THE INTEGRATION OF GESTALT PLAY THERAPY IN OCCUPATIONAL THERAPY: A NEEDS ASSESSMENT

by

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DECLARATION

I hereby declare that **THE INTEGRATION OF GESTALT PLAY THERAPY IN OCCUPATIONAL THERAPY: A NEEDS ASSESSMENT** is my own work and that all the references that were used or quoted, were indicated and recognised.

_____ _____

SIGNATURE DATE

(Ms N Fourie)

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I would like to express my thanks to my family for their patience and support.

ABSTRACT

Many fields of interest, of which Pediatrics is one, exist in Occupational Therapy. In the field of Pediatrics there are also diversity fields of interest. Many diagnostic groups are treated in the field of Pediatric Occupational Therapy. The traditional Pediatric Occupational Therapy process aims at treating the child holistically with regards to his cognitive, perceptual, motor and emotional areas of development. It seems that there is a tendency to focus on the more tangible aspects of development rather than the less visible elements such as emotional needs and problems. The question that might be asked is whether Pediatric Occupational Therapists are in fact equipped to deal with emotional needs and problems.

Due to the nature of their work, there is a strong possibility that Pediatric Occupational Therapists can encounter children who suffer from emotional problems. These children are more often than not seen by Occupational Therapists although the therapists might prefer to rather work on the more tangibly aspects of development.

This research study was aimed at assessing the need amongst Pediatric Occupational Therapists to deal with emotional problems. After completing the study it was possible to make valuable conclusions and recommendations. Gestalt Play Therapy was also proposed as a possible approach in dealing with children's emotional needs and problems in the course of their Occupational Therapy intervention.

OPSOMMING

Arbeidsterapie omsluit ‘n breë spektrum van spesialiteitsrigtings, waarvan Pediatrie een is. Binne die veld van Pediatrie blyk daar egter verdere diversiteit te wees met betrekking tot die diagnostiese groepe wat binne hierdie veld hanteer word. Die tradisionele Pediatriese Arbeidsterapie proses het ten doel om die kind holisties te benader met verwysing na die kognitief -perseptuele, motoriese en emosionele ontwikkelingsareas van die kind. Dit blyk egter dat daar ‘n geneigdheid is, en moontlik ook groter gemak bestaan om eerder aan die meer sigbare aspekte soos byvoorbeeld perseptuele en motoriese ontwikkeling te werk. Die vraag kan dus gevra word of Arbeidsterapeute genoegaam toegerus is om ook aan die emosionele behoeftes en probeleme van die kind aandag te kan gee.

Die moontlikheid dat Arbeidsterapeute vanwee die diversiteit met betrekking tot die diagnostiese groepe wat ter sprake is in kontak kan kom met kinders wat ook emosionele behoeftes en probleme het bestaan. Alhoewel hierdie kinders opgeneem word in die Arbeidsterapie proses, is behandeling dikwels net op die tasbare ontwikkelings areas gerig.

Die navorsing was spesifiek daarop gerig om te bepaal of daar wel ‘n behoefte bestaan onder Arbeidsterapeute om kinders se emosionele behoeftes aan te spreek. Na afloop van die studie, en nadat alle toepaslike inligting geïntegreer is, is daar waardevolle afleidings gemaak en is hierdie behoefte onder Arbeidsterapeute bevestig. Gestalt Spelterapie is ook voorgestel as ‘n moontlike benadering wat geïntegreer kan word ten einde die Arbeidsterapeut instaat te stel om meer effektief te werk te gaan met die kind se emosionele behoeftes en probleme.

KEY WORDS

GESTALT PLAY THERAPY	GESTALT SPELTERAPIE
PLAY THERAPY	SPELTERAPIE
OCCUPATIONAL THERAPY	ARBEIDSTERAPIE
PEDIATRIC OCCUPATIONAL THERAPY	PEDIATRIESE ARBEIDSTERAPIE
EMOTIONAL PROBLEMS	EMOSIONELE PROBLEME

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1.1 INTRODUCTION

In the latest edition of Willard and Spackman's Occupational Therapy, a comprehensive Occupational Therapy Handbook; a chapter on Child Abuse and Neglect was a surprising addition. According to Neistadt and Crepeau (2002:636): *"Occupational Therapy Practitioners have a responsibility to be knowledgeable about issues on child abuse and neglect, their legal and ethical responsibilities and their role in providing appropriate therapeutic interventions."*

Considering this statement there seems to be a tendency to move towards an Occupational Therapy intervention process that is more inclusive with regards to not only the cognitive and perceptual problems of the child, but also the emotional scars children might bear due to trauma such as abuse or neglect. Occupational Therapists in the field of Pediatrics might be confronted with these cases on a daily basis without always being aware of it. The latter is confirmed by Florey, (in Neistadt and Crepeau, 2002:622): "*Occupational Therapy Practitioners working with children and adolescents in various service settings are likely to encounter youngsters with significant emotional problems.*"

Although Occupational Therapists are in the ideal setting to encounter and identify children with emotional problems, the question might be asked whether they are in fact equipped to effectively deal with these problems.

1.2 MOTIVATION FOR THE NEED OF THE STUDY

When any research is to be undertaken, a reasonable research problem or phenomenon needs to be identified. The researcher should therefore have sound reasons why the specific research is to be undertaken. There should also be clarity on what the researcher intends to gain from the research. Creswell (in De Vos, Strydom, Fouché and Delport, 2002:96) stresses the importance of focusing on the origin and the outcome of research, rather than the problem statement as such.

Research topics are identified through various sources. Bless and Higson-Smith (in De Vos *et al.,* 2002:96) identified three possible sources:

- Observation of Reality
- Theory
- Previous Research

According to De Vos *et al.* (2002:96), contact with the external world and direct observation thereof, could be seen as the most evident source of selecting a suitable topic for research. This is also supported by Mouton (2001:27) who states the following in this regard; *"…people who are more aware of what is going on around them, who are more sensitive to their surroundings, are more likely to come up with interesting topics for research".* Research problems might therefore, in most cases, arise from concrete problems that were observed in reality (De Vos *et al.,* 2002:96). The researcher's awareness and sensitivity towards the increasing number of children referred for Occupational Therapy whilst they also suffer from primary or secondary emotional problems, motivated the topic for this research study.

The need is firstly to investigate and determine the current status amongst Pediatric Occupational Therapists who deal with children who experience emotional problems. Secondly it is to determine the need for a more integrated process of intervention.

Another factor that contributed to the selection of this topic for this research was the absence of previous research. According to De Vos *et al.* (2002: 90): "*Previous investigations can induce new ones."* In the case of this research study the opposite might be more applicable, where the actual absence of previous investigations and research, as observed during the researcher's literature search on this topic, confirmed that the choice of research might not only be a theoretical contribution but might also pave the way for further research.

Another category that was not referred to by Bless and Higson-Smith (in De Vos *et al.,* 2002:96), but is according to De Vos *et al.* (2002:99) of equal importance in searching for a research topic, is curiosity. De Vos *et al.* (2002:99) explain it further: *'Obviously, a researcher's inquiring mind and personal interests come into play in all of the above*." The

researcher's experience and personal interest in dealing with children with emotional problems therefore also prompted this study.

The selected topic was regarded as a great challenge, and could possibly be a steppingstone to further studies. Professionals are forever exploring new ways in which they could improve the services they are rendering to their clients as well as the work satisfaction they are gaining from it. This study might cause positive outcomes for the client and the therapist, since the emotional needs and dilemmas of the client are treated in an already established relationship. This will not only save time and increase work satisfaction but will also cut down on the costs.

1.3 PROBLEM FORMULATION

The formal problem formulation serves as an effective point of departure and the researcher must explicitly delimit the focus of the study and discuss the research goals and objectives (De Vos et al., 2002: 118).

Contributing to the existing problem is the increasing need to experience and recognize the client as a whole. Therefore the aim is not only to identify and treat the client's motor, perceptual and cognitive abilities but also to integrate and address the client's emotional needs and problems in therapy. The emotional needs of the client form an integral part of the totality. In therapy, it is also possible to over stimulate the client by making him adapt to various therapists, each working in there own special way and specializing on one or more of the above-mentioned areas. The child also has to establish relationships with every one of these therapists.

Through this research, the researcher wished to determine whether the need to address the child's emotional needs in Occupational Therapy exists amongst Occupational Therapists. The researcher personally experienced an inability and lack of knowledge and skills in dealing with children's emotional needs and problems in her daily contact with children. These feelings of inadequacy might also be experienced by other Occupational Therapists in the field of Pediatrics.

1.4 AIM AND OBJECTIVES

1.4.1 Aim

The Aim of research implies "…*the broader, more abstract conception of the end towards which effort or ambition is directed*" (De Vos *et al.,* 2002:107).

The aim of this research was to determine whether there is an existing need amongst Occupational Therapists in practice, to deal with children's emotional needs in therapy.

1.4.2 Objectives

The objectives refer to the process the researcher plans to follow in order to reach the goal that was given under the previous heading. According to De Vos *et al.* (2002:107) the objectives *"…are the steps one has to take, one by one, realistically at grass-roots level, within a certain time-span, in order to attain the dream".*

The objectives that were selected for this research study are as follow:

1.4.2.1 Objective One

To investigate the occurrence of children with emotional problems treated by Occupational Therapists in the field of Pediatrics.

1.4.2.2 Objective Two

To investigate the need amongst Occupational Therapists, in the field of Pediatrics, to deal more effectively with children's emotional needs and problems.

1.4.2.3 Objective Three

To determine whether Gestalt Play Therapy might be a possible solution in dealing with children's emotional problems in Occupational Therapy.

1.4.2.4 Objective Four

To support the above information with an appropriate literature review on Occupational Therapy and Gestalt Play Therapy, and with specific reference to dealing with the child with emotional problems.

1.4.2.5 Objective Five

To integrate this information into the conclusion, in order to make appropriate recommendations and to indicate the need for further research, towards a workable and appropriate process of intervention if the need should exist.

1.5 RESEARCH QUESTION

If the assessment of suitability in deciding on either a qualitative or a quantitative approach would be more towards a quantitative study, De Vos *et al.* (2002: 106) states that the researcher would then focus on writing a formal problem formulation and might include the formulation of a research question.

The researcher posed the following research questions:

1.5.1 Research Question One

Do Occupational Therapists in the field of Pediatrics come in contact with children with primary or secondary emotional problems?

1.5.2 Research Question One

Is there a need amongst Occupational Therapists in the field of Pediatrics to deal with children's emotional needs and problems?

1.5.3 Research Question Three

Could Gestalt Play Therapy be an effective and efficient approach in dealing with children's emotional needs and problems?

1.6 RESEARCH APPROACH

A quantitative approach was selected for the purpose of this study. According to De Vos *et al.* (2002:79) the main aims of this type of research approach is to measure the social world objectively, to test the hypothesis or to predict and control human behaviour. This research approach is always supported by a thorough literature study.

In the problem formulation it was stated that Occupational Therapists could experience that they get increasingly more exposure to children with emotional problems and that they might not always be adequately equipped to deal with these emotional problems effectively. Through a quantitative approach this was investigated on a first hand basis, by means of a questionnaire. The quantitative data, supported by an in-depth literature study, could also motivate the integration of an approach like the Gestalt Therapy approach into the Occupational Therapy process in order to equip Occupational Therapists to deal with emotional problems in children.

The information gathered through the literature study contributed towards the preparation of the questionnaire. Data that was collected by means of this questionnaire was then analysed to determine the possible lack in knowledge and skill as well as the need that exists amongst Occupational Therapists to get better acquainted with an approach that could equip them to deal more effectively with the emotional needs of the child.

1.7 TYPE OF RESEARCH

The type of research chosen for a research study, either applied or basic research, is described by De Vos *et al.* (2002:108) as the broad goals of research. Furthermore: *"The advancement of knowledge and the solution of problems are both scientific necessities",* according to De Vos *et al. (2002:108).*

Applied research was selected and the reason for this decision would be that the researcher ultimately wanted to apply the information gained from this study to practice and further studies.

1.8 RESEARCH DESIGN

Mouton (2001:55) gives a definition of a research design as the plan or blueprint of how the researcher intends to conduct the research.

A quantitative-descriptive (surveys) design was used for the purpose of this research study. This design, according to De Vos *et al.* (2002:142) is often more of a quantitative nature, and it requires questionnaires as a method of data collection. The researcher also selected respondents by means of randomised sampling methods. It was however important that respondents were purposefully selected for this research study.

1.9 RESEARCH AND WORK PROCEDURE

The researcher followed a quantitative approach for the purposes of this research study. After an in-depth literature review, the researcher integrated the information gained from the theoretical overview to set up a questionnaire for the collection of data.

Apart from the importance the literature review had on the development of a questionnaire, a number of other basic principles also had to be taken into consideration.

1.9.1 Information Needed

The researcher should be clear on exactly what information he intends to collect through the use of the questionnaire. This is also outlined by De Vos *et al.* (2002:175): "*Before the researcher can decide on the nature of the questionnaire, there must be clarity on precisely what information is to be obtained*." The following aspects, according to De Vos *et al.* (2002:175) also need to be taken into consideration:

- The questionnaire should be brief although it should include all the questions needed for collecting all the relevant information.
- The opposite could also be true, that the questionnaire should be long enough to avoid any information from lacking in a later stage of the research study.
- The questionnaire should not take up to much of the respondents time

The researcher therefore worked towards ensuring a healthy balance between collecting as much information as possible by using a well-structured questionnaire whilst at the same time taking into consideration the time respondents have to communicate their opinions and ideas.

1.9.2 Format of the Questionnaire

There are quite a few aspects that might have an effect on the format of the questionnaire. According to De Vos *et al.* (2002:176), "…the format of the questionnaire is influenced by whether it is a mailed, telephonic, group-administered or other type of questionnaire. Where, under what circumstances, and by whom it is completed also plays an important role".

The following aspects, according to De Vos *et al.* (2002:176) also need to be discussed under this heading:

- The questionnaire should be accompanied by a covering letter, identifying the person undertaking the research as well as giving a brief description of the purpose of the study. Furthermore the covering letter should indicate the importance of the study as well as who can benefit from the study.
- The sampling procedures should also be explained in the covering letter as well as the steps that were taken to ensure the anonymity of respondents.
- The covering letter forms an integral part of the questionnaire, and may be seen as the first page of the questionnaire.
- The name, address and telephone number of the researcher or a contact person should be clearly indicated on the covering letter as well.
- More clarity is needed in cases where the questionnaires are to be mailed to respondents, in order to ensure that they follow the right procedure when they complete the questionnaire.

1.9.3 Writing the Questions

According to de Vos *et al*. (2002:176) certain basic principles apply when you formulate the questions of a questionnaire:

- Brief clear sentences. The vocabulary, as well as the sentence construction of the questions should be understandable to respondents.
- Question and response alternatives should be clear and not biased.
- Only one thought should be contained in every question.
- Every question must have relevance to the purpose of the research study.
- Abstract questions should rather be avoided.
- The sequence in which the questions are posed in the questionnaire should also have relevance.

Again the importance of an in-depth literature review is stressed by de Vos et al. (2002:177) saying, "…*the prospective researcher must be able to determine the potential usefulness of every question, and should therefore have made a thorough literature study of the subject under review".*

All of the above criteria were taken into consideration when constructing the questionnaire. The pilot test also contributed towards the quality of the final questionnaire.

1.9.4 Pilot-Testing of the Questionnaire

Pilot testing of the questionnaire is regarded as a very crucial aspect in the development and finalization of the questionnaire: *"In all cases it is essential that newly constructed questionnaires, be thoroughly pilot-tested before being utilized in the main investigation"* (De Vos *et al.,* 2002:177). The main aim of a pilot-test would be to rectify errors that might hamper the success of the research in a later stage of the study. Only after the necessary modifications were made the questionnaire was presented to the full sample of respondents. By leaving space for comments or an evaluation, the researcher could also obtain valuable feedback on the feasibility of the questionnaire and the data that was collected.

1.9.5 Ways to ensure Completion of the Questionnaire

To ensure an acceptable response rate, the researcher might include the following:

- Enclose an addressed, franked envelope for mailed questionnaires.

The researcher delivered as many questionnaires by hand as possible and also made use of electronic mailing that was followed-up on a regular basis.

1.10 FEASIBILITY OF THE RESEARCH

The researcher must consider the validity, reliability of data collection instruments, generalization of the sample to the population from which it was drawn, access to data and ethical problems at this stage.

After an in-depth, literature study it became clear that the research was viable, and in actual fact necessary. The researcher was surprised by the lack of literature on the integration of intervention methods that address the child's emotional needs in the Occupational Therapy process.

The viability of any research is also affected by the time and money necessary to conduct the study. The information applicable to this study was, where possible, integrated into the program and routine followed at the researcher's practice. Time was therefore spent productively at the researcher's existing practice. By doing so the researcher eliminated travelling time to another location so that she could still give all her attention to the growth and needs of her practice. Travelling time was allowed for the handing out and picking up, of completed questionnaires. Expenses were, where possible kept to the minimum.

Concerning the reliability of the data-collection instruments, the researcher used a questionnaire for the purpose of collecting data from the respondents. The thorough literature study also served as a background for the formulation of the questions and indicated the shortfalls that needed to be integrated and measured with the questionnaire. The questionnaire was carefully planned and questions were stated in such a way that all respondents were able to understand exactly what was requested. Careful planning also ensured that the information gathered was of optimal value to the researcher in conducting her study. Please refer to Annexure A, for the questionnaire.

Respondents included only qualified Occupational Therapists. No private or confidential information was included in the questionnaire. This decreased the ethical responsibilities of the researcher. Although respondents were readily available, the researcher anticipated some difficulty in getting completed questionnaires back. This aspect was not

really predictable. The questions used in the questionnaires were formulated in such away to be clear and familiar to the respondents. The background and experience of Occupational Therapists could also have had an effect on their responses.

1.10.1 Literature Study

The literature for this research study was selected according to the two key concepts that were identified (Occupational Therapy with specific reference to the treatment of emotional problems in children and Gestalt Play Therapy). The core theory on Gestalt Therapy has remained very much the same over the years. Because of this older literature on Gestalt Therapy contains very valuably information on this subject.

For years Play Therapy has been synonymous with Social Work, and to a lesser extent, Psychology. With this Masters Degree, in which a variety of disciplines are integrated, numerous connections with other disciplines were established. Although the researcher was introduced to Play Therapy on a pre-graduate level, the application of specialised Play Therapy techniques in the field of Occupational Therapy is a fairly new field of expertise. The availability of sources that explain the integration of these two fields was therefore limited.

1.10.2 Consultation with Experts

The researcher identified two experts. The experts that were identified both integrated two of the main concepts (Occupational Therapy and Play Therapy) referred to in this research study.

- *Marli Aronstam*:

Senior Lecturer, Department of Occupational Therapy at the University of Pretoria. This expert is involved in the training of Occupational Therapy Students and is familiar with the curriculum that is currently followed in the training of Occupational Therapy Students. She also has a sound theoretical knowledge of Paediatrics in Occupational Therapy.

- *Karien Labuschagne*:

Social Worker with Post-graduate training in Play Therapy, working in Private Practice.

1.10.3 Pilot Study

The pilot study was explained more thoroughly under a previous heading. The purpose of a pilot study is to test the validity of the questionnaire that will be sent out to the respondents. Bless and Higson-Smith (2000:155) offers a comprehensive definition of a pilot study: *"A Small study conducted prior to a larger piece of research to determine whether the methodology, sampling, instruments and analysis are adequate and appropriate."*

The pilot study had to determine whether the questions, asked in the questionnaire, were appropriate, clear and valuable with regards to the aim of the study. The necessary corrections and modifications were then be made in order to ensure that the main investigation could proceed without any complications. The researcher piloted three questionnaires, with Pediatric Occupational Therapists that were excluded from the sample.

1.10.4 Universe, Population and Sampling

The proposal should also include information on the population and sample involved. According to De Vos *et al.* (2002:198): "*The term sample always implies the simultaneous existence of a population or universe of which the sample is a smaller section."*

Arkava and Lane (in de Vos *et al*., 2002:198) make a distinction between the terms universe and population. According to them universe *"…refers to all potential subjects who possess the attributes in which the researcher is interested".* On the other hand, population is defined as something *"…that sets boundaries on the study units".* The researcher also refers to Arkava and Lane (in de Vos *et al.*, 2002:199) to define the term sample as it was referred to in this research study: *"A sample comprises the elements of the population considered for actual inclusion in the study."* The researcher therefore studied the sample in order to understand the population it presents.

For the purpose of this study the universe referred to all Occupational Therapists, with the population being all the Occupational Therapists in the field of Pediatrics. The main reason why a sample is drawn from a population, according to de Vos *et al*. (2002:199), is

feasibility. The sample consisted of Pediatric Occupational Therapists, selected randomly in the geographical area of Pretoria.

The Respondents involved randomly selected Occupational Therapists in the field of Pediatrics. Because the researcher intended on delivering most of the questionnaires by hand, Occupational Therapists closest to the researcher was targeted, although the researcher also send some of the questionnaires by electronic mailing.

1.11 ETHICAL ASPECTS

Because we deal with people in the social sciences, it is very important to adhere to the ethical guidelines set for research. De Vos *et al.* (2002:62) confirms this by stating that: *"The fact that human beings are the objects of study in the social sciences, brings unique ethical problems to the fore that would never be relevant in the pure, clinical laboratory settings of the natural sciences."*

The following ethical issues were taken into consideration in this research study:

1.11.1 Harm to Respondents

No subjects for experimental or testing purposes were included in this research study since respondents only had to complete a questionnaire. The most important consideration was to ensure that respondents were well informed concerning the impact the investigation could have on them, before they decided to participate in the study. Respondents had the right to decide whether they wished to withdraw or to participate. The cover letter, that accompanied the questionnaires, played an important role in explaining the research study to the respondents. The researcher was also available to answer any questions with regards to the purpose of the study.

1.11.2 Informed Consent

According to de Vos *et al.* (2002:65): *"Informed consent becomes a necessary condition rather than a luxury or an impediment."* Informed consent relies on accurate and complete information. Information regarding the purpose, nature and impact of the study was being explained in the covering letter.

1.11.3 Deception of Subjects and/or Respondents

This issue of deception is described by Corey *et al.* (in de Vos *et al*, 2002:66) as the *"…withholding of information, or offering of incorrect information in order to ensure participation".* Deception of respondents could be avoided by adhering to the issue of informed consent.

1.11.4 Violation of Privacy/ Anonymity/Confidentiality

The privacy of respondents could be guaranteed by giving information anonymously, according to de Vos *et al.* (2002:67). Although the research was not aimed at collecting personal or sensitive information from respondents, it was none the less important that the privacy of respondents were respected. For this purpose their anonymity were guaranteed. This could also be done by making use of proper scientific sampling, according to de Vos *et al.* (2002: 68) this could be done. Respondents were also not compelled to provide personal information on their questionnaires. Questionnaires were completed returned anonymously by respondents. The information gathered through the questionnaires, was only used and analysed by the researcher. Information received from respondents was, where necessary kept in safe storage and will be destroyed after the study has been completed.

1.11.5 Release or Publication of the Findings

The researcher intends to publish the findings of this research study in order to incorporate successful and adequate treatment of emotional problems into the Occupational Therapy process. With the writing of such a report or publication the researcher has certain very important responsibilities. The report should be an honest reflection of the investigation and should contain enough information to ensure that the reader has a full understanding of exactly what the investigation entailed. If certain errors occurred in any stage of the research, it should be mentioned in order to avoid deception. The shortcomings of the study must therefore be clearly stated in the report. This will serve to guide future researchers in the same field.

The researcher ultimately aims at presenting a study that complies with all the above-mentioned ethical aspects and also meets the ethical requirements set by the Ethics Committee of Huguenot College.

1.12 MAIN CONCEPTS AND DEFINITIONS

The main concepts that were identified in this study are clearly stated in the title. These concepts are Gestalt Play Therapy, Occupational Therapy and Emotional Problems.

These concepts can be defined as follow:

1.12.1 Gestalt Play Therapy

Gestalt Therapy can be defined as follows:

> *"Gestalt is a form, a configuration or a totality that has, as a unified whole, properties which cannot be derived by summation from the parts and their relationships. It may refer to physical structures, to physiological and psychological functions or symbols or to symbolic units"* (English & English, 1958:2753).

Gestalt is a German word that refers to pattern, shape, form or configuration (Hough, 1998:122). The definition of Gestalt in a therapeutic setting, is further explained by Hough (1998:123) as a theory were people are concerned with creating meaning in their lives, so that the whole pattern of their sensory experience is seen as more important than the individual elements of that specific experience.

Because the study specifically refers to Gestalt **Play** Therapy, the researcher also wishes to define the term "play". Oaklander's (1988:160) definition of play is referred to in this regard.

> "Playing is how children try out and learn about their world. Play is therefore essential for healthy development. For children's play is serious, purposeful Business through which they develop mentally, physically and socially. Play is the child's form of *self-therapy* through

> which confusions, anxieties and conflict are often worked through. Through the safety of play children can try out their own new ways of being. Play performs a vital function for the child. Play also serves as a symbolic language."

The researcher defines Gestalt as the totality of human living. Gestalt Therapy is aimed at treating the individual, as a "whole" within his environment. Concerning the child, play is used as a vehicle through which this is accomplished.

1.12.2 Occupational Therapy

According to Neistadt & Crepeau (2002: 5): *"Occupational Therapy is the art and science of helping people do the day-to-day activities that are important to them despite impairment, disability and handicap. Occupation in Occupational Therapy refers to all of the activities that occupy people's time and give meaning to their lives. Impairment refers to loss or abnormality of physical or psychological structures or functions."*

Occupational Therapy is the use of purposeful activity with individuals who are limited by physical injury or illness, psychosocial dysfunction, developmental or learning disabilities, poverty and cultural differences or the aging process in order to maximize independence, prevent disability and maintain health. This is a definition of Occupational Therapy taken form the minutes of the 1981; AOTA Representative Assembly quoted in Turner *et al*. (1999:5).

The researcher's definition of Occupational Therapy supports the importance of giving meaning to live, by minimizing the impact of physical, cognitive and emotional dysfunctions or problems.

1.12.3 Emotional Problems

According to Coleman, Butcher & Carson (1980:489-490) less serious disorders of childhood:

> "Often are referred to simply as emotional disturbances, to indicate that they are not so much disorders as problems with which the child needs

> help. If such assistance is not received, however, the developmental problems of childhood sometimes merge almost imperceptibly into more serious and chronic disorders when the child passes into childhood e.g. Hyperactive Syndrome, Conduct Disturbances, Disturbances of emotion such as Depression, Autism, Stuttering etc."

According to Oaklander (1978:182), "…*parents bring children into therapy because something unusual has happened and they want to be sure that the child expresses and finishes any overwhelming feelings resulting from the incident. Examples of such happenings might be death or illness of a loved one, abuse, molestation, or a deeply frightening experience such as an accident or an earthquake".* Oaklander (1978:57) also refers to children in therapy as "*children in trouble*."

The researcher feels comfortable with the term 'emotional problems'. The latter referring to less serious emotional problems that are susceptible to treatment and has good prognosis. For the purpose of this study the term emotional problems will be used to refer to the disturbances/disorders referred to in the above-mentioned definitions.

1.12.4 Needs Assessment

The researcher defines a needs assessment as an integral part of a process and more specifically as the phase whereby it is established whether there is a relevance or need for something. When a need is indicated it motivates relevant further studies. Research is needed where a need exists.

1.13 SUMMARY

According to literature there seems to be a tendency to move towards an Occupational Therapy Intervention process that is more inclusive with regards to not only the cognitive and perceptual problems of the child, but also the emotional scars children might bear due to trauma such as abuse and neglect. This also entails that Occupational Therapists find themselves in the ideal setting to encounter and identify children with emotional problems. In spite of the frequency with which Occupational Therapists are confronted with children with emotional problems, the question might be asked whether they are in fact adequately

equipped to deal with these emotional problems. This indicated a gap that could be filled by researching the possible integration of Gestalt Play Therapy into Occupational Therapy.

When any research is to be undertaken, a reasonable research problem or phenomenon needs to be identified. The researcher should therefore have sound reasons why the specific research is to be undertaken. After the topic was selected the researcher formulated a formal problem. The existing need amongst Occupational Therapists to address the child's emotional needs in therapy was formulated as the formal problem in this research study. The latter was further defined and supported by the research aim and research objectives.

A quantitative approach, using a semi-structured questionnaire, was selected for the purpose of this study. The quantitative data was supported by an in-depth literature study and the questionnaire was to be set up according to the research objectives and supported by the literature study. After pilot-testing the questionnaires, the necessary corrections and alterations were made before it was send to the respondents. The sample was randomly and deliberately selected, consisting of Occupational Therapists in the field of Pediatrics. Questionnaires were sent via electronic mail or delivered by hand.

This chapter also outlined the ethical guidelines that had to be adhered to and also defined the most important key concepts applicable to this study. In conclusion this chapter was necessary in planning and indicating the way in which the study had to be conducted to reach the main aim and the objectives.

The following chapter will look at Gestalt Play Therapy with specific reference to the child with emotional problems.

2. GESTALT PLAY THERAPY WITH SPECIFIC REFERENCE TO THE CHILD WITH EMOTIONAL PROBLEMS

2

2.1 INTRODUCTION

Gestalt Therapy can be described within an existential, experimental and phenomenological perspective. This form of therapy was first established during the nineteen forties, by Fritz and Laura Perls. It was since then refined, defined and developed by numerous pioneers in the field of Gestalt Therapy (Yontef, 1993:5).

According to Yontef (1993) Gestalt Therapy describes the individual as a total being in the context of all his subsystems. Gestalt Therapy consciously focuses on the current thoughts and feelings of the individual rather than past or future experiences. With this focus in mind the individual is guided towards complete awareness within the here and now. Through awareness the individual can eventually experience his thoughts and feelings and accept responsibility. In the course of this process the individual will start to self-regulate with a sense of unity and integration. In short, Gestalt could be defined as an organized whole.

In this approach the therapist is also encouraged to participate in the therapeutic process of exploration and the facilitation of growth. In this process of facilitation the therapist also explores and discovers her most valuable instrument in ensuring successful therapy, the dimension of the “self” (Gibson and Mitchell in Yontef, 1993:122). The Gestalt Therapist is aware of this “self” as well as the “self” of the child and uses this sense of self to make the child aware of the here and now and to ultimately help the child to take responsibility by being self supportive.

In Gestalt Therapy there is no room for interpretation, prejudice or judgment. The therapist plays a participating, subjective role. Gestalt Therapy takes place within a free and spontaneous and awakened environment. At the same time it requires responsibility from both therapist and individual. The child is encouraged to discover the true “self” in the course of an explorative approach that strives towards total existence and integration.

This chapter on Gestalt Play Therapy is based on the Schoeman Model for Play Therapy. The Scoeman Model is based on the Gestalt Approach and is but one of the available models for Play Therapy. The main reason why this model was selected is that it was purposefully developed to address the specific emotional needs of children in the South African population. Gestalt Play Therapy could in essence be regarded as Gestalt Therapy with the *child* with emotional needs. (Compare Schoeman, 2001:104.) Greater optimism for using Gestalt methods, particularly with children, is found in the writings of Oaklander (1978) and Owmby (1983).

2.2 PERSPECTIVES UNDERLYING GESTALT THERAPY

The three perspectives underlying the Gestalt Approach will now be discussed in further detail. The reason for this would be to elaborate on the definition of Gestalt Therapy and to explain its' relevance to the child with emotional needs.

2.2.1 The Phenomenological Perspective

According to Yontef (1993:5), Gestalt Therapy can be explained as a phenomenological-existential therapy. Deist (1984:192) defines phenomenological as follows:

> "A method of philosophical inquiry concentrating on describing the essence of objects as they present themselves to human consciousness. To ensure that his consciousness is focused on the particular phenomenon to be inquired into, the inquirer must carry out two reductions: First he must eliminate from his field of attention all other phenomena that might interfere with the process of cognition; second, he must eliminate from his field of attention all previous knowledge and interpretation of the particular phenomenon. Only then is the inquirer entitled to report what he perceives."

The phenomenological perspective implies that the individual sets aside his usual way of thinking, in order to distinguish between what belongs to the here and now and what may only be remains of the past. The Gestalt Therapist reacts to what the child experiences in the here and now without disapproval or interpretation (Yontef: 1993).

This perspective implies that the individual is regarded as a product of the here and now, his environment, circumstances as well as his unfinished business from the past as it affects him in the present. This perspective underlies and supports the fundamental idea of Gestalt Therapy, where the individual is working towards alternatives and integration that is appropriate within his unique environment and circumstances. According to Oaklander (1978:184) the child that is seen in therapy is usually preceded by *"stacks of paper relating to the child: test results, diagnostic reports, court proceedings, school records etc."* This certainly provides for interesting reading and in effect makes the child a hostage of his past. The therapist can only experience the child as he presents himself to the therapist, in the here and now. According to Oaklander (1978:184) the therapist should approach the child, *"…without an overlay of preconceived biases and judgments about (him)*".

The therapist therefore puts aside all usual or previous ways of thinking and only relates to the child in the way that he[1] presents himself to the therapist at that given time.

The way in which the therapist relates to the child prepares the grounds on which the child will set aside previous ways of thinking and handling situations in order to develop his own ways of thinking and appropriately deal with similar (past) situations in the future.

2.2.2 The Field Perspective

Yontef (1993) defines the field as the whole by which the parts are in direct relation and reaction to one another. Each separate part is influenced by events in the rest of the field. All systems are involved here; home, church, school, etc. The individual in his unique living space implies a field. The individual cannot be seen separate from his living context. Perls refers to it by saying that the individual cannot interpret anything in isolation or out of context. In the Gestalt approach, the field is a holistic, process-orientated concept (Crocker, Brownwell, Stemberger & Gunther, 2001:1-3).

Another important factor in this perspective is the fact that every individual has a unique perspective pertaining to a certain event. According to Yontef (2003:5) individual

[1] *For the purpose of this study the therapist's gender will be referred to as female and the child or patient's gender will be referred to as male*

perspectives are different merely due to the fact that the child stands in his unique field whilst the therapist forms part of her own unique field. In consequence to this reality is the unique perspective of every individual and differs from person to person. The therapist cannot evaluate the child according to her own experiences of reality. The field approach is inherent to Gestalt, because of it's descriptive rather than it's interpretive nature. If information is not directly obtainable it can be accessed by studying the phenomenological perspective or by making use of experimentation and dialogue.

The therapist is strives towards exploring the child in his own field. In order to understand the child's field in full, the therapist needs to take into account the child's perspectives on reality by obtaining sufficient information about the child's field. In Gestalt Therapy information is not approached directly. The therapist functions according to the presumption that the child will only share information that is currently on his figure-ground, in the here and now. In the case of the child with emotional problems, the field the child is living in is either contributing or affected by the child's behaviour. As Oaklander (1978:181-182) puts it: *"By the time the parents make that first phone call seeking help, the situation generally has become very difficult, if not unbearable, for either the child or the parents. Even if the parents aren't directly affected by the child's behaviour, they have reached such a point of discomfort, anxiety, or concern that they feel driven to take action."*

Other life areas like the child's school performance and social functioning can also be aversely affected by his behaviour. There exists a reciprocal interaction between the child and his field - both the child and the field impacts each other all the time. Children are vulnerable to their environment and may even feel threatened by it. According to Coleman, Butcher & Carson (1980:490): "*Likewise, children are more dependent on other people than adults. Though in some ways this dependence serves as a buffer against outer dangers, it also makes them highly vulnerable to experiences of rejection, disappointment, and failure*."

The child should not only be studied as a total being, but should also be studied in his own field. The interaction between the child and his field should be integrated into the therapy process because this interaction is the place that the child calls home and should be returning to after therapy is completed.

2.2.3 The Existential Perspective

Existentialism is based on the phenomenological method, and implies that the individual is so caught up in his conventional ways of thinking that he does not see the world for what it really is. In Gestalt Therapy the individual is made conscious of his own awareness. The individual is therefore given the opportunity to rediscover him self. Yontef (2003:6) explains it as follow: *"The existential view holds that people are endlessly remaking or discovering themselves. There is no essence of human nature to be discovered "once and for all." There are always new horizons, new problems and new opportunities.*"

Existentialism could be seen as a healing opportunity for the child with emotional problems or who has experienced emotional trauma such as abuse. Because the individual is described as endlessly discovering and rediscovering himself, it provides ample opportunity for these children to work through their problems and fears in order to discover new horizons, new opportunities and new problems as well as new ways of dealing with these problems.

Against the background of the fundamentals of Gestalt Therapy, the importance of the "self", entering the therapy process could now be emphasized.

2.3 THE SELF AND THE THEORY OF PERSONALITY IN GESTALT

The child as well as the therapist is regarded as two totally different individuals entering the therapy process. They should also be accommodated as such. The term "self" is defined by Odendal, Schonnes, Swanepoel, Du Toit, & Booysen (1985:951) as the own being, the person, ego, an individual's own individuality or essence. The "self" could therefore be described as the essence of an individual's being, internally connected to himself as an organism, and externally connected to his environment. According to Yontef (1993:331): *"The self in Gestalt Therapy Theory is the person's system of contacts."* The child's "self" is thus the "self" in contact with his environment.

The Gestalt theory of change also refers to the "self" as a creative and responsible organism that determines his own set of rules and his own morality. Personality is described as a process through which the individual interacts with his world. In Gestalt Therapy the "self" is furthermore viewed as the sum total of the individual's characteristics

(e.g. cognition, values, beliefs, habits, emotions and preconceptions) (Yontef, 1993). When a child is seen in therapy it is important to accommodate and include al the above-mentioned characteristics since all of them together equals the child. The therapist should acknowledge the child's cognitive abilities when choosing certain therapy techniques and should also respect cultural and spiritual beliefs.

It is furthermore impossible to separate the "self" and the theory of personality from one another. There is a strong connection between the theory of personality and the "self" in Gestalt and field theory. This connection is based on the fact that the organism has no existence isolated from its environment. Yontef (1993:33) refers to Perls, Hefferline and Goodman when he claims that: *"Self may be regarded as the boundary of the organism, but the boundary is not itself isolated from the environment; it contacts the environment; it belongs to both environment and organism."* De Witt and Booysen (1994:14) also mention that the individual's personality can ultimately develop and be expressed in interaction with its environment and other individuals.

In Gestalt Therapy the therapist integrates the phenomenological and field theory rather than concepts and genetics, which in turn means that more attention is given to the process and less is given to the content (Yontef 1993). The individual's personality develops gradually and is never static. For this reason the individual's personality is described as a non-static process (De Witt and Booysen, 1994:36). Yontef (1993:33) uses an appropriate metaphor to explain this process: *"People grow through biting off an appropriate- size piece (food, ideas, relationships), chewing it (considering), and discovering whether it is nourishing or toxic. If nourishing, the organism assimilates it and make it part of itself. If toxic, the organism spits it out (rejects it)"*

According to Oaklander (1978:58) children often grow up with misconceptions about themselves, and in the process they swallow whole pieces of incorrect information about themselves therefore *"…a child may believe she is stupid because her father, while angry, called her stupid out of his own frustration".*' Children respond to these characteristics and act them out resulting in feelings of low self-esteem.

The individual is continually growing and developing by exploring new methods, the unknown and assimilating what is appropriate. The therapist as well as the child is

therefore continually experimenting in order to discover the true "self" (Yontef, 1993:33). The child with emotional needs are guided by the therapist in discovering his true "self" since this self could have been discarded by incidents of abuse, loss of a loved one or other traumatic experiences. The therapist assists the child in separating himself from incorrect outside evaluations, feedback and happenings and helps the child to rediscover his own being (Oaklander, 1978:58).

The therapist also needs to supply a secure environment for this to take place and should also *"…provide methods for children to express their feelings, to get what they are keeping guarded inside out into the open, so that together we can deal with this material"* (Oaklander, 1978:193). By doing so the child can ultimately get closure, make choices, unburden himself in the process of becoming who he actually and truly is, his true "self". Satir (1987:17) further defines this by describing *"…(t)herapy as a deeply intimate an vulnerable experience, requiring sensitivity to one's own state of being as well as to that of other".* Children affected by incidents such as sexual abuse or violence usually carry sensitive experiences and emotions inside of them. These experiences and emotions should be treated as sensitive and often painful. The therapist should also be aware of her own anxieties and weaknesses (e.g. the level of comfort in dealing with issues such as sexual abuse). Schiller (1991) makes the following statement in this regard*: "You cannot accept another person's weakness until you are able to accept your own."*

The individual is regarded as the primary role player in determining his own behaviour, and can only hold himself responsible for his choices. The theory of personality therefore supports the tasks of the therapist and also the ultimate goal in therapy namely to **facilitate** individual growth towards responsibility and integration. It is important though to realize that the therapist is responsible for creating an atmosphere in which the child can be the primary role player in determining his own behaviour. In other words the child himself must distinguish between behaviour he sees as potentially "healthy" and "nutritious" and behaviour that might be potentially "poisonous" or "harmful" referring to the above-mentioned metaphor (Yontef, 1993).

The child with emotional needs should ultimately be able to function outside the therapeutic relationship and become increasingly self-supportive and less environmentally supported. According to Yontef (1993:153), responsibility forms an integral part of the

therapeutic relationship through which the child should take responsibility to regulate and support him self so that he is eventually able to function optimally outside the therapeutic relationship. The child with low self-esteem should ultimately be able to assert himself against children outside the therapeutic environment without the support of the therapist and/or the environment.

In therapy the therapist should be enthusiastic about play and should also give the child ample opportunity to explore, experiment and discover by means of play. The specific role of the therapist in her relationship to the child is further explained by Polster and Polster (1973: 237), as being:

> "The therapist is his mentor and companion, helping to keep in balance the safety and the emergency aspects of the experience, providing suggestion, orientation and support. By following and encouraging the natural development of the individual's incomplete themes through their own directions into completion, the therapist and the patient become collaborative in the creation of a drama which is written as the drama unfolds."

Phillipson (1989:6) also refers to the importance of keeping a balance where knowledge and skill is concerned. The child's knowledge and skill is expressed in his ability to be himself, to choose his own past and future and to make the most appropriate adaptations to his environment. The child should in turn be willing to expose these areas to the therapist in the course of the therapy process.

The therapist's knowledge and skills on the other hand, remains to be on a different level. She should secure and explore a therapeutic-orientated relationship whilst at the same time and relying on the correct application of her senses and staying in touch with her own feelings and emotions. In addition to this she should also show creativity in the selection of therapy methods and techniques. Phillipson (1989:6) sees no harm in the therapist being completely comfortable with her own knowledge and skills.

According to Oaklander (1978:194): *"Each therapist must find her own way. Therapy is an art: unless one can combine skill and knowledge and experience with an inner intuitive,*

creative, flowing sense, probably not too much will happen." Play Therapy with the emotionally needy child also requires the sum total of the "self" from the therapist.
Together with the idiosyncrasy of the different "selves" that enter the therapy process, Gestalt Therapy also integrates a vast amount of models, methods and techniques, that are further moulded into ensuring the best possible outcome for the child with emotional problems.

2.4 DIVERSITY WITHIN THE GESTALT APPROACH

The different models, methods and techniques in Gestalt Therapy are integrated, with an equal amount of success, into the therapy process of the child. They could also, in various ways and on various levels be applied in Play Therapy with the child who suffers from emotional problems. According to Oaklander (1978:53) the mere drawing action, without any form of intervention, could be regarded as a powerful expression of the "self" that contributes to the development of self-identity, and offers an outlet for emotions and feelings. Projections such as drawings, story telling, and sculpting is also regarded by Oaklander as a fun and safe way for the child to express his inner feelings and emotions. Oaklander (1978:193) furthermore states that projection will often, "…be the only way the child will be willing to disclose herself" or even traumatic incidents such as sexual or physical abuse. Children put powerful information on the table through projection. This information should always be handled with extreme care.

Every therapist ultimately needs to identify a method or techniques she feels comfortable with and through which she can express herself in therapy. The therapist's self-expression should contribute to the confluence in therapy so that the feelings and emotions of both the therapist and the child can be integrated into a unit. The therapist must be aware of, and be receptive to the availability of numerous methods and techniques in Gestalt Therapy. Enactment is only one of the methods used in therapy and Polster and Polster (1973:243) refer to the fact that many individuals experience discomfort with this method. The child should also be taken into consideration when the therapist plans on using a certain method or technique in therapy. The therapist should also feel herself comfortable in applying a certain method or techniques in therapy.

There could also be certain mediums e.g. sand or clay that all children might not be comfortable in handling. According to Oaklander (1978:57) most of the children seen in

Play Therapy, for many different reasons, have one thing in common – an impairment in their contact functions. The latter refers to the tools of contact e.g. vision, speech, touch, hearing, movement, smell and taste. Impaired contact functions should be taken into account when media such as clay or sand are used in therapy. This impairment might also affect the way in which the child responds to therapy.

Fortunately Gestalt Therapy allows ample opportunity for the therapist to experiment with various methods and techniques to ultimately establish a method of work that she can relate to and that is also suitable for the children she sees in therapy. Even a well established therapist like Oaklander, has not created a new, or unique therapy approach, but has instead applied existing methods and techniques in her own creative and original way. In doing so she has created her own method of work with which she feels comfortable (Oaklander, 1978:53-63).

Due to the diverse nature of Gestalt Therapy the researcher decided to select a specific and appropriate model at the hand of which the therapy process can be described in further detail. The Schoeman Model was identified for this purpose.

2.5 SCHOEMAN'S MODEL: A GESTALT APPROACH IN THERAPY WITH THE CHILD

The researcher specifically chose this model for a variety of reasons. This model has great multi-cultural value and can therefore be applied effectively to the South African context. It is also adaptable whilst at the same time offering enough structure for the purpose of this chapter.

The Schoeman Model also emphasizes and explains important terminology, commonly associated with the Gestalt Approach. The Schoeman Model for Play Therapy was furthermore compiled in such a way that it allows the therapist to enter the often inaccessible and disturbing world of the traumatised child. Play also forms an integral part of this model, making it appropriate to the child's world and allowing the therapist to enter this world. According to Oaklander play is also a form of self-therapy for the child, allowing him to deal with confusions, anxieties and conflicts.

2.5.1 The importance of Play in the Therapeutic Process

Play could in truth be defined as the child's "work", since it occupies the biggest part of his day. The child explores, and gives meaning to his world through play. Oaklander (1978:160) defines play as follows:

> "Playing is how children try out and learn about their world. Play is therefore essential for healthy development. To a child, play is serious, purposeful business through which he develops mentally, physically and socially. Play is the child's form of self-therapy through which confusions, anxieties and conflict are often dealt with. Through the safety of play children can try out their own new ways of being. Play performs a vital function for the child. It is far more than just the frivolous, light-hearted pleasurable activity that adults usually make of it. Play also serves as a symbolic language. Children experience much that they cannot as yet express in their language, and so they use play to formulate and assimilate what they experience."

From this citation it is evident that play forms an integral part of the child's world. Play develops through exploration and within a safe environment where the child feels secure enough to try out new things and in the process to discover the "self". The explorative and experimental nature of play makes it an ideal medium for Play Therapy with the child with emotional problems.

The Schoeman Model supports the importance of play, and within this model the effect of language, is minimized by the presence of play. Play can be regarded as a universal language. Knox (1988:35) defines play as follows: *"Play has been characterized as being intrinsic, spontaneous, fun, flexible, totally absorbing, vitalizing, challenging, non-literal and an end in and of the self."*

The world of the traumatized child is uncertain, disturbing and also difficult to access. In the multi-cultural context of South Africa the Schoeman Model, in handling the traumatized child, has filled a significant gap. The use of play in therapy with the child facilitates the therapy process with children from different cultural backgrounds (Schoeman, 1996).

The role of play cannot be emphasized enough so that it is important to have sufficient knowledge about theories of play and the course of normal development in children. Normal development can be regarded as important knowledge for Play Therapy with the child. This knowledge should constantly be integrated into the therapy process (Oaklander, 1978:56).

Play can be regarded as an outlet for feelings and emotions experienced by the child with emotional needs and problems. Apart from the fact that children's verbal skills are sometimes restricted (Oaklander, 1978:161), they also experience difficulty to express the powerful and sensitive material they carry along inside themselves (Oaklander, 1978:193). Play not only allows for the child to express himself but also creates a safe distance between the child and his experiences.

2.5.2 Establishing a Therapeutic Relationship

The first step in the Schoeman Model (1996:30) lays the foundation for the therapy process. Under no circumstances can therapy commence without establishing a sound relationship between the therapist and the child. The therapist works from the hypothesis that the child will not share his secrets with a complete stranger. It has already been mentioned that the relationship between the child and therapist is regarded as intimate and vulnerable (Satir, 1987:17).

Under normal circumstances a child might have difficulty relating to a stranger, but even more so when this stranger expects him to share his most disturbing, and best kept inner secrets. Children are also brought up not to talk to strangers. Establishing a strong therapeutic relationship is therefore crucial. The development of this relationship depends on a variety of factors. Schoeman highlights the most important attributes needed, to establish and maintain a therapeutic relationship. Schoeman refers to it as the ABC-Framework.

Children affected by abuse and emotional disturbances might find it difficult to establish purposeful relationships. Renn (1989:15-28) gives an appropriate example of a boy that was emotionally abused by his parents, leading to an inability to express feelings and emotions as well as establishing purposeful relationships. This ultimately led to

depression. The latter is but one example of how children's relationships can be affected and distorted. It also stresses the importance of establishing a trusting and meaningful therapeutic relationship between the child and the therapist. After thorough investigation Schoeman (2001:6 - 38) developed a framework that includes all the aspects necessary to establish such a relationship:

- *Awareness*

Schoeman refers to Yontef (1993:203) when describing Awareness as "… *a form of experiencing. It is the process of being in vigilant contact with the most important event in the individual's environment field with sensory-motor, emotional, cognitive and energetic support".*

- *Bidding One's Time*

The therapist should always allow for enough time and should never rush the child or be impatient with the child. The child needs enough time in order to solve his problems independently.

- *Clichés and Confluence*

The therapist should at al times be conscious of being in confluence with the child and not the other way around. When the child is in confluence with the therapist, it is not possible for him to make his own decisions or to develop his self-esteem.

- *Dialogue*

The child should learn, and become comfortable with reasoning, discussion, negotiation and taking into consideration all the different aspects and perspectives of a given situation. This will enable the child to meaningfully participate in dialogue.

- *Equilibrium*

The child needs to maintain equilibrium between his external and internal needs. Children tend to behave in the way they think others expect them to behave. They also think that this behaviour will result in other recognising and acknowledging them. This can affect the child's self-regulatory mechanism.

- *Friendship*

The therapist should see the child as an equal and the relationship should in fact be that of an enjoyable friendship.

- *Guardianship*

The therapist's role further extends to that of the child's guardian in the process of giving the necessary support and protection. Under no circumstances should the therapist try to give the impression that the child is not capable of looking after himself.

- *Humbleness*

Children are more likely to take risks in a secure relationship, where the therapist sees herself as equal to the child.

- *Information*

By giving information, the therapist indicates to the child that she trusts him enough to contribute towards his own growth and establishment of a positive self-esteem.

- *Joy*

Play needs to be joyful. If the child does not experience any enjoyment, he will be reluctant to come back for his next session.

- *Kindness and Honesty*

The child depends on the therapist's integrity when sharing confidential information with her. The therapist, in turn should respect the child's honesty.

- *Laughter*

Although the therapist should under no circumstance laugh at the child, there is a time and place for everything. Therapy therefore, also allows for the sharing of emotion between the child and the therapist.

- *Making Contact*

It is crucial that the therapist should make contact with the child. In the absence of contact it is impossible to forge a relationship with the child. The therapist needs to approach the relationship with passion and perseverance.

- *The Concept of "Now"*

The therapist wants to keep the contact in the "here and now" in order to work towards workable solutions for the present situation.

- *Organismic Self-Regulation*

The therapist should be certain that the child's needs and thus his ability to grow are addressed in therapy. If the child's needs are not taken into consideration, growth might not be possible.

- *Polarities*

The child divides his world into opposites or polarities. Emotions, moral standards, values, likes and dislikes are seen within this context. The child finds it difficult to understand how it is possible to experience opposite emotions towards the same person. It is therefore the role of the therapist to clear up these concepts for the child.

- *Critique*

Aggression as well as negative criticism, keeps the child from reaching his introjects. The therapist will for this reason, never criticize the child himself but will sensitively give criticism with regards to his behaviour. The emphasis is placed on the "how" of the behaviour and not the "why" of the behaviour.

- *Responsibility*

If the child is given the opportunity to be himself, the possibility of exploration and experimentation is increased. The child should be taught to take responsibility for what he says and does in order to work towards solving his own problems. Schoeman refers to Landreth (1991:195) saying: *"Children cannot discover and develop their inner resources and, in the process, experience the power of their potential unless opportunities to do so exist. Responsibility cannot be taught, responsibility can only be learned through experiencing."*

- *Sincerity*

The child learns through introjects e.g. copying and role-play. If the introjects are keeping the child from making decisions regarding his likes and dislikes, it is not healthy. The

therapist should be sincere in her relationship with the child and should not carry her own needs over to the child.

- *Transference*

When the child associates the therapist with someone else, it is necessary to bring the child back to the "here and now". The therapist should ensure that the child does not carry over any feelings onto the therapist.

- *Unfinished Business*

Unfinished business can be described as unexpressed emotions, anxiety or unfulfilled needs. Unfinished business accumulates and the therapist needs to work through these emotions, anxieties or unfulfilled needs, with the child. It is very important for the therapist to deal with unfinished business since it can have a detrimental effect on the therapeutic relationship.

- *Violence*

In Gestalt Therapy the child is encouraged to work through negative emotions by means of direct verbal responses.

- *Warmth*

The therapist contributes warmth to the relationship by not putting too much pressure on the relationship. This warmth is expressed, mainly through non-verbal actions.

- *X-Ray Vision*

The therapist should look much further than the verbal communication of the child and also take note of the non-verbal communication.

- *"Yes, I Can"*

Both the therapist and the child should have faith in their own abilities and should be willing to take risks. The therapeutic relationship allows for mistakes to happen, but expects the child to take responsibility for his own actions.

- *Zest*

The therapist should be aware of her own energy level. Her enthusiasm and energy should be carried over to the child. The child will in turn be more willing to take risks in the therapeutic relationship.

Since the therapist and the child both enter the therapy process as a unique "self", it is important to remember that the "self" can only exist by firstly differentiating itself from others and secondly connecting itself to others (Yontef, 1993:33). In the therapy process, *contact* is regarded as synonymous with the therapeutic relationship. It is the process through which the therapist and child get to know one another and establish boundaries and restrictions (Schoeman, 2001:76-78). Contact relates directly to the establishment of relationships, where more than one individual is involved. The child on the other hand exists alone in his relationship with others.

Contact could further be defined by as the interaction between the individual and the environment (Yontef, 2003:18), and includes all systems. It connects the individual and the environment and other individuals with one another. This encounter between the individual and the environment takes place on the contact boundary. This is also the point where the individual starts taking responsibility and where change and development take place. This boundary between the individual and his environment should be appropriately as well as strong enough to ensure that not too much exchange takes place. Disturbances on this boundary are possible.

Most children seen in Play Therapy have some impairment in their contact functions. According to Oaklander (1978:57): *"Children in trouble are unable to make good use of their contact functions in relating to the adults in their lives, to other children, or to their environment in general."* Children will then often adopt behaviour they find helpful in getting them through difficult situations and may resort to aggressive, hostile, angry and hyperactive behaviour. In therapy the original contact functions need to be restored in order for the negative behaviour to subside and the healing process to take place. The contact established between the therapist and the child through the therapeutic relationship contributes to the restoration of the contact functions.

A result of the contact between the therapist and the child is dialogue. Dialogue according to Yontef (1993:2-6) is the direct result of the "self" of the therapist and the "self" of the child interacting within a therapeutic relationship. This supports the assumption that there is no "self" without others. The therapeutic relationship is important in the sense that the therapist is this important other to the child. In the context of this relationship the child can ultimately come to insight and self-knowledge that leads to growth.

Dialogue can be either verbal or non-verbal. True dialogue can also accommodate both the I-it and the I-thou relationships. The I-it relationship represents that part of the therapeutic relationship where the therapist decides on which method to experiment with in order to facilitate self-discovery and revelation of the self. The I-thou relationship on the other hand contains and requires no experiment since it refers to a sincere encounter between two people. The latter is not facilitated, and creates a feeling of unity. Within the process of dialogue the therapist has a responsibility to ensure an interpersonal environment of security in which dialogue can transpire.

The therapist needs to be aware of verbal and non-verbal behaviour, and should also respond appropriately to this behaviour. The therapist should be cautious not to count on her theoretical knowledge alone but to always tune into the verbal and non-verbal behaviour of the child in the here and now. The purpose of Gestalt Therapy is indeed not to be prescriptive or interpretive.

Contact and dialogue are important and are accommodated in the therapeutic relationship. It also takes place throughout the therapeutic process. This aspect is also integrated into the Schoeman Model, since this model attaches much value to the importance of establishing a therapeutic relationship (Schoeman, 1996:30). Although the establishment of a therapeutic relationship can be regarded as an important point of departure, it should also be emphasized that individuals are sensory integrated beings. They are therefore not only absorbed by the therapeutic relationship but also through their sense by their environment.

2.5.3 Sensory Contact

According to Schoeman (1996:57) sensory contact is supported by the supposition that every individual is a unique, sensory integrated being. The individual perceives his environment through his five senses (vision, hearing, smell, taste and touch). The interpretation of sensory information allows him to experience his world. The therapist should at all times be convinced of the fact that the child is in contact with her own senses and identity.

The aim of sensory contact is to enhance the child's sensory perception. In order for meaningful therapy to take place sensory awareness should be addressed in the beginning of each session. Schoeman (1996: 57) also emphasizes the importance of the therapist being in contact with her own identity in order to successfully reflect the perceptions of the child. Sensory contact allows for ample opportunities to experiment with a wide range of sensory stimuli in order to gain valuable information surrounding which stimuli is stimulating to the child or on the other hand not tolerated by the child.

Sensory contact is aimed at leading the child towards awareness. According to Yontef (2003) awareness can be regarded as the only aim in Gestalt Therapy: "*The overall aim of Gestalt is the development of full awareness, because people change not by forcing them to change, but by becoming fully aware of who and what they are in the here and now.*" The Gestalt Theory of change can also be included. Growth and change only takes place in the presence of awareness, self-acceptance and authentic self-expression (the true you). Awareness entails includes that the individual should become aware of his environment and others, get to know his environment, take responsibility for his own choices, discover his true "self" and ultimately reach self-acceptance and experience growth and change. Mackewin (1997:14) claims that individuals have deeply rooted physical, psychological and emotional patterns that might interfere with awareness of the true "self".

Oaklander (1978:58-59) also stresses the importance of awakening the senses, in her work with children in trouble: *"As her senses awaken, she begins to know her body again, she can recognize, accept and express her lost feelings… she can make choices and verbalize her wants and needs and thoughts and ideas".* The latter paves the way for

contact between the child and his world, and also indicates the beginning of healing (Oaklander, 1978:58).

Since Gestalt Therapy supports the uniqueness of all individuals in a sound therapeutic relationship it also allows for the child's own way of doing and being. This refers to the unique process of the child.

2.5.4 The Child's Process

In previous discussions, mention was made of the theory of "self" in Gestalt Therapy. The child's process links up with this theory of the "self". The process of the child in essence refers to *what* the child does and *how* he does it. The "self" can be regarded as the process of the child. It is the part of the child, including al the different aspects of the "self", with which he enters the therapy process. The child does not necessarily have knowledge about his process and also explores this throughout the therapy process (Yontef, 1993:331).

Schoeman (1996: 91) cannot put enough emphasis on the importance of the therapist being aware of the child's process. The therapist must get to know the child's unique way of functioning, in other words the *what* and *how* of doing things. It is also important that the child should be made aware of his own process in order for him to grow towards a self-supported, healthy and functional individual.

The therapist's process is just as important in the therapy process as that of the child. The therapist also needs to be aware and comfortable with her own process since it can have an effect on the child in therapy. The child's process will however still be the determining factor in setting the pace for therapy. The "self" of both the therapist and the child are not static since it is subjected to constant change and growth (De Witt and Booysen, 1994:36).

Development forms an integral part of the child's process. It is assumed that healthy development with specific reference to the fulfilment of the child's emotional needs, gives the foundation for sufficient development of self-esteem and a positive self-concept. Sufficient self-esteem in turn, will allow and facilitate contact between the individual and his environment whereby the child's process is developed even further (Yssel, 1999:90).

Through organismic self-regulation, a balance is established although the process of the child will determine *how* this balance is maintained (through either fight or flight).

While the therapist is in the process of defining the child's process, it is also important to keep in mind that the therapist has to create a favourable atmosphere in which it is possible for the child to introduce his process and to discover not yet known aspects there of. The therapist is also given the opportunity to recognize and to rediscover her own process in the same favourable atmosphere. Because the child's process is not static, the therapist remains in the process of constantly observing and defining it throughout the therapy process. Yontef (1993:61) states that observation is fundamental to the experiment approach in Gestalt Therapy. Throughout the therapy process, the child's *what* and *how* of dealing with his environment and other individuals in his environment, has to be observed and defined. The process of *how* is regarded as more important than the content of actions and perceptions. The role of the therapist is by no means to interpret the child's process on his behalf, but to give the child enough opportunities to introduce and discover his own process.

Although observation is fundamental in determining the child's process, there are other ways of determining and defining the child's process as well (Yontef, 1993:61). Fantasy, for one, is regarded as a powerful experiment because it allows for exploration beyond the immediate person, place and situation. Fantasy can sometimes also be more effective than real life situations. The way the child handles situations, and reacts to it in his fantasies (fantasy process) often represents his way of dealing with situations in real life (life process). Fantasy is therefore not only valuable in determining the child's process, but also in assisting the child in understanding his process. It also provides the child with a safe environment away from the painful reality. In addition fantasy plays an important role in the child's development of play. Many theories on the development of play mention the role and importance of fantasy. Fantasy can be regarded as a category of play that it is not necessarily restricted to a certain age group (Oaklander, 1978:11-12).

According to Schoeman (2001:109-111), not all children feel comfortable with expressing themselves through fantasy. Some children for instance, can identify themselves better with more constructive activities such as drawing, playing with clay or doing projective sand tray work. Fantasy takes place on a more abstract level.

Experiment plays an important role in determining the child's process. As the therapist becomes familiar and comfortable with the child's process the therapy process can be continued with singleness of purpose. The therapy process is dependent on the needs and the process of the child and not merely on theory alone. When selecting the most appropriate projection techniques, the therapist can select it according to her knowledge of the child's process (Yssel, 1999:10).

The child's process is regarded as the way he handles his environment and could also be determined in a non-threatening way through the use of play (Oaklander, 1978: 161). Whether the "self" is mentally healthy, neurotic or psychotic, the child's *what* and *how* of dealing with his environment is still regarded as his unique process. Play Therapy fortunately allows for this information on *what* and *how* to be brought to the surface. Oaklander (1978: 58) confirms that children with emotional needs and problems often resort to behaviour of anger, aggression, hostility, hyper activity etc. This behaviour is reflected in their interaction with their environment. By becoming familiar with the child's process the therapist is able to accept the child and guide him in discovering him self and becoming aware of inappropriate behaviour and the influence it has on his environment.

With sufficient knowledge of the child's process and level of development the therapist can continue to the next step in the Schoeman Model (Schoeman, 1996:64) namely projection.

2.5.5 Projection

Projection means that the child projects something from within himself on something or someone in his environment. It can be simplified to the process of breaking open and exposing information. Projection implies that the information being exposed is representative of what is on the child's figure-ground in the here and now. Projection also relates strongly to fantasy.

In the therapy process projection is utilized as a form of communication (Schoeman, 1996:65). At this stage of the therapy process the therapist is already familiar with the process of the child and can therefore select appropriate and purposeful techniques to facilitate projection. The therapist, according to Schoeman (1996:65-66), will have to make the following decisions:

Firstly the therapist needs to decide whether or not to use an open or a closed projection. A closed projection implies more structure and means that the child will not necessarily have a choice in the matter. This type of projection could be used with great success in cases where the child is anxious, unsure of himself and lacks initiative and creativity. It can also be appropriate to children with low self-esteem or children presenting with childhood depression. This type of projection can also be used appropriately where the therapist wants to focus on a specific aspect in therapy. It should not be regarded as totally closed or rigid, since the child's figure will still be brought to the surface no matter what type of projection is used. An open projection, on the other hand, implies that the child decides what he wants to create as well as the medium he prefers to use. The therapist then takes it from there. Both these types of projections will only project that which is on the child's figure-ground in the here and now.

After deciding on the type of projection, consideration should be given to the type of play to be selected. Creative play, biblio-play and dramatized play are some of the forms of play that could be selected. The medium of play refers to the media that will be used to create the projection and can include painting, drawing, sand tray and any other art media. The child with low self-esteem might be reluctant to get involved in something like role-play or an activity that includes a high level of possible failure.

Projective techniques are introduced to the therapy process for the following reasons (Schoeman, 1996:67):

- *Projection in the here and now*

By introducing projection techniques the child is given the opportunity to explore his unfinished business through the use of his five senses. Projection exposes the child's figure-ground in the here and now. Schoeman (1996:67) refers to it as*: "Even the past exist now as a memory because it is of concern."*

- *Projection as a stimulant to growth*

Projection brings the child closer to discovering his true "self".

- *The handling of unfinished business*

The child with unfinished business often bottles it up inside. This internalisation has physical as well as emotional consequences, and can influence the process of organismic self-regulation. Through the use of projection, unfinished business is brought to the surface in a less conscious and threatening way. This unfinished business can then be addressed in therapy.

The use of projection techniques, within the Schoeman Model, is not at all restricted to a certain sequence or a certain amount within a given therapy session. It is used at the therapist's own discretion and according to the needs of the child.

Oaklander (1978:53) feels strongly about the power of projection and is of the opinion that the mere act of drawing, without any form of therapy, gives ample opportunity to express feelings, the "self" and self-identity. Although projection allows for feelings of hurt, aggression and discomfort to be brought to the surface, it also puts these feelings at a safe distance from the child and thus allows him to deal with these issues form a safe distance (Oaklander, 1978:193). Projection and the sensible application thereof, is an indispensable tool in allowing the child with emotional needs and problems to come within a safe distance of his inner feelings in order to deal with them.

There are various reasons why projection is introduced into the therapy process. The full potential of projection is optimally utilized when the child can own the projected emotions or elements of his process. By doing so the child takes responsibility and growth can take place. This process does not necessarily come easy.

2.5.6 The Different Layers of Neuroses: Its Contribution to, and Influence on the Therapeutic Process

The process of owning will be explained by referring to the Five Layer Theory of Perls. Perls proposed five layers of neurosis to illustrate how unhealthy functioning prevents the child from growth and resultant maturity (Schoeman, 2001:91). This theory clearly explains how fragmentation takes place in the life of the child and how the psychological fragmentation stands in the way of personal growth and healing. This theory, furthermore, indicates different phases in the therapy process and sets a good framework, whereby the therapist can conduct her therapy.

According to Oaklander (1978:192): *"Children do not come into my office announcing, this is what I want to work on today"* and it is therefore up to the therapist to *"…provide the means by which we will open doors and windows to their inner worlds. I need to provide methods to children, to express their feelings…so that together we can deal with this material"* (1978:192-193). The child may not always enter therapy willingly, without fear or with all the answers and solutions at hand. The therapist will therefore ultimately aim at establishing a sound relationship and a secure environment in which the child can gradually work through all the different stages (five levels) to finally ensure growth and maturation (Oaklander, 1978:181-185). The therapist will guide the child through the following stages, in therapy:

2.5.6.1 The Phonic Layer

This is the first, outer layer of interpersonal interaction. The contact that takes place on this level is superficial and behaviour on this level is mainly founded in introjects. The child often pretends in the roles he is playing. The superficial communication, that is synonymous with this layer, may also have great therapeutic value. Through experiment it can be used to increase the child's knowledge of establishing relationships (Phillipson, 2002:5).

This layer also includes unresolved conflicts, the so-called *"unfinished business*" that also refers to any form of unresolved and incomplete emotions (Stephenson, 1975:189). Unfinished business is the main cause of emotional blocks and stagnation. As an example a child that was sexually, physically or emotionally abused will suppress the emotions that were experienced during this phase of therapy. At this stage the child is not yet ready to talk about these feelings although the importance of ultimately dealing with these emotions is evident. The therapist will guide the child to express, confront and deal with these emotions.

2.5.6.2 The Phobic Layer

On this level, the child increasingly becomes aware of the pretentious behaviour and roles that make up a big part of the previous level. At the same time he is also confronted with the anxieties connected to keeping up these pretences. On this level the therapist has to make the child aware of the roles he (the child) play. The therapist can yet again make

use of experimentation to verify non-verbal communication and attitudes. These attitudes can also be brought to the child's attention (Stephenson, 1975:38).

In the course of this layer the child begins to feel safer in the therapeutic environment and becomes aware of the emotions he needs to confront. According to Hamilton (1997:90-91) experimentation now plays an important role since it is the vehicle through which the child is encouraged to take risks. The therapist is not biased and shows empathy towards the child and the emotions he is increasingly becoming aware of.

2.5.6.3 The Impasse

Stephenson (1975: 38) explains this layer as, "…a nothingness in which the forces of resistance are equal to what he is resisting". On this level the child becomes aware of his problem and he also gradually lets go of the environmental support and the so-called games of pretence that belong with the previous layers. At this stage the child also feels an inability to deal with his own anxieties and dislikes. He might even experience that there is no help available for him.

Resistance is fairly common in this phase and can be viewed as a creative way in which the child regulates himself. Resistance can also allow for a safe place or comfort zone to be established. The comfort zone can eventually stand in the way of growth. The therapist has to remove the child from this comfort zone by creating a safe environment ("safe-emergency"). In the context of this safe environment the child is able to discover and explore. Experiment is truly introduced in this phase. Resistance is also appropriately applied to move the child out of this phase (Hamilton, 1997:67). The child is now aware of the emotions or so called unfinished business that was experienced during the period of abuse and can start confronting them.

2.5.6.4 The Implosive Layer

As soon as the therapist and the child have worked through the resistance of the previous layer, they can move on to the next phase, namely the implosive layer. During this phase the child increasingly becomes aware of all the limitations that were placed on him. High levels of anxiety and low energy levels usually identify this layer.

The child has the need to work on his problems and to plan ahead. This phase can be regarded as the process of owning, as also identified in the Schoeman Model. It also refers to that part of the Schoeman Model where the child gets the opportunity to work on alternatives. Suitable alternatives are identified by referring to similar situations from the past and their applicability in the "here and now". The child is also prepared for dealing with similar situations should they arise in the future (Phillipson, 2002:6). The child is now prepared to find his own solutions and work towards self-support.

2.5.6.5 The Explosive Layer

As soon as the child has successfully experimented with the new behaviour and methods/alternatives, he moves on to the explosive layer. Referring to the Schoeman Model, owning, finding appropriate alternatives, and empowerment have already taken place by now. The explosive layer, as the name indicates, is characterised by outbursts of energy. The child becomes aware of the energy that was wasted in the previous phases/layers and expresses this energy through his actions and behaviour (Phillipson, 2002:7). In the course of the previous layers the environmental support was gradually broken down and eliminated, making room for self-support (Stephenson, 1975:76). Empowerment may also flow over from the previous layer and in this phase move on towards self- nurturing.

Self-nurturing, the last step in the Schoeman Model, aims at leaving the child with something he enjoys and that makes him feel good. It is also a component of organismic self-regulation. During the therapy process the child is encouraged to project his unfinished business, make contact with it and to ultimately nurture these emotions, anxieties and unfulfilled needs, in order to lead to a feeling of integration. With this feeling of integration, the child leaves the therapy session (Schoeman, 1996:69).

As Polster and Polster (1973: 278) state, a mere hour therapy per week can hardly facilitate sufficient growth. Therapy should therefore continue beyond the boundaries of therapy sessions in order for it to have a more powerful impact. It is also important to note that new methods and possibilities, discovered during therapy, can only be brought into action within the child's true living circumstances. The therapy process prepares the child to feel ready within himself to face the challenges of reality. Even if the child experiences failure, it is regarded as an opportunity for growth.

2.6 SUMMARY

Gestalt Play Therapy is a holistic approach that deals with the child with emotional needs or that has been affected by trauma. The child is not only viewed as a holistic and complex human being, but is also considered within his greater field of functioning. Emotional needs and trauma are not only caused by the field but also has a direct impact on the child's field. Through this approach the child is given the opportunity to focus on the here and now, in other words the emotions he is currently experiencing or the issues that is causing discomfort in the present. The child gets an opportunity to work through his unfinished business and ultimately rediscovers his true self.

For the South African context, a model based on Gestalt Play Therapy principles, were developed. South Africa is a land rich in culture and is home to many different cultural groups. Emotional needs, problems and trauma is in every sense of the word, part of many children's lives, irrespective of age, race, culture and socio-economic background. This model embraces play as a universal language in entering the sad, protected and sometimes disturbing worlds of children with emotional needs, problems and who has experienced emotional trauma. This allows for the therapist to work around the restrictions of limited language skills and verbal abilities.

Gestalt Play Therapy does not only allow for healing in the child but also allows enough room for the Play Therapist to find and express her "self" in the therapy process. In the following chapter Pediatric Occupational Therapy, with specific reference to the child with emotional problems, will be discussed in more detail.

3. PEDIATRIC OCCUPATIONAL THERAPY WITH SPECIFIC REFERENCE TO THE CHILD WITH EMOTIONAL PROBLEMS

3

3.1 INTRODUCTION

The Moral Treatment Movement preceded Occupational Therapy in the 1800s. This movement recognised the health promoting benefits of engaging oneself in a broad spectrum of activities or occupations. Although the Moral Treatment Movement contributed, Occupational Therapy as a profession was mostly the product of a confluence of various social movements around the turn of the century.

Eleanor Clarke Slagle can be regarded as an early leader in the profession of Occupational Therapy. She studied under the head of the Settlement Movement. The Settlement Movement was initially established to minimise the debilitating effects of poverty, industrialisation and cultural alienation suffered by immigrants. This movement, congruent to the beliefs of Occupational Therapy, believed in the power of creative activity.

Occupational Therapy was further supported and developed by people such as Meyer and Lathrop (Clark, Wood & Larson, 1998:14), both renowned psychiatrists in their time, who identified and explored the value of occupation in treating mental illness. People from the field of education and sociology also influenced Occupational Therapy.

Interestingly enough, Occupational Therapy found it's roots in The Mental Health Professions although it diversified over the years into many other fields of speciality. The definition that is currently used to explain the term Occupational Therapy did not change much from the beliefs of the initial movements from which it originated: "Occupational Therapy is the art and science of helping people do the day-to-day activities that are important to them despite impairment, disability or handicap (Neistadt and Crepeau, 1998:5)."

Later on, Occupational Therapy later needed a scientific foundation to support the values and beliefs of the profession. Out of this need Occupational Science was born with the purpose to nurture the profession of Occupational Therapy in the 21st century.

Occupational Therapy is regarded as the profession, whereas Occupational Science can be described as the academic discipline that supports the profession scientifically. According to Neistadt and Crepeau (1998:13) the academic discipline studies humans as occupational beings, focussing mainly on how they realise their sense of meaning through occupation. Occupational Scientists, according to Neistadt & Crepeau (1998:13) are, *"…interested in how one's sense of "self" emerges out of daily experiences and how those experiences become linked in a meaningful life story".*

Although Occupational Science was established upon 20th century values and beliefs of Occupational Therapy, it is still relevant to the profession of Occupational Therapy in the 21st century. It still provides a foundation that is scientifically validated and that enables practitioners to deliver better services to their clients (Neistadt and Crepeau, 1998:20).

3.2 THE ILLNESS AND DISABILITY EXPERIENCE

Although the need for scientific validation can be regarded as a very important component when providing a service to clients, it should be taken into account that the client's experience of illness and disease should take precedence over all. It is important to be aware of the therapeutic role and the needs of the client that enters the therapy process.

3.2.1 The Individual's Perspective

Although Occupational Therapists have a professional and scientific understanding of the body, a partnership with the client enables them to identify the unique needs of the client. Because of this Occupational Therapists are able to integrate science and emotion and therefore contribute their knowledge in the process of returning meaning to their clients' lives (Beer in Neistadt and Crepeau, 1998:33).

According to Missiuna & Pollock (2000:101-103) client-centred Occupational Therapy aims at giving the child the opportunity to select appropriate goals that should be addressed in therapy. Young children should therefore be provided with the opportunity to assess their level of performance and set goals for themselves accordingly. Occupational Therapists often establish goals on behalf of the child without using any formal through which the child's goals can be prioritised. Instead of lining goals up with the child's need, goals are

set according to the needs of parents and teachers. Studies that included older children indicated clearly that parents and children often have different priorities in therapy.

If Occupational Therapists are committed to include the child in the process of goal setting and prioritising, they need to establish a partnership with the child. In the course of this partnership, the child should be invited to share his own views (Missiuna and Pollock, 2000:108). Law and Mills (1998:10) state that *"…clients hold the most important information about their needs and should be encouraged to make choices and to define the occupational performance issues for which they require occupational therapy intervention".* Although the child is regarded as the most knowledgeable when it comes to his own needs and the prioritising of these needs, he cannot be separated from his family relationships.

3.2.2 The Family's Perspective

Although there are still many questions that need to be answered in order to fully comprehend the term 'family-centred care' in practice, there is currently a tendency towards this approach.

This approach is infiltrating the "**culture of Western Biomedicine**" that has developed over a period of 250 years and that is aimed at treating the pathology. Occupational Therapists started to appreciate the centrality of families in the patient's process of healing, recovery and adaptation. Family-centred care has already been established within the field of Pediatrics, and can be traced back as far as the turn of the century (Mattingly and Lawlor, 1998:43-45).

According to Mattingly and Lawlor (1998:43) the age of patients are irrelevant since *"…no matter what the age, ethnicity, socio-economic status, or geographical location, at times of severe illness or disability, families tend to matter".* The opposite is actually more applicable since families are more often than not underrated in health care. Baloueff (1998:569) also confirms the role as well as the pressure and stressors families of disabled children, or children with special needs, are faced with.

According to Mattingly and Lawlor (1998:45-49) the main reasons why families are underrated and misunderstood, is the professional culture in which Occupational Therapists find themselves. In this culture professionals learn certain values and beliefs. Mattingly and Lawlor (1998:51) state that, "…practitioners, as the instruments for intervention, bring their selves and their cultural views of families into the clinical interaction. Occupational Therapy Practitioner come to their profession with life experiences of being a member of a family".

Mattingly and Lawlor (1998:45-49) described some of the troublesome assumptions that are regularly made about the illness experience and families:

3.2.2.1 The disability belongs to the Individual

This assumption is probably the most pervasive since it is interpreted as treating the pathology as though it could be separated from the individual having the illness or disability. Occupational Therapists, however, have already developed sensitivity for recognising the individual behind the illness or disability.

3.2.2.2 The professional is the expert

Based on this assumption the professional regards herself as the healer. This means that she acts as the expert in assessing, diagnosing and ultimately identifying the correct intervention. All this happens without taking the needs and priorities of the patient or family into consideration. The patient should take on a submissive role, with the personal information, family situation and work history of the patient being of little importance.

3.2.2.3 The Client is the recipient of care

The patient is regarded as the passive recipient of treatment delivered by the professional. Currently it is known that therapy can only be effective when clients are motivated to participate in the therapy process (Lawlor and Cada in Mattingly and Lawlor, 1998: 47). Occupational Therapists have embraced a more holistic approach to treating children in therapy.

3.2.2.4 Illness and disability generates only negative experience

This supports the false assumption that all families experience only negative feelings with regards to illness and disability. This assumption presumes that all families will experience predictable attitudes to illness and disability. It does not take the fact that all families will not necessarily have the same experiences, into account.

3.2.2.5 There is one family perspective per family

Families consist of different individuals, meaning that family members might not always share the same feelings. Due to this each individual's perspective should be considered. In the field of Pediatrics the opinion and perspective of the mother, or significant caretaker, is usually regarded as the only perspective presentative of the whole family's viewpoint.

According to Gutman, McCreedy & Heisler (2004:21-25) parents of children with sensory and emotional problems need to be made aware of their children's needs by getting them involved into the therapy process. Involvement in therapy does not only increase the parents knowledge and insight into their children's problems, but also makes it possible for the therapist to observe parental behaviours that could contribute to the child's dysfunctional behaviours. According to Baloueff (1998:569*): "Families are the primary social unit in which children live and receive care and nurturing, consequently, they provide the central influence in the lives of the children."* The family being the primary social unit, could on the one hand be regarded as a positive factor whilst on the other hand as a breeding ground for certain emotional disturbances such as attachment disorders.

Occupational Therapy has already started moving away from the traditional models of medicine, towards family-centred care. Family-centred care can be defined as *"…an experience that happens when practitioners effectively and compassionately listen to the concerns, address the needs, and support the hopes of people and their families"* (Lawlor and Cada in Neistadt and Crepeau, 1998:44).

3.2.3 The Therapeutic Relationship

Many regard the therapeutic relationship as a crucial component of therapy. According to Reade, Hunter & McMillan (1999:161): *"There is no doubt that time must be allocated for the development of a potentially therapeutic relationship and it is vital that the child does not feel rushed."* The relationship that is established between the child and the Occupational Therapist is crucial in ensuring a safe, non-threatening therapy environment for the child. According to Gutman *et al*. (2004:11) the relationship that is established between the child and the Occupational Therapist should be one of acceptance and trust. The child should be encouraged to be himself when he is with the therapist. Gutman *et al*. (2004:11) state that many children in therapy, "…*are in hiding and attempt to maintain the secrecy of their problems, particularly psychosocial problems"*. As the child feels increasingly secure in his relationship with the Occupational Therapist, he will share his difficulties more readily. Ainscough (1998:224-225) indicated the effective use of play/activity in establishing a therapeutic relationship between the child and the Occupational Therapist.

In modern society all parents are to some extent dependent on experts. In cases where parents have a disabled child, this dependence increases (Baloueff, 1998:573). The initial relationship that is established between the professional and the parents are therefore crucial and Baloueff goes even further by claiming that the parent's involvement in therapy as well as the benefit therapy holds for the child, depends on this relationship. Because Occupational Therapy has embraced family-centred care, the child's family plays an integral part in the therapy process. Due to this the Occupational Therapist has to establish a therapeutic relationship with the parents. The therapeutic relationship will continue to get stronger and will also be nurtured throughout the therapy process. These relationships will also form the foundation of the therapy process and will ensure an optimal therapeutic environment.

3.3 OCCUPATIONAL THERAPY WITH THE CHILD WITH EMOTIONAL PROBLEMS

A broad field of practice exists within Pediatric Occupational Therapy. Intervention with children who suffer from emotional problems is only one of the fields of interest in the broader spectrum of Pediatric Occupational Therapy. Emotional problems may also be secondary to other physical or developmental problems.

3.3.1 The Pediatric Population

Baloueff (1998: 569) broadly defines Pediatrics as the age between birth and twenty-one years. Pediatric Occupational Therapy has expanded over the past two decades and currently almost one-third of all Occupational Therapists find themselves in the field of Pediatrics. The population that is treated in Pediatric Occupational Therapy includes a diverse group of diagnostic entities such as mental retardation, Cerebral Palsy, genetic and chromosomal anomalies, Autism, learning disabilities, severe orthopaedic impairments, visual and hearing impairments, serious emotional disturbances and traumatic brain injury.

This chapter is aimed at describing the intervention process of Occupational Therapy with regards to the child with emotional disturbances. According to Florey (1998: 622) at least 12% of the pediatric population could be diagnosed with a mental disorder of some sort, where at least 50% of these children will be severely disabled by this disorder. Even children that were primarily diagnosed with a chronic medical condition stand a serious risk of also developing a secondary psychiatric disorder.

According to these diagnostic entities the Pediatric Occupational Therapist is also involved in the treatment of children with emotional disturbances. The most prominent psychiatric disorders in childhood, according to Florey (1998:630), are Attention Deficit and Hyperactivity Disorder, Conduct Disorder, mood disorders and Autism. These disorders correlate with the disorders that were categorised under the heading of emotional problems that was defined as one of the main concepts in the first chapter. According to Coleman, Butcher & Carson (1980:489-490) less serious disorders of childhood:

> "Often (they) are referred to simply as emotional disturbances, to indicate that they are not so much disorders as problems with which the child needs help. If such assistance is not received, however, the developmental problems of childhood sometimes merge almost imperceptibly into more serious and chronic disorders when the child passes into childhood e.g. Hyperactive Syndrome, Conduct Disturbances, Disturbances of emotion such as Depression, Autism and Stuttering."

The referral to psychiatric disorders by Florey (1998:630) overlaps with those disorders defined by Coleman, Butcher & Carson as emotional disturbances. The disorders that were mentioned may vary in levels of severity and resistance to intervention. For the purposes of this chapter it was decided to refer to emotional disturbances that are susceptible to treatment and has good prognosis.

The Occupational Therapy process consists of two equally important actions namely. evaluation and treatment. The main vehicle through which these actions are driven, in Pediatric Occupational Therapy, is play.

3.3.2 The Use of Play in Occupational Therapy

According to Schaaf (1990:68) the *"…major goal of occupational therapy is to enhance a person's ability to interact in the environment in a competent manner."* Play is further regarded as the most important means through which a child integrates and responds to information from his environment. Enhancing playful behaviour could be regarded as one of the most important goals in Occupational Therapy with the child. Couch, Deitz & Kanny (1998:111) also regard play as *"…one of the primary occupational therapy roles addressed in the theoretical foundation of occupational therapy"*. The three roles addressed in Occupational Therapy are self-care, work and play. It was also confirmed that Occupational Therapists use play in practice for the purpose of evaluation as well as intervention.

According to Ainscough (1998:224) Occupational Therapists are regarded as familiar with the scope of activities as well as the ability to analyse activities with the purpose of finding the appropriate activity to match the cognitive, physical or emotional need to be

addressed. Activities *"…form a third part in the relationship between the occupational therapist and the client"* (Ainscough, 1998:224). Activities can become a means of communication as well as a vehicle for expressing difficult emotions. Activities also have various advantages, according to Ainscough (1998:224-225):

- On the one hand activities provide enough structure, sequence and method whilst on the other hand it allowing a non-directive relationship.
- Activity gives the child the opportunity to explore issues and themes that are important to him.
- Building a relationship with the child can be aided through the use of activities.
- Activities give the child the opportunity to explore feelings and emotions in a non-verbal way.
- Experiences of achievement and success are also encouraged through the use of activities.

It should always be kept in mind that a child brings his own thoughts and responses to any give activity. Play is regarded as the natural medium of self-expression used by children (Reade *et al*., 1999:157).

3.3.3 Evaluation

According to Reade *et al*. (1999: 158): *"Play therapy may only commence following assessment and when systematic issues have been examined."* Intervention is therefore dependent on assessment and is prioritised according to the goals that are set by the child in partnership with his parents and the therapist.

The process of evaluation is described by Florey (1998:625), as *"…a comprehensive process of obtaining information that is derived from specific assessment tools and methods".* Through evaluation the Occupational Therapist determines the child's strengths and weaknesses. Evaluation is the first step in the therapy process. On the basis of the results obtained during the evaluation the Occupational Therapist establishes certain goals and objectives for ongoing therapy (Schaaf, 1990:68). Children presenting with behavioural and emotional problems seldom experience problems that are applicable to their behavioural, affective and interpersonal areas only. Children with behavioural and

emotional problems are often also screened for visual-motor and motor problems. When problems are indicated within the visual-motor and motor areas, a full in-depth assessment is recommended.

Florey (1998:626) identified four types of evaluation methods, for assessing the child with behaviour and emotional problems namely structured observations, interview, standardised tests and checklists or inventories.

After the therapist has assessed the child and set up goals and objectives for therapy, treatment can start.

3.3.4 Treatment

According to Gutman *et al*. (2004: 13): *"It is important to remember that therapists must address the emotional aspects of a child's pathology as well as skill deficit."* Occupational Therapists can not only address the tangible deficits in children but also need to be aware of, and address the emotional issues children bring to therapy.

Reilly, according to Florey (1998:628-630), has developed general principles for treating children with psychiatric problems. The main focus of treatment is to establish a milieu to explore and to evoke and reconstitute appropriate skills and behaviours. It is also recommended that an interdisciplinary approach should be followed in psychosocial programs with children. The following characteristics form part of the milieu set by the Occupational Therapist when treating children with emotional problems:

- Play and task environments need to be integrated into the treatment milieu and the child needs to get the opportunity to associate with adults and peers.
- The play milieu includes toys, crafts, projects, games and activities that are gradually graded in complexity.
- Crafts, projects and activities should be in the developmental range of the child.
- Social and learning behaviour should be integrated into the play and task environment.

The following are suggestions to ensure a positive treatment environment for children with psychosocial problems (Florey according to Reilly, 1998:628-630):

- The play and task environment should be populated by peers. One-on-one intervention can initially be utilised although it remains crucial that the child should be integrated into a group setting gradually. The child needs to become familiar with social and behavioural demands as determined by the group. It is advisable that younger children be placed in a group of older children or adolescents. This provides the younger children with an opportunity to benefit from learning tasks and skills within a brother-sister relationship whilst the older children get the opportunity to practice their skills within a less intimidating relationship.
- Social skills learning should be a part of the task and play environment. Social skills are regarded as one of the constructs of social competence, and developmental considerations need to be kept in mind when selecting the social skills that will be taught.
- Programs should be conducted within natural childhood activities such as interacting with toys, crafts, and games. Activities should be analysed according to three major dimensions. These three dimensions are cognitive, motor and social complexity. Cognitive complexity refers to the level of problem solving processes required to master all the steps needed to complete a certain activity. When an activity is selected the therapist needs to be acquainted with the number of steps, the sequence of these steps, the complexity of the steps and how much patience and persistence will be necessary to complete the task. Motor complexity refers to the amount of fine and visual motor skills required to complete the activity. Social complexity refers to the permissible opportunities for social exchange (e.g. sharing and co-operating in the use of space and materials as well as peer and adult interaction).
- Intervention should be embedded within natural childhood models for play and school. The play environment should incorporate activities that are familiar to the child in the sense that it is appropriate to his level of development (e.g. therapy with the younger child should allow for a play environment that includes media for constructive, simple group games and imaginative play).

- Expectations regarding behaviour should be explicit and known. According to Florey (1998:630*): "Rule behaviour is a major focus in childhood, and expectations for behaviour can be phrased as specific rules."* Rules should be clearly outlined to ensure safety and predictability in the general manner of proceeding. The child should be well aware of the consequences breaking the rules.

The above-mentioned characteristics can be integrated into the intervention program with the child who suffers from emotional problems. A specific treatment program to address the psychosocial problems that are seen in children with regulatory disorders has also been developed (Gutman *et al*., 2004:2). Regulatory disorders are commonly treated in Occupational Therapy and many of the psychosocial problems, associated with these disorders can also be synonymous with other disorders that are treated in Occupational Therapy.

The article written by Gutman *et al*. (2004:1-32) was an attempt to identify the psychosocial problems of some children with regulatory disorders and to describe the steps taken in treatment. According to the above-mentioned authors Occupational Therapists have the responsibility to address the psychosocial problems children might bring to therapy with them. Therapists on the other hand aren't always equipped to deal with these problems and prefer to rather focus on the more tangible tasks of development e.g. fine motor tasks, motor control tasks etc. (Gutman *et al*., 2004:3).

Gutman *et al*. (2004:11-26) stipulated the following to ensure the effective treatment of psychosocial problems in children with regulatory disorders. Regulatory problems refer to the problems experienced by children that are unable to regulate the sensory information received from their environment. These problems are often dealt with in Occupational Therapy through the application of specialised techniques to promote sensory integration. These children however also experience certain secondary psychosocial problems. The guidelines set out by Gutman *et al*. (2004:11-26) could be regarded as the steps that need to be taken in ensuring the effective treatment of these psychosocial problems in children with regulatory disorders. These guidelines are as follow:

3.3.4.1 Building a Relationship with the Child

The Occupational Therapist has the responsibility of establishing a therapeutic relationship with the child, built on trust and acceptance. According to Ainscough (1998:224) this relationship between the therapist and the child is of central importance. This relationship will form the foundation for a therapeutic environment that can enable the child to experience success. This experience of success is a crucial component in the process of enhancing the child's self-esteem.

A therapeutic relationship based on trust and acceptance empowers the child to share more and more information with the therapist. The information will also include confidential information relating to the difficulties that the child might be experiencing. According to Gutman *et al.* (2004:12)*; "Many of these children are in hiding and attempt to maintain the secrecy of their problems-particularly psychosocial problems."*

The time that it takes for the child to establish a therapeutic relationship with the therapist might differ from one child to another and should never be rushed.

3.3.4.2 Helping the Child Identify Dysfunctional Behaviours

According to Gutman *et al*. (2004:12-13) the Occupational Therapist should make the child aware of his dysfunctional behaviours without causing any anxiety in the child. Children are very often ridiculed at school because of these dysfunctional behaviours. This leads to feelings of low self-esteem. Children that manifest dysfunctional behaviours are also often labelled.

The Occupational Therapist aims at making the child aware of the dysfunctional behaviour with the underlying presumption that awareness ultimately leads to change. The child should also be made aware of the effect his behaviour might have on other people. Once dysfunctional behaviours have been identified the therapist should allow for ample opportunities to practice the new appropriate behaviours that can replace the dysfunctional behaviours. Functional behaviour should also be reinforced.

3.3.4.3 Helping the Child Manage Emotions

In order for children to manage their own emotions, they need to be aware of their emotions. They also need to acquire suitable vocabulary to describe their feelings. Once children are more aware of their feelings and are able to verbalise these feelings, it is possible for them to bring less pleasant emotions to the surface (Gutman *et al*., 2004:13-14).

3.3.4.4 Helping the Child learn needed Social Interaction Skills

Children need to be instructed regarding basic interaction skills in individual or group sessions (Gutman *et al*., 2004:17-18). Interaction skills can first be learned and practised in the safety of a one-on-one situation and later be addressed in a group setting. Within the safety of the individual sessions, mistakes should be allowed and accepted in a non-threatening manner.

When the child displays sufficient social skills in the individual sessions, in a small group setting can commence. In the group the child should be familiar with aspects such as co-operation, time limits, sharing, turn taking and competition. Interaction between group members (rather than interaction between the members and the therapist) should be encouraged. Children should be made aware of relational transitions (e.g. saying goodbye and ending a conversation). Resolving conflict, also forms part of social skills and should therefore be addressed. Children need to be taught appropriate ways to deal with conflict without having to resort to displays of physical aggression. By developing children's social skills they become aware of the effect their behaviour could have on other people. In addition they also get the opportunity to minimise this effect appropriately.

3.3.4.5 Identifying Parental Behaviours that Influence Therapy

Mattingly and Lawlor (1998:43-45) agree with Gutman *et al.* (2004:18) that the involvement of the family as well as their positive contribution towards the therapy process, play an important role in the therapy process. Occupational Therapists have started appreciating the centrality of families in the patient's process of healing, recovery and adaptation. Family-centred care has already been established within the field of Pediatrics, and could be traced back as far as the turn of the century.

The involvement of parents in the therapy process is not only necessary in order for them to support the child, but also presents the therapist with an opportunity to identify parental factors that could cause emotional and behavioural problems in the child. According to Gutman *et al*. (2004:21) parents of children with sensory and emotional problems need to be made aware of their children's needs by getting them involved into the therapy process. This does not only increase the parents knowledge and insight into their children's problems but also makes it possible for the therapist to observe parental behaviours that may contribute to the child's dysfunctional behaviours. This view is also supported by Baloueff (1998:569): *"Families are the primary social unit in which children live and receive care and nurturing, consequently, they provide the central influence in the lives of the children."* This could on the one hand be regarded as a positive factor whilst on the other hand as a breeding ground for certain emotional disturbances such as attachment disorders.

Gutman *et al* (2004:18-21) have identified six forms of parental behaviours that could have a negative effect on their child's therapy. These behaviours should also be addressed in therapy:

- *Parental Denial*

Parents might be reluctant to acknowledge their child's problem. A parent in denial will probably be resistant to therapy. Blame shifting can also be a part of this dynamic.

- *Parental Resistance to Therapy*

When a parent finds it difficult to admit that his child might experience difficulty he could find it even more difficult to buy into the therapy process. These parents are resistant to therapy and will go to great lengths to convince the therapist that their child does not have any problems and that problematic behaviour can be regarded as isolated occurrences. These parents often attempt to justify problems at the hand of external circumstances such as high levels of stress or exposure to too much television. They often do not have the ability to observe patterns in their child's behaviour (e.g. isolated incidents of behaviour that could actually be linked with the same overall problem).

- *Parents and Children in Hiding-Collusion*

This group of parents is aware of their child's psychosocial problems but makes every attempt to conceal this behaviour from the rest of the world. Although the child is made aware of his problems, he is also sworn to secrecy. Maintaining the secrecy requires a lot of energy and often leads to feelings of anxiety, anger and depression.

These parents are more often then not reluctant to leave their child alone with the therapist. This behaviour is caused by fear that the child might disclose any of these secrets to the therapist. Once the therapist has established a trusting relationship with both the child and the parents, the psychosocial problems can be acknowledged and addressed.

- *Parents and Children in Enmeshed Relationships*

The relationship of hiding-collusion, where parents and children are in constant collusion, hiding their problems from the outside world, can often lead to development of an enmeshed relationship. An enmeshed relationship can be described as a symbiotic relationship between the parent and the child. Part of the dynamics in such a relationship is the gradual immobilisation of appropriate boundaries. When there are no boundaries between a parent and a child, it is difficult for the child to form his own identity. These children often feel responsible for their parents' emotional state, and can even be motivated to attempt managing their parents' feelings. When parents are difficult to please in this regard, the child could develop feelings of resentment towards this parent.

- *Unrealistic Parental Expectations*

Parents will often come to therapy with unrealistic expectations regarding their child and what therapy can offer them. In these cases the parents should be made aware of their child's capabilities and dispositions. Their expectations should be in line with the child's aptitude, neuro-chemical and genetic predisposition. The Occupational Therapist should also explain to parents what Occupational Therapists do and to what extent their expectations can be met through Occupational Therapy.

- *Dysfunction in Family System*

Occasionally a parent brings a child to therapy, with the expectation that if this child's problems are addressed it could solve the rest of the family's problems. In these cases it should be suggested that the whole family receive counselling. It might also be true that this one member, in accordance with the presented problem, does in fact contribute to many of the family's problems.

3.4 WORKING THERAPEUTICALLY WITH PARENTS

Therapy with the child will not be effective if parental behaviour that influence the child and the therapy process are not addressed in therapy. The following seven goals suggested by Gutman *et al.* (2004:21) can be appropriate when dealing with the parents therapeutically:

3.4.1 Practice Emphatic Listening

The most important goal for is to practice emphatic listening through which the therapist acknowledges the difficulty parents might be experiencing with regards to their child's psychosocial problems. When children experience these problems it does not necessarily reflect on the parent's parenting skills. In spite of this, parents do sometimes experience feelings of incompetence and guilt.

3.4.2 Provide Education

Parents often lack knowledge and understanding of what psychosocial problems, and the effect is it has on their child's functioning are. By providing relevant, easy-to-understand information, the therapist can help parents to develop insight in what their child experiences as well as why certain forms of behaviour is exhibited. Parents should also be encouraged to do independent research and to integrate all relevant information into parent-child interaction.

3.4.3 Establish Realistic Parental Expectations

Once they acknowledge their child's psychosocial problems and understand the impact it has on the family and the child's functioning, realistic expectations for therapy can be set. These expectations should be congruent with the child's unique strengths and challenges.

3.4.4 Establish Healthy Boundaries and Limit Setting

Another very important aspect that should be addressed in therapy is to re-establish appropriate boundaries between parent and child. Therapy starts of by allowing parent and child to independently experience their own emotions whilst at the same time identifying their own separate needs. When parents find it difficult to leave their child alone, they are gradually weaned from the therapeutic setting. This allows the child to develop his own separate independent identity.

3.4.5 Involve Parents in Therapy

When parents are referred to Occupational Therapy, or any other form of therapy, they might feel out of control and overwhelmed. The Occupational Therapist can give parents a sense of control by involving them in the therapy process. Parents can join in for therapy sessions. In doing this, they learn what and how to do tasks and activities with their child at home. In the course of their involvement, they might even be motivated to develop a home program for their child. This program could be aimed at making certain routines, e.g. preparing for school in the mornings, less chaotic and traumatic.

3.4.6 Empower Parents to feel like Experts and to become Advocates

When a child is referred for therapy, parents often loose faith in their own parenting abilities. Therapy should assist the parent to regain their confidence in this regard and should also make the parents aware of the fact that nobody knows their child as well as what they do. Disempowered parents are not likely to petition for their child's needs. This causes them to be incapable of protecting their child by securing the services needed to support their. Gutman *et al*. (2004:25) state: *"Again, it is critical to note that the most effective way to help a child may be to help the parent."*

3.5 WORKING THERAPEUTICALLY WITH TEACHERS

It is important that the teacher should understand the child with psychosocial problems. Many of the guidelines that were applied to working therapeutically with the parents are also applicable in this regard (Gutman *et al,* 2004:26):

- Practice emphatic listening

- Provide education about psychosocial deficits
- Help the teacher to better understand the effect these psychosocial problems might have on the child's functioning in the classroom and on the playground.
- Assist the teacher in setting up more realistic expectations for the child.
- Give teachers more control in the classroom by teaching them appropriate ways of handling troublesome situations.

3.6 SUMMARY

A holistic approach is definitely appropriate when working with the child with emotional problems. Emotional problems are often secondary to certain developmental problems the child might experience and are not always the main reason for referral. Therapists might therefore initially not be aware of any possible emotional problems that could be present. Many reasons could be given for this e.g. parents who deny that their child experiences any psychosocial problems and therapists who prefer to focus on the more tangible tasks of development.

As soon as the emotional problems are identified, it should be addressed in therapy. It seems that children are often referred to an Occupational Therapist for the purpose of Play Therapy. This happens because dealing with emotional development falls in the scope of Occupational Therapy. The question remains whether Occupational Therapists are able and qualified to practice Play Therapy. Occupational Therapists have to assess their effectiveness in dealing with the emotional issues children bring to therapy, and should also commit themselves to continual professional development.

The following chapter refers to the empirical data

4. EMPIRICAL DATA 4

4.1 INTRODUCTION

The aim (end goal) of this research was to determine whether there is an existing need amongst Occupational Therapists in practice to deal with children's emotional needs and problems more effectively. In order to reach this goal a Quantitative study was conducted using a semi-structured self-completion questionnaire as data gathering instrument. (Refer to Annexure A)

Three questionnaires were completed for the pilot study. The main aim of the pilot-test was to identify and rectify errors that might have hampered the success of the research in any stage of the study. The questionnaire was only presented to the full sample after the necessary modifications were made.

Questionnaires were distributed amongst a sample of Occupational Therapists practising in the field of Pediatrics. The sample was compiled by means of a convenience sample were n=33. Data gathering was done during August and September of 2005. Questionnaires were distributed by hand and through electronic mailing.

Responses were coded and data captured in SPSS (Statistical Product and Service Solutions), a statistical analysis software package.

4.2 DATA ANALYSIS

The first level of analysis involved testing for internal consistency of data. Reliability Analysis confirmed that the data showed internal consistency across a random split of the database. (Refer to Annexure B) This suggests that if measurements from repetitive random and representative samples were obtained from the same target population (using the same sample methodology), it would yield consistent results.

Reliability refers to the extent to which a variable or a set of variables is consistent in what it intends to measure (Hair, 1998:3). If multiple measurements are taken, the reliable measures will all be consistent in their values. In other words, a database is seen as

internally consistent (or stable) if random sub-samples from the original sample yield consistent or similar results when compared. The data is thus not biased (or distorted) by a possible unknown effect not included or taken into account during the sample design. The scientific sampling design process further augments internal consistency.

Testing for internal reliability or consistency was achieved by using a split-half method. The database was randomly split into two approximately equal sized groups and a comparative analysis was done.

The second level of analysis involved compiling frequency tables. (Refer to the various tables within this Chapter). The information that was obtained from the questionnaires was conveniently clustered to address the different objectives. The demographic information was used to determine the profile of the Occupational Therapists that needed to be targeted for future marketing of workshops and short courses. The occurrence of children with emotional needs and problems as well as Occupational Therapist's awareness of this diagnostic group was investigated. Possible outcomes and solutions explored the integration of Gestalt Play Therapy as a way of dealing with children's emotional needs and problems, into Occupational Therapy.

4.3 RESULTS AND FINDINGS:

The frequency tables will now be discussed and appropriately integrated with literature. The necessary derivations will also be made.

4.3.1 Basic Demographic Information

The demographic information that was obtained from the questionnaires will now be discussed in more detail. This information will be especially valuable in establishing a profile on respondents that could be used for future marketing purposes.

4.3.1.1 Age Distribution

Table 1 shows the age distribution of the sample.

Table 1: Age Distribution (n=33)

		f	%
Age:	18 - 24 years	3	9.1%
	25 - 34 years	21	63.6%
	35 - 49 years	7	21.2%
	50 - 59 years	1	3.0%
	60+ years	1	3.0%
Total		**33**	**100.0%**

The majority of respondents, 64% (21 out of 33) were distributed between the ages of twenty-five and thirty-four years. This Table might be an indication that more Occupational Therapists leaving University go into the field of Pediatrics. Pediatric Occupational Therapy has expanded over the past two decades. Currently almost one-third of all Occupational Therapists is finding themselves within the field of Pediatrics (Baloueff, 1998: 569). There also seems to be notably less Occupational Therapists in the field of Pediatrics, who are over the age of 49. This could possibly be due to the fact that this field requires a reasonable amount of energy from the therapist. Younger therapist might also relate better to children.

4.3.1.2 Language Distribution

The following Table shows the language distribution of the sample.

Table 2: Language Distribution (n=33)

		f	%
Home language:	Afrikaans	28	84.8%
	English	4	12.1%
	Other African e.g. Sotho, Zulu etc.	1	3.0%
Total		**33**	**100.0%**

According to this Table the majority of respondents (85%) indicated that their home language is Afrikaans. Four (4) respondents indicated that there home language is English whilst one (1) respondent's home language is indicated as an other African language. This study was mainly conducted in greater Pretoria and surrounding areas. It could be agreed that this is mainly an Afrikaans speaking community and therefore Afrikaans speaking Occupational Therapists were also represented accordingly in the sample.

4.3.1.3 Educational Qualification

Table 2 indicates the highest educational qualification obtained by respondents.

Table 3: Educational Qualification (n=33)

		f	%
Highest educational qualification:	Diploma	5	15.2%
	Degree	21	63.6%
	Honors	5	15.2%
	Masters	2	6.1%
Total		**33**	**100.0%**

The majority of the sample, 64% (21 out of 33) indicated that they have a degree in Occupational Therapy. Four (4) respondents qualified by means of a Diploma, whilst five (5) respondents had an honors degree and two (2) respondents obtained their masters degrees. It could be assumed that the older respondents have qualified by means of a Diploma. The five older respondents correlate with the number of respondents that graduated from the Vona du Toit College and the Pretoria College of Occupational Therapy that used to be the centre responsible for the training of Occupational Therapists.

Only a small percentage of the sample has post-graduate training e.g. honors or masters degrees. This could be explained by the fact that the full sample indicated that they were working full-time, possibility allowing too little time for extra studies. A great percentage of the sample also indicated that they are working in private practice. Further studies might therefore have great financial implications due to the loss of income that could be incurred as a result of attending classes or time used to complete assignments.

4.3.1.4 Year of Graduation

Table 4 shows the year in which the respondents have graduated.

Table 4: Year of Graduation (n=33)

		f	%
Year that you graduated:	1965	1	3.0%
	1970	1	3.0%
	1976	1	3.0%
	1980	2	6.1%
	1981	2	6.1%
	1983	1	3.0%
	1990	1	3.0%
	1993	1	3.0%
	1995	2	6.1%
	1996	3	9.1%
	1997	2	6.1%
	1998	2	6.1%
	1999	3	9.1%
	2000	1	3.0%
	2001	2	6.1%
	2002	5	15.2%
	2003	2	6.1%
	2004	1	3.0%
Total		**33**	**100.0%**

The sample consisted of a good representation of respondents that graduated over a period of 40 years, between 1965 and 2004. This table had little significance apart from the fact that it was used to determine internal reliability when compared with the age distribution of the sample. It could therefore have been left out of the questionnaire.

4.3.1.5 Graduating Institution

The following Table shows from which institutions the respondents graduated

Table 5: Graduation Institution (n=33)

		f	%
From which institution did you graduate?	University of Pretoria	17	51.5%
	University of the Free State	7	21.2%
	Vona du Toit College	3	9.1%
	Pretoria College of Occupational Therapy	2	6.1%
	University of the Witwatersrand	2	6.1%
	MEDUNSA	1	3.0%
	Stellenbosch University	1	3.0%
Total		**33**	**100.0%**

More than halve of the sample, 52% (17 out of 33) graduated from the University of Pretoria. Seven (7) respondents graduated from the University of the Free State, three (3) from the Vona du Toit Occupational Therapy College, two (2) from the Pretoria College of Occupational Therapy, two (2) from Wits University and one from MEDUNSA and the University of Stellenbosch, respectively. As was mentioned earlier, this study was mainly conducted in greater Pretoria and surrounding areas. The University of Pretoria is therefore the main institution responsible for the training of Occupational Therapist in this demographic area. The Vona du Toit College, as well as the Pretoria College of Occupational Therapy falls in this demographic area increasing the number of respondents that graduated in Pretoria to 22 out of 33 (67%).

4.3.1.6 Practising Hours

Table 6 indicates whether respondents are practising full-time or part-time.

Table 6: Practising Hours (n=33)

		f	%
Are you practising:	Full-time	33	100.0%
Total		**33**	**100.0%**

The full sample, 100% indicated that they are practising full time. In private practice it is becoming more and more competitive. Changes in the structuring of medical aids (e.g. less benefits allocated to paramedical services or where all day to day services are paid from one savings account) also contribute to circumstances that compel Occupational Therapists in private practice to work full-time. Parents who work full-time also prefer early or late appointments. Many Occupational Therapists who work at schools also work at private practices, after school. The salaries earned by Occupational Therapists in private practices as well as those working at schools and government institutions do not compare well with other medical career groups with the same educational level.

4.3.1.7 Years in Practice

The following Table indicates, in years, how long respondents have been in practice.

Table 7: Years in Practice (n=33)

		f	%
How long have you been practising?	0 - 1 years	2	6.1%
	2 - 4 years	10	30.3%
	4 - 8 years	8	24.2%
	8 - 10 years	5	15.2%
	More than 10 years	8	24.2%
Total		**33**	**100.0%**

It shows that 30% (10 out of 33) of the sample had been practising for between two and four years by the time the questionnaires were completed. 24% (8 out of 33) had been practising for between four and eight years, 15% (5 out of 33) indicated that they had been

practising for between eight and ten years whilst 24% (8 out 33) indicated that they had been practising for longer than ten years. Only 6% (2 out of 33) had been practising for less than one year.

Correlating with Table 1, this table shows that 70% of respondents have been for between 2 to 10 years. This confirms that the field of Pediatrics is serviced by a younger generation of Occupational Therapists. It would have been more meaningful to let respondents indicate specifically how long they have been practising instead of only giving the option 'for more than ten years'. This information might have confirmed the proposition that Pediatric Occupational Therapists are mostly younger than 49. This table also indicates that younger therapists should be targeted for future marketing.

4.3.1.8 Fields of Interest

This Table shows respondents fields of interest.

Table 8: Fields of Interest (n=33)

		F	%
What are your fields of interest?	Learning Difficulties	29	87.9%
	Developmental Delays	28	84.8%
	Sensory Integration	22	66.7%
	Neuro-Developmental therapy	15	45.5%
	Emotional Problems	11	33.3%
	Physical Disabilities	10	30.3%
	Medico-Legal	3	9.1%
	Cranio-Sacral therapy	2	6.1%
	Vocational rehab	1	3.0%
	Incontinence Spina Bifida	1	3.0%
	Hand Therapy	1	3.0%
	Pre-vocational training	1	3.0%

Respondents could indicate more than one field of interest therefore the total of the frequency column is not applicable. The main areas indicated were learning difficulties (29 out of 33), developmental delays (28 out of 33), sensory integration (22 out of 33), neuro-

developmental therapy (15 out of 33), emotional problems and physical problems (11 and 10 out of 33 respectively). Developmental Delays and Learning Difficulties are both referring to groups of children experiencing a unique variety of problems. It could therefore be said that these two main fields of interests, as indicated by the respondents, encompass all the aspects addressed by traditional Occupational Therapy (e.g. poor gross and/or fine motor development, poor postural control, poor visual perceptual development etc.). Developmental delays also lead to learning difficulties, as children grow older. Many Occupational Therapists are dealing with more than one field of interest, in order to make their practices more viable. Occupational Therapists who work at schools also deal mainly with developmental delays and/or learning difficulties.

According to Florey (1998: 622) at least 12% of the Pediatric population could be diagnosed with a mental disorder of some sort, where at least 50% of these children will be severely disabled by this disorder. For the purpose of this study it was decided to refer to the term emotional problems thus referring to less serious emotional disorders. It could however be reasoned that if 12% of the Pediatric population is affected by a mental disorder of some sort an even greater percentage might be affected by less serious emotional problems.

Even children that were primarily diagnosed with a chronic medical condition stand a serious risk of also developing a secondary psychiatric disorder. This stresses the Occupational Therapy Practitioner's role and responsibility in dealing with children's emotional needs and problems. Children with developmental delays and learning difficulties also stand a great chance of developing secondary emotional problems apart from the primary problems that only required traditional Occupational Therapy.

Sensory integration, as a form of treatment is practised by many Occupational Therapists and requires post-graduate training. Psychologists use Sensory Integration Therapy in cases where abuse took place and the child's senses, or contact functions were distorted.

4.3.1.9 Place of Practice

Table 9 indicates the institutions where respondents are working at.

Table 9: Place of Practice (n=33)

		f	%
Where are you currently practising?	Private Practice	20	60.6%
	School	20	60.6%
	Community Service	2	6.1%
	Hospital	1	3.0%

Respondents could indicate more than one option. An equal amount of respondents (20 out of 33) indicated that they are practising in both private practice and a school environment, respectively. The minority of the respondents (2 out of 33) indicated that they are busy doing compulsory community service and one 1 respondent works in a hospital setting.

Many Occupational Therapists who work at schools also work as locums at private practices, after school. Since the salaries of Occupational Therapists, in general, are not competitive many therapists need to work extra hours in order to generate a better income. The majority of the sample also indicated that they are between the ages of 25 and 34. It can be assumed that many of them might be unmarried and thus without extra financial support. Alternatively they might also be contributing to a relatively young household.

4.3.1.10 Geographical Area

Table 10 shows the geographical area in which the respondents are practising.

Table 10: Geographical Area (n=33)

		f	%
Are you practising in a:	Metro Area	30	90.9%
	Non-Metro Area	3	9.1%
Total		**33**	**100.0%**

The majority of the sample, 91% (30 out of 33) indicated that they are practising in a metro area whilst 9% (3 out of 33) are practising in a non-metro area. This study was mainly conducted in a Metropolitan area.

The results obtained in these frequency tables showed little observable variation across demographic groups. This suggests that responses were independent of demographic classification.

4.3.2 Occurrence and Awareness

The questions that investigated the occurrence of children with emotional needs and problems seen by Occupational Therapists as well as awareness with the aim of identifying and addressing children's emotional needs and problems in therapy amongst Occupational Therapists. This section was specifically designed to address the first two objectives for this research study. The following frequency Tables were appropriately selected and will now be discussed.

4.3.2.1 Referrals for Primary Emotional Problems

This Table shows the incidence of children with primary emotional problems that were referred for Occupational Therapy over the last six months.

Table 11: Referrals for Primary Emotional Problems (n=33)

		f	%
During the past six months: Were children, who experienced primarily emotional problems, referred to you for therapy?	Yes	20	60.6%
	No	13	39.4%
Total		**33**	**100.0%**

The majority of the sample, 61% (20 out of 33) indicated that they received similar referrals over the past six months whilst 40% (13 out of 30) answered in the negative. According to Table 11 there could be an increase in the referrals to Occupational Therapists of children with primary emotional problems. The researcher also experienced this increase in her practice. Contact with referring Psychologists also indicated that there is an overall increase into the referral of children with primary emotional problems.

According to Florey (1998: 622) at least 12% of the Pediatric population could be diagnosed with a mental disorder of some sort, where at least 50% of these children will be severely disabled by this disorder. The incidences of children who are affected by emotional problems are high. Due to this the amount of such referrals could also increase. Parents sometimes prefer to take their children to an Occupational Therapist, instead of a Psychologist due to the stigma attached to the latter profession.

4.3.2.2 Referrals for Secondary Emotional Problems

The following Table shows the incidence of children with secondary emotional problems that were referred to an Occupational Therapist over the last six months.

Table 12: Referrals for Secondary Emotional Problems (n=33)

		f	%
During the past six months: Were children, who also experienced secondary emotional problems referred to you?	Yes	32	97.0%
	No	1	3.0%
Total		**33**	**100.0%**

The majority of the sample, 97% (32 out of 33) indicated that they have received referrals of children with secondary emotional problems over the past six months. Only 3% (1 out of 33) answered in the negative.

According to Florey (1998: 622) at least 12% of the Pediatric population could be diagnosed with a mental disorder of some sort, where at least 50% of these children will be severely disabled by this disorder. Even children that were primarily diagnosed with a chronic medical condition stand a serious risk of also developing a secondary psychiatric disorder. The incidences of children who are disabled by emotional problems are therefore high. Emotional problems and trauma increasingly affect children. Many conditions treated by Occupational Therapists also include secondary emotional problems (e.g. children with learning difficulties that facilitate the development of secondary emotional problems such as low self-esteem, aggression etc.).

4.3.2.3 Identification of Primary Emotional Problems

The following Table indicates whether respondents have identified any children with primary emotional problems, over the past six months.

Table 13: identification of Primary Emotional Problems (n=33)

		f	%
During the past six months: Did you identify any children with primary emotional problems, without referral indication?	Yes	22	66.7%
	No	11	33.3%
Total		**33**	**100.0%**

In this table 67% (22 out of 33) of the sample indicated that they have identified primary emotional problems in some of the children they saw in therapy. These primary emotional problems were not mentioned in the initial referral of the child. These children were seen over the past six months. Thirty three percent (11 out of 33) of the sample indicated that they have not identified any children with primary emotional problems.

Parents and teachers are not always knowledgeable concerning the origin of a child's problems (e.g. a child might be referred due to poor scholastic performance where the main root of his problem might be depression because of the loss of a loved one or even a pet). The Occupational Therapist should then be able to identify the origin of the child's problems so that it could be addressed appropriately in order to improve the child's school performance. As was earlier mentioned almost 12% of the Pediatric population are affected by a mental disorder of some sort where 50% might be disabled by it. Again the possibility of seeing these children in therapy is great.

4.3.2.4 Identification of Secondary Emotional Problems

Table 14 indicates whether respondents have identified any children with secondary emotional problems, over the past six months.

Table 14: Identification of Secondary Emotional Problems (n=33)

		f	%
During the past six months: Did you identify any children with secondary emotional problems?	Yes	30	90.9%
	No	3	9.1%
Total		**33**	**100.0%**

This Table indicates that the majority of respondents, 91% (30 out of 33) also identified secondary emotional problems apart form the problems requiring traditional Occupational Therapy, in some children they saw in therapy. This was identified in children that were seen over the past six months. In this Table 9% (3 out of 33) of the sample answered in the negative.

Many conditions seen and treated by Occupational Therapists also include secondary emotional problems. Occupational Therapists can not only address the tangible deficits in children's skills but also need to be **aware** of, and address the emotional issues the children bring to therapy. Gutman *et al*. (2004:13) stress Occupational Therapists' responsibility to be aware of and to identify the additional emotional problems that children experience when they come to therapy.

Referring to Tables 13 and14 there might have been uncertainty on what exactly the differences are between primary and secondary emotional problems. The latter could have affected respondents' responses to these questions.

4.3.2.5 Emotional Problems Observed in Practice

The following Table shows the emotional problems and symptoms most commonly observed by Occupational Therapists in practice.

Table 15: Emotional Problems Observed in Practice – No1 (n=33)

		f	%
Which of the following emotional problems (primary or secondary), or symptoms thereof, have you observed in practice?	Poor attention and concentration	33	100.0%
	Hyperactivity	32	97.0%
	Low self-esteem	32	97.0%
	Aggression	31	93.9%
	Anxiousness	26	78.8%
	Enuresis (bedwetting)	26	78.8%
	Depressed mood	25	75.8%
	Anxiety with Separation	24	72.7%
	Tearfulness	22	66.7%
	Destructiveness	21	63.6%
	Encopresis (soiling)	19	57.6%
	The lonely child	19	57.6%
	Psychosomatic symptoms	15	45.5%

Table 16: Emotional Problems Observed in Practice – No2 (n=33)

		f	%
Any other emotional problems or symptoms you would like to add?	Hugging female staff more often (taken away from mother)	1	25.0%
	Suicidal ideation, Self-mutilation behaviour	1	25.0%
	Defiant behaviour	1	25.0%
	Personality: Very strong willed/hemispherical dominance	1	25.0%

Respondents could indicate more than one option. Respondents indicated a wide range of emotional problems. The full sample (33 out of 33) sees children with attention and

concentration problems. Other emotional problems included; hyperactivity (32 out of 33), low self-esteem (32 out of 33) and aggression (31 out of 33).

Attention deficit and hyperactivity were also indicated in the literature, as the most prominent emotional disorders experienced by children. The most prominent disorders in childhood, according to Florey (1998:630) are Attention Deficit and Hyperactivity Disorder, Conduct Disorder, Mood Disorders and Autism.

According to the above-mentioned information there is a significant occurrence of children with primary and secondary emotional problems who are seen by Pediatric Occupational Therapists. Children with primary and secondary emotional needs and problems are not only referred for Occupational Therapy but respondents also indicated that they have identified these problems in children that were already seen in therapy.

In Occupational Therapy there seems to be an increasing tendency to move towards an intervention process that is more inclusive. This implies the ability to identify and deal with the child's motor, cognitive and perceptual problems as well as the emotional needs and problems the child might experience. Florey, (in Neistadt and Crepeau, 2002:622) confirms this by stating that: *"Occupational Therapy Practitioners working with children and adolescents in various service settings are likely to encounter youngsters with significant emotional problems.*"

According to Baloueff (1998: 569), who broadly defines the field of Pediatrics as concerned mainly with individuals between birth and twenty-one years, Pediatric Occupational Therapy has expanded over the past two decades. Currently almost one-third of all Occupational Therapists is find themselves in the field of Pediatrics. The population that is treated in Pediatric Occupational Therapy includes a diverse group of diagnostic entities such as mental retardation, cerebral palsy, genetic and chromosomal anomalies, autism, learning disabilities, severe orthopaedic impairments, visual and hearing impairments, emotional disturbances and traumatic brain injury.

According to Baloueff children with emotional disturbances form part of the population of children seen by Occupational Therapists, apart from the other diagnostic groups as were

mentioned above. The occurrence of these children seen by Occupational Therapists will therefore also be evident.

The most prominent emotional disturbances in childhood, according to Florey (1998:630), are Attention Deficit and Hyperactivity Disorder, Conduct Disorder, Mood Disorders and Autism. Poor attention and concentration as well as hyperactivity were also indicated by the majority of the respondents as the most prominent emotional problems seen in children. According to Coleman *et al.* (1980:489-490) less serious disorders of childhood:

> "Often (they) are referred to simply as emotional disturbances, to indicate that they are not so much disorders as problems with which the child needs help. If such assistance is not received, however, the developmental problems of childhood sometimes merge almost imperceptibly into more serious and chronic disorders when the child passes into childhood e.g. Hyperactive Syndrome, Conduct Disturbances, Disturbances of emotion such as Depression, Autism & Stuttering."

According to literature Occupational Therapists in the field of Pediatrics can expect to see children with emotional needs and problems since this diagnostic group is part of the Pediatric Occupational Therapy population. Occupational Therapists in the field of Pediatrics are most likely to encounter children with emotional needs and problems. Both literature as well as the respondents that participated in the research study confirmed this.

4.3.2.6 Awareness of Emotional Needs and Problems

This Table shows whether respondents agree or disagree with the statement that Occupational Therapists should be aware of children's emotional needs and problems.

Table 17: Awareness of Emotional Needs and Problems (n=33)

		f	%
Occupational Therapists in the field of Pediatrics should be aware of children's emotional needs and problems.	Agree	1	3.0%
	Definitely agree	32	97.0%
Total		**33**	**100.0%**

This Table shows an overwhelming majority of respondents agreeing to the statement that Occupational Therapist's should be aware of children's emotional needs and problems, where 97% (32 out of 33) definitely agreed and 3% (1 out of 33) agreed. This is confirmed by Gutman *et al*. (2004:13) who is of the opinion that Occupational Therapists cannot only address the tangible deficits in children but also need to be **aware** of, and address the emotional issues children brings to therapy.

4.3.2.7 Effective Handling of Emotional Needs and Problems

Table 17 shows the need amongst Occupational Therapists to deal more effectively with children's emotional needs and problems.

Table 18: Effective Handling of Emotional Needs and Problems (n=33)

		f	%
Do you think there is a need to deal more effectively with the emotional needs and problems of the child in therapy?	Yes, through workshops	21	63.6%
	Yes, through post graduate training	20	60.6%
	Yes, through structured short courses	18	54.5%
	Yes, it should be dealt with more intensively/comprehensively	11	33.3%
	Yes, through in-depth literature studies or reading	5	15.2%
	No	1	3.0%
	Guided self-study & mentoring relationship	1	3.0%

Respondents could choose more than one of the options. The majority of respondents (31 out of 33) reacted positively to this question. One respondent reacted negatively to this question.

Twenty-one respondents indicated that they could deal more effectively with children's emotional needs and problems by attending workshops on this topic, 18 indicated structured short courses, 20 post graduate training and 10 respondents indicated that emotional needs and problems in children should receive more attention during under graduate studies.

It could be advised that dealing with the emotional problems and needs of children in Occupational Therapy should be dealt with in more detail on an undergraduate level. This table also confirmed that future education and training in dealing with the child's emotional needs and problems should be presented in the form of workshops.

4.3.2.8 Successful Outcome in the case of Primary Emotional Problems

The following Table shows to what extent the successful outcome of therapeutic intervention is affected if the child experiences primary emotional problems.

Table 19: Successful Outcome in the Case of Primary Emotional Problems (n=33)

		f	%
To what extent is the successful outcome affected (a) If the emotional problem is the primary problem.	To a lesser extent	5	15.2%
	In-between	3	9.1%
	Significantly	14	42.4%
	To a great extent	11	33.3%
Total		**33**	**100.0%**

The majority of respondents indicated that the positive outcome of intervention is affected, where 33% (11 out of 33) indicated that it is affected to a great extent and 42% (14 out of 33) indicated that it is significantly affected. Fifteen percent (5 out of 33) indicated that the positive outcome of therapy was to a lesser extent affected by the presence of primary emotional problems. The majority of the sample again indicated the importance of dealing with the child's primary emotional problems in order to attain success in treatment.

This Table did not indicate whether the child received only Occupational Therapy or Occupational Therapy in conjunction with another form of therapy presented by another professional. In Table 20, respondents indicated that they do not address primary emotional problems to the same extent as they do secondary emotional problems.

It should be stressed that a multi-disciplinary approach is always valuable, especially when the therapist who work with the child does not feel herself adequately equipped to deal with the primary emotional problems. Respondents indicated that they refer mostly to Psychologists and Play Therapists in the case of dealing with the child's emotional problems.

4.3.2.9 Successful Outcome in the case of Secondary Emotional Problems

The following Table indicates to what extent the successful outcome of therapeutic intervention is affected by the presence of secondary emotional problems.

Table 20: Successful Outcome in the Case of Secondary Emotional Problems (n=33)

		f	%
To what extent is the successful outcome affected (b) If the child has secondary emotional problems.	Not at all	1	3.0%
	To a lesser extent	3	9.1%
	In-between	9	27.3%
	Significantly	17	51.5%
	To a great extent	3	9.1%
Total		**33**	**100.0%**

The majority of respondents indicated that the positive outcome of intervention is affected. Fifty two percent (17 out of 33) indicated that it is significantly affected and 9% (3 out of 33) indicated that it is affected to a great extent. 9% (3 out of 33) indicated that the positive outcome of therapy was only to a lesser extent affected by the presence of secondary emotional problems, whilst a mere 3% (1 out of 33) was of the opinion that it is not affected at all.

Again respondents confirmed the effect emotional problems have on the outcome of therapy. More respondents indicated that they do in fact deal more specifically with secondary emotional problems in therapy. Low self-esteem (secondary problem) due to poor scholastic performance (primary problem) will improve gradually when the child's skills are improved and better scholastic performance is ensured.

4.3.2.10 Dealing with Primary Emotional Problems

Table 21 shows to what extent primary emotional problems are addressed by Occupational Therapists.

Table 21: Dealing with primary Emotional Problems (n=33)

		f	%
To what extent do you address emotional problems... (a) When it is experienced as the primary problem.	Not at all	1	3.0%
	To a lesser extent	7	21.2%
	In-between	15	45.5%
	Significantly	4	12.1%
	To a great extent	6	18.2%
Total		**33**	**100.0%**

The majority of the sample, 46% (15 out of 33) placed there opinion as in-between although one third of the sample indicated that they do address primary emotional problems significantly, 12% (4 out of 33) and 18% (6 out of 33) indicated that they address it to a great extent. Only 3% (1 out of 33) of the sample does not address primary emotional problems and 21% (7 out of 33) only address it to a lesser extent.

Although Occupational Therapists are urged to be aware and to get involved in dealing with children's emotional needs and problems, the question could be asked whether they do in fact feel/are adequately equipped to deal with these problems. According to Gutman *et al*. (2004:3) Occupational Therapists have the responsibility to address the psychosocial problems children might bring to therapy with them. Therapists on the other hand aren't always equipped to deal with these problems and prefer to rather focus on the more tangible tasks of development (e.g. fine motor tasks, motor control tasks etc.).

4.3.2.11 Dealing with Secondary Emotional Problems

The following Table indicates to what extent secondary emotional problems are addressed by Occupational Therapists.

Table 22: Dealing with Secondary Emotional Problems (n=33)

		f	%
To what extent do you address emotional problems... (b) When it is experienced as the secondary problem.	Not at all	1	3.0%
	To a lesser extent	4	12.1%
	In-between	15	45.5%
	Significantly	10	30.3%
	To a great extent	3	9.1%
Total		**33**	**100.0%**

The majority of the sample, 46% (15 out of 33) placed their opinion as in the middle although almost 40% (13 out of 33) indicated that they either address secondary emotional problems significantly or to a great extent. Only 3% (1 out of 33) of the sample does not address secondary emotional problems and 12% (4 out of 33) only address it to a lesser extent. More respondents did however indicate that they are dealing with secondary emotional problems compared to primary emotional problems. It should again be mentioned that there could have been uncertainty regarding the exact difference between primary and secondary emotional problems.

4.3.2.12 Reasons for not addressing Primary or Secondary Emotional Problems

Table 23 shows possible reasons why Occupational Therapists might not be addressing primary or secondary emotional problems experienced by children seen in Occupational Therapy.

Table 23: Reasons for not addressing Primary or Secondary Emotional Problems (n=33)

		f	%
If you do not address primary or secondary emotional problems, what would your main reason for this be?	I feel that other people are better equipped	17	51.5%
	I do not feel adequately equipped	11	33.3%
	I do not have enough time	3	9.1%
	I do not feel that it is part of the OT's role	1	3.0%
	Child is already in therapy at a psychologist	1	3.0%
Total		**33**	**100.0%**

Fifty two percent (17 out of 33) of the sample indicated that other people are better equipped to deal with children's emotional needs and problems and 33% (11 out of 33)

indicated that they do not feel adequately equipped. These two opinions could have been clustered together making it 85% of the sample indicating that they are not adequately equipped to deal with children's emotional needs and problems.

Nine percent (3 out of 33) indicated that they do not have sufficient time and 3% (1 out 33) of the sample indicated that it is not part of the Occupational Therapy Practitioner's role to deal with children's emotional needs and problems. In many of the frequency tables it became clear that one respondent continuously gave an answer/opinion totally different from the majority or the rest of the sample. It could have been the same respondent that gave these answers and/or opinions.

These results again confirm the statement by Gutman *et al*. (2004:3) that Occupational Therapists aren't always equipped to deal with emotional problems and prefer to rather focus on the more tangible tasks of development.

4.3.2.13 Professionals, Occupational Therapists refer to

In the following Table respondents indicated to whom they are referring children if primary or secondary emotional problems are identified in the course of Occupational Therapy Intervention.

Table 24: Professionals, Occupational Therapists refer to (n=33)

		f	%
If you do not address primary or secondary emotional problems, to which professional do you refer the child?	Psychologist	28	84.8%
	Play Therapist	17	51.5%
	Psychiatrist	8	24.2%
	Social Worker	3	9.1%
	Doctor	1	3.0%
Total		**33**	

Respondents could indicate more than one professional. The majority of the sample (28 out of 33) refers children to a Psychologist and 17 refer to a Play Therapist. Eight respondents indicated that they refer children to a Psychiatrist whilst only 3 refer to a Social Worker and 1 to a Doctor.

Play Therapy has its roots in Social Work. It is a specialised field and although it forms part of the curriculum of Social Work students, many professionals, including psychologists, acquire this specialised skill through post-graduate training. Social Work could therefore be added to the Play Therapist option. Psychologists on the other hand, are not always equipped to do Play Therapy with the traumatised child or the child with emotional needs. In many cases children who are already receiving therapy from a Psychologist are also referred for Occupational Therapy. According to Schaaf (1990:68) children presenting with behavioural and emotional problems seldom experience problems that are contained in their behavioural, affective and interpersonal areas. Children with behavioural and emotional problems are often also screened for visual-motor and motor problems.

The majority of respondents agreed that Occupational Therapists in the field of Pediatrics should be aware of children's emotional needs and problems. Almost 100% of the sample also indicated that there is an existing need amongst Pediatric Occupational Therapists to deal more effectively with children's emotional needs and problems. The majority of respondents also indicated that there is a need amongst Occupational Therapists to equip themselves better in order to deal more effectively with children's emotional needs and problems.

The latter is supported by Gutman *et al.* (2004: 13) stating that: *"It is important to remember that (Occupational) therapists must address the emotional aspects of a child's pathology as well as skill deficit."* Occupational Therapists can therefore not only address the tangible deficits in children but also needs to be **aware** of, and **address** the emotional issues children brings to therapy. The Occupational Therapist's responsibility does not stop at the mere awareness of the child's emotional needs and problems but also includes dealing with these aspects.

The latest edition of Willard and Spackman's Occupational Therapy, a comprehensive Occupational Therapy Handbook; had a surprising chapter on Child Abuse and Neglect with specific emphasis on the emotional problems and needs of the child. In this chapter Neistadt and Crepeau (2002:636) stipulated the following, clearly: *"Occupational Therapy Practitioners have a responsibility to be knowledgeable about issues on child abuse and*

neglect, their legal and ethical responsibilities and their role in providing appropriate therapeutic interventions."

In the above-mentioned tables respondents indicated that the positive outcome of therapy is definitely affected by the presence of primary and secondary emotional problems. Although most respondents are aware of the importance of dealing with the child's emotional needs and problems and the effect it has on overall progress, only a small percentage of the sample indicated that they are in fact addressing either primary or secondary problems. In possible answer to why they might be doing this, respondents indicated that they feel other people are better equipped and that they find their own level of skill insufficient.

Gutman et al. (2004:3) confirm that Occupational Therapists aren't always equipped to deal with emotional problems and prefer to rather focus on the more tangible tasks of development.

4.3.3 Possible Solutions and Outcomes

The questions that were clustered under this section were aimed at investigating possible solutions in dealing with children's emotional needs and problems. These questions were specifically designed to address the third objective of this study. The following frequency tables apply.

4.3.3.1 Familiarity with the field of Play Therapy

Table 25 indicates Occupational Therapist's familiarity with the specialised field of Play Therapy.

Table 25: Familiarity with the field of Play Therapy (n=33)

		f	%
Are you familiar with the specialised field of Play Therapy in dealing with the child's emotional needs and problems?	Yes, became aware through extra reading	9	27.3%
	Yes, became aware during course of undergraduate studies	9	27.3%
	Yes, got familiarised through a structured short course	7	21.2%
	Yes, got familiarised during post-graduate studies	2	6.1%
	Yes, through advertising	2	6.1%
	Yes, through close teamwork with play therapists	2	6.1%
	No, not at all	1	3.0%
	Yes, got familiarised through a workshop	1	3.0%
Total		**33**	**100.0%**

The majority of respondents indicated that they are familiar with this specialised field of intervention. Most of the respondents, 27% (9 out of 33) became aware through extra reading and 27% (9 out of 33) got acquainted during the course of their under graduate studies. Only 3% (1 out of 33) of the sample was not at all familiar with the specialised field *of* Play Therapy.

According to one of the consulting experts, a Play Therapist in private practice, Occupational Therapists are not fully aware of the value of Play Therapy and who to refer to for Play Therapy. In her practice she receives very few referrals from Occupational Therapists. This table might be a good indication of respondents' theoretical knowledge on Play Therapy even though the integration of this knowledge might still be lacking.

4.3.3.2 The Integration of Gestalt Play Therapy

The following Table shows respondent's opinions on the integration of Gestalt Play Therapy into the traditional Occupational Therapy process in order to deal more effectively with children's emotional needs and problems.

Table 26: The Integration of Gestalt Play Therapy (n=33)

		f	%
Can the integration of Gestalt Play Therapy be efficient in dealing with emotional needs and problems?	I would not consider it	1	3.0%
	In-between	4	12.1%
	I consider it	15	45.5%
	I consider it very strongly	13	39.4%
Total		**33**	**100.0%**

The majority of respondents embraced the possibility of such an integration. Thirty nine percent (13 out 33) indicated that they would consider it strongly and 46% (15 out of 33) indicated that they would consider it. It is not sure whether respondents were in fact familiar with the **Gestalt** Approach. Play Therapy on the other hand is regarded as one of the treatment techniques applied in Occupational Therapy. Not only does it form part of under graduate studies in Occupational Therapy, but it is also confirmed in literature by Reade *et al*, (1999:158) who see Play Therapy as a natural consequence of evaluation: *"Play therapy may only commence following assessment and when systematic issues have been examined."*

4.3.3.3 Advantages to Play Therapy

Table 27 shows the distribution of advantages gained from the integration of Play Therapy into the Occupational Therapy process.

Table 27: Advantages to Play Therapy (n=33)

		f	%
What advantages could be gained through the integration of Play Therapy?	A more holistic approach could be ensured	26	78.8%
	Faster overall improvement in the child's performance	24	72.7%
	Better work satisfaction	12	36.4%
	Financial advantages to the client	9	27.3%
	Real issues can be dealt with if pure O.T. is ineffective.	2	6.1%
	Addressing the child's emotional needs	1	3.0%

Respondents could indicate more than one option. Twenty-six respondents indicated that such an integration would ensure a more holistic approach, whilst 24 feels that it could be responsible for faster overall improvement in the child's performance. Better work satisfaction was indicated by 12 of the respondents and financial advantages to the client, by 9 respondents. It is however, in retrospect, not certain whether the last two options were clear enough and whether it even had any meaning to respondents.

The majority of the sample indicated that they would consider the integration of Gestalt Play Therapy into a traditional Occupational Therapy process in order to deal more effectively with children's emotional problems. Almost 100% of the sample also indicated that they are, to different degrees, familiar with the field of Play Therapy.

According to literature, Gestalt Play Therapy could in essence be regarded as Gestalt Therapy with the *child* with emotional needs. (Compare Schoeman, 2001:104). Greater optimism for using Gestalt methods, particularly with children, is found in the writings of Oaklander (1978) and Owmby (1983). Gestalt Play Therapy could be regarded as a valuable approach in dealing with children's emotional problems.

In Gestalt Therapy the "self", being the child or the therapist, is viewed as the sum total of the individual's characteristics. This includes cognition, values, beliefs, habits, emotions and preconceptions (Yontef, 1993). When a child is seen in therapy it is important to accommodate and include al these characteristics. The therapist should acknowledge the child's cognitive abilities when choosing certain therapy techniques and should also respect cultural and spiritual beliefs. Integrating Gestalt Play Therapy and Occupational Therapy could ensure a more holistic approach and could even speed up the overall therapy time. The majority of the sample indicated both these advantages.

According to Oaklander (1978:57) most of the children seen in Play Therapy have one thing in common impairment in their contact functions. Contact functions refer to the senses (vision, speech, touch, hearing, movement, smell and taste). Some of the last mentioned areas such as visual abilities, touch and movement are regarded as synonymous with Occupational Therapy. Occupational Therapists have a solid foundation regarding their knowledge about child development and intervention, and could therefor also add value to the field of Play Therapy. On the other hand the addition of Play

Therapy to the traditional intervention process in Occupational Therapy could also ensure an increase in the potential of Occupational Therapy with the child.

Play Therapy and Occupational Therapy also share certain aspects of importance:

- Occupational Therapists have a professional and scientific understanding of the human body, although a partnership with the client also enables them to identify needs that are expressed by the client and not only based on their knowledge of how things are suppose to be. Because of this Occupational Therapists are able to integrate science and emotion and therefore to contribute their knowledge in an effort to return meaning to their clients' lives (Beer in Neistadt and Crepeau, 1998:33). Occupational Therapists are able to allow their clients to get involved in the therapy process and take responsibility for their own progress.

  In Gestalt Therapy the individual is regarded as the primary role player in determining his own behaviour. In essence this means that he can only hold himself responsible for his choices. According to Yontef (1993:153), responsibility forms an integral part of the therapeutic relationship. The child should take responsibility to regulate and support himself, so that he is able to function optimally outside the therapeutic relationship. Gestalt Therapy places a lot of emphasis on the child involved in the process of making his own decisions.

- According to Schaaf (1990:68) the *"major goal of occupational therapy is to enhance a person's ability to interact in the environment in a competent manner".* The influence of the environment as well as the child's ability to function optimally within his own environment is crucial. The Occupational Therapist should be aware of the child's environment and should integrate this knowledge into the intervention process.

  Yontef (1993) defines the field as the whole by which the parts are in direct relation and reaction to one another. Each separate part is influenced by events in the rest of the field. All systems are involved here – home, church, school etc. The individual in his unique living space implies a field. The individual can therefore not be seen as separate from his living context. The child should not only be studied as

a total being, but should also be studied in his own field. The interaction between the child and his field should be integrated into the therapy process because this interaction is the place the child calls home and will return to after therapy is completed.

- Play is further regarded as the most important means through which a child integrates and responds to information from his environment. Enhancing play behaviour could therefore be regarded as one of the most important goals in Occupational Therapy with the child. Couch, Deitz & Kanny (1998:111) also regard play as *"one of the primary occupational therapy roles addressed in the theoretical foundation of occupational therapy."* According to Ainscough (1998:224) Occupational Therapists are also regarded as familiar with the scope of available activities and the means to analyse these activities with the goal of finding the appropriate activity matching the cognitive, physical or emotional needs to be addressed.

  Play is also regarded as the medium for therapy in Play Therapy. It is evident that play forms an integral part of the child's world (Oaklander, 1978:160). Play develops through exploration in a safe environment where the child feels safe enough to try out new things. In the course of playing the child also discovers the "self". The explorative and experimental nature of play makes it an ideal medium for Play Therapy with the child with emotional problems.

- Under no circumstances can therapy commence without establishing a sound relationship between the therapist and child. The therapist works from the hypothesis that the child will not share his secrets with a complete stranger. In Occupational Therapy the relationship between the child and the therapist is also regarded as very important.

Many Therapists regard the therapeutic relationship as a crucial component of therapy. According to Reade et al. (1999:161): *"There is no doubt that time must be allocated for the development of a potentially therapeutic relationship and it is vital that the child does not feel rushed."*

According to literature the integration of Gestalt Play Therapy into Occupational Therapy does not only seem viable, but also valuable.

4.4 SUMMARY:

This chapter integrated the qualitative data and the information obtained through a literature study. The integration of this information forms the core of this study and will ultimately indicate whether the aim of this research was in fact accomplished or not. Literature could be integrated with the information that was obtained through the questionnaires and also supported the conclusions based on the information gained through the questionnaires.

The researcher obtained valuable information regarding the profile of Occupational Therapists that should be targeted in marketing of workshops and short courses.

The occurrence of children with emotional needs and problems seen by Occupational Therapists were also investigated. The awareness amongst Occupational Therapists with regards to children's emotional needs and problems were also thoroughly investigated and gave interesting and valuable outcomes. Lastly this chapter also explored the possibility of the integration of Gestalt Play Therapy into Occupational Therapy amongst Occupational Therapists.

5. GENERAL SUMMARIES, CONCLUSIONS AND RECOMMENDATIONS

5

5.1 INTRODUCTION

This study was aimed at assessing the need amongst Pediatric Occupational Therapists to deal more effectively with children's emotional needs and problems. Gestalt Play Therapy was also explored as a possible solution in addressing children's emotional needs and problems. Occupational Therapy and Gestalt Play Therapy were identified as the key concepts and were also defined as such.

The first Chapter was assigned to planning the research process and setting up the research goal, objectives and research questions. The latter had to be kept in mind throughout the study. The researcher decided on a quantitative study using a semi-structured, self-completion questionnaire as data gathering instrument, was used. The questionnaire was designed to specifically address the research objectives. (Refer to Annexure A)

An in-depth literature review pertaining to the key concepts was defined as one of the research objectives, and would later direct the compilation of the research questionnaire. Chapter two was assigned to a literature study on Gestalt Play Therapy with specific reference to the child with emotional problems.

In chapter three, Occupational Therapy was discussed. This chapter highlighted the child with emotional problems, as seen in Occupational Therapy. The empirical information was enclosed in chapter four. The information that was gathered through the research questionnaires, were coded and data was captured. Information was analysed through three levels of analysis.

In the course of chapter five all the chapters will once again be outlined in the form of a summary, conclusion and appropriate recommendations.

5.2 CHAPTER ONE: GENERAL INTRODUCTION

5.2.1 Summary

According to literature there seems to be a tendency to move towards an Occupational Therapy intervention process that is more inclusive with regards to not only the cognitive and perceptual problems of the child, but also the emotional scars children might bear due to trauma such as abuse and neglect. This also entails that Occupational Therapists find themselves in the ideal setting to encounter and identify children with emotional problems. In spite of their ideal positioning, the question might be asked whether Occupational Therapists are in fact adequately equipped to deal with these emotional problems. Research is a good way of exploring and confirming something that is still uncertain or unknown.

When any research is to be undertaken, a reasonable research problem or phenomenon needs to be identified. The researcher should therefore have sound reasons why the specific research is to be undertaken. The researcher's awareness and sensitivity towards the increasing number of children, with primary or secondary emotional problems, firstly and fore mostly motivated the topic for this research study.

Although literature indicated a tendency to move towards integrating the emotional needs and problems of the child into Occupational Therapy, no literature could be found to specifically support the integration of Gestalt Play Therapy into Occupational Therapy. This further motivated the topic for the research. The researcher's experience and personal interest in dealing with children with emotional needs and problems also prompted this study. After the topic was selected the researcher formulated the problem namely the existing need amongst Occupational Therapists to address the child's emotional needs in Therapy. The latter was further defined and supported by the research aim and research objectives.

A quantitative approach, using a semi-structured questionnaire, was selected for the purpose of this study. The quantitative data was supported by an in-depth literature study and the questionnaire was also set up according to the research objectives and supported by the literature study. Through pilot-testing the questionnaires, the necessary corrections could be made before it was send to the respondents. The sample was randomly and

deliberately selected, consisting of Occupational Therapists in the field of Pediatrics. Questionnaires were either sent by electronic mailing or delivered by hand.

This chapter also outlined the ethical guidelines that had to be adhered to and also defined the most important key concepts applicable to this study. This chapter was necessary in planning and indicating the way in which the study had to be conducted in order to reach the main aim and the objectives.

5.2.2 Conclusions

Based on the research, the following conclusions were made:

- The study was conducted according to the initial proposal without having to make any major changes or adaptations.
- The literature study, referring to the information in chapter two and three, proved to be relevant to the topic and also provided the researcher with valuable information in designing the questionnaire.
- Due to the fact that the questionnaire was designed with both the literature study and objectives of the research in mind, the process of integrating and interpreting the date was greatly simplified.
- Despite pilot testing the questionnaire, certain questions or options, still proved to be slightly inappropriate or unclear.
- The literature could be integrated with the responses of respondents in order to make valuable conclusions.
- Electronic mailing proved to be a sufficient and also time saving method of sending out the questionnaires. Because respondents were able to work on the original document the problem of legibility was eliminated. It also saved travelling time and reminders could be sent to respondents on a regular basis. This ensured a high percentage of returned questionnaires.

5.2.3 Recommendation(s)

The following recommendation can be made:

- The role/involvement of the parents in the treatment of the child with emotional problems can be further explored or incorporated into future studies.

5.3 CHAPTER TWO: GESTALT PLAY THERAPY WITH SPECIFIC REFERENCE TO THE CHILD WITH EMOTIONAL PROBLEMS

5.3.1 Summary

Gestalt Play Therapy is a holistic approach. It could in essence be regarded as Gestalt Therapy with the child. Three perspectives underline this approach. The phenomenological perspective implies that the individual sets aside his usual way of thinking, in order to distinguish between what belongs to the here and now and what may only be remnants of the past. The Gestalt Therapist reacts to what the child experiences in the here and now, without disapproval or interpretation. This will ultimately prepare the grounds on which the child will set aside previous ways of thinking and handling of past situations in order to develop his own ways of thinking and appropriately deal with similar situations in the future. The field perspective is defined as the whole through which the parts are in direct relation and reaction to one another. All systems are involved here – Home, church, school etc. The third perspective, Existentialism could be defined as the healing opportunity for the child with emotional problems or trauma such as abuse.

In Gestalt Play Therapy the child is not only viewed as a holistic and complex human being, but is also considered in his greater field of functioning. Emotional needs and trauma is not only caused by the field but also has a direct impact on the child's field. Through the Gestalt approach the child is given the opportunity to focus on the here and now that presents itself in the emotions he experiences at that moment or the issues that is causing discomfort in the present. The child gets the opportunity to work through his unfinished business and ultimately to rediscover his true "self".

The Schoeman Model is a Gestalt Play Therapy work model developed for the South African Context. South Africa is a land rich in culture and is home to many different ethnic groups. Emotional needs and problems are in every sense of the word part of children's lives, irrespective of age, race, culture, socio-economic background or any other distinguishing factor. This Schoeman model embraces play as a universal language in entering the sad, protected and sometimes disturbing world of children with emotional needs, problems and trauma. This allows the therapist to work around the restrictions of

language skills and verbal abilities that is so much a part of the cultural diversity of our country.

Gestalt Play Therapy does not only allow for healing in the child but also allows enough room for the Play Therapist to find and express her ”self” in the therapy process. This approach embraces the child as well as the therapist for who they are and gives both the opportunity to find their own solutions applicable within their own fields, and to ultimately discover their true “selves”.

5.3.2 Conclusions

Based on the research, the following conclusions were made:

- Gestalt Play Therapy is an appropriate approach to deal with children’s emotional needs and problems.
- This approach integrates the whole system in which the child functions.
- This approach was also specifically adapted for the South-African context.
- The Gestalt approach, according to literature, shows meaningful correlation with the Occupational Therapy process.
- Literature provides ample grounds for the Integration of Gestalt Play Therapy into Occupational Therapy.

5.3.3 Recommendation(s)

The following recommendation can be made:

- Other models used in Gestalt Play Therapy can be explored with regards to the possibility of integrating it into Occupational Therapy.

5.4 CHAPTER THREE: PEDITARIC OCCUPATIONAL THERAPY WITH SPECIFIC REFERENCE TO THE CHILD WITH EMOTIONAL PROBLEMS

5.4.1 Summary

Occupational Therapy found its roots in the mental health professions although it also diversified over the years into many other fields of speciality. Occupational Therapy could still be defined by the same definition stemming from the beliefs of early movements: “Occupational Therapy is the art and science of helping people do the day-to-day activities

that are important to them despite impairment, disability or handicap (Neistadt and Crepeau, 1998:5)."

Occupational Therapy gradually needed a science underlying the values and beliefs of Occupational Therapists and from there; Occupational Science was born with the purpose to nurture the profession of Occupational Therapy in the 21st century.

Although the need for scientific validation cannot be disregarded in delivering a valuable service to clients, it should also be taken into consideration that the client's experience of illness and disease should take precedence over all. Occupational Therapists are able to integrate science and emotion and therefore contribute their knowledge in the process of returning meaning to their clients' lives. There is also a developing tendency towards family-centred care in Occupational Therapy.

Occupational Therapy includes a broad field of practice. Dealing with children's emotional needs and problems could be regarded as only one of the fields of interest within the broader spectrum of Pediatric Occupational Therapy. The use of play as well as the importance of a therapeutic relationship is also highlighted in this chapter.

A holistic approach is definitely indicated when working with the child with emotional problems. Emotional problems could also be secondary to certain developmental problems the child might be experiencing, and are not always the main reason for referral. Due to this therapists might initially not be aware of any possible emotional problems. Many reasons could be given for this. Parents could for example deny that their child is experiencing any psychosocial problems; therapists might also prefer to focus on the more tangible tasks of development rather than emotional problems.

When the emotional problems are identified, it should be addressed in therapy. Children are often referred to an Occupational Therapist for the purpose of Play Therapy. Dealing with emotional development falls in the scope of Occupational Therapy. The question remains whether Occupational Therapists are able and qualified to practice Play Therapy. Occupational Therapists have to assess their effectiveness in dealing with the emotional issues children experience and should commit themselves to continuing professional development.

5.4.2 Conclusions

Based on the research, the following conclusions were made:

- Addressing emotional needs and problems fall within the scope of Occupational Therapy.
- Dealing with children's emotional problems can be regarded as one of the fields of interest in the broader spectrum of Pediatric Occupational Therapy.
- Literature has already confirmed the occurrence as well as the awareness amongst Occupational Therapists with regards to children with emotional needs and problems.
- Emotional problems may be secondary to other physical or developmental problems that are generally addressed by Occupational Therapy interventions.
- Occupational Therapists have the responsibility to acquire knowledge relevant to the aspects concerning which they do not feel adequately equipped.
- Occupational Therapists have the responsibility to follow a multi-disciplinary approach and refer patients to other professionals if they lack knowledge and skill in a specific area.
- Play Therapy is a familiar approach used in Occupational Therapy to deal with children's emotional needs and problems.
- The involvement of parents and teachers are crucial in ensuring better outcomes.
- The integration of Gestalt Play Therapy into Occupational Therapy can be undertaken with success.

5.4.3 Recommendation(s)

The following recommendation can be made:

- The importance of parental and educator involvement should be further explored.

5.5 CHAPTER FOUR: EMPIRICAL DATA

5.5.1 Summary

The aim of this research was to determine whether there is a need amongst Occupational Therapists in practice, to deal with children's emotional needs and problems more effectively. In order to reach this goal a quantitative study using a semi-structured self-completion questionnaire as data gathering instrument (Refer to Annexure A) was

conducted. Responses were coded and data captured in SPSS (Statistical Product and Service Solutions).

Chapter four was devoted to integrating the quantitative data that was gathered by means of the questionnaires with the information contained in the literature chapters. The integration of this information formed the core of the study and was to indicate whether the aim of the research was in fact reached or not. Literature could, with success, be integrated with the information that was obtained through the questionnaires and also supported this information.

The researcher also obtained valuable information regarding the profile of Occupational Therapists that should be targeted in marketing with regards to workshops and short courses.

The occurrence of children with emotional needs and problems, seen by Occupational Therapists, were investigated. The awareness amongst Occupational Therapists with regards to children's emotional needs and problems were also thoroughly investigated and yielded interesting and valuable outcomes. Lastly this chapter also explored the possibility of the integration of Gestalt Play Therapy into Occupational Therapy.

5.5.2 Conclusions

Based on the research, the following conclusions were made:

- The questionnaire was relevant with regards to what it was supposed to investigate.
- Although the first section had no direct relevance to the research objectives, it proved to be valuable in establishing a profile of the respondents. This profile can be useful in the marketing of workshops and short courses.
- The design of the questionnaire made it possible to cluster the frequency tables in order to address the research aim and objectives.
- Respondents' opinions correlated well with literature, which made it possible to successfully integrate all the information.
- Uncertainty regarding the use of subject related terminology in the questionnaire (e.g. primary compared to secondary emotional problems and the Gestalt Play

Therapy compared to only Play Therapy) might have had an influence on responses.

- Electronic mailing proved to be an efficient way of distributing the questionnaires as well as receiving them back from respondents.

5.5.3 Recommendation(s)

The following recommendations can be made:

- The demographic information could have been integrated as an objective, since it added value in determining the profile of the respondents for marketing purposes.
- For future studies it could be considered to involve a sample that is geographically more diverse. This might eliminate issues such as respondents being generally Afrikaans speaking because of the fact that the geographical area they come from was generally Afrikaans speaking.

5.6 TESTING OF THE AIM AND OBJECTIVES

The Aim of research implies *"the broader, more abstract conception of the end towards which effort or ambition is directed*" (De Vos *et al,* 2002:107). The aim of **this** research was to determine whether there is a need amongst Occupational Therapists in practice, to deal with children's emotional needs in therapy.

The objectives in turn refer to the process the researcher plans to follow in order to reach the goal that was given under the previous heading. According to De Vos *et al* (2002:107) the objectives *"are the steps one has to take, one by one, realistically at grass-roots level, within a certain time-span, in order to attain the dream."*

The following objectives and research questions were selected in order to reach the end goal that was mentioned in the previous paragraph:

5.6.1 Objective One

To investigate the occurrence of children with emotional problems treated by Occupational Therapists in the field of Pediatrics.

Objective one is accompanied by the following research question:

- ***Do Occupational Therapists in the field of Pediatrics come in contact with children with primary or secondary emotional problems?***

The majority of respondents confirmed that children with emotional problems attend Occupational Therapy. Reference was made to both primary and secondary emotional problems. The occurrence of both primary and secondary emotional problems in children who report for Occupational Therapy was also confirmed by literature according to which 12% of the Pediatric population can be diagnosed with an emotional disorder of some sort and almost 50% can be handicapped by this disorder. There was a notable correlation between existing literature and the opinions of the respondents.

Baloueff (1998: 569), who broadly defines Pediatrics as the age between birth and twenty-one years, further states that Pediatric Occupational Therapy has expanded over the past two decades and that currently almost one-third of all Occupational Therapists find themselves in the field of Pediatrics. The population that is treated in Pediatric Occupational Therapy includes a diverse group of diagnostic entities such as mental retardation, cerebral palsy, genetic and chromosomal anomalies, autism, learning disabilities, severe orthopaedic impairments, visual and hearing impairments, emotional disturbances and traumatic brain injury. Baloueff also confirms that children with emotional disturbances form part of the population of children seen by Occupational Therapists, apart from the other diagnostic groups as were mentioned above. The occurrence of children with emotional problems, seen by Occupational Therapists, will therefore be inevitable.

There seems to be an increasing tendency to move towards a more inclusive intervention process in Occupational Therapy. This refers to not only being able to identify and deal with the child's motor, cognitive and perceptual problems, but also to deal with the emotional needs and problems of the child.

According to the above-mentioned information it can be agreed that both respondents and literature confirm the occurrence of children with primary and secondary emotional problems. The research question can be answered as follows: Occupational Therapists in

the field of Pediatrics are most likely to encounter children with emotional needs and primary and/or secondary emotional problems.

5.6.2 Objective Two

To investigate the need amongst Occupational Therapists, in the field of Pediatrics, to deal more effectively with children's emotional needs and problems.

Objective two is accompanied by the following research question:

- ***Is there a need amongst Occupational Therapists in the field of Pediatrics to deal with children's emotional needs and problems?***

The majority of respondents agreed with the statement that Occupational Therapists, in the field of Pediatrics, should be aware of children's emotional needs and problems. Almost the full sample indicated that there is a need amongst Pediatric Occupational Therapists to deal with children's emotional needs and problems more effectively. The majority of respondents also indicated the need to equip themselves pertaining to interventions related to children's emotional needs and problems. The respondents' opinions once again correlated well with information that was gathered from literature. Literature confirmed that Occupational Therapists should be knowledgeable concerning children's emotional needs and problems. Emotional needs and problems should also be addressed in conjunction with other more tangible aspects of development.

In this regard Gutman *et al.* (2004: 13) states that: *"It is important to remember that (Occupational) therapists must address the emotional aspects of a child's pathology as well as skill deficit."* Occupational Therapists can not only address the tangible deficits in children but also need to be **aware** of, and **address** the emotional issues children bring to therapy. The Occupational Therapist's responsibility does not stop at the mere awareness of the child's emotional needs and problems but also includes dealing with these problems.

A chapter on Child Abuse and Neglect came as a pleasant surprise in the latest edition of Willard and Spackman's Occupational Therapy, a comprehensive Occupational Therapy Handbook. This chapter gave special attention to the emotional problems and needs of children scarred by abuse and neglect. In this chapter Neistadt and Crepeau (2002:636)

stipulate the following, clearly: *"Occupational Therapy Practitioners have a responsibility to be knowledgeable about issues on child abuse and neglect, their legal and ethical responsibilities and their role in providing appropriate therapeutic interventions."* Gutman et al. (2004:3) however confirms that Occupational Therapists aren't always equipped to deal with these problems and prefer to rather focus on the more tangible tasks of development.

Neistadt and Crepeau support the notion that Occupational Therapists should be aware of children's emotional needs and problems, and furthermore add that they have a responsibility to equip themselves in cases where they lack knowledge. The problem of insufficient skill can be addressed by means of workshops and short courses. The target market was also established by using the demographic information. The research question can be answered as follows: There is a need amongst Occupational Therapists to equip themselves to deal with children's emotional needs and problems more effectively.

5.6.3 Objective Three

To determine whether Gestalt Play Therapy might be a possible solution in dealing with children's emotional problems in Occupational Therapy.

The following research questions accompanies the third research objective:

- ***Can Gestalt Play Therapy be an effective and efficient approach in dealing with children's emotional needs and problems?***

The majority of respondents reacted positively towards a proposed integration of Gestalt Play Therapy into Occupational Therapy. This integration will provide a way of addressing children's emotional needs in the course of Occupational Therapy intervention. Almost 100% of the sample indicated that they are, to different degrees, familiar with the field of Play Therapy.

Literature regards Gestalt Play Therapy as Gestalt Therapy with the child. (Compare Schoeman, 2001:104). Greater optimism for using Gestalt methods, particularly with children, is found in the writings of Oaklander (1978) and Owmby (1983). Gestalt Play Therapy can be regarded as a valuable approach in dealing with children's emotional

problems. Reade *et al.* (1999:158) see Play Therapy as a natural consequence of Occupational Therapy evaluation: *"Play therapy may only commence following assessment and when systematic issues have been examined."*

In Gestalt Therapy the "self" is viewed as the sum total of the individual's characteristics (cognition, values, beliefs, habits, emotions and preconceptions) (Yontef, 1993). When a child is seen in therapy it is important to accommodate and include al these characteristics, since all of them together equals the child. The therapist should acknowledge the child's cognitive abilities when choosing certain therapy techniques and should also respect cultural and spiritual beliefs. htegrating Gestalt Play Therapy and Occupational Therapy can ensure a more holistic approach and can even speed up the overall therapy process. Both these advantages were also anticipated by a majority of the sample. Literature indicated that Gestalt Play Therapy and Occupational Therapy share certain important aspects. The research question can be answered as follows: The integration of Gestalt Play Therapy into the Occupational Therapy Process can enable Occupational Therapists to deal more effectively with children's emotional needs and problems.

5.6.4 Objective Four

To support the above information with an appropriate literature review on Occupational Therapy and Gestalt Play Therapy, and with specific reference to dealing with the child with emotional problems.

A literature review pertaining to Occupational Therapy and Gestalt Play Therapy both with specific reference to the child with emotional problems provided appropriate and valuable support in reaching the above-mentioned objectives.

5.6.5 Objective Five

To integrate this information into the conclusion, in order to make appropriate recommendations and indicate the need for further research, towards a workable and appropriate process of intervention if the need should exist.

All the information was successfully integrated into the conclusion and appropriate recommendations were made.

5.7 FORMULATION OF THE HYPOTHESIS

This research study was aimed at assessing a specific need amongst Occupational Therapists, namely the need to deal more effectively with children's emotional needs and problems. Although this study delivered valuable information it could be regarded as the first phase of a more in-depth study. This study also identified certain needs and gaps in the current Occupational Therapy process that can be addressed by means of follow-up studies. The following hypothesis can give direction to future studies.

- If Pediatric Occupational Therapists can get more exposure to Gestalt Play Therapy (through workshops and short courses) they will be more confident to deal with children's emotional needs and problems.
- The integration of Gestalt Play Therapy into the traditional Occupational Therapy process will ensure that the emotional needs and problems of children are better dealt with.

5.8 CONCLUDING STATEMENTS

The introduction of Gestalt Play Therapy to the Occupational Therapy process can be regarded as a fairly new phenomenon although the treatment of emotional problems, fall well within the scope of Occupational Therapy. Emotional problems are regarded as one of the fields of interest, practised by Occupational Therapists. There is however a tendency in Occupational Therapy to move towards a more holistic approach in working with children so that an increasing number of Occupational Therapists prefer to work in more than one field of interest.

The topic for this study was appropriately chosen and very few changes or alterations needed to be made. The plan (research proposal) according to which this study was conducted was also supportive and changes were made immediately where possible. A quantitative study, using semi-structured questionnaires was used. After these questionnaires were received back from respondents the data was captured and frequency tables were set. These frequency tables were clustered appropriately and

integrated with the relevant literature. The integration of information ultimately led to valuable conclusions and recommendations that can be considered for future studies.

Overall this research study was aimed at assessing the need amongst Occupational Therapists to deal more effectively with children's emotional needs and problems. This study was undertaken as a challenge and proved to be just that, even though successful outcomes were attained.

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Annex A : Questionnaire

Dear Respondent

This research project forms part of a Masters Degree in Play Therapy (M.Diac Play Therapy) at Huguenot College, UNISA.

The aim of the study is to investigate whether the need to deal with the emotional needs of children more effectively exists amongst Occupational Therapists. The results obtained from this study will also indicate the extent to which there is a need for a more integrated therapy process that includes addressing the emotional needs of the child. Such a process would constitute a more holistic treatment model, resulting in better outcomes and ultimately more work satisfaction for the therapist.

The questionnaire accompanying this letter does not contain questions of a personal nature. Your anonymity is ensured by the fact that you are not required to disclose your name or any contact details. The information obtained through this questionnaire will also be dealt with in a professional manner.

Any queries can be directed to Natasja Fourie at (012) 546-5980 or to natasja@lantic.net

The questionnaire is for self-completion. Please read each question and mark the applicable selection with an X or complete in the area highlighted in

Yellow

E.g.

Gender:	Male	1	**X**
	Female	2	

SECTION A: BASIC DEMOGRAPHIC INFORMATION

Age:	18 - 24 years	1		
	25 - 34 years	2		
	35 - 49 years	3		
	50 - 59 years	4		
	60+ years	5		/1

Home Language:	Afrikaans	1		
	English	2		
	Other African e.g. Sotho, Zulu etc.	3		
	Other e.g. German, Portuguese	4		/2

Highest educational qualification:	Diploma	1		
	Degree	2		
	Honours	3		
	Masters	4		
	Doctorate	5		/3
Year that you graduated				/4

From which institution did you graduate?		/5

Are you practising:	Full-time	1		
	Part-time	2		/6

How long have you been Practising?	0 - 1 years	1		
	2 - 4 years	2		
	4 - 8 years	3		
	8 - 10 years	4		
	More than 10 years	5		/7

What is/are your field(s) of interest? (You may indicate more than one)	Sensory Integration	1		
	Neuro-Developmental Therapy	2		
	Developmental Delays	3		
	Learning Difficulties	4		
	Emotional Problems	5		
	Physical Disabilities	6		
	Other (please specify)	7		/8

Where are you currently practising?	Private Practise	1		
	School	2		
	Hospital	3		
	Community Service	4		
	Other (please specify)	5		/9

Are you practising in a:	Metro Area	1		
	Non-Metro Area	2		/10

SECTION B: AWARENESS:

The following section refers to your contact with children with emotional needs and problems. Reference is made to both primary and secondary emotional problems.

Please tell me to what extent you agree with the following statement

1 = Do not agree at all
2 = Do not agree
3 = Neither agree nor disagree
4 = Agree

5 = Definitely agree

Occupational Therapists in the field of Pediatrics should be aware of children's emotional needs and problems.

Do not agree at all	1		
Do not agree	2		
Neither agree nor disagree	3		
Agree	4		
Definitely agree	5		/11

During the past six months:

	Yes	No	
(a) Were children, who experienced primarily emotional problems, referred to you for therapy?			/12
(b) Were children, who also experienced secondary emotional problems, apart from the problems requiring traditional Occupational Therapy, referred to you for therapy?			/13
(c) Did you identify any children with primary emotional problems, where there was no indication of these problems in the referral?			/14
(d) Did you identify any children with secondary emotional problems, apart from the problems requiring traditional Occupational Therapy?			/15

Which of the following emotional problems (primary or secondary), or symptoms thereof, have you observed in practice? (You may indicate more than one)

Aggression	1		
Destructiveness	2		
Anxiousness	3		
Anxiety with Separation	4		
Depressed mood	5		
Psychosomatic symptoms e.g. children complaining of chronic stomach ache, earache and headache in the absence of any underlying medical problem or condition.	6		
Enuresis (bedwetting)	7		
Encupresis (soiling)	8		
The lonely child	9		
Hyperactivity	10		
Poor attention and concentration	11		
Low self-esteem	12		
Tearfulness	13		/16

Any other emotional problems or		
Symptoms you would like to add?		/17

SECTION C: POSSIBLE OUTCOMES/SOLUTIONS:

The following section refers to dealing with the child's emotional needs and problems. It investigates the current status as well as the role of Play Therapy as part of a solution in dealing more effectively with the child's emotional needs and problems.

Do you think there is a need amongst Occupational Therapist's to deal more effectively with the emotional needs and problems of the child in therapy? (You may indicate more than one)

No	1	
Yes, it should be dealt with more intensively/ comprehensively on an under-graduate level	2	
Yes, through in-depth literature studies or reading	3	
Yes, through structured short courses	4	
Yes, through workshops	5	
Yes, through post graduate training	6	
Other (please specify)	7	

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To what extent is the successful outcome of your therapeutic intervention affected by the emotional problems of the child?

(a) If the emotional problem is the primary problem.

(b) If the child has secondary emotional problems apart from the problems requiring traditional Occupational Therapy.

		a	**b**
Not at all	1		
To a lesser extent	2		
In-between	3		
Significantly	4		
To a great extent	5		

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To what extent do you address emotional problems with the child in the course of your Occupational Therapy intervention?

When it is experienced as the primary problem (a).

When it is experienced as the secondary problem (b).

		a	b
Not at all	1		
To a lesser extent	2		
In-between	3		
Significantly	4		
To a great extent	5		

/20

If you do not address primary or secondary emotional problems in the course of a child's traditional Occupational Therapy Intervention, what would your main reason for this be?

I do not have enough time	1	
I do not feel adequately equipped	2	
I feel that other people are better equipped to deal with the emotional needs and problems of the child	3	
I do not feel that it is part of the Occupational Therapist's role	4	
Other: (please specify)	5	

/21

If you do not address primary or secondary emotional problems in the course of your Occupational Therapy intervention with the child, to which professional do you generally refer the child?

Psychiatrist	1		
Doctor	2		
Psychologist	3		
Play Therapist	4		
Social Worker	5		
Remedial Teacher	6		
Other (please specify)	7		/22

Are you familiar with the specialized field of Play Therapy in dealing with the child's emotional needs and problems?

No, not at all	1		
Yes, became aware of Play Therapy through extra reading	2		
Yes, became aware of Play Therapy during the course of undergraduate studies	3		
Yes, got familiarized with Play Therapy through the course of post-graduate studies	4		
Yes, got familiarized with Play Therapy through a structured short course	5		
Yes, got familiarized with Play Therapy through a workshop	6		
Other (please specify)	7		/23

The integration of Gestalt Play Therapy into the traditional Occupational Therapy process with the child could be an efficient consideration in dealing with the child's emotional needs and problems.

I would not consider it at all	1	
I would not consider it	2	
In-between	3	
I consider it	4	
I consider it very strongly	5	/24

What advantages could be gained through the integration of Play Therapy into the Occupational Therapy Process?
(You may indicate more than one)

No significant advantages	1	
A more holistic approach could be ensured	2	
Better work satisfaction	3	
Financial advantages to the client	4	
Faster overall improvement in the child's performance	5	/25
Other (please specify)	6	

SECTION D: RECOMMENDATIONS:

Do you have any comments on one or more of the above-mentioned questions?

THANK YOU FOR YOUR PARTICIPATION

Annex B : Reliability Analysis (Cross tabs)

B.1 AGE RANDOM SPLIT

Table 28: Crosstab - Age: Random Split

Crosstab

			Random split:		
			A	B	Total
Age:	18 - 24 years	Count	1	2	3
		Expected Count	1.5	1.5	3.0
		% within Random split:	5.9%	12.5%	9.1%
		% of Total	3.0%	6.1%	9.1%
	25 - 34 years	Count	9	12	21
		Expected Count	10.8	10.2	21.0
		% within Random split:	52.9%	75.0%	63.6%
		% of Total	27.3%	36.4%	63.6%
	35 - 49 years	Count	5	2	7
		Expected Count	3.6	3.4	7.0
		% within Random split:	29.4%	12.5%	21.2%
		% of Total	15.2%	6.1%	21.2%
	50 - 59 years	Count	1	0	1
		Expected Count	.5	.5	1.0
		% within Random split:	5.9%	.0%	3.0%
		% of Total	3.0%	.0%	3.0%
	60+ years	Count	1	0	1
		Expected Count	.5	.5	1.0
		% within Random split:	5.9%	.0%	3.0%
		% of Total	3.0%	.0%	3.0%
Total		Count	17	16	33
		Expected Count	17.0	16.0	33.0
		% within Random split:	100.0%	100.0%	100.0%
		% of Total	51.5%	48.5%	100.0%

Table 29: Crosstab – Chi-Square Test

Chi-Square Tests

				Monte Carlo Sig. (2-sided)			Monte Carlo Sig. (1-sided)		
					99% Confidence Interval			99% Confidence Interval	
	Value	df	Asymp. Sig. (2-sided)	Sig.	Lower Bound	Upper Bound	Sig.	Lower Bound	Upper Bound
Pearson Chi-Square	4.021[a]	4	.403	.439[b]	.426	.452			
Likelihood Ratio	4.840	4	.304	.439[b]	.426	.452			
Fisher's Exact Test	3.891			.439[b]	.426	.452			
Linear-by-Linear Association	3.598[c]	1	.058	.081[b]	.074	.088	.047[b]	.042	.052
N of Valid Cases	33								

a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is .48.

b. Based on 10000 sampled tables with starting seed 307647058.

c. The standardized statistic is -1.897.

B.2 HIGHEST EDUCATIONAL QUALIFICATION

Table 30: Crosstab – Highest Educational Qualification - *Random Split

Crosstab

			Random split:		
			A	B	Total
Highest educational qualification:	Diploma	Count	4	1	5
		Expected Count	2.6	2.4	5.0
		% within Random split:	23.5%	6.3%	15.2%
		% of Total	12.1%	3.0%	15.2%
	Degree	Count	11	10	21
		Expected Count	10.8	10.2	21.0
		% within Random split:	64.7%	62.5%	63.6%
		% of Total	33.3%	30.3%	63.6%
	Honours	Count	1	4	5
		Expected Count	2.6	2.4	5.0
		% within Random split:	5.9%	25.0%	15.2%
		% of Total	3.0%	12.1%	15.2%
	Masters	Count	1	1	2
		Expected Count	1.0	1.0	2.0
		% within Random split:	5.9%	6.3%	6.1%
		% of Total	3.0%	3.0%	6.1%
Total		Count	17	16	33
		Expected Count	17.0	16.0	33.0
		% within Random split:	100.0%	100.0%	100.0%
		% of Total	51.5%	48.5%	100.0%

Table 31: Chi-Square Test

Chi-Square Tests

				Monte Carlo Sig. (2-sided)			Monte Carlo Sig. (1-sided)		
					99% Confidence Interval			99% Confidence Interval	
	Value	df	Asymp. Sig. (2-sided)	Sig.	Lower Bound	Upper Bound	Sig.	Lower Bound	Upper Bound
Pearson Chi-Square	3.621[a]	3	.305	.364[b]	.352	.376			
Likelihood Ratio	3.872	3	.276	.382[b]	.369	.394			
Fisher's Exact Test	3.572			.364[b]	.352	.376			
Linear-by-Linear Association	2.076[c]	1	.150	.169[b]	.160	.179	.116[b]	.107	.124
N of Valid Cases	33								

a. 6 cells (75.0%) have expected count less than 5. The minimum expected count is .97.

b. Based on 10000 sampled tables with starting seed 307647058.

c. The standardized statistic is 1.441.

B.3 REFERRALS OF PRIMARY EMOTIONAL CASES

Table 32: Referrals of Primary Emotional Cases

During the past six months: (a) were children, who experienced primarily emotional problems, referred to you? * Random split:

Crosstab

			Random split:		
			A	B	Total
During the past six months: (a) Were children, who experienced primarily emotional problems, referred to you?	Yes	Count	9	11	20
		Expected Count	10.3	9.7	20.0
		% within Random split:	52.9%	68.8%	60.6%
		% of Total	27.3%	33.3%	60.6%
	No	Count	8	5	13
		Expected Count	6.7	6.3	13.0
		% within Random split:	47.1%	31.3%	39.4%
		% of Total	24.2%	15.2%	39.4%
Total		Count	17	16	33
		Expected Count	17.0	16.0	33.0
		% within Random split:	100.0%	100.0%	100.0%
		% of Total	51.5%	48.5%	100.0%

Table 33: Chi-Square Test

Chi-Square Tests [d]

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)	Point Probability
Pearson Chi-Square	.863[b]	1	.353	.481	.284	
Continuity Correction[a]	.328	1	.567			
Likelihood Ratio	.869	1	.351	.481	.284	
Fisher's Exact Test				.481	.284	
Linear-by-Linear Association	.837[c]	1	.360	.481	.284	.185
N of Valid Cases	33					

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.30.

c. The standardized statistic is -.915.

d. For 2x2 cross tabulation, exact results are provided instead of Monte Carlo results.

B.4 CAN GESTALT PLAY DEAL WITH NEEDS?

Table 34: Can Gestalt Play Therapy efficiently deal with needs?

Can the integration of Gestalt Play Therapy be efficient in dealing with emotional needs and problems? * Random split:

Crosstab

			Random split:		
			A	B	Total
Can the integration of Gestalt Play Therapy be efficient in dealing with emotional needs and problems?	I would not consider it	Count	1	0	1
		Expected Count	.5	.5	1.0
		% within Random split:	5.9%	.0%	3.0%
		% of Total	3.0%	.0%	3.0%
	In-between	Count	3	1	4
		Expected Count	2.1	1.9	4.0
		% within Random split:	17.6%	6.3%	12.1%
		% of Total	9.1%	3.0%	12.1%
	I consider it	Count	8	7	15
		Expected Count	7.7	7.3	15.0
		% within Random split:	47.1%	43.8%	45.5%
		% of Total	24.2%	21.2%	45.5%
	I consider it very strongly	Count	5	8	13
		Expected Count	6.7	6.3	13.0
		% within Random split:	29.4%	50.0%	39.4%
		% of Total	15.2%	24.2%	39.4%
Total		Count	17	16	33
		Expected Count	17.0	16.0	33.0
		% within Random split:	100.0%	100.0%	100.0%
		% of Total	51.5%	48.5%	100.0%

Table 35 : Chi-Square

Chi-Square Tests

				Monte Carlo Sig. (2-sided)			Monte Carlo Sig. (1-sided)		
					99% Confidence Interval			99% Confidence Interval	
	Value	df	Asymp. Sig. (2-sided)	Sig.	Lower Bound	Upper Bound	Sig.	Lower Bound	Upper Bound
Pearson Chi-Square	2.731[a]	3	.435	.429[b]	.416	.441			
Likelihood Ratio	3.168	3	.366	.429[b]	.416	.441			
Fisher's Exact Test	2.609			.429[b]	.416	.441			
Linear-by-Linear Association	2.587[c]	1	.108	.124[b]	.115	.132	.082[b]	.075	.089
N of Valid Cases	33								

a. 4 cells (50.0%) have expected count less than 5. The minimum expected count is .48.

b. Based on 10000 sampled tables with starting seed 307647058.

c. The standardized statistic is 1.608.