me to feel better now is just to go back home, be with my family and go back to school. I enjoyed the time I spent with the researcher, and I felt really special to do the work with you.

After working with some of her fears B said that she thinks that maybe she doesn't need to be scared about her friends because they love her and they wouldn't make her feel bad. The researcher thought that this awareness carried a very relevant meaning for B at the present time in her life, specifically as she was going home in the next few days.

Conclusion of, B's (Case 1) Gestalt Play Therapy Process:

The following are suggested as possible conclusions by the researcher based on B's Gestalt play therapy process: B has experienced much stress in her present life. She not only endured being diagnosed with a life threatening illness, but also had to go through the harsh reality of losing her leg. Some of the feelings she has experienced included: angry, sad, worried, bored, lonely and happy. Her anxieties have revolved around coping with her illness, having lost her leg, and how people, specifically her friends would react when they were to see her again. Such anxiety has remained with her at the conclusion of the play therapy sessions. Through Gestalt play B was provided with the means to express some of her feelings. B described the play therapy process as being a good experience. B has a positive outlook for the future.

4.2.2 Case Study 2

The second child will be referred to as M to ensure the anonymity of the child and his family.

4.2.2.1 Background Information

M is a nine-year-old boy. He is Portuguese and English speaking and initially comes from Angola. He lives with his father. M's biological mother left M and his father when M was three years old. M has no contact with her. M is in Grade two. M's diagnosis is a B-cell Lymphoma with HIV. B-cell lymphoma is a type of cancer that forms in the B cells, which is a type of the immune system cell. Treatment involves chemotherapy with or without concurrent radiation. (National Cancer Institute, [sa]). HIV is T-cell leukaemia/lymphoma virus. HIV is a retrovirus that primarily infects vital organs of the human immune system and thus causes damage to the immune system. Patients with HIV infection have an increased risk of attaining other malignant cancers (Wikipedia, 2007). M also had

Tuberculosis (TB) a number of years back, which he was cured of. TB is an infectious disease caused by bacteria. It most commonly affects the lungs (MedicineNet.com, 2007).

M was admitted to the hospital in May 2006. The study commenced in July 2006. At the commencement of the study M had not been told that he had cancer. When asked what was wrong with him in the interview, M said he had TB and HIV. M said that he knew his father did not want him to know what was wrong with him but he knew because he “hears the doctors when they talk”. Subsequently during the course of the study, M’s father was counselled in letting M know about his true diagnosis, which he later did.

4.2.2.2 Responses of M’s Parent/Guardian to Interview

The following are the responses of M’s father to the interview conducted with him at the commencement of the study.

My child was hospitalized previously in 2002. A growth was removed from his face. I told him, when he had to go to hospital. He knew about going three days before he went. M was not prepared for hospitalization. He was not happy about going. He cried a lot. He has been here for two months and two weeks. The areas that describe M’s emotional state during his stay in hospital are mostly anxious and angry. He doesn’t show how he feels. M is very quiet. Sometimes I don’t know how he is feeling. What is difficult for him is mostly being away from home and from his friends. The behaviours M has shown during hospitalization are changes in appetite; depressive behaviour/excessive sadness; and restlessness. The procedures that M has undergone since his admission are injections, anaesthetic, chemotherapy, and surgery. M does not know the exact reason why he is in hospital or about his diagnosis. M’s current level of anxiety (where 1 is not at all anxious and 10 is very anxious) is a 6.

4.2.2.3 Responses of M to Interview

The following are the responses of M to the interview conducted with him at the commencement of the study:

I was in hospital when I had an operation to remove a growth on my face (2002). I knew I was coming to hospital. I felt scared. Now I feel a little bit happy; a little bit scared; before I sleep I pray. I think I have to stay for a long time. I know what is wrong with me; I have TB and I am HIV positive. My dad speaks to me about what is going on. My dad visits me whenever he can, but he doesn’t stay with me. When he leaves I sometimes feel a bit sad, and sometimes I feel a little bit cross.

The following are the feelings M experienced during his hospitalization: angry (that he became sick); very tired (the sickness made him very tired); shy (when he had to meet new people); sad (when his dad had to leave); scared (when his dad did not come); lonely (when no one came to visit); sick (sometimes); anxious (about his illness); happy (when his dad came); bored (when there was nothing to do).

4.2.2.4 How I Feel in Hospital Questionnaire

The responses to the questionnaire are presented in Table 4.3. Only the responses that are essentially characterized by anxiety or emotional distress will be indicated.

Table 4.3. Case Study M - How I feel in hospital Questionnaire

<ul style="list-style-type: none">▪ I can <i>often</i> talk to people about my illness.▪ I <i>sometimes</i> worry that I might not get better.▪ At night I <i>sometimes</i> have bad dreams▪ At night it is <i>sometimes</i> difficult to fall asleep.▪ In hospital I <i>sometimes</i> worry a lot.▪ I <i>sometimes</i> feel scared.▪ My hands <i>sometimes</i> feel sweaty or cold.▪ I <i>sometimes</i> have trouble asking other children to play with me.▪ If I get upset or scared I <i>often</i> can tell someone right away.▪ I <i>sometimes</i> find it difficult to eat in hospital.▪ My three wishes: I would be better; could be a doctor one day; people liked me	<ul style="list-style-type: none">▪ I <i>sometimes</i> worry about my illness.▪ I <i>often</i> get scared when my dad goes away.▪ Hospital is <i>often</i> a scary place.▪ I <i>sometimes</i> feel tense or uptight.▪ The treatment I am getting <i>often</i> makes me anxious.▪ I <i>sometimes</i> can't relax when I am in hospital.▪ I <i>often</i> feel shy when I meet new people.▪ I <i>sometimes</i> worry about what other people think of me.▪ <i>Sometimes</i> I am afraid that other kids will make fun of me.▪ I <i>sometimes</i> find it hard to make new friends.
--	--

Discussion: The nature of M's anxieties can to some extent be exemplified in his responses to some of the questions. M was facing a number of complex, confusing and anxiety provoking experiences. It could be hypothesized that M's main concerns included the following: not recovering from his illness; being in hospital; his father's absence; his treatment; and being ridiculed by others. Some similarities can be found between B's and M's responses. Some of these include a general anxiety about their illness, being ridiculed by others, and being alone in hospital. It could be suggested that for M, being in hospital and having a life-threatening illness was a scary experience.

4.2.2.5 Play Therapy Sessions

◆ Session One

A free drawing and a diagnostic drawing were completed in the session. Thereafter, a sensory awareness exercise exploring hearing and vision was carried out.

The Child's Process: M chose the happy face. He said he was happy because his dad had been to visit. M was very quiet at the beginning of the session. As the session progressed he seemed to have become more relaxed. In a later session, when asked about the first session M said that he had felt a bit shy as he didn't know the researcher, and was anxious that he might be asked questions that were difficult to answer.

M's first free drawing was a picture of a birthday cake with icing and candles. See Figure 4.7 On page 79. He called it "cake". This was on his foreground as one of the children in the ward had just had a birthday and they all had cake. M wanted to do another drawing. He drew a picture of himself with his father (Figure 4.8). M said he loved his father. He wished his father could stay with him more often.

After the free drawings, the researcher did the sensory awareness work with M. He was asked to become aware of the room he was in and to notice all the things he could see and hear. He was then asked to specifically notice the colours and shapes and the specific sounds. After the first session, the therapeutic relationship had already begun to take a more secure form.

The Diagnosis Drawing (Figure 4.9 on page 79) suggested that M appeared to have some understanding of his diagnosis. It seemed that in some areas of his understanding he was aware and understood his diagnosis, whereas in other areas, he had a lesser understanding. He marked the following areas in his diagnosis drawing: His nose as sometimes bled; his mouth and neck, there was a growth at the side of his neck that the doctors had removed; his stomach, when he ate he had to go to the toilet.

At the time of the drawing, M did not know that he had cancer. In describing his experience of the session, M said that the drawing made him feel happy. He liked to draw as it made him feel better. While he was drawing he was thinking of nothing specific, he was just drawing. He did not find anything difficult about the session and he just enjoyed the drawing.

◆ Session Two

M was then given a drawing to do of anything or anywhere that made him safe and happy. Thereafter the "All About Me Questionnaire" was completed, in order to get to know M better. The details of the questionnaire will not be discussed as most of the content is provided in the child's interview. M also completed a mandala drawing.

The Child's Process: In session two M chose the angry, sad, and worried faces. He had been shouted at by a nurse for something he said he had not done. M noted that he hated fighting with people. M was also very anxious, as his dad had not been to visit him. He

described how his dad would sometimes fight a lot and on one occasion had been to jail. After he had shared these thoughts and feelings, he called his dad to put him at ease. A discussion followed about what he could do when he was worried as he was. As M was so agitated when the researcher started the session, she decided to assist him to calm down by allowing him to draw something that made him feel safe and happy. He drew a picture of a garden (Figure 4.10 on page 79). When asked to give his picture a name M called it “a garden”. M said he loved being outside and playing with his friends. He had a garden at home and he loved to be there.

At the end of the session, M asked if he could do another drawing. M was invited to do a mandala drawing/painting. Doing a mandala drawing or painting is known to be a very calming experience. M’s body language suggested that he was feeling calmer whilst he was drawing his mandala. His drawing appears in Figure 4.11 on page 79. At the end of the drawing he said he liked drawing in “a round ball”. He called his picture “a ball”.

M was not very happy at the beginning of the session. The session focused on allowing him to experience his feelings but also to help him find ways to feel stronger and better about himself. M was a very responsive child. He appeared to be much calmer and more grounded at the end of the session. He commented at the end of the session that he was feeling much better. The play therapy appeared to be a self-empowering process for M. He said he wasn’t feeling angry anymore.

◆ Session Three

The Safe Place/Ally Within meditation was carried out. Thereafter, M drew his safe place. A discussion was then carried out that led M into using his safe place whenever he needed.

The Child’s Process: M was not feeling well in this session. He said he felt sick and missed his dad. However, he asked to carry on with the session. As M was working he began experiencing severe pain. He had a hemorrhage. It took a while to get him back to bed. The researcher stayed with him throughout, as he had asked her to stay. Once he

WORK FROM CASE STUDY 3: M

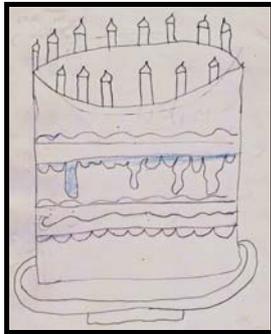


Figure 4.7. Free Drawing 1:
"Cake"

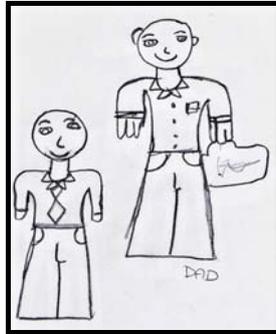


Figure 4.8. Free Drawing 2:
M and Father

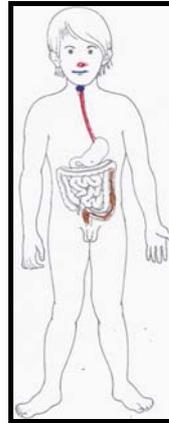


Figure 4.9
Diagnosis Drawing



Figure 4.10. Safe Place:
"A Garden"



Figure 4.11. Mandala 1
"A Ball"

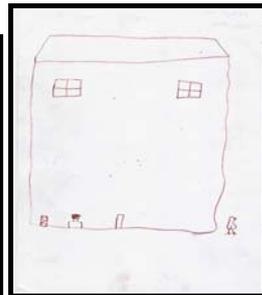


Figure 4.12. Safe Place 2:
"Berea Family House"



Figure 4.13. Collage:
1. "food things and baby cute, and TV stuff"
2. "going to the beach, and feeling better and a pet to play with"

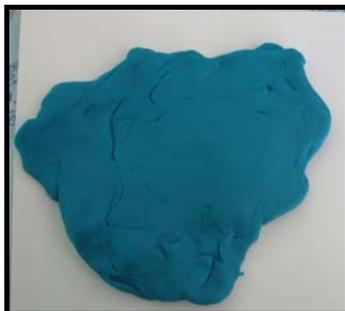


Figure 4.14. Cancer out of
Play Dough



Figure 4.15. Drawing of
Illness: "Blood TB"



Figure 4.16. Mandala 2:
"A Happy Face"

was sure his dad was on his way he managed to get back to bed. He still wanted the researcher to stay with him. She read him a meditation to help him to calm down. The researcher did a relaxation exercise and then the “safe place” meditation with him.

M gradually quietened down and relaxed. He slowly closed his eyes as he listened to the meditation. As he relaxed the researcher could see that M's whole body was no longer tense. When the researcher told M he could open his eyes, at the end of the meditation, he said he felt as though he had just had a very deep sleep. He could not believe how far he had gone and then how clearly he could see his safe place. He said his safe place was in Berea, and it was the flat where he lived. He felt safe there because it was “home”. He could go outside and play in the garden with his friends. He also noted that he missed home and wished he were going there soon. His drawing of his safe place is shown in Figure 4.12 on page 79. M was led through the process of using his safe place whenever he needed by just seeing it in his mind.

◆ Session Four

In this session the Scribble Drawing was completed. The collage exercise was then conducted wherein M was to choose pictures to describe his life in the present and his life in the future.

The Child's Process: M presented as upset and very irritable. He had had an argument with two other boys in the ward who had accused him of breaking a radio. He cried for a while and mentioned that things were going bad at the hospital and at home. M and the researcher talked for some time until M felt calmer. He then wanted to go on and do something different. The researcher did the “scribble” exercise with him. This is how he described his symbols: *a square*: as it reminded him of the shape; *a river*, the color reminded him of one”; *a pattern*” as his shoes have the Nike pattern on them”; *a pipe*, *his dad* smoked one; *a stick*, it just looked like one.

After this exercise, M said he felt a lot better, and wanted to go on. The researcher then introduced the “collage” exercise to him. This is his experience of the collage (this is illustrated in Figure 4.13 on page 79). On the “present” side M chose the following symbols: *Scull*: when his head is sore, his brain is hot and feeling sick, it feels like his head is cracking. He can't put his head up, he must go to sleep; *cat*: he wants “to have a pet to play

with”; *robot*: “ when he crosses the road he must know the colours; swimming *pool*: he wants to swim. He wants to just lie on the water”; *flowers*: his favourite flower is the rose. When someone wants something special he can give him a flower – with many colours. He said he has lots of flowers at home; *train*: when he goes to visit his family at home (in Angola) he goes by train; *hamburgers*: he loves them; *the world*: he wants to go all over the world; *radio*: he likes to rock and roll”; *child on the beach*: he can go and swim and have fun, make castles and eat the food there; *baby in crib*: he thinks “its cute, cries and laughs, and smiles; *food things*: what he likes to eat; *baby with mom and dad*: reminded him of when he was a baby and he had a mother and a father. M also described how his mom left him and his dad when he was three years

M did not want to talk any further about his mom and how he felt. He went back to the picture he had made. M called the present side of his picture “food things and baby cute, and TV stuff and headaches and families”. The future he called “going to the beach, and feeling better and a pet to play with”.

The researcher focussed on the “future” side of the collage and helped M to focus on what he can look forward to in the future. He said he made a decision to pay for the radio because that would be the best thing. His affirmation message was “ I always speak up for myself”. M said he could always say how he feels and if he is scared, likes or doesn't like something he can tell his dad.

◆ Session Five

The Healing Cells meditation was conducted to help M feel stronger than his illness. Then M built his illness out of play dough. He then asked if he could do a drawing of his TB.

The Child's Process: M appeared to be very withdrawn and subdued. He chose the sad face to describe how he was feeling. He said that his dad had told him about the cancer and it was worrying him a bit. M was asked to share those things that he was afraid of or was worried about. He said he was afraid that he will get very sick and he might die. The meaning of the experience and what could be done to help him to feel better were further discussed. M wanted to go on with the session's activities. The researcher began with the “healing cells” meditation. The researcher did a deep relaxation exercise with M prior to the meditation. Then, the whole process of how his body was fighting all the foreign beings in

his body was discussed and worked through in detail with M. Thereafter, the “build the illness out of clay” was introduced.

Before M had the tumour in his neck it was a yellow ball. He rolled out a shape of a ball. He then shaped the blue clay into a flatter piece and placed it on the side of his face. M said that this was his face when it was that big. He moulded the side of his face with the clay, and then commented, “this was part of my face” (this is illustrated in Figure 4.14 on page 79). The ritual of destroying the cancer and making it into a formless structure followed. After this, M asked if he could draw. He said he wanted to do a drawing of his “TB” see Figure 4.15 on page 79). He said: “The red is the TB that I think is still inside my body”. M was led through a visualization process of seeing his illness outside of his body and no longer being inside of his body.

Affirmation message: “I am powerful and loving”. With his affirmation M said that being powerful made him feel like a giant and he could do whatever made him happy. Being loving meant that he loves other people and people like his dad love him.

◆ Session 6

This was the last session of the play therapy process. M painted another mandala. Thereafter he completed the incomplete sentences and the final interview.

The Child’s Process: M chose the happy face. However he said he felt a little sad that it was his last session with the researcher.

The whole experience of the mandala, and how it signified wholeness and completeness was re-introduced to M. He decided he wanted to paint this time. His painting appears in Figure 4.16 on page 79. He called his painting “a happy face”. He said it was about how happy he felt because everyone was so nice to him and he was happy that he might go home soon. M’s incomplete sentences are presented in Table 4.4.

Table 4.4. Case Study - 2M Incomplete Sentences.

<ul style="list-style-type: none"> ▪ If I were the king <i>I wanna make the world safe</i> ▪ Something I don't like to think about is <i>things that make me angry, sad, when people fight with me</i> ▪ Being in hospital is <i>so bad and not nice</i> ▪ What I miss the most from home is <i>my dad, my friends</i> ▪ Sometimes I dream about <i>my dad staying with me here in hospital, having MacDonalds</i> ▪ When I had to go to hospital I felt <i>sad, I thought and felt bad that I left my family and friends at home</i> ▪ I feel very sad when <i>nobody came to visit me</i> ▪ When I am scared <i>I try to go to sleep</i> ▪ When children stay in hospital they feel <i>bad and sad</i> ▪ The most difficult thing about being in hospital is <i>when they inject you, give you lots of medicine</i> ▪ <i>My three wishes: watching wrestling every day; were fighting in wrestling; to be strong</i> 	<ul style="list-style-type: none"> ▪ Doctors make me feel <i>better and healthy</i> ▪ My favourite place to be is <i>Yeoville in Berea</i> ▪ When I need to talk to someone I talk to <i>my dad, my friends</i> ▪ Taking my medicine <i>makes me healthier and better</i> ▪ I am very good at <i>soccer, painting and writing</i> ▪ I get anxious when <i>my dad has to leave</i> ▪ I don't like to be alone when <i>its at night</i> ▪ When it is time to go to theatre I <i>feel scared and bad</i> ▪ Right now I feel <i>sad</i> ▪ What I miss about school is <i>my friends, learning interesting things</i> ▪ I worry a lot about <i>my dad, my family, my uncle and my granny</i>
---	--

From the above responses the following hypotheses can be made; M was anxious about his illness and about being in hospital; he was worried about being away from home; he missed his father; he missed being away from school and being with his friends; and he was concerned about his family. These can only be causing M much stress. Intervention measures to help him cope better is critical for maintaining his quality of life. Such intervention should essentially be ongoing throughout the course of his illness and treatment process.

M's responses to the final interview were as follows:

The play therapy made me feel better than before. It helped me to forget about my illness, things that are going on with me. What I learnt from play therapy was that it reminded me of how much I love to draw. I enjoyed learning things I never knew. I think play therapy will help other children to feel a little bit better. Sometimes the hospital makes me feel anxious; especially in the beginning I felt scared and worried when my dad had to leave. It is so bad to be in hospital. But the doctors helped me to get better. I think if I could have the play therapy more often it might help me to feel better. Play therapy helped me to feel better because it helped me forget about stuff for a while; I liked those stories that took me far away. What I still worry about now while I am in hospital is that I worry if I will die. I worry that my dad won't come. What would help me to feel better is if my dad could stay; if I could go back home. What I want to say to you is thank you for coming to see me. I liked it when you came because it gets so boring here with nothing to do. We did fun things together. I felt good inside when we did some things together.

Conclusion of, M's (Case 2) Play Therapy Process:

M was struggling with a number of stressful experiences. He had two life threatening illnesses and at times he found it difficult to not have his mother in his life. The sessions seemed to bring M some peace. He found it easier to express himself through alternate media than with words. He constantly mentioned how doing play therapy helped him not to feel so bored, and to feel much happier. His common feelings that he experienced during his illness included angry, tired, worried, lonely, scared, bored and shy. He was much more anxious and shy at the first session. When he saw that there was nothing stressful or difficult about the sessions he was greatly relieved. His strongest anxieties involved his dad leaving him, worries about his illnesses, being ridiculed by others. For him hospital and being ill was an unpleasant experience. He still missed his mother, and his family and friends.

4.2.3 Case Study 3

The third child will be referred to as L to ensure the anonymity of the child and his family.

4.2.3.1 Background Information

L is an eleven-year-old boy. He lives with his mother. L speaks Sotho and English. He is presently in Grade 6. In November 2005, L fell off his bike, and injured his leg. His leg did not heal. Further tests were done and a growth was found. He was diagnosed with Osteosarcoma. He was admitted at the hospital in January 2006. His leg was amputated in May 2006. The study commenced in May 2006 just before L lost his leg.

4.2.3.2 Responses of L's Parent/Guardian to Interview

The interview was conducted with L's mother. The following are the responses of L's mother to the interview conducted with her at the commencement of the study. It took place after L lost his leg.

My child has not been in hospital before this. His first time was in January when he injured his leg. My child is very sad and gets very anxious when I have to leave him. L knew within the last 12 hours before his admission that he had to go to hospital. It was the doctor who told him the he had to go. L was not prepared for the hospitalization. When he was told he was stressed, very sad, very scared and anxious. L has been in hospital for four months now. Emotionally he has been anxious; frightened; sad; confused; angry; withdrawn; he doesn't show how he feels. While he has been here he sometimes cries when I have to leave him; he keeps quiet (withdrawn), and is unable to speak about his feelings; he has shown depressive behaviour/excessive sadness – he could not believe he had lost his leg; he has sometimes verbally expressed fear; sometimes has nightmares; often has insomnia; difficulty eating. What has been the most difficult for L since his hospitalization has been

being away from home; losing his leg; injections; intravenous medication; staying in bed; physical pain resulting from illness; eating different food; being with strangers (sometimes); being away from his friends. He has had the following procedures: Injections; anaesthetic; surgery; chemotherapy. My child's current level of anxiety is about a 5.

4.2.3.3 Responses of L to Interview

The following are the responses of L to the interview conducted with him at the end of the study:

I have never been in hospital before this time. I knew I was going to hospital when I felt sick. I felt all right before I had to go to hospital. Now I feel sad. I want to go home. I have to stay for a long time. I know what is wrong with me. I have cancer. People, like my parents, doctors or nurses talk to me about what is going on with me. My mom is able to visit with me often while I am in hospital. My mom is allowed to stay with me at night but sometimes she can't because she has to work. When my mom leaves I feel very sad.

The feelings L experienced during his illness were as follows: exhausted (sometimes, especially before the operation); shy (often); sad (often); scared (only about his operation - now he knew things would get better); lonely (often); sick (sometimes); worried/anxious (often); happy (a little); relaxed (sometimes); bored (often).

4.2.3.4 "How I Feel in Hospital Questionnaire"

L's responses to the questionnaire are presented in Table 4.5. Only the responses that are essentially characterized by anxiety or emotional distress will be indicated.

Table 4.5. Case Study L - How I feel in hospital questionnaire.

<ul style="list-style-type: none"> ▪ I can <i>sometimes</i> talk to people about my illness ▪ I <i>often</i> worry about my illness. ▪ I sometimes worry about other people laughing at me ▪ I very often get scared when my parents go away ▪ At night I sometimes have bad dreams/nightmares ▪ I sometimes feel different to other children ▪ Sometimes I'm afraid that other kids will make fun of me ▪ At night it is sometimes difficult to fall asleep ▪ I sometimes feel tense or uptight ▪ I often find it difficult to eat when I am in hospital 	<ul style="list-style-type: none"> ▪ I very often can't relax when I am in hospital ▪ If I get upset/scared I can <i>sometimes</i> can tell someone ▪ I often feel scared ▪ I sometimes feel shy when I meet new people ▪ My hands sometimes feel sweaty or cold ▪ My treatment sometimes makes me anxious ▪ Hospital is sometimes a scary place. ▪ I sometimes find it hard to make new friends. ▪ In hospital I often worry a lot ▪ I sometimes worry about what other people think of me
---	---

Discussion: The intensity of L's stressful reality is described clearly in his responses to the questionnaire. His responses illustrate some of the anxieties and concerns that were on his foreground. These include: being worried about his illness; concern about his family leaving him; wondering how other people will react when they know that he lost his leg. Being in hospital for L was a scary and stressful experience.

4.2.3.5 Play Therapy Sessions

◆ Session One

The sensory awareness exercise was completed. L became aware of his surroundings by noticing the ward, the colours and shapes visible and the prominent sounds. Thereafter L completed the diagnostic and free drawings.

The Child's Process: L was very quiet. He appeared to be withdrawn. He chose the tired face. This session took place the week before he was to have surgery. It was understandable that he should seem so pensive. It was a very difficult time for him. L said he just did not want any more pain and so he knew he had to have the surgery so that the pain would go away. L wanted to go on with the tasks planned. It took him some time to decide what to draw. His drawing was of a boy who was in hospital, illustrated in Figure 4.17 on page 88. He couldn't give his picture a name.

After the free drawing, L did the diagnostic drawing (Figure 4.18 on Page 88). L's diagnostic drawing indicates that he had some understanding of his diagnosis. L struggled with the sensory awareness exercise.

◆ Session Two

A sensory awareness exercise was done that focused on touch, smell and taste. The "All About Me Questionnaire" was completed. The details of the questionnaire will not be discussed as most of the content is provided in the child's interview.

The Child's Process: This session took place two weeks after L had the surgery and had lost his leg. He was withdrawn and very quiet. He experienced some difficulty talking about what was on his mind. He did say that he was a bit glad now because he did not feel the pain he felt before. The researcher introduced the "All About Me Questionnaire". In order to help him connect a bit with his environment and with himself the sensory awareness exercise was completed. L commented how he enjoyed doing something different. After the two tasks were completed, L said he felt tired, so the session was terminated.

Session Three

The session took place three weeks after L had had his surgery. He was provided with space to talk about what he was feeling. The Safe Place meditation was presented to L.

The Child's Process: L chose the happy face. L said he was feeling much better. He admired B (case study 1), the child who had lost her leg and was recovering well. L commented that she helped him to think he would also be okay. Some discussion was carried out about some of the above issues. The researcher then continued with the Safe Place meditation. L could not do the meditation with his eyes closed. He did seem to be following the meditation. Afterwards, L said he felt okay. He said he enjoyed listening to the meditation. He was too tired to draw. He described his safe place. He said it was by the sea. He felt safe there. L was shown how he could always go to his safe place no matter where he was, and he could have the same feeling of being safe and protected.

Affirmation message: "I always choose what is best for me". L was asked how he could make this a part of his life and he said he chose to do whatever he thought was best for him.

◆ Session Four

The Healing Cells meditation and collage were completed in this session. Another meditation, the healing cells meditation was carried out with L. L then completed the collage exercise.

The Child's Process: The happy face was chosen. L chose the happy face. He said he was feeling okay. The researcher carried on with the Meditation/ Creative Visualisation: Healing Cells exercise. L was led through a deep relaxation exercise prior to the meditation. L did the meditation with his eyes open. When the meditation was over, L noted how he felt relaxed and calm inside.

Thereafter, after making sure that L was able to do more work he completed the personal collage exercise (illustrated in Figure 4.19 on page 88). L battled a little to describe his pictures. It can be seen how images were rich with meaning and significance.

WORK FROM CASE STUDY 3: L

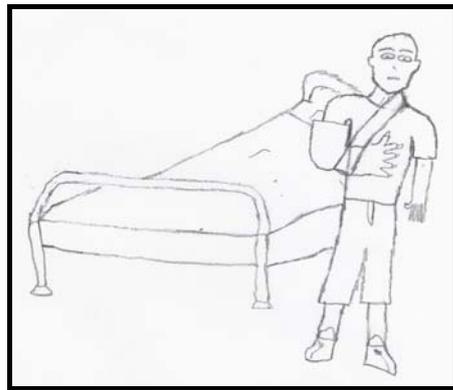


Figure 4.17. Free Drawing

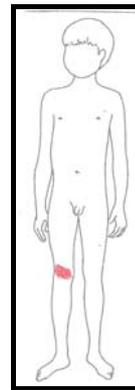


Figure 4.18.
Diagnostic Drawing



Figure 4.19. Collage



Figure 4.20.
Cancer out of clay 1



Figure 4.21.
Cancer out of clay 2

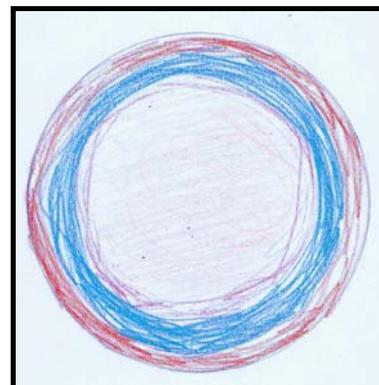


Figure 4.22 .Mandala

On the side for the present L had the following symbols: *injection*: he had these often; *dynamite*: sometimes he felt scared that things might explode, like when his mom would leave him he feels he might explode, or when he felt pain inside it felt like his body might explode; *duck*: they are so sweet and so calm when they float on the water; *eagle*: its free and can go anywhere whenever it wants; *person being wheeled in a bed*: reminded him of himself; *two doves*: he liked the church and he knew people were praying for him and this was helping him to get better.

On the opposite side depicting the future and what he would like it to be like he chose the following to symbolize his feelings: *a beach*: he liked the sea and he always felt happy when he was there; *crutches*: he had to learn to walk with crutches; *books*: are about school and learning which he wanted to go back to when he was better; *music*: is something he wanted to do; *teddy bear*: meant something he wanted to be; *a shark*: he liked them because they are so strong and others are scared of it; *man at the bottom of a ladder*: he felt like that man, that he was going somewhere but he doesn't know yet where that was yet.

Affirmation message: "I achieve whatever I set my mind to". L thought about the future and tried to visualise some of the future visions and the meaning of his affirmation message in the present here and now.

In this session L described the s exercise of making the collage as fun and interesting. He did not really feel better or worse, maybe the same as before. He did not find anything difficult. He felt relieved that he found a few pictures because he was worried that he wouldn't find any, in the beginning. He said he learnt a bit about what he was thinking about life and how he was feeling.

◆ Session Five

The session involved the completion of the build the cancer out of play dough.

The Child's Process: L chose the happy face. He said he was feeling okay. His mom had come to stay with him for a few days. He was introduced to the play dough. He experimented with the dough, moulding it into different shapes and forming various structures. Making "the cancer" seemed to bring some hesitation. He thought for a while before he started making a form. He carefully formed his structures. He made two

structures. These are illustrated in Figures 4.20 and 4.21 (illustrated on page 88). He clearly portrays the cancer growing in his knee area and affecting the two joints in his leg. L said that was where he thought the cancer was. He then worked at “destroying the cancer” ritual. What he learnt in this session he said was how he could think about his cancer going away and it reminded him that the doctors had taken all the bad stuff out and now he could get better.

Affirmation message: “I am a winner”. He said this reminded him that he would get better, and he would win over the cancer.

◆ Session Six

The session began with a discussion of L’s safe place (done in session three). The use of his safe place whenever he needed was re-elaborated. Then the mandala drawing: symbolic of completion of a process and, Incomplete Sentences were completed prior to the final interview.

The Child’s Process: L was led through the process of what the mandala symbol signified. L completed his mandala without difficulty. He could not think of a name for his drawing. L’s incomplete sentences appear in Table 4.6. He struggled to answer some of the incomplete sentences. He said that he found these difficult to do.

Table 4.6 Case Study L - Incomplete Sentences

<ul style="list-style-type: none"> ▪ I would like to <i>be a doctor</i> ▪ What I like about my family is <i>they love me</i> ▪ The hardest decision I ever made is <i>letting them take my leg.</i> ▪ When I had to go to hospital <i>sad</i> ▪ I feel very sad when <i>people talk about my leg</i> ▪ Being in hospital is <i>bad</i> ▪ Something I don’t want to think about is <i>the past.</i> ▪ When I am older <i>I am going to get married.</i> ▪ <i>My three wishes: To go home; to have video games; for my mom to get anew job</i> 	<ul style="list-style-type: none"> ▪ My favourite place to be is <i>home</i> ▪ I like <i>watching TV</i> ▪ I am happiest when <i>I am with my mom.</i> ▪ When I need to talk to someone I talk to <i>my mom</i> ▪ Doctors <i>make me feel bad</i> ▪ I like to be alone when <i>sometimes</i> ▪ I get anxious when <i>my mom leaves.</i> ▪ My favourite animal is <i>an elephant</i> ▪ When I get better I <i>want to go back to school.</i> ▪ When children stay in hospital they feel <i>sick</i>
---	--

L’s incomplete sentences also indicate what remains to be stressful to L. His principle concerns included the following: having lost his leg; when his mom had to leave him; remaining in hospital; missing school; being away from home. The other children also experience a number of these themes. As L seemed to be finding it difficult to cope at that present time, a recommendation to the social worker for further counselling was made.

L's responses to the final interview were as follows:

The play therapy helped me to feel good inside. It helped me to not feel bad about what has happened to me. What I learnt from play therapy was that I didn't have to talk if I did not want to, I could just draw and that made me feel good inside. I enjoyed the stories the most and the drawing. What I still worry about now while I am in hospital is mostly that my mother can't be with me all the time, and I worry about my leg. It is hard to think that its gone even though I know that it had to go so I could feel better. I still feel bad about what happened to me. I think that play therapy can help other children like me.

Conclusion of, L's (Case 3) Play Therapy Process:

L had been through some major trauma. He had been diagnosed with a life threatening illness and had had to make a very difficult decision of losing his leg and getting better being without any more pain, or losing his life. His main feelings were shy, lonely, scared, anxious bored and sad and a little happy. His anxieties involved: not having his mom with him, people's reactions to his leg, and his own concerns about his experiences. L found it easier to express himself non-verbally than verbally. He found play therapy to be a positive experience.

4.2.4 Case Study 4

The fourth child will be referred to as A in order to ensure the anonymity of the child and his family.

4.2.4.1 Background Details

A is a fourteen year old boy. His home language is Tswana and English. He is presently in Grade 10. His father passed away in 2002. He lives with his mother, two sisters and a brother. He was initially admitted at a hospital in Rustenburg in November 2006. He was transferred to the Johannesburg Hospital in December 2006. He was diagnosed with Burkitt's Lymphoma. This is a form of cancer that affects a part of the immune system known as the lymphatic or lymphoid system. Treatment includes chemotherapy and radiation therapy (Online Medical Dictionary [sa]).

The parental interview was done with A's mother.

4.2.4.2 Responses of A's Parent/Guardian to Interview

The interview was conducted with A's mother. It was as follows:

My child was hospitalised in November 2006. When he was hospitalized he felt scared. He feels better now. He has difficulties in sleeping. He knew about a week before he went into

hospital. It was very sudden and he wasn't prepared. He has been here for at least three months. He was very scared to go and very worried. The most difficult things for him to accept are being away from home, intravenous and oral medication, eating different foods, medical treatments and being away from his friends. The procedures he has had include: lumbar punctures, oxygen, anaesthetics, and chemotherapy. A does not know everything about his diagnosis. This is because he is so scared of cancer and HIV that he said if he had them he would take pills to die. So I want to protect him.

4.2.4.3 Responses of A to Interview

This is my first time in hospital. I knew I was going to hospital when I got sick. Before I had to go I felt painful, scared and angry. The doctor explained to me that I have cancer and I have to get the medication. Nothing was explained to me about my hospitalization when I came. When I was here I did not expect to get the medication with the drip machine. I have to stay for about six months. I feel better now. I have blood cancer. My mom and the doctors talk to me about what is going on. My mom can stay with me when she can. When she leaves I feel so bad. What I don't like in hospital is when they take my blood, and when they put me on the drip. What I like about hospital is they help me so much and that I have met new friends.

The feelings that A had experienced included the following: angry (to be in hospital); very tired (sometimes he just felt tired); shy (never); worried/anxious (about what would happen with him); happy (when I feel better); bored (it sometimes became boring in hospital).

4.2.4.4 "How I Feel in Hospital Questionnaire"

The responses to the questionnaire are presented in Table 4.7. Only the responses that are essentially characterized by anxiety or emotional distress will be indicated.

Table 4.7 Case Study A - How I feel in Hospital Questionnaire.

<ul style="list-style-type: none"> ▪ I can <i>very often</i> talk to people about my illness. ▪ I <i>sometimes</i> worry about my illness. ▪ I am <i>often</i> nervous when the doctor comes. ▪ If I get upset I can tell someone right away (doctors and nurses). 	<ul style="list-style-type: none"> ▪ In hospital I worry a lot. ▪ At first I was <i>very</i> scared ▪ My hands <i>sometimes</i> feel sweaty ▪ Hospital is a scary place (at the beginning)
--	--

When completing the questionnaire A came across as anxious and apprehensive. He found some of the questions difficult to answer. For the questions that do not appear here A responded with *never* feeling that way. Responses suggest that A was experiencing some anxiety with the following issues: concern about his illness and being in hospital. When he was first admitted A found hospital to be a scary place. The common themes with the previous case studies can be noted.

4.2.4.5 Play Therapy Sessions

◆ Session One

Various drawings were completed. These include the diagnostic drawing and free drawing. Sensory awareness involving visual and auditory senses concluded the session.

Discussion: A chose the proud and confident feelings. He had just completed a course of chemotherapy and his mom was with him. Whilst drawing he thought about how he wanted to become an artist. Nothing was experienced as difficult. He enjoyed the drawing the most and he learnt that he could draw very well. His diagnostic drawing depicted how A's illness started under his arm (Figure 4.23 on page 95). In the free drawing he drew a house. He called it "family house" (Figure 4.24 on page 95). His drawing was very detailed and he drew for a long time. He said this was for his family, where he'd like his family to live, and where he would like to be.

Affirmation message: I love myself and I take loving care of my body. A described these words as being true in his life. About the session A commented that he felt good inside and he had enjoyed himself.

◆ Session Two

In this session, a sensory awareness experience that involved touch, smell and taste were carried out. The "All About Me" task, scribble drawing and personal symbols were completed in this session. The details of the "All About Me Questionnaire" will not be discussed as most of the content is provided in the child's interview.

Child's Process: A chose the happy face. He said he was happy because he was feeling much better than how he was feeling the last few days. He struggled with the scribble drawing, specifically in identifying symbols in his drawing. He could only locate various shapes, such as circles, rectangle, square and a number eight. A was more relaxed when he answered the questions of the questionnaire. It may be that the exercise had put him at ease. Nothing was expected of him, and he could just talk about himself. While he was working he thought about his of family, and of being at home.

◆ Session Three

A was taken through the Meditation/Creative Visualisation: The Ally Within/A Safe Place. He was asked to draw his safe place. He was then led through the process of using this image of his safe place whenever he needed, at any time or any place. This was his special place and he could go there any time he needed.

The Child's Process: The proud and confident face was chosen. A's drip had been removed for a while. A was once again very quiet. He was able to close his eyes but only briefly. His safe place was his home. He called it "my plan house" (illustrated in Figure 4.25 on page 95). Commenting on the session A said that he was reminded of his home and his family. This made him feel good.

◆ Session Four

Session four also involved a meditation (Healing Cells). Thereafter, A completed a collage of his present experiences and his future expectations.

The Child's Process: A very happy face was chosen. In this session A showed a strong interest in taking part in the session. In previous sessions he seemed somewhat hesitant to participate. A was able to close his eyes, during the meditation. His collage was titled "my life" (Figure 4.26 on page 95). On the side addressing his present experiences he chose the following: *Vegetables and fruit*: he liked to eat them; *doctor and child*: he was in hospital and the doctors treated him; *a priest*: sometimes the priest came to pray for him; *school*: he was going to school and he liked to go to do his studies; *medicine*: he was getting.

On the opposite side (depicting future expectations) he chose: *the sea*: he wanted to go there and be in a motel by the sea; *a laboratory technician*, when he is older he wanted to become a scientist; *an aeroplane*, because he wanted to fly in one; *a ship*: he wanted to travel; *grapes and apples*: when he completed his treatment he would eat this; *a priest*: he did not want to forget to go to church; *a computer*: he wanted to study; *cell phone*: because he wanted to have one; *a couple dancing*: he wanted to be a dancer. A tried to visualise the future symbols as being a part of his life in the here and now.

Affirmation message: "I never give up. The relevance of this message to A's present life was discussed. A was led through the process of attaining a deeper awareness of the meaning of this message. At the end of the session, A noted that he felt "so good" after the session and he was feeling much stronger than before. When he did the collage he said he was thinking about his life.

◆ Session Five

A explored and experimented with the play dough making various forms and shapes. A was then asked to "build his cancer out of play dough. He first imagined how his illness looked like, to visualise the colour/colours, shape, or substance etc. He then made a form out of the play dough.

The Child's Process: A chose the relaxed face. He was still off the drip so he could still go to school (hospital school). The form he made for his cancer is illustrated in Figure 4.27 on page 95. It was called "tumour" because it was like the growth that was removed under his arm. A then "destroyed the cancer". At the end of the session, A noted that he enjoyed working with the play dough. Whilst working he was thinking about his illness. What he learnt during the session was how his illness looked like, and learning how to make it go away. He said he learnt about his life and to look forward to things that were still to come.

Affirmation message: "I am very clever in my own way". A acknowledged this as being relevant in his present life by saying that he was very clever because he could do many things.

◆ Session Six

In this final session, a discussion was carried out that emphasized the use and meaning of the Safe Place. A painted a mandala and finally completed the incomplete sentences and final interview.

The Child's Process: A had a headache at the beginning of the session. However he wanted to go on with the session. A called his painting "wheel, colours". The painting reminded him of a wheel – going forward and made of the different colours of the rainbow. He was asked to become the wheel and describe himself. He said he was round and made of different colours and he could move wherever he could go. When asked where he

wanted to go he said he wanted to go home and be with his family. His painting of the mandala is shown in Figure 4.28 on page 95.

A's incomplete sentences are presented in Table 4.8.

Table 4.8. Case Study A - Incomplete Sentences

<ul style="list-style-type: none"> ▪ I don't like to be alone <i>when it is night</i> ▪ Most of my friends don't know that I am afraid of <i>my illness</i> ▪ When I had to go to hospital <i>I felt so bad</i> ▪ I feel very sad when <i>I'm going to hospital</i> ▪ I wish I could loose the fear of <i>my illness</i> ▪ When I am older <i>I will marry</i> ▪ In hospital what helps me to feel better is <i>the treatment</i> ▪ The most difficult thing about being in hospital is <i>when I remember home/I miss home</i> ▪ My three wishes: <i>to finish my studies, to be in a big house, to have a wife and kids</i> 	<ul style="list-style-type: none"> ▪ My favourite place to be is <i>home</i> ▪ I am happiest when <i>I see my family</i> ▪ Something that really bothers me <i>is my illness</i> ▪ Right now I feel <i>excited</i> ▪ When I need to talk to someone I talk to <i>my mother and the doctor</i> ▪ When they take my blood <i>I feel so scared</i> ▪ Doctors <i>help me to feel better</i> ▪ I get anxious when <i>my family doesn't phone me and I miss home</i> ▪ Other children <i>miss their homes</i> ▪ I worry a lot about <i>my illness</i> ▪ When children stay in hospital they feel <i>so bad</i>
--	---

The experience of being diagnosed with a life threatening illness such as cancer brings can bring much anxiety for a child. This has been portrayed in the previous case studies. It can also be seen in the case of A. His responses in the incomplete sentences delineate the following concerns: anxiety about his illness; being in hospital; being away from home and his family; having procedures such as blood tests.

A's responses to his final interview were as follows:

The play therapy helped me to feel better. I learnt to work with my hands, to think about my home, and to forget about my illness for a while. Other children can forget about their illness and their home, with the play therapy. So I think play therapy can help other children. The hospital makes me feel anxious, sometimes. It would be nice to have more play therapy times. What I still worry about while I am in hospital is about my illness and why I am not going home. What would help me to feel better are play therapy and when my mom can stay with me. I would also like to say thank you fro working with me. A said that he noticed a change inside of him after the play therapy, but he couldn't explain exactly what the change was.

Conclusion of, A's (Case 4) Play Therapy Process:

A experienced some apprehension at the commencement of the study. He became more comfortable when the sessions progressed. A's common feelings included anger, anxiety, boredom happy and tired. His anxieties revolved around being in hospital, being away from home and his illness. Hospital for A was a difficult experience. A noted that the play therapy helped him to be more at ease, and to feel stronger inside. Play therapy also helped him to not think about home for a while. A had a good outlook for the future.

4.2.5 Case Study 5

4.2.5.1 Background Information

S is a twelve-year-old Swazi and English-speaking boy who is presently in Grade 8. S has been diagnosed with Acute Myeloblastic Leukaemia. This is a fast, progressive malignant disease in which there are an excessive amount of immature blood-forming cells in the blood and bone marrow (MedicineNet.com, 2007). S was admitted to the Johannesburg hospital in December 2006 and had thus been in hospital for two months when the study commenced. He was at two other hospitals prior to going to the Johannesburg Hospital.

4.2.5.2 Responses of S's Parent/Guardian to Interview

The following are the responses of S's mother to the interview conducted with her at the commencement of the study:

My child hasn't been hospitalized before this time. He is very quiet and just keeps to himself. I told him that he was going to hospital. S was prepared for hospitalisation. He knew that no one could help him without him going to hospital. When he was told he had to go he was seriously ill and he did not have any problems because he knew that going to hospital would help him. He has been here for two months and he still has to stay for some time. During his stay he has been anxious, confused, sad and sometimes he doesn't show what he feels. He sometimes cries when I have to leave, always feels anxious, has shown depressive behaviour and sometimes has difficulty sleeping. The most difficult things that S is experiencing are: being away from home, staying in bed, physical pain, eating different food, being with strangers and being away from his friends. The procedures S has undergone include lumbar puncture, spinal tap, injections, chemotherapy and anaesthetic. My child's current level of anxiety (where 1 is not at all anxious and 10 is very anxious) is 6.

4.2.5.3 Responses of S to Interview

I went to hospital first at Leratong and then at a hospital in Springs. Then in December I came to the Johannesburg Hospital. I didn't know that I had to go. The doctor did not tell me about going into hospital. Just before I had to go I felt bad. What I thought would happen in hospital was that I would not arrive and I would die because I was very sick. I feel better now about being in hospital. Yes I know what is wrong with me I have blood cancer. Everyone here talks to me about what is going on. My mother stays with me here whenever she can. When she leaves I feel bad. The scariest thing about being in hospital is to be away from home. What I worry about now is about cancer. I am thinking that if you have cancer it will not go away, that you will always have it. I don't like the food drip, taking my blood. What I like about hospital is that if you are sick you can get better.

Feelings experienced during his illness and hospitalization include: angry (sometimes when he feel pain somewhere); very tired (often); shy (sometimes); sad (often when his parents don't come and when he was in pain); scared (at the beginning); lonely (often, when no one

come); sick (sometimes); worried/anxious (sometimes); happy (sometimes); relaxed (sometimes); bored (often).

4.2.5.4 “How I Feel in Hospital Questionnaire”

The responses to the questionnaire are presented in Table 9. Only the responses that are essentially characterized by anxiety or emotional distress will be indicated.

Table 4.9. Case Study S - How I Feel In Hospital Questionnaire

<ul style="list-style-type: none"> ▪ I can sometimes talk to people about my illness ▪ I very often worry about my illness ▪ I sometimes worry that I might not get better ▪ I often get scared when my parents go away ▪ At night I sometimes have bad dreams ▪ I often like to keep the light on when sleep ▪ In hospital I sometimes worry a lot 	<ul style="list-style-type: none"> ▪ I often find it difficult to eat when I am in hospital ▪ If I get upset or scared I sometimes can tell someone right away ▪ I often feel shy when I meet new people ▪ I find it hard to make new friends ▪ I am sometimes afraid of the dark
--	--

S also shares similar anxieties as experienced by the other children in the study. His main concerns included: anxiety about his illness, being without his family, and being in hospital. Professionals who work with the child now acknowledge the awareness that anxiety is part of the hospitalized oncology child’s life. What has become a challenge for these professionals is to know what intervention measures can be provided to alleviate such emotional distress.

4.2.5.5 Play Therapy Sessions

◆ Session One

During the first session S was presented with the various drawing exercises that included the free drawing, and diagnostic drawing. He was also led through a sensory awareness exercise, which focused on visual and auditory senses.

The Child’s Process: S chose a relaxed face and said he was glad to have his mother with him. With the diagnostic drawing S appeared to have some understanding of his diagnosis (Figure 4.29 on page 102).

His free drawing was very detailed and carefully drawn, and he worked slowly and with much concentration. He presented as very quiet but eager to go on with the session. His

drawing was called “house” (illustrated in Figure 4.30 on page 102). He said he had drawn his house. It reminded him of home and how much he wished he could be back home.

◆ Session Two

In this session the “All About Me Questionnaire” was completed. His responses to the All About Me questions will not be presented in this context. A sensory awareness task was completed that involved touch, smell, and taste.

The Child’s Process: S chose the happy face. He had no difficulty with the “All About Me Questionnaire” was completed. S also did a sensory awareness exercise. He seemed to respond well to this. S was unable to complete any further tasks, as he felt ill after the sensory awareness so the session was terminated.

◆ Session Three

The Safe Place Meditation was carried out. After the meditation S was asked to draw his safe place and was led through the process of using this image of his safe place whenever he needed, at any time or any place.

The Child’s Process: S was able to close his eyes for the task. However at the end of the mediation S said he could not see his “safe place”. He was then asked to think about a place where he would feel safe and protected. He chose his bedroom to be his safe place, which he drew. He explained his bedroom in detail and named his drawing “my bedroom” (Figure 4.31 on page 102).

Whilst drawing he worked carefully and with great detail and appeared to be finding the drawing pleasurable and relaxing. At the end of the session, he said that the drawing helped him to feel relaxed. Whilst he was drawing he said he was thinking about when he was in his room and also when he was relaxed in his room.

Affirmation message: “Everyday in every way I am getting better and better”. S said the message was true to him because all the help he was getting was helping him to get well and he would go home soon.

◆ Session Four

The Meditation/ Creative Visualisation - Healing Cells was carried out first. Then the personal collage was completed.

The Child's Process: S seemed much better and much stronger than the previous sessions. He came across as more confident, more alert and more energetic. During the meditation S was able to close his eyes. At the beginning of the collage exercise S was worried that he would only find one picture. He was reassured that it did not matter how many pictures he found. The symbols he chose for the present included the following: *a smile*: he is happy; *pears and apples*: he likes to eat them and it gave him energy; *a horse and a bird*: are animals he likes; The future symbols included: *the sea*: it's a place he wanted to go to when he was well again; *a place with a mountain, snow and a river*: he also wants to go there in the future; *tomatoes*: he likes to eat it; *doctor*: this is what he wanted to be when he grew up, a doctor who works with children. Focusing on making the future part of the here and now was undertaken. The collage is illustrated in Figure 4.32 on page 102.

After the session S said that the play therapy made him feel good about himself. He remembered all the things he wanted to do when he gets well. He learnt to notice what was happening now and what would happen next.

Affirmation message: "I always speak up for myself". S related this with his life by stating that he would always say how he feels and tell his mom what he needs.

◆ Session Five

In this session S built the cancer out of play dough. He was initially led through a process of experiencing the play dough by noticing the texture, temperature, and the way it could be moulded into different forms. Then he was asked to visualize his illness and imagine what it looks like, what shape and colour it was. When he was ready he was to "make" his cancer with the play dough. After this he was taken through the "destroying the cancer" ritual.

The Child's Process: A happy face was chosen. His structure is illustrated in Figure 4.33 on page 102. It was called "cancer". S made a structure that demonstrated his back and said that the cancer was on his back. It sometimes gave him a lot of pain, nausea and tiredness. He also said that it was something in his bone marrow that made his blood weak.

WORK FROM CASE STUDY 5: S

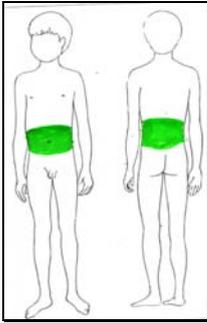


Figure 4.29.
Diagnostic Drawing

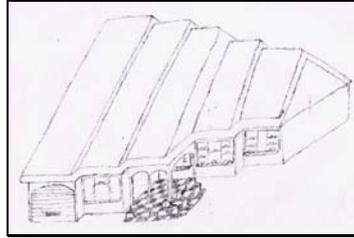


Figure 4.30. Free Drawing

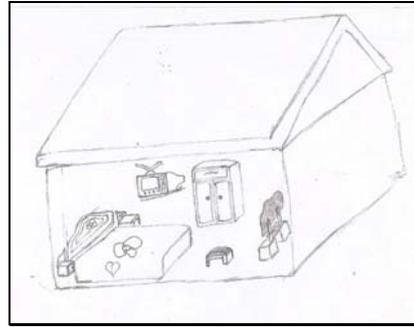


Figure 4.31. Safe Place: My Room



Figure 4.32. Collage: My Life



Figure 4.33. Cancer out of play dough

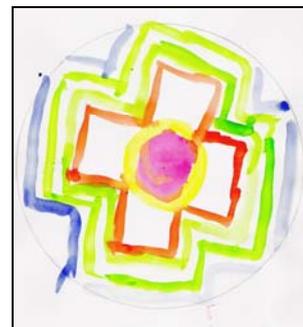


Figure 4.34. Mandala

S said that working with the play dough made him think of his illness. He learnt something about his illness. He said he felt so relieved when he broke up his “cancer”.

◆ Session Six

In this last session a discussion of the “safe place” was reviewed, in order to recapitulate on how he could use his safe place in the future. The “mandala ritual” was completed prior to the incomplete sentences and final interview.

The Child’s Process: S said he was excited to paint. He named his mandala “the twelve sided circle”. He found it difficult to describe himself as the circle. He said it was just a circle that had twelve sides. It is illustrated in Figure 4.34 on page 102. After the mandala painting, S completed the incomplete sentences and then the termination interview. S’s incomplete sentences appear below in Table 4.10.

Table 4.10. Case Study S - Incomplete Sentences

<ul style="list-style-type: none"> ▪ When I had to go to hospital <i>I felt bad</i> ▪ I feel very sad when <i>I am getting very sick</i> ▪ When I am scared <i>I am getting a very high BP</i> ▪ I hate it when <i>I am sick</i> ▪ In hospital what helps me to feel better is <i>to play</i> ▪ Doctors make me feel <i>better</i> ▪ What I miss most from home <i>is my parents</i> ▪ Something that really bothers me <i>is to fight (when people fight)</i> ▪ When I need to talk to someone I talk to my parents 	<ul style="list-style-type: none"> ▪ When they take my blood <i>I feel scared</i> ▪ I like to be alone when <i>I have a headache</i> ▪ I get very anxious when <i>I am sick</i> ▪ When children stay in hospital they feel <i>bad</i> ▪ When it is time to go to theatre <i>I feel scared</i> ▪ Right now I feel <i>better</i> ▪ Other children <i>don't like hospital</i> ▪ I am happiest when <i>I am going to Mpumalanga</i> ▪ If I had three wishes I would wish for <i>my brother, my mother and my dad to be here with me</i> ▪ I don't like to be alone <i>when I am sick</i> ▪ Being in hospital is <i>sometimes good and sometimes bad</i>
---	--

It can be seen; through the responses provided in the incomplete sentences that S also shares the same concerns and thoughts as the previous four children in the case studies. The need to go home, worry about his illness, missing his parents and family, and anxiety when medical procedures are done are all key sources of anxiety for S. He still experiences hospital as being a difficult place to be in.

S’s responses to the termination interview are described below.

The play therapy made me feel happy. I learnt to paint and draw and do other things. I noticed a change after the play therapy. I learnt a lot about how I can change things with my drawing. I think play therapy can help other children to do interesting things like drawing and painting, and listening to stories. What I still worry about now about being in hospital, is that I worry about when I am sick; about my family and that I can't see my brother and sister. What I want to say now is thank you for letting me do all these fun things with you.

Conclusion of, S's (Case 5) Play Therapy Process

S was generally a very quiet child. He was receiving some very aggressive chemotherapy during the time of the illness and as the play therapy sessions took place. He expressed a great liking for drawing and responded well with some of the projective media. His feelings about his illness and being in hospital included sad shy, lonely, anxious, happy and bored. Play therapy seemed to assist S to be able to express his feelings in a means that did not involve words, until he was ready to verbally express himself. He was anxious about being away from and his family, being in hospital, and about his illness. S said that play therapy helped him to feel happy. S said hospital was sometimes good and sometimes bad.

4.2.6 Case Study 6

The sixth child will be referred to as D to ensure the anonymity of the child and his family.

4.2.6.1 Background Details of D:

D is a thirteen-year-old boy. He speaks Northern Sotho and English. He is presently in Grade 9. D has been diagnosed with Osteosarcoma. He was admitted to the Johannesburg Hospital, in September 2005. His left leg had to be amputated at the knee area. A few months after his surgery, he got a severe infection in his right arm, caused when the intravenous treatment leaked out of the vein. When the research began in May 2006, D was about to have surgery on his arm. He was under a lot of pain and discomfort. D was very withdrawn as he was struggling with a number of difficult issues. He also had to learn to walk with his prosthetic leg.

It was difficult to complete some of the tasks planned for the sessions, as D was not feeling very well and also had to undergo further surgery on his arm, during June 2006, when the research study was running. The researcher attempted to adjust some of the tasks and used a number of the creative visualizations with D in order to provide him some support. What he was able to complete during the various sessions is presented below.

Due to the vast distance from the hospital and D's home, and the nature of D's parents' work they were unable to be with D for long periods of time. His twenty-two year old brother came to stay with D at the hospital until D was discharged. His parents gave verbal consent for the research to be carried out with D and D's brother completed the parent/guardian initial interview.

4.2.6.2 Responses of D's Parent/Guardian to Interview

The interview was carried out with D's Brother. The following are the responses of D's brother to the interview conducted with him at the commencement of the study:

My brother has not been hospitalised before. He used to have nightmares but he seems better since I came to be with him. D knew within the last week before he had to go into hospital. His father told him he had to go in. He was not prepared to go into hospital. D was very anxious when he went in. D has been here for eight months. What describes his emotional state is anxious, sad, confused and angry. Since he has been here he sometimes cried when his family left him, has been anxious, has had nightmares and insomnia. The areas that have been the most difficult for D to accept are injections; physical pain resulting from illness; eating different food. Procedures he has undergone include physiotherapy; oxygen; Injections; anaesthesia; chemotherapy; surgery. D's current level of anxiety (where 1 is not at all anxious and 10), before surgery it was 10, he is much better now, so now it is a 1.

4.2.6.3 Responses of D to Interview

I have never been in hospital before. I came here in September (2005). I did not know I was going into hospital. I felt scared when I learnt I had to go to hospital. Right now I feel that I just want to go home. I feel sad sometimes. I have been here since September (2005). I know what is wrong with me; I have cancer in my knee. My parents, doctors or nurses talk to me about what is going on with me. My mom and dad live far away (Limpopo) so they can't stay with me and can only come sometimes. My brother stays here with me. When my mom and dad come and then have to leave I feel like crying. Sometimes my brother has to leave also, and then I feel sad, and bored.

The feelings that D identified during his illness and hospitalization include the following: angry (sometimes); exhausted (often); shy (often); sad (sometimes, especially when parents had to leave); scared (often); lonely (sometimes); sick (sometimes); worried/anxious (often); happy (sometimes); relaxed (never); bored (sometimes, when his brother would leave).

4.2.6.4 "How I Feel in Hospital Questionnaire"

The responses to the questionnaire are presented in Table 4.11. Only the responses that are essentially characterized by anxiety or emotional distress will be indicated.

Responses to the questionnaire highlighted the nature of D's anxieties. D was concerned about his illness, what others would think of him, and being left alone in hospital. He shared similar stressors as the others in the study. He was still battling to come to terms with his illness and its overall impact on his life. He had begun to manifest with such symptoms as depression, withdrawal tendencies, and anxiety. The sisters in the ward provided this information.

Table 4.11. Case Study D - How I Feel In Hospital Questionnaire

<ul style="list-style-type: none"> ▪ I can <i>sometimes</i> talk to people about my illness ▪ I <i>often</i> worry about my illness. ▪ I <i>sometimes</i> worry I might not get better. ▪ In hospital I <i>sometimes</i> worry a lot ▪ At night I <i>often</i> have bad dreams/nightmares ▪ I sometimes worry that people will laugh at me ▪ I <i>sometimes</i> find it difficult to eat in hospital ▪ My hands <i>sometimes</i> feel sweaty or cold 	<ul style="list-style-type: none"> ▪ I <i>sometimes</i> feel scared. ▪ I <i>sometimes</i> can't relax when I am in hospital ▪ I <i>often</i> feel anxious when I get my treatment ▪ I am sometimes anxious when the doctor comes ▪ I <i>very often</i> get scared when my brother leaves ▪ I <i>sometimes</i> feel shy when I meet new people ▪ If I get upset or scared I <i>sometimes</i> can tell someone
--	---

◆ Session One

D chose the “happy” face. D was reluctant to do the “free drawing exercise”. After thinking for a while he decided to draw a picture of a person (Figure 4.35 on page 108). He was unable to make up a story.

Sensory awareness, focusing on sight and hearing were conducted. D was to focus on his surroundings and notice the objects and the sounds.

The Child’s Process: D appeared as very low in mood and withdrawn. He found it very difficult to communicate his feelings. However, despite feeling low he always wanted to attempt at least one task that the researcher presented to him. The researcher thought that it might be good to focus on the sensory awareness as D had been physically immobile for many months and had also had complications with his right arm. This had to be causing D a lot of frustration. Through these exercises D could renew and strengthen his awareness of his senses as it is through these modalities that one can experience one’s self and make contact with the world (Oaklander, 1988: 109). D’s free drawing is shown in Figure 4.36.

◆ Session Two

The sick face was chosen. D’s arm was very painful he could not draw or paint anything. He was willing to do the sensory awareness exercise. This focused on touch. The meditation was then completed. The “Ally Within/A Safe Place” was carried out.

The Child’s Process: With the sensory awareness, D explored the textures and forms of various objects. Going on to the meditation D was unable to close his eyes. He did not complete his drawing of his safe place. The researcher led him through the image of his safe place, which he could think of and be there in his mind whenever he needed a quiet and safe place. D also said that his safe place was home.

◆ Session Three

A mandala painting was completed.

The Child's Process: D said he felt a little better than the last session. He chose the happy face. Although the mandala exercise was scheduled for the sixth session, the researcher decided to let D complete a mandala painting, as she felt this may help to ease his distress and bring some sense of calmness and wholeness to him. D wanted to paint. His painting is illustrated in Figure 4.38 on page 108.

D's painting was slow and very careful. After this exercise D said he felt very tired.

Affirmation message: "I am glad I am me". He said he was glad to be who he was. He was just feeling so sick and had so much pain. He wanted it all to be over. D had not been very well during this session and the previous one, yet he was willing to do at least some of the tasks presented to him.

◆ Session Four

This session entailed: The feeling faces and collage.

The Child's Process: A happy face was chosen. D was a bit anxious about performing the collage. He was reassured that the researcher would assist him in cutting out and pasting his chosen pictures. His collage was called "a life". On the side of the present time in his life he chose the following: *The help/do not enter/railroad crossing*: this was about how he felt at that moment about things happening to him; *eagle*: it was about being free and flying to where ever one wanted as he wanted to be able to do; *rabbit* and *pig*: animals that were at his home; *dog*: reminded him of his dog, which he has at home and whom he misses a lot; *plane*: was about going to a place far away, but taking a long time to get there.

On the opposite side depicting the future and what he would like to happen included the following: *beach*: was his favourite place to be and wanted to go there when he went home; *band*: he loved his music; *fruit and chocolate cake*: he liked these a lot.

WORK FROM CASE STUDY 6: D

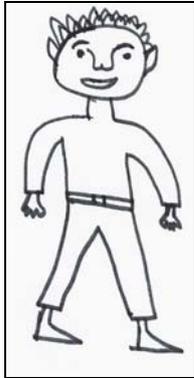


Figure 4.35.
Free Drawing



Figure 4.36. Collage: "A Life"



Figure 4.37. Cancer out of
Play Dough: "Cancer"

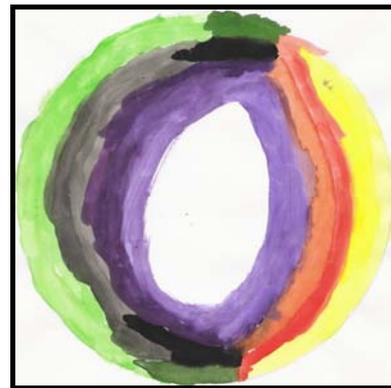


Figure 4.38. Mandala:
"Rainbow 1"



Figure 4.39. Mandala:
"Rainbow 2"

The pictures D chose for his collage are very expressive of current feelings. The researcher believed that being able to express himself through such projective media was essential for D's emotional healing. It was also interesting to note how D did not have any pictures about his experience in the hospital. When this was pointed out D said that he did not want to put "hospital" pictures in his collage. He wanted all that was happening to be over and that things could go back to the way they were. Focusing on the here and now and on what will take place in the very near future were things that were focused on with D. Through expressing himself in some visual or artistic media, he may have been able to express his feelings in a more comfortable way. D's collage is illustrated in Figure 4.36 on page 108.

Affirmation message: "I am unique in this world; there is no other person like me". He said that he knew he was special because there was no other person like him.

◆ Session Five

In this session the "building the cancer out of play dough" and incomplete sentences were completed.

The Child's Process: D chose the happy face. He was feeling good about things. He was presented with the task to build his illness out of play dough. His left arm was in a cast following the recent surgery. D was keen to work with his other hand (non-dominant hand). D was asked to visualise what the cancer looked like, its colour, shape, form, etc. He then explored the play dough and experimented with its form and texture. He then began to build his form. The picture of his model occurs in Figure 4.37 on page 108. He called it "cancer". This experience of taking what one visualises one's illness to be and to make this thought into a play dough form is believed by the researcher to be a very powerful experience. It allows one to create one's idea of one's illness and it can also, quite symbolically and realistically help one to retain one's power over it. This was the essence for this task.

D did not hesitate with this task. He worked very slowly, as he was working with his non-dominant hand. He could easily describe what he had made. He described the cancer as being like a crab. But instead of moving from one place to another, it was increasing in size. This is why he had to lose his leg. He then completed the ritual of "destroying the cancer". D easily flattened the "cancer" until it was formless. He said he felt good breaking up the cancer.

The session was concluded with D completing the Incomplete Sentences. Some of the ones he completed clearly illustrate what might have been on his foreground. They appear in Table 4.12.

Table 4.12. Case Study D - Incomplete Sentences

<ul style="list-style-type: none"> ▪ I would like to be <i>a doctor</i> ▪ Something I don't like to think about is <i>about what happened to me</i> ▪ Most of my friends don't know that I am afraid of <i>what's going to happen to me</i> ▪ The hardest decision I ever made was <i>to tell the doctor to take off my leg</i> ▪ I feel very sad when <i>maybe someone hit me</i> ▪ When I leave the hospital I <i>want to go back to school</i> ▪ I hate it when <i>they bring me down with the drip</i> ▪ Doctors make me feel <i>bad</i> 	<ul style="list-style-type: none"> ▪ Being in hospital <i>bored</i> ▪ I feel uncomfortable when people <i>tell me about having only one leg</i> ▪ When children stay in hospital they feel <i>others feel good, others feel bad</i> ▪ My favourite place to be <i>Durban</i> ▪ The worst experience about my illness <i>loosing my leg</i> ▪ I worry a lot about <i>my leg</i> ▪ If I had three wishes I would wish for <i>marry a wonderful wife; to have a beautiful house; to have beautiful children</i>
--	---

The following concerns remain with D: he was anxious about being ill, having lost his leg, and concern about what the future would hold. D's hospital experience has been a stressful one. When compared with the responses of the other children, D experiences similar anxieties and concerns. A recommendation to the social worker for further counselling was made for possible additional support to be provided to D.

◆ Session Six

This session comprised of the mandala painting the as symbolic of a completion of a process. This was to be the last session with D. Once D completed this the researcher concluded with a discussion of the "safe place" (that was done in session three) to remind D that he could always feel safe and protected no matter where he was. The session was concluded with the final interview.

The Child's Process: D chose the happy face, as he was happy that the drip was being removed for a while. He seemed to be enjoying completing the Mandala. He called it Rainbow (illustrated in Figure 4.39 on page 108). In describing his painting he said that it was made of different colours and this was why he called it "rainbow". He battled to describe himself as a rainbow or to say what the colours meant to him.

D's responses the final interview were as follows:

The play therapy helped me to feel better. The time I spent with you really helped me. I learnt about the different ways of working with how you feel. I think play therapy can help other children. I enjoyed painting and drawing the most. I am not sure if I noticed any changes inside after we worked together. I just noticed that I felt better sometimes after play therapy. What I still worry about most while I am here in hospital is when I see all these young people dying I think that the next day it could be me. Maybe if I could have had more play therapy it would help me more.

Conclusion of, D's (Case 6) Play Therapy Process:

D has had to endure a very stressful life experience. He had to decide if he could keep or lose his leg. He experienced immense physical pain from his leg and his arm. Most of the times, D was very quiet and withdrawn. Towards the fifth/sixth session, his mood had lifted and he was moving around in his wheelchair and spending time with the other children in the ward. Despite his distress, D was willing to try some of the exercises presented to him. Helping him express some of his feelings and finding some kind of self-awareness and self-support seemed to have been a positive experience for D.

4.3 SUMMARY

This chapter illustrated the personal experiences of the children that participated in the research study. The children were presented with a play therapy process in order to help them to cope better with possible feelings of anxiety. As the children were taken through the Gestalt play therapy process, the researcher attempted to explore and describe their experiences.

The play therapy sessions involved various play therapy techniques. These included: drawing and painting, meditation, collage, working with play dough, sensory awareness, and the use of visualisation and meditation. Specifically, the application of play therapy was based on the foundation of the play therapy relationship and on the Gestalt approach to play therapy. Strengthening the child's sense of self, allowing the child to connect with his outer world through a heightened awareness, and the promotion of self-support involved some of the objectives of this study. Children were presented with a variety of mediums, to provide them with a means of expressing any feelings that they were struggling with. The prevalence of common and less common themes that emerged from each child's experience will be discussed in Chapter five. In addition, the following and final chapter will also elaborate on the relevant findings and conclusions of the study.

CHAPTER 5

CONCLUSIONS, RECOMMENDATIONS, POSSIBLE SHORTCOMINGS AND FINAL REMARKS OF THE RESEARCH PROCESS

5.1 INTRODUCTION

A child that is diagnosed with a life threatening illness such as cancer, and is also hospitalized, for treatment is faced with many stressors that can lead to emotional distress such as anxiety. Some of the complexities that face this child include being diagnosed with a life-threatening illness, being taken through a potentially long course of treatment, enduring side effects such as nausea and vomiting, hair loss, weight gain or loss, being away from school and friends, and being hospitalized for numerous times. (Gariépy & Howe 2003: 523; Papaikonomou & Nieuwoudt, 283; Patenaude & Kupst, 2005: 14) It is noted by the researcher that some children also go through surgery that may affect their lives in a profound way.

The present study built on the ideas of previous studies mentioned in earlier chapters, specifically in chapter 2, that have used play therapy with the hospitalized child. Some of these ideas stem from studies done by Chambers (1993), Gariépy and Howe (2003), Haiat, *et al.* (2003) and Savans (2002).

Following from such ideas, in this study the researcher fundamentally incorporated the ideas of Gestalt play therapy and applied them to the context of the hospitalized oncology child. The researcher attempted to explore and describe the effect of Gestalt play therapy on feelings of anxiety that were experienced by the hospitalized oncology child. It included six case studies that occurred over a period of at least six sessions. Each case study was taken through a Gestalt play therapy process. The Gestalt play therapy techniques allowed the child in the study to work through at least some of his distress. The tasks were specifically aimed at assisting the child to strengthen himself, and to bring a moment of calmness and wholeness within a very foreign, intrusive and stress provoking reality.

5.2 GOAL AND OBJECTIVES REVISITED

In reflecting on the study a review of the goals and objectives becomes necessary. In this study, the goal was to utilize Gestalt play therapy as a means of limiting or minimizing feelings of anxiety experienced by the hospitalized oncology child. Consequently, a number of objectives ensued in order to accomplish the overall goal of the study. These include the following:

- ◆ A primary objective of the study was to perform the Gestalt play therapy process with the hospitalized oncology child to explore its significance in assisting the child's adjustment process. The researcher developed a Gestalt play therapy process that was based on the principles of Gestalt therapy theory. The development of the Gestalt play therapy process is based upon the assumption that play may offer the child a way to gradually assimilate the anxiety being experienced, which would allow the child to gain a better sense of control over his life. The process was presented with each child. The children all responded positively to the play therapy sessions. This was noted from the children's responses through their interviews and questionnaires at the conclusion of the study. The Gestalt therapy process was based on the following objectives:

- ❖ An essential aspect in achieving the process of Gestalt play therapy, was establishing the therapeutic relationship. This was achieved through the promotion of a safe and secure interpersonal connection with the child and the researcher, through which the child could explore and experience his Gestalt play therapy process. This was based on responses provided by the children and through procedural observations. In the researcher's opinion, this was achieved with all the children in the study.

- ❖ The child was presented with the opportunity to work through and assimilate the anxiety he was experiencing. This was done through the use of various channels of expression, which included drawing, painting, clay work, and collage. All the children were able to produce at least some form of a physical representation of their emotional and inner world.

- ❖ Providing the child with a means of gaining a greater sense of control over his life. Through working with and mastering the sources of emotional expression, the child was given the opportunity to achieve a sense of control over his inner self and in his life. The children generally commented that having the chance to just draw or paint, etc. was for them uplifting, and also fun.

- ❖ Attaining awareness, in order to be in touch with the child's own existence in his present life experience and allowing the child to consciously connect with his immediate experiences and explore the meaning of this awareness. Some children found it difficult to do the sensory awareness work. The researcher however, maintains that providing the child with the opportunity was in itself a means of increasing the child's awareness.
- ❖ Helping the child develop a strong sense of self to strengthen his sense of well-being and the inner strength to express any buried emotions. A number of self-enriching and self-empowering sources of support were presented to the child. The researcher thought it essential to provide at least some means of promoting the child's positive self worth. It was hoped that providing the children with this opportunity provided the stepping-stones of enhancing the child's self-worth and sense of well-being.
- ❖ The achievement of integration that provides a feeling of being whole and complete. This was promoted through the integration of all the above objectives. All the above tasks were aimed at achieving this objective. The children were provided with as many opportunities that were possible, in the very short six sessions, to achieve some sense of integration.
- ◆ To gain insight and knowledge of the experience of the research participant by collecting and interpreting data through observations, descriptions and interviews in order to explore and describe the outcome of the Gestalt therapy process with the hospitalized oncology child.

Once the Gestalt play therapy process was concluded the researcher proceeded to describe the results obtained through identifying relevant themes, feelings etc., and identifying whether significant changes could be seen through analysis of findings and thereafter recommendations can be suggested based on the findings of the study.

5.3 SUMMARY OF FINDINGS AND LITERATURE CONNECTIONS

The findings in this study were integrated with findings reviewed in the literature. This is described further in this section. Medical advances in the diagnosis and treatment of paediatric oncology have increased the chances of survival for the child with cancer. As survival rates for paediatric cancer have improved, psychological care of the oncology child has become more prominent (Dejong & Fombonne, 2006: 14). Numerous studies have

acknowledged that cancer in children has evolved from being an acute disease with a high fatal outcome to being a life threatening disease with a higher possibility of cure, but with the risk of long-term physical, psychological and social effects (Di Gallo-Allain, 2003; Eiser, *et al.*, 2000; Papaikonomou, & Nieuwoudt, 2004; Patenaude & Last, 2001). There has been an increasing recognition of the need to expand the field of medical care, from being dominant on medical interventions to providing psychosocial support for the oncology child.

Thus, it has been acknowledged in the literature that many advances have been made in the psychosocial care of the hospitalized oncology child. Numerous studies have emphasised that children with a chronic illness such as paediatric cancer are at an increased risk for psychosocial problems (Eiser, 1990; Meijer, *et al.*, 2000: 309; Taieb, *et al.* 2003; Vitulano, 2003). The findings of this study that focused on the prevalence of anxiety in the life of the oncology child supports the views of other researchers such as Mitchell, *et al.* (2006) and Taieb, *et al.* (2003), that have noted that the experience of the oncology child can bring about strong feelings of anxiety and other emotional distress.

Subsequently, an emphasis has been placed on the necessity of intervention measures to be applied in the context of the hospitalized child. This has also been recognised extensively in the literature. Play has been increasingly perceived as being imperative in helping the oncology child cope with emotional distress (Chambers, 1993; Doherty, 1992; Gariépy & Howe, 2003; Savans, 2002). Play has been acknowledged as significantly contributing in alleviating anxiety and increasing adjustment (Gariépy & Howe, 2003). The essential inclusion of play therapy in the psychosocial support of the oncology child is strongly supported by this study.

Further findings indicated the following:

- ◆ In working with the hospitalized oncology child the researcher witnessed how he lives through some very arduous experiences. With these experiences numerous emotional consequences emerge for the child. At the onset of the study children were asked to complete “How I Feel in Hospital Questionnaire” to assess the nature of the child’s anxieties. With all the children it was recognized that they experienced or were experiencing an array of emotional distress, including anxiety. The prevalence of anxiety in the life of the oncology

child is discussed in the literature. Some of these studies include Eiser (1990), Meijer *et al.* (2000), Patenaude and Last (2001) and Vitulano (2003).

◆ In the present study it was seen that for the oncology child his anxiety is multidimensional and takes various forms with differing experiences. In the literature this idea concur with Gariépy & Howe (2003) and Mitchell, *et al.* (2006). Some of the anxieties that children experienced in this study included:

- ❖ A general worry about their illness
- ❖ Being in hospital
- ❖ Being away from home
- ❖ Having family and friends far away
- ❖ Missing school
- ❖ Feeling shy when meeting new people
- ❖ The various treatments they are getting
- ❖ Feeling pain and discomfort
- ❖ Being ridiculed by others, due to loss of hair or having had major bodily changes
- ❖ Fear of death

Most of these findings have also been mentioned in such studies as Mitchell, *et al.* (2006) Papaikonomou and Nieuwoudt (2004) and Patenaude and Kupst, (2005).

◆ It was found that the children in the study experienced various emotional reactions to their experiences with medical procedures. These not only include anxiety but also included such feelings as sadness, fear, anger, loneliness, boredom, and happiness. This is supported by Gariépy and Howe (2003).

◆ The children in the study were at various stages in their illness. Children who had been more recently diagnosed expressed greater feelings of anxiety than children who were towards the end of their treatment. This was reflected in the children's responses to the "How I Feel in Hospital Questionnaire" and "Incomplete Sentences". Thus, it was the researcher's perception that the feelings of anxiety experienced by the child may have been influenced by the actual stages of their illness. The researcher did not find studies that supported these findings.

◆ Furthermore, although differing in diagnosis, in some aspects the children seemed to share the same fears and concerns. With this finding the researcher was unable to locate other studies that reflected similar outcomes.

- ◆ The oncology children in the study generally suffered from a low self-esteem. This was also noted in their responses to the “How I Feel in Hospital Questionnaire” and “Incomplete Sentences” and through observations. The idea that self-esteem of chronically ill children is inhibited by physical and psychological stressors is also noted in studies such as Patenaude and Kupst (2005), and Vitulano (2003).
- ◆ Children whose parents were able to stay with them in the hospital appeared to experience a lesser anxiety and emotional distress than children who were often alone and had only some contact with their family. No studies could be found to support this finding.
- ◆ This study was able to demonstrate some association between anxiety and the hospitalized oncology child. The children in the study all experienced some form of anxiety. Anxiety was assessed and evaluated through the use of questionnaires, observations during the play therapy sessions, and through the identification of the child’s mood before and after play therapy was carried out. Although some association could be found, it was difficult to ascertain whether there was a direct link between the process of Gestalt play therapy and its role in reducing or minimized feelings of anxiety that were experienced by the hospitalized oncology child. Some of the reasons that could have influenced this finding are discussed in more detail in the following paragraph.

5.4 POSSIBLE SHORTCOMINGS

The following factors are perceived by the researcher to have contributed to the study not being able to obtain established evidence of the effectiveness of Gestalt play therapy, on the feelings of anxiety experienced by the hospitalized oncology child. Data that was attained through the interviews, questionnaires, the Gestalt play therapy process and procedural observations allowed the researcher to acquire these conclusions.

- ◆ The fact that the children in the study were, at the commencement of the study, at various stages of their treatment, may have influenced the nature of anxiety that was experienced and the outcome of their play therapy experience.
- ◆ Children in the study were diagnosed with different kinds of cancer. This may have also contributed to the nature of their anxiety and to their reaction to the play therapy.
- ◆ The minimal length of time that was available for the research study was perhaps too short a time period to be able to observe more tangible evidence of a significant impact of the children’s experience of Gestalt play therapy on their feelings of anxiety.

- ◆ Only a small group of children were available for the study. The small sample size may have limited the scientific value of the findings. It may also have limited the researcher's ability to detect patterns of the behaviour of interest that may apply to subgroups of children with a specific disease and/or treatment, rather than to general populations
- ◆ The use of adequate comparative control groups may have made the study more viable for the observation of significant results.
- ◆ The child participants were not always well enough to participate in the planned research programme. At times it was necessary to adapt certain tasks or even omit them to suite the each child's needs. This may have also influenced findings
- ◆ The researcher was unable to obtain a current South African standardised scale for measuring the effect of medical anxiety. Anxiety was observed in the behaviour of the child, and in questionnaires. This may also be a factor that influenced the description or presence of anxiety in the child before and after the play therapy process.
- ◆ Another factor was that it was the researcher herself that collected all the data, and applied the play therapy sessions. This may have added bias to the child's responses and experience.
- ◆ The effect of play therapy may not be evident in the immediate moment, and may continue to develop and present itself in the forth-coming life experience of the oncology child.

5.5 RECOMMENDATIONS

In the past four decades the progress in the treatment of paediatric cancer both biologically and psychosocially has evolved and improved. In more recent years a stronger focus has been placed on improving the quality of life for these children in a more holistic manner.

Even with this greater awareness of the emotional distress that the hospitalized oncology child experiences, it is not possible at times, due to the lack of resources, quality time, availability of play therapists and social workers, and other related reasons, to assist the child psychosocially as well as medically.

Some thoughts of possible steps forward remain on the researcher's mind. These include the following:

In an ideal context, children would be able to work with their emotional distress, with a specialist practitioner, whether it is a play therapist, social worker or psychologist. The relevance of such child specialists for the oncology child needs to be recognised as an essential component in the child's treatment process. The integration between play therapy, social work, and child psychology may be a critical step in that direction.

- ◆ Longitudinal studies, that can be carried out over an extended period of time are necessary to provide more in-depth observations of the experiences of both cancer patients and survivors and what could be done to optimally support them.

- ◆ Even with the improvement of treatment methods and an increase in survival rates, paediatric cancer remains a life-threatening illness. Another area that is critical for the support of these children is to develop intervention methods that would address the fear and anxiety of recurrences, as the possibility of recurrence may remain with a survivor indefinitely. Play therapists, psychologists and social workers can provide critical support in this area.

- ◆ Conducting more research that considers the following criteria could be addressed: participants have the same diagnosis, are at the same or similar stage in their diagnosis, are of the same age group, and the samples are of substantial number, and includes samples of comparison, possibly within the same context of treatment. Conducting studies that require years of data collection in order to acquire an adequate sample of research participants would be ideal, as this would enhance the sophistication of the research. Although it is difficult to conduct such research, it would provide critical insight on the experiences of the hospitalized oncology child, should this be feasible for future research.

5.6 FINAL REMARKS

The hospitalized oncology child is faced with immense adversity. Facing a life threatening illness and its intense treatment measures is a very harsh reality that confronts the oncology child. It has been increasingly more recognised that children need to be supported not just medically, but also psychosocially. In the more recent years, support provided to the oncology child has evolved into being more focused on working the child in a more holistic manner.

Many studies have focused on the involvement of intervention measures that assist the oncology child through their experience. The use of play therapy as an intervention

measure is being used with the oncology child's life as a possible means of providing some emotional release and a working though means of dealing with their experiences.

The importance of bringing some peace to the children involved in the study was emphasized. The researcher proposes that children should under all circumstances, be provided with maximal support, and assisted in all ways possible to have an optimal life experience. It is the hope that this study will bring further awareness to practitioners to assist them in guiding the child to feel safe and to experience the world as described in this poem by E. E. Cummings (1960: 76).

*i thank You God for most this amazing
day:for the leaping greenly spirits of trees
and a blue true dream of sky;and for everything
which is natural which is infinite which is yes*

*(i who have died am alive again today,
and this is the sun's birthday; this is the birth
day of life and love and wings, and of the gay
great happening illimitably earth)*

*how should tasting touching hearing seeing
breathing any – lifted from the no
of all nothing – human merely being
doubt unimaginable You?*

*(now the ears of my ears awake and
now the eyes of my eyes are opened)*

APPENDICES

Appendix 1: Ethics Committee Approval Document

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Constantinou

CLEARANCE CERTIFICATE **PROTOCOL NUMBER M051143**

PROJECT The Impact of Gestalt Play Therapy on
Anxiety Experienced by the Hospitalized
Oncology Child

INVESTIGATORS Miss M Constantinou

DEPARTMENT Social Work/Oncology Ward

DATE CONSIDERED 05.11.25

DECISION OF THE COMMITTEE* Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 06.01.06 **CHAIRPERSON**.....*PE Cleaton-Jones*
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable

cc: Supervisor :

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix 2: Parent/Guardian Informed Consent

Dear Parents/Guardians

1. INTRODUCTION:

My name is Melany Constantinou. I am a Masters Play Therapy student, studying at the University of South Africa. I am presently conducting a study entitled: "The Effect Of Gestalt Play Therapy On The Feelings of Anxiety Experienced By The Hospitalised Oncology Child." My aim is to develop a method using play, to make hospitalisation more comfortable for children by helping them to feel better. This is based on the idea that therapeutic play can help to minimize the possible stress and anxiety of the hospitalized child. I will use this study to help me observe how a child reacts to play therapy, and see what effect this intervention may have.

I would like to invite your child to participate in this research study. Your child's participation in the study is entirely voluntary.

This information leaflet is to help you to decide if you would like to consider allowing your child to participate in this study.

Before agreeing to allow your child to participate, it is important that you read and understand the following explanation of the purpose of the study, the study procedures, benefits, risks, discomforts, and precautions as well as the alternative procedures that are available to you and your child, and your right to withdraw your child from the study at any time.

If you have any questions, do not hesitate to ask me.

You should not agree to allow your child to take part unless you are satisfied about all the procedures involved. Please be completely truthful with me regarding your child's health history, since you may otherwise negatively influence results of this study.

If you decide to allow your child to take part in this study, you will be asked to sign this document to confirm that you understand the study. You will be given a copy to keep.

You may discuss with and inform your child's doctor of his/her possible participation in this study. If you wish, I can also notify your personal doctor in this regard.

Dr Poole, the head of the Paediatric Oncology Unit has been notified of this study and of what it will entail.

2. PURPOSE OF THE STUDY:

Your child has been diagnosed as suffering from a life threatening illness and is currently in hospital. I would like you to consider allowing your child to take part in this research project that will be briefly explained as follows:

The purpose of this study is to observe what effect therapeutic play may have on the hospitalised oncology child.

The study will be based on the idea that therapeutic play may help the child feel better and cope better with what he/she is going through.

The researcher is aware that paediatric cancer is a life-threatening chronic illness, and thus, the hospitalization and the treatment process can result in excessive feelings of anxiety and distress for a child experiencing these realities.

3. DESCRIPTION OF THE RESEARCH

The research is based on the idea that therapeutic play has a significant role to play in alleviating anxiety and in assisting in the process of increasing the adjustment of the child.

Children are often unable to express their fears or communicate their emotions appropriately, and furthermore, often cannot understand why they need to be subjected to such trauma, in the first place. It can be that children do not know how to deal with their experiences,

Gestalt play therapy has been acknowledged as a powerful means of helping children to work through traumatic experiences. Gestalt play therapy is a form of play therapy that focuses on the needs of the child.

Explained briefly: Adults use language to think about and talk about what is bothering them; children use play to act upon and react to their feelings.

Gestalt Play therapy is a form a play therapy that focuses on that which is immediately present. So how the child is feeling, and what the child is experiencing in the present moment is what the therapy will be focused on.

Play is seen as the natural medium through which children learn and communicate. So children use play to make sense of their world, resolve conflicts, and communicate feelings. Play therapy provides an environment where children can express themselves fully and work through their problems in a natural way.

Through play therapy a child can create a world they can master, practice social skills, overcome frightening feelings and/or experiences, and symbolically triumph over traumas or upsets that have threatened their well-being.

The manner that each child responds to the play therapy sessions will be observed and recorded in detail. The research will focus on describing how each child responds to the play therapy.

4. TO ALLOW THE CHILD TO PARTICIPATE IN THE STUDY PARENTS WILL BE ASKED TO:

Sign this consent form to give the researcher permission to include the child in the study, and to acknowledge that the parent understands what this research study will entail.

Complete a short interview and a children's behaviour checklist at the onset of the study, prior to any interventions having been implemented.

5. TO PARTICIPATE IN THE STUDY THE CHILD WILL BE ASKED TO:

Be interviewed by the researcher. At the interview the whole process of the study will be explained to the child in a format that will be understood by the child.

To sign an assent form. This is to make sure the child completely understands what will happen in the study, and this will also be the researcher's permission to conduct the study.

Complete an interview

Complete some drawings

Complete an anxiety questionnaire

Attend 6 sessions of play therapy that will be administered by the researcher; each session will be between 30-45 minutes, and will be carried out twice a week for 3 weeks.

Be interviewed again by the researcher, at the end of the study to see how the child has experienced the play therapy sessions and how he/she is feeling.

6. LENGTH OF THE STUDY AND NUMBER OF PARTICIPANTS:

The study will be performed at the Johannesburg Hospital, Paediatric Oncology Ward 286

Six participants will participate in this study

The participants will be between the ages 9-14 years (depending on the age group available when the study is undertaken). The total amount of time required for your participation in this study will be a maximum of 30-45 minutes, twice a week for three weeks.

7. HOW CHILDREN WILL BE SELECTED:

Children will be randomly selected from the children's ward and will be in the age group of either 6-10 years or 11-13 years of age. Each child participant will be a patient in the oncology ward, and the parents and child will have provided consent/assent for the child to be a participant in the study.

8. PROCEDURES

The researcher will conduct all interviews and will also conduct the play therapy intervention sessions.

During each play therapy session the following play techniques will be used:

drawings, painting; collage; clay; visual imagery/meditation/relaxation therapy

9. WILL ANY OF THESE STUDY PROCEDURES RESULT IN DISCOMFORT OR INCONVENIENCE?

The actual play therapy sessions will not result in any discomfort or inconvenience. The researcher will attempt to adapt the times of each play session at the convenience of each child. The researcher is aware that there may be days in which the child may not feel well enough or feel up to the play procedures. Should this happen the session will be postponed until the child feels he/she is up to it. So even though the sessions are planned for eight weeks, the researcher is prepared to carry over sessions into forthcoming weeks, should this need arise. At no times will a child be forced to participate, or be inconvenienced or led to experience any discomfort in any way due to the procedures of the study.

10. RISKS OF THE STUDY:

At this stage the researcher does not foresee any risks that a child might experience should they agree to participate in the study

11. BENEFITS:

The potential benefit from your child's participation in this study may be that the therapeutic play might assist in helping your child cope better with what he/she is experiencing due to their illness and being hospitalized as a result. If your child is experiencing any feelings of anxiety, fear or any other signs of distress, play therapy may help to alleviate the intensity of such feelings.

It is also important to note that should your child react positively to therapeutic play, it may not be clearly seen immediately after intervention takes place. However, this does not necessarily imply that the child has not responded positively to the play intervention. Often, significant benefits may occur in an indistinct manner, so they are not immediately seen, and the true effects may be revealed days, weeks or even months after intervention has taken place.

Your child's participation in this study will contribute to other psychotherapeutic knowledge that may help other children who are going through the same life experiences as you child.

12. YOUR CHILD'S RIGHTS AS A PARTICIPANT IN THIS STUDY:

Your child's participation in this study is entirely voluntary and your child can decline to participate, or stop at any time, without stating any reason. You may also withdraw your child as a participant in this study should you feel it necessary to do so. You do not need to state a reason. Your child's withdrawal will not affect his/her access to other medical care, nor will it present your child with any disadvantage.

13. DISCONTINUATION OF STUDY TREATMENT.

Please inform me as soon as possible, should you or your child wish to withdraw your child from this study.

14. FINANCIAL ARRANGEMENTS:

Neither you nor your medical scheme will be expected to pay for any study related visit or study procedures.

15. REIMBURSEMENT FOR STUDY PARTICIPATION:

You and your child will not be paid to participate in this study.

16. ETHICAL APPROVAL:

This study protocol has been submitted to the University of the Witwatersrand, Human Research Ethics Committee (HREC). Approval was granted in January, 2006

17. SOURCE OF ADDITIONAL INFORMATION:

For the duration of the study, your child will be under my personal care, and I will be supervised and supported by my supervisor. If at any time between my visits with your child, you feel that your child needs further assistance, or you have any questions during the study, please do not hesitate to contact me.

The 24-hour telephone number through which you can reach me is: 0723349265

If you want any information regarding your child's rights as a research participant, or complaints regarding this research study, you may contact Prof. Cleaton-Jones, Chairperson of the University of the Witwatersrand, Human Research Ethics Committee (HREC), which is an independent committee established to help protect the rights of research participants at (011) 717 2229.

18. CONFIDENTIALITY:

All information will be confidential and the child's true identity will not be revealed, during or after the study is completed.

All information obtained during the course of this study, including hospital records, personal data and research data will be kept strictly confidential. Data that may be reported in scientific journals will not include any information that identifies your child as a participant in this study.

This information will be reviewed by authorised representatives of the University of South Africa.

The information might also be inspected by the University of the Witwatersrand, Human Research Ethics Committee (HREC), as well as your personal doctor. Therefore, you hereby authorise me to release your medical records to my supervisors at the University of South Africa, and the University of the Witwatersrand, Human Research Ethics Committee (HREC).

These records will be utilised by them only in connection with carrying out their obligations relating to this research study.

Any information uncovered regarding your child's test results or state of health as a result of his/her participation in this study will be held in strict confidence. You will be informed of any finding of importance to your child's health or continued participation in this study but this information will not be disclosed to any third party in addition to the ones mentioned above without your written permission.

19. CHILD INTERVIEW

In order to allow your child to participate in this study I would like to ask your permission to conduct a short interview with you and your child respectively. This is just a procedure that will provide valuable information for this research project.

With your permission, I would like to carry out an interview with you and on another occasion, I would like to carry out an interview with your child. Please find attached, a form that describes exactly what I will be asking your child. Once I have had play therapy sessions with your child, I would like your permission the re-conduct similar interviews. These are simply to obtain a clearer picture of how your child has experienced the play and how he/she is coping that time.

20. RECORDING CONSENT

It is essential that you are aware that the results obtained during the course of the study will be printed and published as a dissertation at UNISA. Data may also be reported in scientific journals at a later stage. However, all information obtained during the course of this study, including hospital records, personal data and

research data will be kept strictly confidential. This means that at no time will your child's name be revealed publicly. Your child's true identity will be disguised at all times, in all settings. The information obtained in the study may also be reviewed by authorised representatives of the University of South Africa. The information might also be inspected by the University of the Witwatersrand, Human Research Ethics Committee (HREC).

I thus request your permission to be able to disclose such information to the relevant authorities. However, once again I must stipulate that even though information will appear publicly, your child's true identity will never be disclosed. It is still necessary for me to know that you understand this and that you agree to allow me to record and reveal the results obtained in this study in the nature explained above.

In addition, it is important that should a situation arise where your child presents with problems are beyond the scope of the researcher's ability to provide sufficient intervention, I request that I may approach your doctor or the social worker at the Hospital, to discuss appropriate intervention. I will consult with you at all times prior to any information being disclosed to a third party other than myself.

21. TAPE RECORDING OF SESSIONS

I would like to ask your written consent to audio tape my sessions with your child. These recordings will only be used to assist with my therapeutic processing of the sessions, and will not be accessible to any one else. Your child's identity will never be revealed, and all information will be treated as strictly confidential.

22. CONSENT FROM PARENTS/LEGAL GUARDIANS (On behalf of minors under 18 years old):

I hereby confirm that I have been informed by the researcher, Melany Constantinou, about the nature, conduct, benefits and risks of the research study (Protocol Number: M051143; Title: The Effect of Gestalt Play Therapy on the Feelings of Anxiety Experienced by the Hospitalized Oncology Child)

I have also received, read and understood the above written information (Participant Information Leaflet and Informed Consent) regarding the research study.

I am aware that the results of the study, including personal details regarding my child's sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.

In view of the requirements of research, I agree that the data collected during this study can be processed in a computerised system by UNISA or on their behalf.

I may, at any stage, without prejudice, withdraw my consent for my child's participation in the study.

I have had sufficient opportunity to ask questions concerning the study.

It has been explained to me that I will be free to withdraw my child from the study at any time, without any disadvantage to future care.

I hereby grant consent for the recording of material obtained during the study.

I hereby confirm that I have been informed by the researcher, Melany Constantinou, about the manner in which the sessions will be tape recorded during this study

I hereby grant permission to Melany Constantinou to carry out an interview with my child.

I have understood everything that has been explained to me and I consent for my child to participate in this clinical study.

Appendix 3: Parent Interview

Please answer the following questions to the best of your ability. Be specific and detailed in your response.

1. PERSON AGE BIRTHDATE EDUCATION OCCUPATION

Mother

Father

Children

2. Others at home.....
3. Do both parents work? Yes () No (). If yes, who cares for the children in the absence of the parents?
.....
4. Has the child ever been separated from the family for longer than 24 hours? (e.g. night with grandparents, camps, etc.) Yes () No ().
If yes, please explain. How did your child respond to this experience?.....
5. Has the child been hospitalised before? Yes () No ()
If yes, please complete the following questions:
 - i. How old was he/she when hospitalised?
 - ii. Where was the child hospitalised?
 - iii. What was the reason for his/her hospitalisation?
 - iv. How long did he/she stay in the hospital?
 - v. Describe his/her reaction to the hospital:
6. Does your child have any emotional difficulties? (E.g. fears, nightmares, behaviour problems...) Yes ()
No () If yes please explain:
7. When did your child know he/she was going to be hospitalized?
 - a. Within the last 8 hours prior to admission
 - b. Within the last 24 hours
 - c. Within the last week
8. Who told the child he/she was going to be hospitalized? (May tick more than one)
 - a. Mother.....
 - b. Father
 - c. Physician
 - d. Nurse
 - e. Other.....Please explain:
9. Was your child prepared for the hospitalisation? Yes () No ()
If yes, please specify how and by whom.....
10. When your child was told he was going to hospital how did he/she respond?.....

11. Length of stay in Hospital: (Please Tick Appropriate Block)

0-3 Days	
4-7 Days	
8-14 Days	
15-21 Days	
Longer (please state how long)	

12. Please tick the following areas that you believe best describes your child's emotional state during his/her stay in hospital.

a) Anxious	
b) Frightened	
c) Sad	
d) Content	
e) Confused	
f) Angry	
g) Uncertain	
h) Withdrawn	
i) Aggressive	
j) Doesn't show how he/she feels	

1 = Never
 2 = Seldom
 3 = Sometimes
 4 = Often
 5 = Always

13. Please Complete as Indicated

Which of the following behaviours was experienced or did you observe in your child during his/her hospitalization?

Please indicate on a scale of 1-5 how often this behaviour was observed by marking the appropriate number that best describes your child's behaviour:

Crying for No Apparent Reason	1	2	3	4	5
Emotional Outbursts	1	2	3	4	5
Changes in Appetite	1	2	3	4	5
Anxiety	1	2	3	4	5
Depressive Behaviour/Excessive Sadness	1	2	3	4	5
Regressive Behaviour eg. Thumbsucking	1	2	3	4	5
Withdrawal	1	2	3	4	5
Aggression	1	2	3	4	5
Verbal Expression of Fear	1	2	3	4	5
Enuresis (Bed Wetting)	1	2	3	4	5
Encopresis (Soiling self)	1	2	3	4	5
Nightmares	1	2	3	4	5
Insomnia (difficulty sleeping)	1	2	3	4	5

(PLEASE CIRCLE THE APPROPRIATE RESPONSE)

14. Does your child experience eating problems in the hospital: Yes () No ()

15. Please tick the follow areas that you believe will be the MOST difficult for your child to accept during his/her hospitalization:

Being away from home	
Injections	
Intravenous medication	
Oral medication	
Staying in bed	
Surgery	
Physical pain resulting from illness	
Eating different food	
Medical treatments	
Being with strangers	
Being away from friends	

16 Describe how you feel your child will respond to this hospital experience:

17. Which of the following procedures did your child undergo during his/her hospitalization?

Lumbar Puncture	
Spinal Tap	
Physiotherapy	
Oxygen	
Injections	
Anaesthetic	
Radiation	
Chemotherapy	
Surgery	

18. Does your child complain of physical discomfort that has not been accounted for by his/her diagnosis: Yes () No ()

If yes, please explain:

19. Has your child, at any time during his hospitalisation behaved in a manner that he/she did when he/she was younger: Yes () No ()

20. Do you believe your child knows why he/she has to be in the hospital? Yes () No ()

21. Do you believe your child understands his/her diagnosis? Yes () No ()

22. When you knew your child was going to hospital, how did YOU respond? (please describe your feelings, worries etc.):.....

23. As a parent, which of the following best describes YOUR feelings about leaving your child in the hospital:

a) Angry	
b) Frightened	
c) Worried	
d) Sad	
e) Confused	
f) Unsure	
f) Helpless	

24. What was the average amount of visiting time per day that you were permitted to see or be with your child?

0-3 hours	
3-5 hours	
6-8 hours	

25. Were you permitted to stay with your child at the hospital during his/her stay? Yes () No ()

26. What do you feel we should know about your child while he/she is in the hospital:

Please rank your child's current level of anxiety on the following scale: (circle one)

Not at all Anxious Very Anxious

1 2 3 4 5 6 7 8 9 10

Appendix 4: Child Participant Assent Form

1. INTRODUCTION

Hello. My Name is a Melany Constantinou. I am doing a study for the university about children in hospital. You are invited to consider being a part of this research study. Being part of this study is entirely voluntary; this means that you don't have to take part if you don't want to. You also need to know that if you decide that you don't want to carry on being a part of this study once the study has started, you can always decide to stop. All you need to do is tell your mom or dad, or me that you want to stop and you can stop immediately.

I will explain what the study is about and then you can decide if you want to join the study. Please tell me if there is anything that you don't understand.

Before agreeing to being a part of this study, it is important that you understand what this study will be about so I will explain to you what will happen if you do agree to take part.

If you decide to take part in this study, I will ask you to write your name on this form. This will mean that you understand what this study is about. I will give your mom and dad a copy of this form to keep.

I have also explained to your parents what this study is about. They will also give me permission to allow you to take part.

I will also speak with your doctor so that they will know that you are going to take part in the study. I will only do this if you and your parents say it is ok for me to speak to your doctor.

2. WHAT THIS STUDY WILL BE ABOUT:

My study is about children in hospital. When children go to hospital it is because they don't feel very well. Hospitals can be scary places to be in especially if you don't feel well. Sometimes children in hospital need special help to help them learn about their worries and feelings that they have because they are in hospital. That is where I come into the picture. My job is to help children who are in hospital to feel a little better.

What we will do together is play. Most children like to play. When children play, it helps me to understand their feelings and their worries better. That is because children play their feelings better than they talk about them. I will help children understand their feelings while they play. Children seem to feel better when they understand their feelings. That is because children sometimes have feelings they don't know they have.

Children sometimes feel better when they play, because playing can be fun.

These are some of the things we will do when we visit together, if you and your parents decide to take part in the study:

- Draw and paint pictures
- Make pictures using paints and cutting pictures out of magazines
- Playing and making things out of clay or play dough
- Relaxation and calming exercises

3. WHAT TO DO IF YOU CHANGE YOUR MIND AND DON'T WANT TO BE A PART OF THE STUDY:

Remember, being a part of this study will be your choice. If you do not want to take part then that is ok. Also, if you want to stop at any time you can and you do not have to tell anybody why. Just let me or your parents know that you don't want to take part and you can stop. Nothing will happen to you if you don't take part.

CONFIDENTIALITY:

This is a long word.

This is what it means: It is like a one way secret: when we will visit each other, I will never tell anyone about the things we will do, your ideas or feelings. I will keep all of this private. But you can talk about anything to anyone if you want to. If I have to tell people about our work, I will never use your real name, so no one will ever know that the work I am talking about is the work I did with you.

4. ASSENT BY PARTICIPANT:

By signing or writing your name on this form means:

- That you understand what this study is going to be about
- You would like to take part in this study
- Give permission to the researcher, Melany Constantinou, to include you in her study
- Understand that if at any time you don't want to carry on being a part of the study, then you will let the researcher or your parents know and you will be taken out of the study.
- You know that if you don't understand something or need to know something you will ask the researcher, Melany Constantinou
- You can contact the researcher, Melany Constantinou, if you need to any time while you are part of this study.

The 24-hour telephone number through which you can reach Melany Constantinou is: 0723349265

VERBAL PARTICIPANT INFORMED CONSENT:

(Applicable when participants cannot read or write and are incapable of giving written consent)

- I, the undersigned, Melany Constantinou, have read and have explained fully to the participant, study number: and/or his/her relative/friend/legal representative, the participant information leaflet.
- The report I have given has explained both the possible risks and benefits of the study as well as the alternative treatments available for his/her illness. The participant and/or his/her relative/friend/legal representative have indicated that they understand these.
- The participant and/or his/her relative/friend/legal representative indicated that he/she understands that the participant will be free to withdraw from the study at any time for any reason and without jeopardising his/her subsequent treatment.
- I have also informed the participant and/or his/her relative/friend/legal representative of the existence of relevant compensation arrangements in case of an injury attributable to the medicine(s) used in the clinical study, to which he/she agrees.

I hereby certify that, the participant and/or his/her relative/friend/legal representative, acting on his/her behalf, has agreed to participate in this study.

Appendix 5: Child Interview

Pseudonym: _____

Date of Admission: _____

Date of Discharge: _____

Diagnosis: _____

1. Have you been in hospital before:

2. Did you know you were going to go to hospital when you felt sick?

3. How did you feel just before you had to go to hospital?

4. How do you feel about being in hospital now:

5. Do you have to stay for very long?

6. What is wrong with you?/Do you know what was wrong with you?

7. Do people, like your parents, doctors or nurses talk about what is going on with you?

8. Is your mom and dad able to visit with you often while you are in hospital?

9. Is your mom and dad able to stay with you at night while you are in hospital?

10. How do you feel when your mom and dad had to leave you?

Appendix 6: Child's Drawing – Diagnosis

Child is instructed to draw in a given body outline what they think is “Wrong with them”.

Equipment used: a box of assorted crayons, human figure outline, and a table surface on which to draw.

Instruction: “Here is an outline of a boy/girl. Please draw for me what is wrong with you.

“Draw for me what you think is wrong with you in your body”.

“Draw for me what you think is making you feel sick, inside your body”.

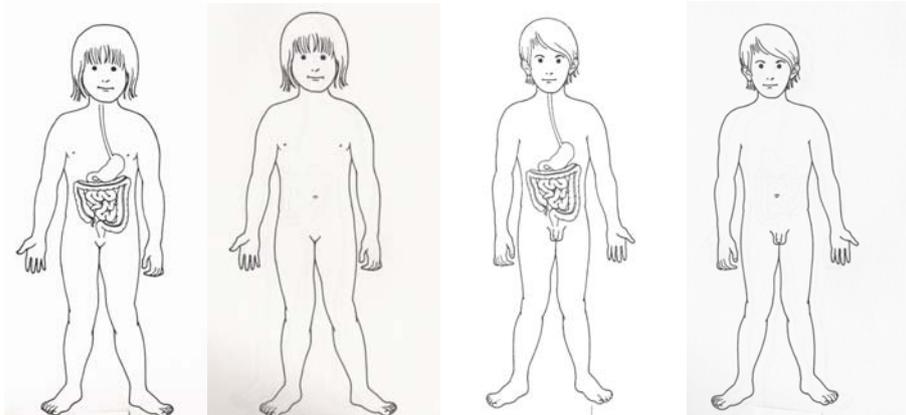
SCORING

	Point
1 a) Does not draw anatomical part	1
b) Draws part of anatomical part	2
c) Draws anatomical part	3
2. a) Does not put anatomical part in the right part of the body	1
b) Puts anatomical part close to the right part of the body	2
c) Places anatomical part in appropriate body location	3
3. a) Colours in black, brown or red	1
b) Colours in blue, green or purple	2
c) Colours in pastels	3
4. a) Uses one colour	1
b) Uses two to four colours	2
c) Uses four or more colours b.....	3
5. a) Demonstrates no understanding of diagnosis	1
b) Demonstrates some understanding of diagnosis	2
c) Demonstrates understanding of diagnosis	3

Total scores of 1 to 7 Little understanding of diagnosis

Total scores of 8 to 12 Some understanding of diagnosis

Total scores of 13 to 17 Good understanding of diagnosis



Appendix 7 How I Feel In Hospital Questionnaire

		never	s/times	often	v/often
1. I can talk to people about my illness	0	1	2	3	
2. I worry about my illness	0	1	2	3	
3. I worry I might not get better	0	1	2	3	
4. I worry about other people laughing at me	0	1	2	3	
5. I get scared when my parents go away	0	1	2	3	
6. At night I have bad dreams/nightmares	0	1	2	3	
7. I feel different to other children	0	1	2	3	
8. I am afraid that other kids will make fun of me	0	1	2	3	
9. I am nervous/anxious when the doctor comes	0	1	2	3	
10. At night it is difficult to fall asleep	0	1	2	3	
11. I am afraid that other children will think I am stupid	0	1	2	3	
12. I like to keep the light on at night when I go to sleep	0	1	2	3	
13. I feel tense or uptight	0	1	2	3	
14. In hospital I worry a lot	0	1	2	3	
15. I feel like crying for no real reason	0	1	2	3	
16. I find it difficult to eat when I am in hospital	0	1	2	3	
17. I worry about what other people think of me	0	1	2	3	
18. I avoid watching scary movies or TV shows	0	1	2	3	
19. I can't relax when I am in hospital	0	1	2	3	
20. If I get upset or scared I can tell someone right away	0	1	2	3	
21. I feel scared	0	1	2	3	
22. I have trouble asking other people to play with me	0	1	2	3	
23. I feel shy when I meet new people	0	1	2	3	
24. My hands feel sweaty or cold	0	1	2	3	
25. I have pains in my chest	0	1	2	3	
26. I am afraid of the dark	0	1	2	3	
27. I don't like to try to do new things	0	1	2	3	
28. I don't have a very good appetite	0	1	2	3	
29. The treatment I am getting makes me anxious	0	1	2	3	
30. Hospital is a scary place	0	1	2	3	
31. I find it hard to make new friends	0	1	2	3	

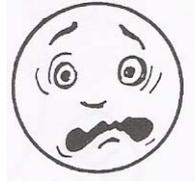
Appendix 8: Feeling Faces

Which of these feelings have you been feeling/ have you felt, while you have been ill?



1. often
2. always
3. sometimes

angry



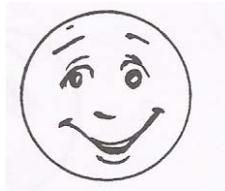
1. often
2. always
3. sometimes

scared



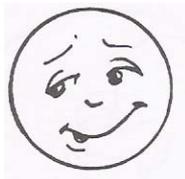
1. often
2. always
3. sometimes

very tired



1. often
2. always
3. sometimes

proud/confident



1. often
2. always
3. sometimes

shy



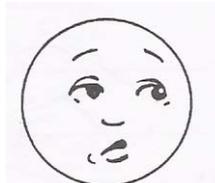
1. often
2. always
3. sometimes

bored



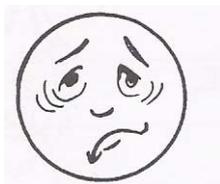
1. often
2. always
3. sometimes

sad



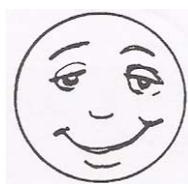
1. often
2. always
3. sometimes

lonely



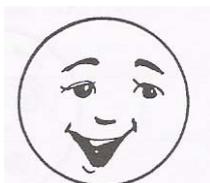
1. often
2. always
3. sometimes

sick



1. often
2. always
3. sometimes

relaxed



1. often
2. always
3. sometimes

happy



1. often
2. always
3. sometimes

worried/anxious

Appendix 9: All About Me Questionnaire

- ★ My name is _____
- ★ I am _____ years old.
- ★ I am in Grade _____
- ★ My school is _____
- ★ My teacher's name is _____
- ★ The people I live with are _____
- ★ My favorite food is _____
- ★ I don't like to eat _____
- ★ My favorite colour is _____
- ★ My favorite animal is _____
- ★ What I like to do on the weekend _____
- ★ My favorite games are _____
- ★ Things that make me happy _____
- ★ Things that I do not like are _____
- ★ I am here because _____

Appendix 10 Incomplete Sentences

1. I would like to _____
2. If I were the king _____
3. The people I like best _____
4. What I like about my family _____
5. Something I don't like to think about is _____
6. In hospital the people I like are _____
7. Most of my friends don't know that I am afraid of _____
8. When I had to go to hospital I felt _____
9. I feel very sad when _____
10. I am not very good at _____
11. I wish I could loose the fear of _____
12. When I am older _____
13. When I am scared I _____
14. I hate it when _____
15. My friends _____
16. In hospital what helps me to feel better is _____
17. At night at the hospital _____
18. Doctors make me feel _____
19. My favourite place to be is _____
20. My worst experience in the hospital has been _____
21. Sometimes I dream about _____
22. When the doctor comes I _____
23. What I miss the most from home is _____
24. Something that really bothers me _____
25. When I need to talk to someone I talk to _____
26. When I have to try something new I _____
27. When they take my blood I _____
28. Taking my medicine _____
29. I am very good at _____
30. I like to be alone when _____
31. I get anxious when _____
32. When children stay in hospital they feel _____
33. Right now I feel _____
34. What I miss about school _____
35. My favourite animal is _____
36. Other children _____
37. I am happiest when _____
38. If I had 3 wishes I would wish for _____
39. I don't like to be alone when _____
40. I worry a lot about _____
41. When my family goes on holiday we _____
46. Being in hospital is _____

Appendix 11: Meditation - The Ally Within/Safe Place

Close your eyes and focus your attention on your breath, moving in...and ... out ... in...and ... out ... of your nostrils. Is the air cold or warm? How are you breathing? Are you taking deep breaths or are you breathing with small, quick breaths? I would like you to take a couple of very deep breaths now. Now breath at your normal rate. As you continue to breath this way I want you to imagine that you are on a path in a very thick forest. It is a beautiful forest with the most luscious green trees and the most colourful flowers of hundreds of different kinds. As you walk you decide to stop and you smell the fragrances of the flowers and the trees and you listen to the sounds of the forest. The birds are singing, the crickets are chirping, you also hear the sound of flowing water. You decide to follow this sound of the water. You come to a small stream and walk over to it and kneel down and run your hand through the water. It is so cool and calming. You feel thirsty so you take a drink from the stream.

What does it taste like? Is it cold; Is it sweet tasting. It soothes your thirst. Then you look into the water and you see your reflection in the water. (Pause).

Suddenly you feel this warm presence standing next to you and you feel completely safe. In the water you see another reflection join yours in the water. This other presence may be that of an old wise being, an animal, or an imaginary being who you feel is your ally, someone whom you have known for a long time, someone whom you can trust. Your ally takes your hand and you feel the warmth from his/her hand and you go with your ally across a bridge to the other side of the stream. You follow and find yourself climbing a hill. Suddenly you find yourself in a place that is your safe place. It could be a place that you have been to or just a place that feels special to you. It could be a place by the beach. Do you like the sea, walking on the beach with the smooth sand under your feet and listening to the waves and the seagulls in the sky? Or maybe you prefer a calm forest with the birds singing up in the trees, and the leaves of the trees giving you safe cover from the sun. Your safe place could even be out of space on your own planet or on the moon. But wherever this place is it is your safe place where you can go to any time you need to just by closing your eyes and imagining the place in your head. And your ally is always with you in your safe place.

Your ally tells you that you may return to this safe and calm place and to visit any time you wish. He/she will always be there waiting for you to help with anything that you may need.

You thank your ally, walk back down the path over the bridge, looking once again at your reflection in the water. You notice how you feel as you walk up the path, out of the forest, and become aware of sitting here in this room, fully present. You feel safe and calm. Count to three to yourself and slowly open your eyes.

(Adapted from Murdock, 1987: 87)

Appendix 12: Healing Cells Meditation

Close your eyes.

Begin to focus your attention on how you are breathing.

Notice how the air around you feels, and notice the air that is now going into your body and out of your body.

The air is entering in your nostrils, and is leaving through your nostrils.

Breathe in and out, in and out....

Is the air warm or cold, ...

Lets take a few deep breaths, In and out, in and out...

Today we are going to communicate some healing commands to your body.

We are going to send your body some healing messages.

I want you to now think of your heart. It is beating and sending all the blood throughout your body. Just imagine how it's working right now. Blood is flowing in and out of your heart and into your body to your brain. Now imagine a strong, powerful army of white healing cells, swimming through your blood system, like a school of fish.

This school of strong with healing cells cleanses your body and purifies your whole immune system. It cleans your all the different parts of your body, your muscles, and bones, your skin, your hair, and it destroys and cleans out all the bad parts, all the disease, all the parts that are sick, as it travels through your body.

Feel the powerful healing energy of this school of white healing cells, as it swims through your blood stream.

(Pause for 2 minutes).

Your body is now strong, and healthy, and pure. Feel it now how strong it feels.

I will now count to ten; Join me at the count of six, opening your eyes at the count of ten. When you open your eyes you will feel relaxed and awake. One... two...three... four...five...six...seven...eight...nine...ten.

(Murdock, 1987: 105)

Appendix 13: Questionnaire For Termination Of Play Therapy

1. How did the play therapy make you feel?
2. What did you learn from the play therapy?
3. What would it do for other children?
4. Did you notice any changes inside you after the play therapy?
5. What did you notice?
6. Do you think play therapy will help other children?
7. Does the hospital make you feel anxious sometimes?
8. If you could have the play therapy more often would it help you to feel better?
9. Does play therapy help you to feel better?
10. What do you worry about now, while you are in hospital?
11. What would help you to feel better?
12. What else would you like to say about our time together?

BIBLIOGRAPHY

- Ablon, S.L. 1996. The therapeutic action of play. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35(4): 545-547
- Adams, M. A. 1976. A hospital play program: Helping children with serious illness. *American Journal of Orthopsychiatry*, 46(3): 416-424.
- Adams, D. E. & Deveau, E. J. 1984. *Coping With Childhood Cancer*. Ontario: Kinbridge
- Amatruda, K. 1998. Glimpsing sacred mountain: A brief sandplay process of a boy with cancer. *Journal of Sandplay Therapy*, VII(2): 71-91.
- Anastas, J. E. 1999. *Research Design for Social Work and the Human Sciences*. 2nd ed. New York: Columbia University Press.
- Angrosino, M. V. & De Pérez, K. A. M. 2000. Rethinking observation. In Denzin, N.K. & Lincoln, Y.S. 2000. *Handbook of Qualitative Research*. 2nd ed. Thousand Oaks: Sage Publications
- Armstrong, F. D. 1995. Commentary: Childhood Cancer. *Journal of Pediatric Psychology*, 20(4): 417-421
- Austin, J. K., & Huberty, T. J. 1993. Development of the child attitude toward illness scale. *Journal of Pediatric Psychology*, 18(4): 467-480.
- Axline, V. 1993. *Play Therapy*. New York: Ballantine Books.
- Babbie, E. & Mouton, J. 2001. *The Practice of Social Research*. Oxford: Oxford University Press.
- Barnett, L. A. 1984. Research note: Young children's resolution of distress through play. *Journal of Child Psychology and Psychiatry*, 25(3): 477-483.
- Barraclough, J. 1999. *Cancer and Emotion. A Practical Guide to Psycho-oncology*. 3rd edition. Chichester: John Wiley & Sons.

- Barrera, M. E., Rykov, M. H., & Doyle, S. L. 2002. The effects of interactive music therapy on hospitalized children with cancer: A pilot study. *Psycho-Oncology*, 11: 379-388
- Bennett, D. S. 1994. Depression among children with chronic medical problems: a meta-analysis. *Journal of Pediatric Psychology*, 19(2): 149-169
- Blom, R. 2004. *Handbook Of Gestalt Play Therapy*. Fichardtspark: Drufoma
- Blount, R. L., Davis, N., Powers, S. W., & Roberts, M. C. 1991. The influence of environmental factors and coping style on children's coping and distress. *Clinical Psychology Review*, 11: 93-116
- Bolig, R. 1984. Play in hospital settings. In Yawkey, T. D. & Pellegrini, A. D. 1984. *Child's Play: Developmental and Applied*. Hillside. New Jersey: Lawrence Erlbaum Associates, Publishers
- Bolig, R., Fernie, D.E., & Klein, E.L. 1986. Unstructured play in hospital settings: An internal locus of control rationale. *Child Health Care*, 15(2): 101-107
- Bossert, E. 1994. Factors influencing the coping of hospitalized school-age children. *Journal of Pediatric Nursing*, 9(5): 299-306.
- Bowmer, N. 2002. Therapeutic play and the impact on anxiety in hospitalized children. *Kentucky Nurse*, 50(1):15
- Brendell, J. R. 1988. Storytelling in child psychotherapy. In Schaefer, C. E. 1988. *Innovative Interventions in Child and Adolescent Therapy*. New York: John Wiley & Sons.
- Brown, J. M., O'Keefe, J., Sanders, S. H., & Baker, B. 1986. Developmental changes in children's cognition to stressful and painful situations. *Journal of Pediatric Psychology*, 11: 343-357.
- Brown, R.T., Madan-Swain, A., Walco, G.A., Cherrick, I., Ievers, C.E., Conte, P.M., Vega, R., Bell, B. & Lauer, S.J. 1998. Cognitive and Academic late effects among children previously treated for acute Lymphocytic Leukemia receiving chemotherapy as CNS Prophylaxis. *Journal of Paediatric Psychology*, 23(5): 333-340.

Brownell, P. 2003. Gestalt global's Gestalt therapy construct library: Constructs from "g" through "p". *Gestalt!*, 7(1). [O]. Available: <http://www.g-gej.org/7-1/a-c.html>
Accessed 2004/03/04

Burbach, D., & Peterson, L. 1986. Children's concepts of physical illness: A review and critique of the cognitive developmental literature. *Health Psychology*, 15: 307-325.

Burns B. S. 1970. The use of play techniques in the treatment of children. *Child Welfare*, XLIX(1): 37-41

Bush, J.P., Melamed, B. J., Sheras, P. L., & Greenbaum, P. E. 1986. Mother-child patterns of coping with anticipatory medical stress. *Health Psychology*, 5(2): 137-157.

Carroll, F. & Oaklander, V. 1997. Gestalt play therapy. In O'Connor, K. & Braverman, L.M. 1997. *Play Therapy and Practice. A Comparative Presentation*. New York: John Wiley & Sons Inc.

Chambers, M. A. 1993. Play as therapy for the hospitalized child. *Journal of Clinical Nursing*, 2: 349-354.

The Chambers Dictionary. 2000. Edinburgh: Chambers.

Chen, E., Zelter, L. K., Craske, M. G., & Katz, E. R. 2000. Children's memories for painful cancer treatment procedures: Implications for distress. *Child Development*, 71(4): 933-947.

Childhood Cancer Foundation of South Africa – CHOC. [sa].

[O]. Available:

www.choc.org.za/cancer_facts.html

Accessed 2006/09/22

Christians, C. G. 2000. Ethics and politics in qualitative research. In Denzin, N.K. & Lincoln, Y.S. 2000. *Handbook of Qualitative Research*. 2nd ed. Thousand Oaks: Sage Publications.

Chronically ill kids put up defences to hide depression. 2002. *Ascribe Newswire: Health*, 29 January: 4. [O]. Available:

<http://web17.epnet.com/DeliveryPrintSave.asp?tb=1& ug=sid+BECC78C4-6C0B-4038-A44B-045E...>

Accessed on 2005/02/25

Claar, R. L., Walker, L.S., & Smith, C. A. 2002. The influence of appraisals in understanding children's experiences with medical procedures. *Journal of Pediatric Psychology*, 27(7): 553-563

Councill, T. 2003. Medical art therapy with children. In Malchiodi, C.A. *Handbook of Art Therapy*. 2003. New York: The Guilford Press.

Cox, C. T. 2003. The MARI Assessment. In Malchiodi, C.A. *Handbook of Art Therapy*. 2003. New York: The Guilford Press.

Creswell, J.W. 2003. *Research Design. Qualitative Quantitative and Mixed Method Approaches*. Thousand Oaks: Sage Publications

Crisp, J., Ungerer, J. A. & Goodnow, J. J. 1996. The impact of experiences on children's understanding of illness. *Journal of Pediatric Psychology*, 21(1): 57-72

Cummings, E. E. 1960. *Selected Poems. 1923-1958*. London: Faber and Faber

D'Alessandro, D. & Huth, L. 2002. Children and anxiety. [O]. Available:

<http://www.vh.org/pediatric/patient/pediatrics/cqqa/anxiety.html#1>

Accessed on 2005/01/15

DeBord, K. & Amann, N. 1993. Beyond play. Benefits of play in children: Age specific interventions. In *Stress and Coping with Disaster* manual from University Extension in Columbia, Missouri. [O]. Available:

<http://www.ces.ncsu.edu/depts/fcs/human/disas4.html>

Accessed on 2005/08/03

De Clercq, B., De Fruyt, F., Koot, H. M., & Benoit, Y. 2004. Quality of life in children surviving cancer: A personality and multi-informant perspective. *Journal of Pediatric Psychology*, 29(8): 579-590.

- Dejong, M. & Fombonne, E. 2006. Depression in paediatric cancer: an overview. *Psycho-oncology*, 15: 553-556.
- Denzin, N.K. & Lincoln, Y.S. 2000. *Handbook of Qualitative Research*. 2nd ed. Thousand Oaks: Sage Publications.
- De Vos, A. S. 2005. Qualitative data analysis and interpretation. In De Vos, A. S., Strydom, H., Fouché, C. B. & Delpont, C. S. I. 2005. *Research at Grass Roots*. 3rd ed. Pretoria: Van Schaik Publishers.
- De Vos, A. S. 2002. Combined quantitative and qualitative approach. In De Vos, A. S., Strydom, H., Fouché, C. B. & Delpont, C. S. I. 2005. *Research at Grass Roots*. 3rd ed. Pretoria: Van Schaik Publishers.
- De Vos, A. S., Strydom, H., Fouché, C. B. & Delpont, C. S. I. 2005. *Research at Grass Roots*. 3rd ed. Pretoria: Van Schaik Publishers.
- Di Gallo, A. 2003. While my sister went to the disco, I went to hospital and met the doctors: Narrative as a measure of the psychological integration of the experience of cancer in childhood and adolescence. *Clinical Child Psychology and Psychiatry*, 8 (4): 489-502.
- Doverty, N. 1992. Therapeutic use of play in hospital. *British Journal of Nursing*, 1(2): 77-81
- Eisen, A.R. & Kearney, C. A. 1995. *Practitioner's Guide to Treating Fear and Anxiety in Children and Adolescents*. 8th ed. London: Jason Aronson Inc.
- Eiser, C., Hill, J. J., & Vance, Y. H. 2000. Examining the psychological consequences of surviving childhood cancer: Systematic review as a research method in pediatric psychology. *Journal of Pediatric Psychology*, 25(6): 449-460.
- Eiser, C. 1990. Psychological effects of chronic disease. *Journal of Child Psychology and Psychiatry*, 31(1) 85-98
- Eiser, C. 1998. Practitioner review: Long-term consequences of childhood cancer. *Journal of Child Psychology and Psychiatry*, 39(5): 621-633.

- Elkin, D. T., Whelan, J. P., Meyers, A. W., Phipps, S., & Glaser, R. R. 1998. The effect of achievement orientation on response to success and failure in pediatric cancer patients. *Journal of Pediatric Psychology*, 23(1): 67-76.
- Elliott, C.H., Jay, S. M., & Woody, P. 1987. An observation scale for measuring children's distress during medical procedures. *Journal of Pediatric Psychology*, 12(4): 543-554.
- Ellis, J. 2000. Games without frontiers. *Nursing Times*, 96(26): 32-33
- Emmanuel, R. 2001. *Ideas in Psychoanalysis. Anxiety*. Duxford, Cambridge: Icon Books.
- Erikson, E. 1981. *Childhood and Society*. Granada: Triad.
- Fahrenfort, J.J, Jacobs, E. A. M., Miedema, S., & Schweizer, A. T. 1996. Signs of emotional disturbance three years after early hospitalization. *Journal of Pediatric Psychology*, 21(3): 353-366.
- Favara-Scacco, C., Smirne, G., Schiliro, G., & Di Cataldo, A. 2001. Art therapy as support for children with Leukemia during painful procedures. *Medical and Pediatric Oncology*, 36: 474-480
- Fish, M. C. 1988. Relaxation training for childhood disorders. In Schaefer, C. E . 1988. *Innovative Interventions in Child and Adolescent Therapy*. New York: John Wiley & Sons.
- Fonseca, A. C., & Perrin, S. 2001. Clinical phenomenology and assessment of anxiety disorders in children and adolescents. In W. K. Silverman & P. D. A Treffers. 2001. *Anxiety Disorders in Children and Adolescents. Research, Assessment and Intervention*. Cambridge: Cambridge University Press.
- Forsbach, T., & Thompson. 2003. The impact of childhood cancer on adult survivors' interpersonal relationships. *Child Care in Practice*, 9(2): 117-128.
- Fouché , C. B & De Vos, A.S. 2005. Problem Formulation. In De Vos, A. S., Strydom, H., Fouché, C. B. & Delpont, C. S. I. 2005. *Research at Grass Roots*. 3rd ed. Pretoria: Van Schaik Publishers.
- Frank, N. C., Blount, R. L., & Brown, R. T. 1997. Attributions, coping, and adjustment in children with cancer. *Journal of Pediatric Psychology*, 22(4): 563-576.

- Frankenfield, P.K. 1996. The power of humour and play as nursing interventions for a child with cancer: a case report. *Journal of Pediatric Oncology Nursing*, 13(1): 15-20.
- Freud, A. 1952. The role of bodily illness in the mental life of children. *Psychoanalytic Study of the Child*, 7: 69-81.
- Furth, G. M. 2002. *The Secret World of Drawings*. Toronto: Inner City Books
- Gaynard, L., Goldberger, J. & Laidley. 1991. The use of stuffed, body-outline dolls with hospitalized children and adolescents. *Child Health Care*, 20(4): 216-224
- Gariépy, N & Howe, N. 2003. The therapeutic power of play: examining the play of young children with Leukemia. *Child: Care, Health and Development*, 29(6): 523-537.
- Garnezy, N. 1983. Stressors of childhood. In Garnezy N & Rutter M. 1983. *Stress, Coping and Development in Children*. New York: McGraw-Hill.
- Garth, M. 1992. *Moonbeam*. North Blackburn, Victoria: Collins Dove
- Gibbens, M. B. & Boren, H. 1985. Stress reduction: a spectrum of strategies in paediatric oncology nursing. *Nursing Clinics of North America*, 20(1): 83-103
- Gilmore, J. B. 1966. The role of anxiety and cognitive factors in childhood play behaviour. *Child Development*, 37: 397-416
- Golden, D. B. 1983. Play therapy for hospitalized children. In C. E. Shaefer & K. J. O'Connor. 1983. *Handbook of Play Therapy*. New York: John Wiley & Sons, Inc
- Goldberger, J. 1988. Issue specific play with infants and toddlers in hospitals: rationale and intervention. *Child Health Care*, 16(3): 134-141
- Goldberger, M. 1995. Enactment and play following medical trauma. *Psychoanalytic Study of the Child*, 50: 252-271.
- Goodman, R. F. 2001. Children with a chronic illness: The interface of medicine and mental health. *Child Study Center*, 5(4).

- Goodman, R. F. 1991. Diagnosis of childhood cancer. In N. B. Webb. 1991. *Play Therapy With Children in Crisis. A Casebook for Practitioners.* New York: The Guilford Press.
- Gottlieb, S. E. & Portnoy, S. 1988. The role of play in a pediatric bone marrow transplantation unit. In *Children's Health Care*, 16 (3): 177-181.
- Greeff, M. 2002. Information collection: interviewing. In De Vos, A. S., Strydom, H., Fouché, C. B. & Delpont, C. S. I. 2005. *Research at Grass Roots.* 3rd ed. Pretoria: Van Schaik Publishers.
- Gross, A. M. & Drabman, R. S. 1990. *Handbook of Clinical Behavioural Pediatrics.* New York: Plenum Press
- Haiat, H., Bar-Mor, G., & Shochat, M. 2003. The world of the child: A world of play even in the hospital. *Journal of Pediatric Nursing*, 18(3): 209-214
- Hall, D. & Cleary, J. 1988. The development of play for children in hospitals: British and European perspectives. *Child Health Care*, 16(3): 223-230.
- Halteren, H. K., Bongaerts, G.P.A., & Wagener, D. J. 2004. Cancer and psychosocial distress: frequent companions. *The Lancet*, 364 (9437), 824-825.
- Hakim, C. 2000. *Research Design. Successful Designs for Social and Economic Research.* 2nd ed. London: Routledge
- Harbeck-Weber, C. & MaKee, D. H. 1995. Prevention of emotional and behavioural distress in children experiencing hospitalization and chronic illness. In Roberts, M. C. 1995. *Handbook of Pediatric Psychology.* 2nd ed. New York: The Guilford Press.
- Hart, D. & Bossert, E. 1994. Self-reported fears of hospitalized School aged children. *Journal of Pediatric Nursing*, 9(2): 83-90
- Hart, R., Mather, P. L., Slack, J.F. & Powell, M. A. 1992. *Therapeutic Play Activities for Hospitalized Children.* St Louis: Mosby Year Book.
- Hay, L. L. 2006. *You Can Heal Your Life.* Carls, California: Hay House, Inc .

Hellendorn, J. 1988. Imaginative play technique in psychotherapy with children. In Schaefer, C. E. . 1988. *Innovative Interventions in Child and Adolescent Therapy*. New York: John Wiley & Sons.

Hodges, C. 1994. Easing children's pain. *Nursing Times*, 94(10): 55-58.

Jay, S. M. 1988. Invasive medical procedures: Psychological intervention and assessment. In Routh, D.K. 1988. *Handbook of Pediatric Psychology*. New York

Janesick, V.J. 2000. The choreography of qualitative research design. Minuets, improvisations, and crystallization. In Denzin, N.K. & Lincoln, Y.S. 2000. *Handbook of Qualitative Research*. 2nd ed. Thousand Oaks: Sage Publications.

Johnson, M. R., Witt, J. K. & Martin, B. 1987. The effect of fantasy facilitation of anxiety in chronically ill and healthy children. *Journal of Pediatric Psychology*, 12(2): 273-284.

Jones, E.M. 2001. Play therapy for children with chronic illness. In Landreth, G. 2001. *Innovations in Play Therapy*. New York: Brunner Routledge.

Kaduson, H.G. & Schaefer, C. E. 2000. *Short-Term Play Therapy for Children*. New York: Guilford

Katz, E. R., Kellerman, J., & Siegel, S. E. 1980. Behavioural distress in children with cancer undergoing medical procedures: Developmental considerations. *Journal of Consulting and Clinical Psychology*, 48: 356-365

Katz, J., Kellerman, J., & Siegel, S. E. 1981. Anxiety as an affective focus in the clinical study of acute behavioural distress: A reply to Shacham & Daut.. *Journal of Consulting and Clinical Psychology*, 49(3): 470-471.

Kendall, P. C. 1992. The nature of anxiety and its disorders in youth. *Anxiety disorders in youth. Cognitive-Behavioural Interventions*. Needham Heights: Allyn and Bacon

Kielhofner, G., Barris, R., Bauer, D., Shoestock, B., & Walker, L. 1983. A comparison of play behaviour in nonhospitalised and hospitalized children. *The American Journal of Occupational Therapy*, 37(5): 305-312

King, N., J., Gullone, E & Ollendick, T. H. 1990. Fears in children and adolescents with chronic medical conditions. *Journal of Clinical Child Psychology*, 19: 173-177.

Kirchner, M. 2000. Gestalt therapy theory: An overview. *Gestalt!*, 4(3). [O]. Available
<http://www.g-gej.org/4-3/theoryoverview.html>

Accessed 2004/07/01

Klorer, P. G. 2003. Sexually abused children: Group approaches. In Malchiodi, C. A. *The Art Therapy Sourcebook*. 2007. New York: McGraw Hill

Klosky, J.L., Tyc, V.L., Srivastava, D. K., Tong, X., Kronenberg, M., Booker, S. J., de Armendi, A. J., & Merchant, T. E. 2004. Brief Report: Evaluation of an interactive intervention designed to reduce pediatric distress during radiation therapy procedures. *Journal of Pediatric Psychology*, 29 (8), 621-626.

Korb, M. P., Gorrell, J., & Van de Riet, V. 1993. *Gestalt Therapy: Practice and Theory*. 2nd ed. New York: Pergamon.

Krietemeyer, B. C., & Heiney, S. P. 1992. Storytelling as a therapeutic technique in a group of school-aged oncology patients. *Child Health Care*, 21(1): 14-20

Kuykendall, J. 1988. Play therapy. In Oakhill, A. 1988. *The Supportive Care of the Child with Cancer*. London: Wright.

Lampert, R. 2003. *A Child's Eye View*. Goulsboro: The Gestalt Journal Press.

Lander, J., Hodgins, M., & Fowler-Kerry, S. 1984. Children's pain predictions and memories. *Behaviour Research and Therapy*, 30: 117-124

Landreth, G. L. 1991. *Play Therapy: The Art of The Relationship*. Brunner-Routledge: New York

Landreth, G. L. 2001. *Innovations in Play Therapy*. New York: Brunner Routledge

Landreth, G. L. 2001. Facilitative dimensions of play in the play therapy process. In Landreth, G. L. 2001. *Innovations in Play Therapy*. New York: Brunner Routledge

Landreth, G. & Bratton, S. 1999. Play therapy. *ERIC Clearinghouse on Counseling and Student Services*. [O]. Available

<http://0-web17.epnet.com.oasis.unisa.ac.za>

Accessed 2006-02-07

Langton, H. 2000. *The Child With Cancer*. Edinburgh: Brailiere Tindall

LeBaron, S., & Zelter, L. 1984. Assessment of acute pain and anxiety in children and adolescents by self-reports, observer reports, and a behaviour checklist. *Journal of Consulting and Clinical Psychology*, 52: 729-738

Lentz, K. 1985. Fears and worries of young children as experienced in a contextual play setting. *Journal of Child Psychology and Psychiatry*, 26(6): 981-987.

Lewis, D. 2002. *Helping Your Anxious Child*. 2nd ed. London: Vermilion

Lioffi, C. 2002. The place of clinical hypnosis in the pediatric oncology setting. *Hypnos*, xxix(3): 106-111

Lingnell, L. & Dunn, L. 1999. Wholeness and healing for the hospitalized child. In Sweeney, D.S. & Homeyer, L.E. 1999. *The Handbook of Group Play Therapy: How To Do It. How It Works. Whom Its Best For*. San Francisco: Jossey-Bass Publishers

Lizasoain, O. & Polaino, A. 1995. Reduction of anxiety in pediatric patients: effects of a psychopedagogical intervention programme. *Patient Education and Counselling*, 25: 17-22

Lockwood, K.A., Bell, T.S. & Colegrove, R.W. 1999. Long-term effects of cranial radiation therapy on attention functioning in survivors of childhood leukaemia. *Journal of Paediatric Psychology*, 24 (1): 55-66

Loranger, N. 1992. Play intervention strategies for the Hispanic toddler with separation anxiety. *Pediatric Nursing*, 18(6): 571-575.

Lous, A. M., de Wit, C. A. M., De Bruyn, E. E. J., & Riksen-Walraven, J. M. 2002. Depression markers in young children's play: A comparison between depressed and nondepressed 3- to 6- year olds in various play situations. *Journal of Child Psychology and Psychiatry*, 43(8): 1029-1038

Malan, M. 2003. *Coping skills of the oncology child: an educational psychological perspective*. Unpublished M.A. (Education with Specialization in Guidance and Counselling) dissertation. University of South Africa.

- Malchiodi, C.A. *Handbook of Art Therapy*. 2003. New York: The Guilford Press.
- Malchiodi, C. A. *The Art Therapy Sourcebook*. 2007. New York: McGraw Hill
- Manne, S., & Miller, D. 1998. Social support, social conflict, and adjustment among adolescents with cancer. *Journal of Pediatric Psychology*, 23(2): 121-130.
- Marans, S., Mayes, L., Cicchetti, D., Dahl, K., Marans, W., & Cohen, D. J. 1991. The child-psychoanalytic play interview: a technique for studying thematic content. *Journal of the American Psychoanalytic Association*, 39(4): 1015-1036
- Marshall, C. & Rossman, G.B. 1995. *Designing Qualitative Research*. 2nd ed. Thousand Oaks: Sage Publications
- Massimo, L., Zarri, D., & Caprino, D. 2005. Psychosocial aspects of survivors of childhood cancer or leukaemia. *Minerva Pediatrics*, 57 (6): 389-397.
- Matthews, D.A. & Lonsdale, R. 1992. Children in hospital: Reading therapy and children in hospital. *Health Libraries Review*, 9: 14-26.
- May, B. K. & Sparks, M. 1983. School age children: are their needs recognised and met in the hospital setting? *Children's Health Care*, 11(3): 118-121.
- McCandless, M. 1981. Play therapy: Alleviating fear of the hospital. *Health Care Education*, 10(3): 18-21
- McCue, K. 1988. Medical play: an expanded view. *Child Health Care*, 16(3): 157-161
- McArdle, P. 2001. Children's play. *Child: Care, Health and Development*, 27(6): 509-514
- McGrath, P., & Huff, N. 2001. 'What is it?': Findings on preschoolers' responses to play with medical equipment. *Child: Care, Health and Development*, 27(5): 451-462.
- MedicineNet.com. [sa]. [O] Available:
<http://www.medicinenet.com/script/main/hp.asp>
 Accessed on 2007/10/10

Meijer, S. A., Sinnema, G, Bijstra, J. O., Mellenbergh, G. J. & Wolters, W. H. G. 2000. Social functioning in children with a chronic illness. *Journal of Child Psychology and Psychiatry*, 41(3): 309-317.

Melamed, B. G. 1979. Behavioural approaches to fear in dental settings. In Hersen M, Eisler, R.M., & Miller, P.M. 1979. *Progress in Behaviour Modification*, Vol 7. New York: Academic Press.

Melamed, B. G., & Siegel, L. J. 1985. Children's reactions to medical stressors: An ecological approach to the study of anxiety. In Tuma, A. H. & Maser, J. 1985. *Anxiety and the Anxiety Disorders*. Hillsdale, NJ: Erlbaum.

Mellins, C. A., Gatz, M., & Baker, L. 1996. Children's methods of coping with stress: A twin study of genetic and environmental influences. *Journal of Child Psychology and Psychiatry*, 37(6): 721-730.

Melnyk, B. M. 1995. Coping with unplanned hospitalization: The mediating functions of parental beliefs. *Journal of Pediatric Psychology*, 20(3): 299-312

Mitchell, W., Clarke, S., & Sloper, P. 2006. Care and support needs of children and young people with cancer and their parents. *Psycho-Oncology*, 15: 805-816.

Morcombe, J. 1998. Reducing anxiety in children in A&E. *Emergency Nurse*, 6(2): 10-13.

Mouton, J. 2005. *How to Succeed in Your Master's and Doctoral studies. A South African Guide and Resource book*. Pretoria: Van Schaik Publishers

Murdock, M. 1987. *Spinning Inward. Using Guided Imagery with Children for Learning, Creativity and Relaxation*. Boston: Shambala

Jones, M. E. 2001. Play therapy for children with chronic illness. In Landreth, G. 2001. *Innovations in Play Therapy*. New York: Brunner Routledge

National Cancer Institute. 1999. [O]. Available:

http://healthlink.mcw.edu/content/email-article/email_form.pl?9262344

Accessed 2003/11/26

The New Penguin English Dictionary. 2001. Hammondsworth, Middlesex: Penguin Books.

Newman, I. & Benz, C.R. 1998. *Qualitative-Quantitative Research Methodology. Exploring the Interactive Continuum*. Carbondale: Southern Illinois University Press.

Noll, R. B., Maclean, W. E., Whitt, J. K., Kaleita, T. A., Stehbens, J. A., Waskerwitz, M. J., Ruymann, F. B., & Hammond, G. D. 1997. Behavioural adjustment and social functioning of long-term survivors of childhood Leukemia: Parent and teacher reports. *Journal of Pediatric Psychology*, 22(6): 827-841

Oaklander, V. 1988. *Windows To Our Children: A Gestalt Therapy Approach To Children And Adolescents*. Moab, UT: Real People Press.

Oaklander, V. 1993. From meek to bold: A case study of Gestalt Play therapy. In Kottman, T & Schaefer, C. E. 1993. *Play Therapy In Action: A Casebook for Practitioners*. London: Jason Aronson

Oaklander, V. 1997. The therapeutic process with children and adolescents. *Gestalt Review*, 1 (4): 392-317.

Oaklander, V. 1999. Group play from a Gestalt therapy perspective. In Sweeney, D. S. & Homeyer, L. E. 1999. *Handbook of Group Play Therapy. How to Do It. How It Works. Whom Its Best For*. San Francisco: Jossey-Bass Publishers.

Oaklander, V. 2000. Short-term Gestalt play therapy for grieving children. In Kaduson, H G. & Shaefer, C. E. 2000. *Short-Term Play Therapy for Children*. New York: Guilford

Ollendick, T. H. & King, N. J. 1991. Origins of childhood fears: An evaluation of Rachman's theory of fear acquisition. *Behaviour Research and Therapy*, 29: 117-123.

Online Medical Dictionary. [sa]. [O]. Available:
<http://cancerweb.ncl.ac.uk/cgi-bin/omd?Burkitt's+lymphoma>
Accessed on 2007/10/10

Papaikonomou, M. & Nieuwoudt, J. 2004. Exploring parents' stories of coping with their child's cancer: A qualitative study. *South African Journal of Psychology*, 34 (2): 283-300.

Passons, W. 1975. *Gestalt Approaches in Counselling*. New York: Holt, Rinehart & Winston.

- Patenaude, A. F. & Kupst, M. J. 2005. Psychosocial functioning in pediatric cancer. *Journal of Pediatric Psychology*, 30 (1): 9-27.
- Patenaude, A. F. & Last, B. 2001. Cancer and children: where are we coming from? Where are we going? *Psycho-oncology*, 10: 281-283.
- Patton, M. Q. 2002. *Qualitative Research and Evaluation Methods*. 3rd ed. Thousand Oaks, California: Sage Publications
- Perls, F., Hefferline, R. F. & Goodman, P. 1951. Gestalt Therapy. *Excitement and Growth in the Human Personality*. Berkshire: Souvenir
- Peterson, L., Mori, L., & Carter, P. 1985. The role of the family in children's responses with medical procedures. *Journal of Child Clinical Psychology*, 14: 98-104.
- Petrillo, M. & Sanger, S. 1980. *Emotional Care of Hospitalized Children*. Philadelphia: J. B. Lippincott Company
- Phipps, S. 2002. Chronically ill kids put up defences to hide depression. *Ascribe Newswire: Health, January: 4*
- Phipps, S., Faiclough, D., & Mulhern, R. K. 1995. Avoidant coping in children with cancer. *Journal of Pediatric Psychology*, 20(2): 217-232.
- Phipps, S, Larson, S, & Long, A. 2006. Adaptive style and symptoms of post traumatic stress in children with cancer and their parents.
- Prins, P. J. M. 1994. Anxiety in medical settings. In Ollendick T. H., King, N.J., & Yule, W. 1994. *International Handbook of Phobic and Anxiety Disorders in Children and Adolescents*. New York: Plenum Press
- Rae, W. A., Worchel, F. F., Upchurch, J., Sanner, J. H. & Daniel, C. A. 1989. The psychosocial impact of play on hospitalized children. *Journal of Pediatric Psychology*, 14: 617-627.
- Raymond-Speden, E., Tripp, G., Lawrence, B., & Holdaway, D. 2000. Intellectual, neuropsychological and academic functioning in long-term survivors of Leukemia. *Journal of Pediatric Psychology*, 25(2): 59-68

Remocker, A.J. & Storch, E. T. 1992. *Action Speaks Louder . A Handbook of Structured Group Techniques*. 5th ed. Edinburgh: Churchill Livingstone.

Rennick, J. E., Morin, I., Kim, D., Johnston, C. C., Dougherty, G., & Platt, R. 2004. Identifying children at high risk for psychological sequelae after pediatric intensive care unit hospitalization. *Pediatric Critical Care Medicine*, 5(4): 358-363

Thompson, C. L. & Rudolph, L. B. 1992. *Counseling Children*. California: Brooks/Cole Publishing Company

Robb, S. L. 2000. The effect of therapeutic music interventions on the behaviour of hospitalized children in isolation: Developing a contextual support model of music therapy. *Journal of Music Therapy*, XXXVII(2): 118-146

Routh, D. K. 1988. *Handbook of Pediatric Psychology*. New York: Guilford Press.

Russ, S. W. 2004. *Play in Child Development and Psychotherapy: Toward Empirically supported Practice*. Mahwah, NJ: Lawrence Erlbaum

Sanger, M. S., Copeland, D. R., & Davidson, E. R. 1991. Psychosocial adjustment among pediatric cancer patients: a multidimensional assessment. *Journal of Paediatric Psychology*, 16(4): 463-474.

Santrock, J. W. 1995. *Life Span Development*. 4th ed. Dubuque, IA: WCB

Savins, C. 2002. Therapeutic work with children in pain. *Paediatric Nursing*, 14(5): 14-16.

Schaefer, C. E . 1988. *Innovative Interventions in Child and Adolescent Therapy*. New York: John Wiley & Sons.

Schisler, T., Lander, J., & Fowler-Kerry, S. 1998. Assessing children's state anxiety. *Journal of Pain and Symptoms Management*, 16(2): 80-86.

Schultz, J. B., Raschke, D., Dedrick, C., & Thompson, M. 1981. The effects of a preoperational puppet show in anxiety levels of hospitalized children. *Child Health Care*, 9(4): 118-121.

Seja, A. L., & Russ, S. W. 1999. Children's fantasy play and emotional understanding. *Journal of clinical and child psychology*, 28(2): 269-277.

- Shaughnessy, J. J., Zechmeister, E. B., & Zechmeister, J. S. 2003. *Research Methods in Psychology*. 6th ed. New York: McGraw-Hill
- Siegel, L. J. 1988(a). Measuring children's adjustment to hospitalization and to medical procedures. In P. Karoly. 1988. *Handbook Of Child Health Assessment: Biopsychological Perspectives*. New York: John Wiley.
- Simon, A. J. Illness and the psychodynamics of stressful life situations as seen in children's clinic. *Journal of Health and Human Behaviour*, 1(1): 13-17
- Skipper, J. K. & Leonard, R. C. 1968. Children, stress, and hospitalization: A field experiment. *Journal of Health and Social behaviour*, 9(4): 275-287
- Solomon, L. A. 2005. *Creative Beginnings. A Hands-On Innovative Approach to Artmaking For Adults and Children*. Johannesburg: STE Publishers
- Spinetta, J.J. & Maloney, J. L. 1975. Death anxiety in the outpatient leukemic child. *Pediatrics*, 56 (6): 1034-1037.
- Spirito, A., Stark, L. J., & Williams, C. 1988. Development of a brief coping checklist for use with pediatric populations. *Journal of Pediatric Psychology*, 13(4): 555-574
- Springer, K. 1994. Beliefs about illness causality among preschoolers with cancer: Evidence against immanent justice. *Journal of Pediatric Psychology*, 19(1): 91-102
- Stake, R. E. 2000. Case studies. In Denzin, N.K. & Lincoln, Y.S. 2000. *Handbook of Qualitative Research*. 2nd ed. Thousand Oaks: Sage Publications.
- Sturner, R. A. & RothbaumF. 1980. The effects of stress on children's human figure drawings. *Journal of Clinical Psychology*, 36(1): 324-331.
- Strydom, H. 2005. Single system design. In De Vos, A. S., Strydom, H., Fouché, C. B. & Delpont, C. S. I. 2005. *Research at Grass Roots*. 3rd ed. Pretoria: Van Schaik Publishers.
- Strydom, H. 2005. Sampling and sampling methods. In De Vos, A. S., Strydom, H., Fouché, C. B. & Delpont, C. S. I. 2005. *Research at Grass Roots*. 3rd ed. Pretoria: Van Schaik Publishers

Strydom, H. 2002. Ethical Aspects of Research in the Social Sciences and Human Service Professions. In De Vos, A. S., Strydom, H., Fouché, C. B. & Delport, C. S. I. 2005. *Research at Grass Roots*. 2nd ed. Pretoria: Van Schaik Publishers

Sweeney, D. S. & Homeyer, L. E. 1999. *Handbook of Group Play Therapy. How to Do It. How It Works. Whom Its Best For*. San Francisco: Jossey-Bass Publishers.

Susser, M. & Watson, W.B. 1969. Play and the sick child. *Lancet*, 15(1): 369

Taieb, O., Moro, M. R., Baubet, T., Revah-Lévy A. & Flament M. F. 2003. Posttraumatic stress symptoms after childhood cancer. *European Child and Adolescent Psychiatry*, 12 (6): 255-264).

Thompson, R. H. & Stanford, G. 1981. *Child Life in Hospitals*. Springfield, Illinois: Charles C. Thomas Publisher

Townley, M., & Welton, S. 2000. Coping mechanisms. In Langton, H. 2000. *The Child With Cancer*. Edinburgh: Brailliere Tindall

Van Halteren, H. K., Bongaerts, G.P.A., & Wagener, D. J. 2004. Cancer and psychosocial distress: frequent companions. *The Lancet*, 364 (9437), 824-825.

Vitulano, L. A. 2003. Psychosocial issues for children and adolescents with chronic illness: self esteem, school functioning and sports participation. *Child and Adolescent Psychiatric Clinics of North America*, 12: 585-592.

Wachtel, J., Rodrigue, J. R., Geffken, G. R., Grahem-pole, J & Turner, C. 1994. Children awaiting invasive medical procedures: do children and their mothers agree on child's level of anxiety? *Journal of Pediatric Psychology*, 19(6): 723-735.

Walker, C. 1989. Use of art and play therapy in pediatric oncology. *Journal of Pediatric Oncology*, 6(4): 121-126

Walker, C. L., Wells, L. M., Heiney, S. P. & Hymovich, D. P. 2002. Family centered psychosocial care. In Baggot, C. R., Kelly, K. P., Fochtman, D. & Foley, G. V. *Nursing Care of Children and Adolescents with Cancer*. 3rd ed. Philadelphia: W. B. Saunders Company.

Webb, N. B. 1991. *Play Therapy With Children in Crisis. A Casebook for Practitioners.* New York: The Guilford Press.

Webb, J.R. 1995. Play therapy with hospitalized children. *International Journal of Play Therapy*, 4 (1): 51-59.

Weininger, O. 1983. Play and the hospitalized child. *Canadian Counsellor*, 17(2): 67-74.

Wikipedia. 2007. [O]. Available:

<http://en.wikipedia.org/wiki/AIDS>

Accessed on 2007/10/14

Winfree, C., Williams, R., & Powell, G. M. 2002. Children with cancer: Positive benefits of camp. *The Camping Magazine. Martinsville*, 75 (6): 26-34.

Wilson, C. 1991. Use of children's artwork to evaluate the effectiveness of a hospital preparation programme. *Child Health Care*, 20(2): 120-121

Wilson, J. M. 1988. Future Play in health care settings. *Child Health Care*, 16(3): 231-237.

Wilson, K., Kendrick, P., & Ryan, V. 1992. *Play Therapy: A Non-Directive Approach for Children and Adolescents.* London: Baillière Tindall

Winnicott, D. 1964. *The Child, the Family and the Outside World.* Penguin: London.

Wojtasik, S & Sanborn, S. 1991. The crisis of acute hospitalization. Case of Seth, Age 7. In N. B. Webb. 1991. *Play Therapy With Children in Crisis. A Casebook for Practitioners.* New York: The Guilford Press.

Worchel, F. F., Nolan, B. F., Willson, V. L., Purser, J., Copeland, D. R., & Pfefferbaum, B. 1988. Assessment of depression in children with cancer. *Journal of Pediatric Psychology*, 13(1): 101-112.

Worchel, F. F., Copeland, D. R., & Barker, D. G. 1987. Control-related coping strategies in pediatric oncology patients. *Journal of Pediatric Psychology*, 12(1): 25-38

Wymore, J. 2002. Gestalten. *Gestalt!*, 6(2). [O] Available:

<http://www.g-gej.org/6-2/gestalten.html>

Accessed on 2004/03/02

Yan, H., Kantawang, S., Yinghua, Y. 1999. Selected factors influencing self-concept among hospitalized Chinese school-age children with a chronic illness. *International Journal of Nursing Practice*. 5: 38-46.

Yin, R. K. 2003. *Case Study Research. Design Methods*. 3rd ed. Thousand Oaks: Sage

Yawkey, T. D. & Pellegrini, A. D. 1984. *Child's Play: Developmental and Applied*. Hillside. New Jersey: Lawrence Erlbaum Associates, Publishers

Yin, R. K. 2003. *Case Study Research. Design and Methods*. 3rd ed. Thousand Oaks, California: Sage

Yontef, G. 1993. *Awareness, Dialogue and Process. Essays on Gestalt Therapy*. New York: Gestalt Journal Press.

Zelter, L. K., Lebaron, S., Richie, D. M., & Reed, D. 1988. Can children understand and use a rating scale to quantify somatic symptoms? Assessment of nausea and vomiting as a model. *Journal of Consulting and Clinical Psychology*, 56: 567-572