

# **CHAPTER 1: GENERAL INTRODUCTION AND THE EXPLANATION OF THE STUDY**

## **1.1. INTRODUCTION**

The birth of a child with any abnormality is always difficult for any family to accept and cope with. According to Zajicek-Faber (1998:206) families' adjustment to the child's disability has been viewed through a loss lens that highlights their grief reactions (shock, denial, anxiety, fear, and search for meaning and eventual reorientation or acceptance) to the trauma of having a child with a developmental disability. A research study done by Bonnes (1985:43) states that the first two months in the life of an infant born with a severe handicap, such as Spina Bifida, are going to be a time of great stress and crisis for the family.

With reference to the above, the researcher found that not only will the child have to spend considerable time in hospital, with all its attendant problems, but the handicaps associated with the deformity are severe. Therefore, the initial distress, shock, anger, disappointment or guilt are feelings that need to be dealt with. The family will require much help and support to enable them to work through their grief and come to terms with the fact that their child is going to have many problems.

Although medical staff is able to give parents an estimate of the extent to which the child will be affected or disabled, an exact prediction is not possible. According to Zajicek-Faber (1998:208) children with disabilities often face extraordinary problems and stresses that augment the usual problems experienced by adolescents without disabilities. During the researcher's contact with high school learners that have Spina Bifida, it became clear that gaining emotional, as well as physical competence is often quite difficult for them, especially when it is further compromised by cognitive limitations, frustration with communication, lack of normal biologically expected developmental changes, physical problems and coping with inaccessibility.

The stress and strain on the family and caregivers are never really overcome, but the ability to cope can increase with adequate support structures. As stated in Schoeman (2001:93) the aim of Gestalt play therapy is to help people help themselves to grow

up – to mature, take charge of their lives and become responsible for themselves. Therefore the central goal is the deepening of awareness, which promotes a sense of living fully in the here and now. This could assist the learner with Spina Bifida to increase the ability to cope with the disability.

## **1.2 MOTIVATION FOR THE CHOICE OF SUBJECT**

Society is continually being made aware of the needs and demands of the physically or mentally handicapped child. According to Bonnes (1985:36) this awareness is stimulated by the media and medical journals, as well as the general public's own increased interest in these children's plight.

For them normal, exciting and active childhood, where exploration of one's environment is a daily adventure, is often physically impossible and the likelihood of a stimulating and successful school and social life is limited. There are thus fewer opportunities and abilities for the afflicted child to lead a productive and fulfilling life.

According to the researcher, there are many aspects that play a crucial role in the adjustment of a learner with Spina Bifida to the school environment and society. During the researcher's contact with learners that have Spina Bifida, it seems that in general, initially there is a lot of support and dependence on family, care givers and educators while growing up. When the child reaches high school, he needs to develop ways to function independently and to develop organismic self-regulation. In organismic self-regulation, choosing and learning happen holistically, with a natural integration of mind and body, thought and feeling, spontaneity and deliberateness (Yontef, 1993:12).

For the purpose of this study, the researcher only focused on the high school learner with Spina Bifida. The researcher is of opinion that successful adaptation in adolescence requires not only the attachment of a positive outlook to one's disability, the use of competent stress processing and the appreciation of developmental maturation, but also an access to tangible services.

In spite of an abundance of literature and many organisations assisting people with Spina Bifida, there are still many people who are unable to make use of these extra methods of support. During the researcher's contact with Astra School for the Physically Disabled, it became clear that the learners coming from low socio-economic backgrounds find it difficult to cope and deal with their disability, because of the lack of support services, finances and transport. Overall there seems to be a gap in awareness and complete understanding of the "world" of the child with Spina Bifida.

By implementing Gestalt play therapy the researcher determined the needs of these children and how therapy can add value to their lives. Therefore, to inform and educate parents, neighbours and the general public who are involved in raising a child with Spina Bifida, the researcher hopes that understanding and sympathy will be increased and that more assistance on a personal level, and perhaps on a much larger scale also, will result. Bowl and Gardner (1975: vii) are of the opinion that the handicapped child is even more dependent than the ordinary child on the understanding and skill of those adults responsible for his care. His development will be affected if he is handled by uninformed, embarrassed or excessively sentimental adults.

Therefore, there is great need for support and understanding from everyone, from the strangers who pass by on shopping trips and who give a kindly greeting, to the closest relatives and friends who may be able to assume some regular commitment to help the parents. These learners and their families ought to be given all necessary backing so that they can enjoy their days and play as full a part as possible in the life of the community. Then perhaps they may become what they long to be, just ordinary happy families.

### **1.3 PROBLEM FORMULATION**

With reference to the above literature the researcher, for the purpose of this study, formulated the following problem: Any high school learner experiences many developmental changes, but for the learner with Spina Bifida there are not only the social, personal, physical and emotional changes, but also the fact that because of the

disability, more support and help structures are needed. This includes support from family, school and society. The demands are much greater for the disabled learner. By implementing Gestalt play therapy techniques, the researcher determined what value the latter can have for the high school learner that has Spina Bifida who is faced with the above-mentioned issues.

#### **1.4 GOALS AND OBJECTIVES**

According to Fouche (2002a:107) goals and objectives can be defined as the end toward which effort or ambition is directed: the aim or purpose. The terms goal, purpose and aim are often used interchangeably. Their meaning implies the broader, more abstract conception of the end toward which effort or ambition is directed, while objective denotes the more concrete, measurable and more speedily attainable conception of such end toward which effort or ambition is directed. The one (goal, purpose or aim) is the dream; the other (objective) is the steps one has to take, one by one, realistically at grass-root level, within a certain time-span, in order to attain the dream.

The goal of this study was therefore, to determine the value of Gestalt play therapy for high school learners with Spina Bifida. In order to reach this goal, the following objectives were set:

- To do a literature study regarding the child with Spina Bifida, as well as Gestalt play therapy, in order to determine what needs and difficulties these children experience and how Gestalt play therapy can be implemented to address these needs and difficulties.
- To determine the value of Gestalt play therapy for the high school learner with Spina Bifida, by using case studies.
- To make conclusions and recommendations in order to support and assist children with Spina Bifida, as well as their families, friends, educators and the broader community.

## **1.5 RESEARCH QUESTION FOR STUDY**

As stated by Fouche (2002a:106), if a qualitative study was opted for, the researcher would formulate the research question carefully. For the purpose of this study the research question was to determine what value Gestalt play therapy could have for the high school learner with Spina Bifida. In other words, to determine which needs, difficulties, barriers (social/emotional/intellectual), personal problems these learners experience and how Gestalt play therapy can assist in addressing the above.

## **1.6 RESEARCH APPROACH**

For the purpose of this study, qualitative research was used. According to Fouche and Delport (2002:79) qualitative research is concerned with understanding rather than explanation; naturalistic observation rather than controlled measurement and the subjective exploration of reality from the perspective of an insider as opposed to the outsider perspective that is predominant in the quantitative paradigm. For the purpose of this qualitative study, the researcher was therefore concerned with non-statistical methods and small samples were purposively selected. The focus was rather on understanding than explanation and on observation (therapy) than controlled measurement.

## **1.7 TYPE OF RESEARCH**

For the purpose of this study applied research was used. Fouche (2002a:108) states that applied research is aimed at solving specific policy problems or at helping practitioners accomplish tasks. It is focused on solving problems in practice. Mouton (2002:105) states that the primary purpose of applied research is to solve a social problem or to make a contribution to real-life issues.

Research therefore can have a basic or applied goal, with the objective of exploring, describing, explaining, correlating or evaluating. For the purpose of this study, exploratory research was applied. According to Fouche (2002a:109) exploratory research is conducted to gain insight into a situation, phenomenon, community or

individual. This study gained insight into the high school learner with Spina Bifida and determined the value of Gestalt play therapy for these children.

## **1.8 RESEARCH STRATEGY**

According to Fouche (2002b:272) qualitative research differs inherently from quantitative research in that it does not usually provide the researcher with a step-by-step plan or fixed recipe to follow. Therefore the researcher's choices and actions determined the design or strategy. Qualitative studies have a number of choices of strategies. For the purpose of this research, case studies were undertaken.

As stated in Fouche (2002b:275) a case study can be regarded as an exploration or in-depth analysis of a "bounded system" (bounded by time and/or place) or a single or multiple cases, over a period of time. The exploration and description of the case take place through detailed, in-depth data collection methods, involving multiple sources of information that are rich in context. These can include interviews, documents, observations or archival records. The researcher therefore situates this system or case within its larger context, but the focus remains on either the case or an issue that is illustrated by the case. For the purpose of this study the researcher used the data collection method of observation (during therapy sessions) and the taking of field notes, as suggested in Strydom (2002b:285).

## **1.9 WORK PROCEDURE AND RESEARCH METHOD**

As the researcher wanted to determine the value of Gestalt play therapy for high school learners with Spina Bifida, information was collected through therapy sessions where observation and interviewing took place. Therapy can include verbal as well as non-verbal expression of needs and difficulties. Greeff (2002:292) defines qualitative interviews as attempts to understand the world from the participant's point of view, to unfold the meaning of people's experiences and to uncover their lived world prior to scientific explanations.

Through a literature study the researcher gained certain information regarding Gestalt play therapy, as well as Spina Bifida. This information was combined with the

information gained from the therapy sessions, to make certain recommendations and conclusions at the end of the study.

According to Mouton (2002:67) data collection involves applying the measuring instrument to the sample or cases selected for the investigation. He is of opinion that it is important to be constantly reminded that the human senses (eyes, ears and occasionally even taste and touch) are 'first-order' measuring instruments, even if they are qualitative. On the basis of visual, auditory and tactile observations and perceptions, responses and people, actions and events can be classified. However, because truthful representations of the social world are aspired to, it is important to 'augment' observations by more reliable and valid measuring instruments such as scales, questionnaires and observation schedules. If properly constructed and validated over time, such instruments assist in collecting data that are more likely to be reliable than they would be had we not used instruments.

The researcher is of opinion that both instruments, as well as our human senses, are important when collecting any information/data. Through some therapy sessions with learners that have Spina Bifida, information collection varied between the different individuals. Within these sessions the researcher gained information regarding the needs and difficulties of learners with Spina Bifida, and applied some Gestalt play therapy techniques to determine what value this type of approach/therapy can have for these learners.

### **1.10 VIABILITY OF STUDY**

The researcher had contact on a daily basis with learners that have Spina Bifida. It was easy to have access to the learners, as the timetables and structure of the school allowed such contact.

The following aspects were looked at by the researcher, to assure the viability of this study:

### **1.10.1 Literature study**

For the purpose of this study literature regarding high school learners with Spina Bifida, as well as Gestalt play therapy was used. References older than 10 years are used at times, because the information relates to the study and is found to be important to include. At the time of the different literature studies, the only sources available were references older than 10 years. Literature like books, articles, journals, as well as the internet was used.

### **1.10.2 Consultation with experts**

A multidisciplinary team approach was part of this study. This study was undertaken with the co-operation of staff members at Astra School for the Physically Disabled. Contact with these role players was on a daily basis. Consultation with the following experts took place:

- Physiotherapist: D. von Sohnen - Physiotherapy Department at Astra School.
- Occupational therapist: J. van der Merwe - Occupational Therapy Department at Astra School.
- Medical: G. Engel and L. Long - Nursing Department at Astra School.
- Gestalt specialists: Dr Hannie Schoeman – Centre for Play therapy.

All information gained from the above experts, was used only as background to add to current information and to assure the viability of this study. All the above role players were of the opinion that Gestalt play therapy can be of great value for high school learners with Spina Bifida.

### **1.10.3 Pilot study**

Before undertaking a formal study, the researcher implemented some Gestalt play therapy techniques on high school learners with Spina Bifida at Astra School. According to the results of a few therapy sessions, it became evident that Gestalt play

therapy does have a value for these learners. Therefore a formal study was undertaken.

#### **1.10.4 Description of universe, sample and sampling techniques**

According to Strydom and Venter (2002:197) it is imperative to understand the following definitions before research can be undertaken: Universe refers to all potential subjects who possess the attributes in which the researcher is interested. Population is a term that sets the study limits. It refers to individuals in the universe who possess specific characteristics. The term sample implies the simultaneous existence of a population or universe of which the sample is a smaller section. In other words, a sample comprises the elements of the population considered for actual inclusion in the study. It is a small portion of the total set of objects, events or persons that together comprise the subject of our study.

For the purpose of this study, the universe was all high school learners with Spina Bifida. The population was all high School learners with Spina Bifida at Astra School for the Physically Disabled. The sample consisted of four high school learners with Spina Bifida at Astra School for the Physically Disabled. Sampling was done without randomisation, therefore non-probability sampling was implemented. According to Strydom and Venter (2002:203) probability sampling is based on randomisation while non-probability sampling is done without randomisation.

Strydom and Venter (2002:207) describe purposive samples as a type of sample that is based on the judgement of the researcher, in that a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population. The researcher selected the sample based on the following attributes:

- high school learners with Spina Bifida who were easy accessible
- high school learners with Spina Bifida who were available and willing to participate
- high school learners with Spina Bifida whose time-tables were more flexible

It can therefore be defined as a purposive sample.

### **1.11 ETHICAL ASPECTS**

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 purely clinical laboratory settings of the natural sciences. For researchers in the social sciences, the ethical issues are pervasive and complex, since data should never be obtained at the expense of human beings (Strydom, 2002a:62).

The researcher will discuss the following ethical issues that have relevance to this study, as stated by Strydom (2002a:64-73):

- **Harm to experimental subjects and/or respondents:**  
The responsibility to protect respondents against harm reaches further than mere efforts to repair, or attempt to minimise, such harm afterwards. Respondents should be thoroughly informed beforehand about the potential impact of the investigation. Such information offers the respondents the opportunity to withdraw from the investigation if they so wish. For this study the researcher identified respondents who could possibly prove vulnerable during the investigation in order that they may be eliminated beforehand. The researcher also made sure that all respondents were informed thoroughly about the intent of the research, what the potential impact can be, as well as the fact that they can withdraw at any stage if they wish to.
- **Informed consent:**  
Obtaining informed consent implies that all possible or adequate information on the goal of the investigation, the procedures that will be followed during the investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed, as well as the credibility of the researcher, be rendered to potential subjects. The researcher discussed the above issue with all respondents and a formal consent form was handed out both to the learners and their parents, consisting out of the above aspects. See Annexure 1.

- Deception of subjects and /or respondents:  
Deception can be described as deliberately misrepresenting facts in order to make another person believe what is not true, violating the respect to which every person is entitled. The researcher made sure that no information was withheld, or that incorrect information was given, in order to ensure participation of subjects when they would otherwise possibly have refused it.
- Violation of privacy/anonymity/confidentiality:  
Privacy can be defined as that which normally is not intended for others to observe or analyze. The right to privacy is the individual's right to decide when, where, to whom, and to what extent his or her attitudes, beliefs and behaviour will be revealed. This principle can be violated in a variety of ways, and for the researcher it was imperative to be aware of the importance of safeguarding the privacy and identity of respondents, and to act with the necessary sensitivity where the privacy of subjects was relevant. The researcher revealed all information and all learners with confidentiality. No information will be handed out, discussed or written without assuring the privacy of the learners. Only the researcher had access to any information. In order to protect the identities of the learners who were involved in this study, the researcher made use of pen names.
- Actions and competence of researchers:  
The entire research project must run its course in an ethically correct manner. The researcher was constantly aware of her ethical responsibility, from the composition of the research population, the sampling procedure, the methodology utilised, processing of the data, up to writing the research report. This study was completed with the guidance and co-operation of a supervisor.
- Co-operation with contributors:  
The extent to which acknowledgement is given to each participant's contribution deserves careful consideration. All participants who were involved in the planning of this project were satisfied with their share in the project, so that nobody felt dissatisfied at a later stage.

- Release or publication of the findings:

The researcher compiled the report as accurately and objectively as possible so that report writing included doing everything to make sure the report is as clear as possible and contains all the information necessary for readers to understand what was written.

- Debriefing of respondents:

Debriefing sessions during which subjects get the opportunity, after the study, to work through their experience and its aftermath, are possibly one way in which the researcher can assist subjects and minimise harm. For the purpose of this study, ways of debriefing can be: sessions after the study, to rectify any misperceptions that may have arisen in the minds of participants after completion of the project and the termination and withdrawal of the therapy were handled with the utmost sensitivity in cases where subjects benefited from the therapeutic aspect of the research. The researcher explained to all participants the full intent of this study. They were assured that assistance will be given by the researcher to minimise any possible harm. All four participants requested follow-up sessions.

## **1.12 DEFINITIONS OF TERMS AND KEY CONCEPTS**

For the purpose of this study, the following concepts will be defined:

### **1.12.1 Gestalt therapy**

The theory of Gestalt Therapy comprises two ideas. According to Latner (1992:1) the first is that the proper focus of psychology is the experiential present moment. In contrast to approaches which look at the unknown and even unknowable, this perspective is the here and now of living. The second idea is that you are inextricably caught in a web of relationships with all things. These twin lenses, here-and-now awareness and the interactive field, define the subject matter of Gestalt therapy. It is only possible to truly know ourselves, as we exist in relation to other things.

Gestalt theory according to Yontef (1993:1) focuses more on process (what is happening) than content (what is being discussed). The emphasis is on what is being

done, thought and felt at the moment rather than on what was, might be, could be or should be.

The researcher is of opinion that the Gestalt Therapy approach results in a psychology and method with a rich and unique view of everyday life and the depths and difficulties which life encompasses. The researcher believes that this approach is uniquely capable of responding to the difficulties and challenges of living, both in its ability to relieve us of some measure of our misery and by showing the way to some of the best we can achieve.

### **1.12.2 Play therapy**

Play, according to Oaklander (1988:160), is the child's form of improvisational dramatics. Playing is how the child tries out his world and learns about this world, and it is therefore essential to his healthy development. For the child, play is serious, purposeful business through which he develops mentally, physically and socially.

It is stated by Carmichael (1994:6) that play therapy provides children with challenges and opportunities to express themselves in an environment of empathy, warmth and respect.

The researcher is therefore of the opinion that by making use of toys and other creative techniques, children don't need to feel exposed or threatened, as information can be shared in a non-directive way. Due to the fact that the researcher was able to be in contact with children in a therapeutic setup, it became clear that play therapy is an effective, relaxed and enjoyable method of helping children to deal with sometimes traumatic circumstances.

### **1.12.3 Spina Bifida**

Spina Bifida, according to the National Institute of Health (2001:25), is one of the most common congenital defects, occurring within the first 25 days of pregnancy. This deformity is known as a neural tube defect. In addition to an obvious gap in the

skin covering the spine, the vertebrae and the nervous system is damaged. As a result of these defects the child will have some degree of paralysis.

Bonnes (1985:36) is of opinion that Spina Bifida can be defined as a developmental defect of the spinal column, the fundamental defect occurring between the 21<sup>st</sup> and 28<sup>th</sup> day of embryonic life, during the early development of the neural tube.

For the purpose of this study, Spina Bifida refers to those learners with a congenital defect that can result in some degree of paralysis. It's a neural tube defect, where an obvious gap in the skin covering the spine occurs, as well as damage to the vertebrae and nervous system.

#### **1.12.4 High school learner**

The period when attending high school, according to Schoeman (2001:30), generally starts at 12 years and ends at 17/21 years. Therefore, the high school child can also be referred to as an adolescent. During this developmental phase, the following can occur:

- Social, personal, physical and emotional changes
- Changes regarding relationships
- Sexual development together with exploring one's own body
- The need to experiment regarding various aspects

Another definition formulated by Thom (1994:393), is that adolescence can be defined as the developmental phase between childhood and adulthood. For the purpose of this study a high school learner is a learner with Spina Bifida, between the ages of 13 and 17 years.

### **1.13 RESEARCH REPORT LAYOUT**

This study consists of 5 chapters.

Chapter 1 consists of the general introduction and the explanation of the study.

Chapter 2 consists of a literature study. Information regarding Spina Bifida is discussed here. This includes literature as well as information gained from the therapists and staff of Astra School.

Chapter 3 is a discussion of all the Gestalt play therapy terminology as well as the techniques and methods used. This chapter includes discussions regarding the different methods of play therapy as well as Schoeman's model that was incorporated during therapy.

Chapter 4 refers to an in depth discussion regarding the case studies where Gestalt play therapy techniques were implemented (therapy).

Chapter 5 consists of a summary, conclusion and recommendations for further research about this topic.

## **1.14 SUMMARY**

This chapter gives an overview of what this study is all about. The research question as well as the procedure and method are discussed. Various concepts are defined and a summary of what to expect in each chapter is given.

The following chapter will therefore be a literature study about the high school learner with Spina Bifida.

## **CHAPTER 2: THE HIGH SCHOOL LEARNER WITH SPINA BIFIDA**

## **2.1 INTRODUCTION**

The researcher is of opinion that it is very important to know exactly what Spina Bifida is, as well as the implications of this disability for high school learners, in order to understand the “world” of these learners. This chapter provides information regarding the nature of Spina Bifida and addresses issues related to the disability.

## **2.2 THE NATURE OF SPINA BIFIDA**

Spina Bifida is a general term that encompasses a wide variety of neural tube defects. It is used to describe children who have no neurological dysfunction as well as children with mild to severe handicaps. According to the National Institute of Health (2001:30), Spina Bifida is a neural tube defect (a disorder involving incomplete development of the brain, spinal cord and/or their protective coverings) caused by the failure of the fetus’s spine to close properly during the first month of pregnancy. Infants born with Spina Bifida sometimes have an open lesion on their spine where significant damage to the nerves and spinal cord has occurred. Although the spinal opening can be surgically repaired shortly after birth, the nerve damage is permanent, resulting in varying degrees of paralysis of the lower limbs. Even when there is no lesion present there may be improperly formed or missing vertebra and accompanying nerve damage. In addition to physical and mobility difficulties, most individuals have some form of learning disability.

The three most common types of Spina Bifida (see Figures 2.1-2.3) described by Williamson (1987:1), are:

- **Spina Bifida Occulta:** This is the most common type and the least severe. In this condition, there is an abnormal opening in the spine because the back arches of the vertebrae do not fuse. The spinal cord and nerves are typically not damaged, and neurological functioning is usually intact. At the site of the defect, there may be a dimple on the skin, tufts of hair or nothing visible at all. Individuals with Spina Bifida Occulta may not even be aware that they have

the condition. In a minority of cases, however, there can be problems in bowel and bladder continence and in motor control of the legs. See Figure 2.1

- **Meningocele:** This is second in severity and it is the least common of the three types. The meninges (protective coverings) are pushed through the opening in the vertebrae and form a sac (herniation), which is usually covered by normal skin. This sac, called meningocele, contains the meninges and cerebrospinal fluid. The fluid bathes and protects the nerve cells by circulating freely. In this type of Spina Bifida, the spinal cord remains intact. Corrective surgery is performed to reposition the meninges and remove the sac. After surgery the child often has no neurological deficit, although in some cases sensory and motor handicaps may be present. See Figure 2.2.
- **Myelomeningocele:** This is the second most common and the most serious type of Spina Bifida. It usually causes a significant degree of impairment. The vertebrae fail to fuse and the meninges and the spinal cord protrude to form a sac. In such cases, the spinal cord fails to develop properly, and the spinal nerves are damaged. The neurological deficit is not confined to the specific site where the sac is exposed. The spinal cord below the level of the sac is usually abnormal, and the cord is frequently impaired for several spinal segments above the sac. See Figure 2.3.



Figure 2.1 Spina Bifida Occulta (Williamson, 1987:1) Figure 2.2 Meningocele (Williamson, 1987:1)

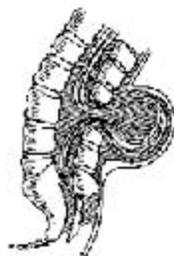


Figure 2.3 Myelomeningocele (Williamson, 1987:1)

Figure 2.4 represents a normal spine and Figure 2.5 a spine with Spina Bifida Occulta, as discussed in the above paragraphs.

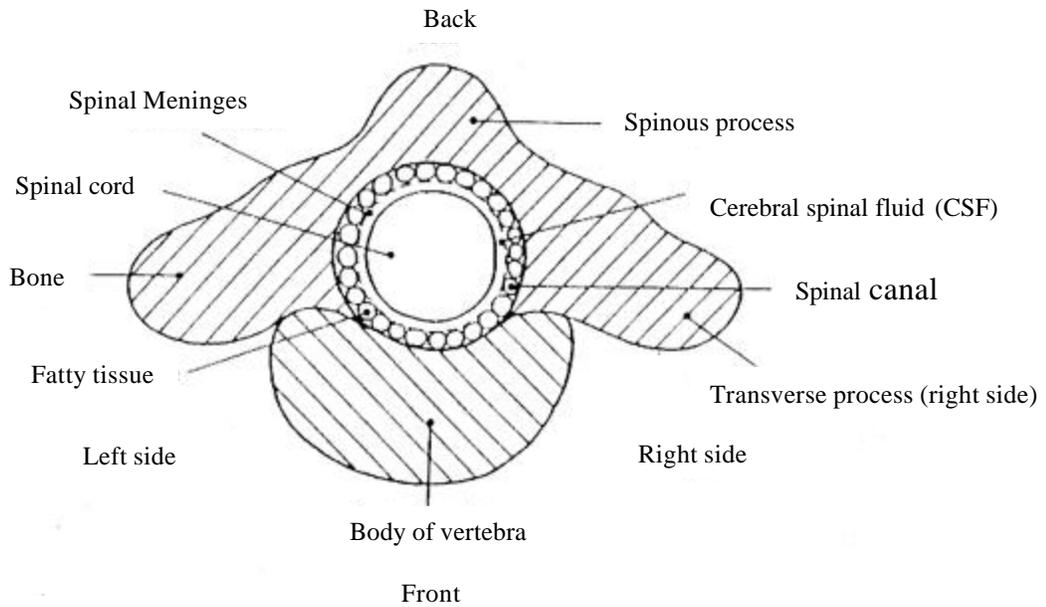


Figure 2.4 Image of a normal spine (Williamson, 1987:1)

Figure 2.5 clearly indicates the absence of spinous process as well as an incomplete arch.

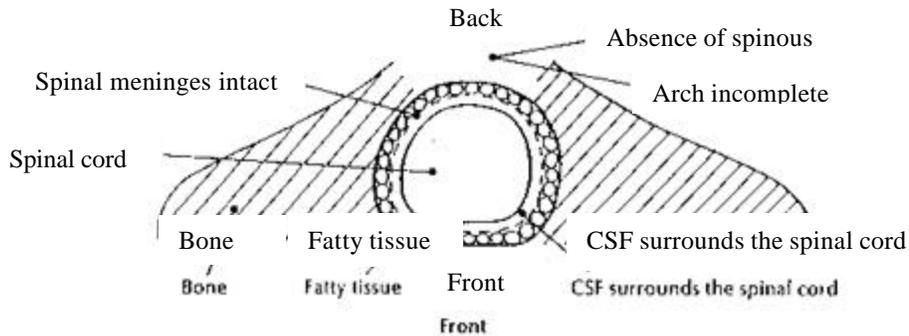


Figure 2.5 Image of a spine with Spina Bifida Occulta (Williamson, 1987:1)

Figure 2.6 below presents an example of a typical lumbar myelomeningocele. The head is to the left and the buttocks to the right.



Figure 2.6 Example of a typical lumbar myelomeningocele (Williamson, 1987:1)

As mentioned above, there are different types of Spina Bifida. In order to summarize each malformation, the researcher compiled below (Table 2.1) a summary of the common Spina Bifida malformations, as stated in Hoeman (1997:62-65).

Table 2.1: Common Spina Bifida Malformations (Hoeman, 1997:62-65)

Type of Malformation	Notes on Management	Complications
<p><b>Spina Bifida Occulta:</b>            *Occurs in 5% of live births when vertebrae fail to close completely but the skin is intact.</p>	<p>*Although a child with occulta may remain asymptomatic for life and the brain develops, problems can emerge at any time; the condition is associated with other spinal cord anomalies.</p> <p>*Changes, especially progressive sensory loss or lower extremity weakness, may be subtle. In a preschool child, constipation may signal beginning of lower motor neuron dysfunction.</p> <p>*Document any skin pigmentation (Mongolian spots), evaluate signs of dermoid sinus and inspect dimpling, hair tufts, or cysts in lumbar-sacral area at each regular visit or when parents report changes.</p> <p>*Neurologic deficits vary from none to bowel, bladder, motor</p>	<p>*Potential problems are lumber-sacral cysts, lipoma, dermoid tumour, tethering of the spinal cord, diastematomyelia, lomeningocoele or infection, especially meningitis.</p>

	and/or sensory problems, including signs of increased tone or spasticity.	
<p><b>Meningocele:</b></p> <p>*Evident at birth when the meninges and cerebral spinal fluid protrude into an external sac, usually at the lumbar-sacral area, as a result of unclosed vertebral arches. The amount of skin coverage varies, but no nerve tissues are involved.</p>	<p>*Current practice is surgical correction within days of birth, usually without complications or residual problems.</p> <p>* Should problems emerge in primary care, a full neurological examination is useful for early identification.</p> <p>*Expect data from baseline tests for ultrasound and/or CT scan of head, and MRI of head and spine to be ordered from specialists in the tertiary setting; tests are repeated on their schedule and child is referred earlier if changes are noted to occur.</p>	<p>*Complications from surgery or infection may occur.</p> <p>*The child has some potential for developing hydrocephalus, despite surgery to repair the site of the lesion.</p> <p>*Because the spinal cord is not extruded and no nerve tissues are involved, neurological deficits for bowel, bladder, or lower extremities are not anticipated.</p>
<p><b>Myelomeningocele:</b></p> <p>*The most severe type of spina bifida with an incidence of 1/1000 live births. Both the meninges and the spinal cord protrude into an external sac without benefit of any skin coverage. The level and severity of the lesion affect the complications and malformations. 75 % of lesions occur in the lumbar-sacral area.</p>	<p>*Interventions at birth depend upon overall condition.</p> <p>*Neurosurgery for shunt to prevent hydrocephalus is indicated with signs of increased intracranial pressure.</p> <p>*Monitor development and psychosocial adjustment during infancy and childhood; refer as indicated.</p> <p>*Lifelong follow-up for multiple functional limitations, motor impairments, sensory deficits - interdisciplinary management with medical specialists, family members and community.</p> <p>*Expect referral for combined medical specialist and physical therapy with flaccid paralysis of lower extremities with gait and postural abnormalities, club feet and hip dysphasia.</p> <p>*Normal cognition evident in 70% of children with myelomeningocele; however, poor socialization and hospitalizations may lead to delays in learning.</p>	<p>*With lumbar-thoracic level lesions, 25% of infants develop hydrocephalus at birth and 90% by 12 months of age. With sacral lesions, 60% of infants develop hydrocephalus during the first year. Children who have had surgical intervention for management of hydrocephalus were found to present with a group of symptoms: fever, abdominal discomfort, wound changes and signs of increased intracranial pressure, which became associated with shunt malfunction within 6 to 8 months following surgery.</p> <p>*Arnoid-Chiari malformation Type II (often with syringomyelia) is a defect associated with myelomeningocele; 80% of children with his malformation develop hydrocephalus. Stridor, sleep apnea and dysphasia in infants and young children with ocular palsy may be clinical signs of brainstem dysfunction.</p> <p>*Complications vary with severity</p>

		<p>of spinal cord/ meningeal herniation, extent of neural malformation and spinal cord level of the lesion. Lower motor neuron signs such as neurogenic bowel and bladder may be obvious early in life while scoliosis or kyphosis may develop insidiously until late childhood and worsen in adolescence.</p> <p>*Children are at risk for problems in their musculoskeletal and urologic systems.</p> <p>*Low self-esteem and learning delays may inhibit achievement of developmental tasks.</p>
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According to Hoeman (1997:62-65) over 80% of all people with Spina Bifida will need a special device, called a 'shunt', implanted to help the fluid drain away. Because so many people with Spina Bifida have hydrocephalus too, Spina Bifida is often called Spina Bifida hydrocephalus. Figure 2.7 below demonstrates the occurrence of hydrocephalus.

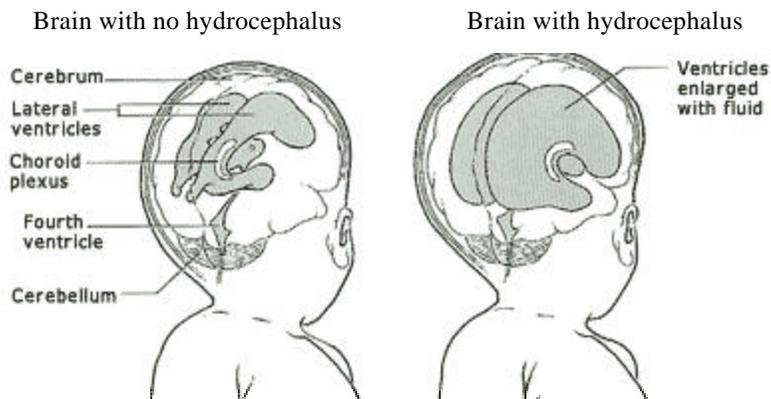


Figure 2.7 Enlargement of the ventricular system characteristic of hydrocephalus (Hoeman, 1997:62-65)

Hoeman (1997:62-65) states that the accumulation of cerebrospinal fluid which is caused by an imbalance in the production and drainage of fluid within the brain. The condition normally requires the surgical insertion of a shunt as shown in Figure 2.8 below. A shunt is an internal device that diverts accumulated cerebrospinal fluid from

the obstructed pathways and allows it to drain. A blocked or infected shunt can relate to physical and cognitive changes in performance at school. The shunt is a long narrow tube with a one-way valve. Inserted under the skin, it simply and effectively drains the spinal fluid to a convenient place - usually the abdomen. It also equalises pressure within the body.

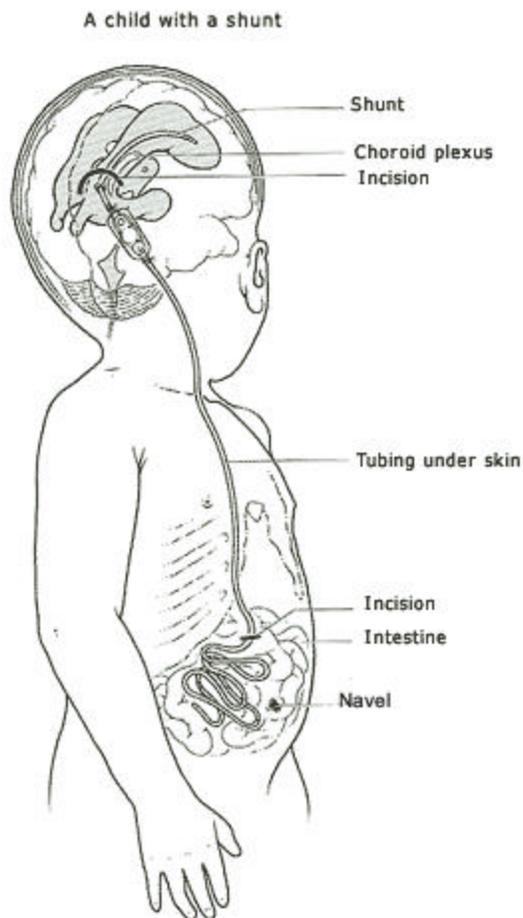


Figure 2.8 Ventricular shunt (Hoeman, 1997:62-65)

### 2.3 SECONDARY CONDITIONS ASSOCIATED WITH SPINA BIFIDA

Special attention is needed to identify and treat secondary disabilities. The National Information and Resource Centre (2002:45) is of opinion that due to the wide range of neurological damage and mobility impairment, it can be difficult to identify some

secondary disabilities. Attention should be focused on the psychological and social development of children and young adults with Spina Bifida. The above-mentioned literature clearly indicates the presence of emotional problems that result from factors such as low self-esteem and lack of social skills training.

Some examples of secondary conditions associated with Spina Bifida, stated by the National Information and Resource Centre (2002:46), are:

- Latex allergy
- Tendonitis
- Obesity
- Skin breakdown
- Gastrointestinal disorders
- Learning disabilities
- Attaining and retaining mobility
- Depression
- Social and sexual issues

## **2.4 PHYSICAL LIMITATIONS**

Children with Spina Bifida need to learn mobility skills and often with the use of crutches, braces or wheelchairs can achieve more independence. According to the National Information and Resource Centre (2002:46), with new techniques children can become independent in managing their bowel and bladder problems. Physical disabilities like Spina Bifida can have profound effects on the child's emotional and social development.

With reference to the above, the researcher is of opinion that it is important that health care professionals, teachers and parents understand the child's physical capabilities and limitations. To promote personal growth, they should encourage children (within the limits of safety and health) to be independent, to participate in activities with their non-disabled peers and to assume responsibility for their own care.

## **2.5 EDUCATIONAL IMPLICATIONS**

Although Spina Bifida is relatively common, as stated by the National Information and Resource Centre (2002:55), until recently most children born with a myelomeningocele died shortly after birth. Now that surgery can be performed in the first 48 hours of life to drain spinal fluid and protect children against hydrocephalus, children with myelomeningocele are more likely to live. Quite often, however, they must have a series of operations throughout their childhood. School programs should be flexible to accommodate these special needs.

Through contact with learners with myelomeningocele, the researcher learned that many children need training to learn to manage their bowel and bladder functions. Some require catheterization, or the insertion of a tube to permit passage of urine. In some cases, children with Spina Bifida who also have a history of hydrocephalus experience learning problems. They may have difficulty with paying attention, expressing or understanding language and grasping reading and maths. According to the National Information and Resource Centre (2002:55), early intervention with children who experience learning problems can help considerably to prepare them for school.

## **2.6 TREATMENT OF SPINA BIFIDA**

According to the National Institute of Health (2001:40), it became evident that there is no cure for Spina Bifida, because the nerve tissue cannot be replaced or repaired. Treatment for the variety of effects of Spina Bifida may include surgery, medication and physiotherapy. Many individuals with Spina Bifida will need assistive devices such as braces, crutches or wheelchairs. Ongoing therapy, medical care and/or surgical treatment may be necessary to prevent and manage complications throughout the individual's life. Surgery to close the newborn's spinal opening is generally performed within 24 hours after birth to minimize the risk of infection and to preserve existing function in the spinal cord.

## **2.7 PREVENTION OF SPINA BIFIDA**

Birth defects can happen in any family. The National Information and Resource Centre (2002:59) stated that many things can affect a pregnancy, including family genes and things women may come in contact with during pregnancy. Recent studies have shown that folic acid is one factor that may reduce the risk of having a Neural Tube Defect baby. Taking folic acid cannot guarantee having a healthy baby, but it can help. Women who have a child with Spina Bifida, have Spina Bifida themselves or have already had a pregnancy affected by any neural defect, are at greater risk of having a child affected by Spina Bifida or another neural tube defect.

## **2.8 FAMILIES OF CHILDREN WITH SPINA BIFIDA**

For a person with Spina Bifida, achieving independence is an ongoing challenge. The expected outcomes for individuals with Spina Bifida have been identified by Peterson (1994:229) as (a) maintaining health status and preventing secondary disability, (b) maximizing potential to participate in society, and (c) fostering independence according to individuals' abilities. A critical point in the life of a young person is the transition from a formal, structured school setting to the world of higher education, employment and life as an adult. This particular transition is clear to most people regardless of whether they have disabilities or not.

The presence of a disabled child in the family creates additional stress that each family member must learn to manage. How family members cope with daily demands and stressors is critical. Williamson (1987:10) is of the opinion that the level of emotional maturity and social integration of the young adult with Spina Bifida is largely dependent on the degree to which previous levels of development have been successfully achieved.

With reference to the above, the researcher is of opinion that the individual with Spina Bifida should enter adolescence with the experience and understanding of his specific physical and psychosocial needs and with goals for independence in all aspects of life. The birth of a physically disabled child precipitates a crisis in the family and brings on enormous grief and chronic sorrow. Although this child's needs and pattern of life are similar to those of a normal child, fulfilling them requires special planning.

Caring for a physically disabled child as stated by Blodgett (1988:177), can be a lifelong process and requires special skills of coping at various junctures in life. Families of normal children are, of course, confronted with developmental crises, but the family with a physically disabled child experiences those critical turning points much more intensely.

## **2.9 TRANSITIONING TOWARD ADULTHOOD**

For all teens, the process of moving from childhood to adulthood is challenging. For young people with disabilities, transitioning to independence presents even more challenges. According to Blomquist and Brown (1998:27), barriers to successful transition for young people with disabilities include low expectations by parents and other significant people in the community, lack of knowledge of existing career and vocational education services and lack of self-advocacy.

Schoeman (2001:30) refers to adolescence as a period of change on a social, personal and physical level. Some other changes that occur in this developmental stage are:

- Relationships with both same and opposite sex tend to be more mature.
- More interest is shown to the opposite sex.
- Sexual development – where questions and experimenting occur.
- Questioning of own values, religion and self-image.
- Value moral characteristics like honesty, loyalty and sincerity.
- Experimenting with alcohol or drugs.
- Physical changes and growth.
- Emotional changes – irregular temper outbursts.
- Aspiration to be independent on all levels – will still seek emotional support from parents and other adults.
- Preparation for marriage and family.
- Achievement of intellectual value system.

With reference to the above, it is evident that the developmental stage of adolescence is one of great changes and a lot of challenges. For the disabled adolescent, this stage has more challenges and barriers to overcome.

During the transition toward adulthood, most teens move from high school to options like work or higher education. They become much less dependent on their families and become more independent in their living arrangements, financial management and health care behaviours. With reference to an article by the National Institute of Health (2001:44), it became clear that teens moving towards adulthood become legally responsible for their decisions, behaviour and resulting consequences. Childhood roles are discarded and adult roles like marriage and parenting are possible. This transition process requires time, energy, information, motivation and support from peers, family and the community.

During the researchers' contact with Spina Bifida learners, it became evident that for teens with disabilities, the challenges are even more daunting. The developmental tasks that all adolescents need to accomplish to become self-directed adults can be greatly affected by how all aspects of the disability are managed. Physical and/or mental disabilities require that time be spent on various regimen consisting of therapies, medications, diagnosis and treatment of symptoms, and development of special individualized accommodations. Comfort with one's body may be hampered by visible or hidden effects of the disabling condition. Ellerton (1996:20) is of the opinion that children with a chronic condition are at increased risk for psychological adjustment problems such as anxiety, depression, peer-conflict, hyperactivity and aggression. Through Gestalt play therapy the researcher aimed to address possible psychological problems, as well as other needs and difficulties.

Brown (1996:89) did a study during which he developed a guide for parents and professionals working with young people who have Spina Bifida. When asked what is needed to help people with disabilities develop skills to be independent and self-determined, aspects of five areas of family and individual experience became evident. These areas are (1) knowledge and sensitivity present both in the family and community including acceptance of the individual with the disability, high expectations, knowledge and opportunities to develop skills; (2) skills in social, academic, basic living and problem solving areas; (3) motivation that comes from within oneself rather than from others (internal locus of control and intrinsic motivation); (4) a sense of vision and a belief in something bigger than oneself; and

(5) accessible community resources and support systems including role models, transportation, equipment and social support. The determinants of independence and self-determination are in Table 2.2.

Table 2.2: Determinants of Independence and Self-Determination (Brown, 1996:89)

<b>1. Knowledge and sensitivity present both in the family and community:</b>	
<ul style="list-style-type: none"> <li>• Acceptance for both the family and for the individual with the disability</li> <li>• Lots of encouragement from all sides</li> <li>• High expectations from people in the environment</li> <li>• Being allowed to fail and make mistakes</li> <li>• Knowledge about the disability</li> <li>• Inclusion in the full variety of family and community activities</li> </ul>	<ul style="list-style-type: none"> <li>• Early and developmentally appropriate intervention</li> <li>• Specific and appropriate education through the school system</li> <li>• Discovering and developing the individual's unique abilities and niche</li> <li>• Opportunities for independence skills to develop such as being granted autonomy and choice</li> <li>• Social peers</li> <li>• From the family: instilling a "can do" attitude, unconditional love, knowledge and expectation of age-appropriate development of behaviours and skills and family members who are role models of needed skills and behaviours.</li> </ul>
<b>2. Skills</b>	
<ul style="list-style-type: none"> <li>• Social</li> <li>• Academic</li> <li>• Basic living</li> <li>• Problem-solving</li> <li>• Networking abilities</li> </ul>	<ul style="list-style-type: none"> <li>• Positive comfort level in variety of situations</li> <li>• Communication</li> <li>• Positive self-advocacy</li> <li>• Self-help skills</li> <li>• Positive self talk</li> </ul>
<b>3. Motivation that comes from within oneself rather than from others (internal locus of control and intrinsic motivation)</b>	
<ul style="list-style-type: none"> <li>• Self motivation</li> <li>• Good self esteem</li> <li>• Goal orientated</li> <li>• Knows self</li> <li>• Decision maker</li> <li>• Optimistic</li> </ul>	<ul style="list-style-type: none"> <li>• Self-confident</li> <li>• Aware of own civil rights which are the same as those of other people</li> <li>• Able to overcome fears</li> <li>• Self-pity is in check</li> <li>• Positive self-worth</li> </ul>
<b>4. Larger meaning :</b>	
<ul style="list-style-type: none"> <li>• Sense of vision and a belief in something bigger than oneself</li> </ul>	
<b>5. Accessible community resources and support systems:</b>	
<ul style="list-style-type: none"> <li>• Inclusion and mainstreaming</li> </ul>	<ul style="list-style-type: none"> <li>• Tools</li> </ul>

<ul style="list-style-type: none"> <li>• Role models for self-determination</li> <li>• Treated as equals and like everyone else</li> <li>• Transportation</li> </ul>	<ul style="list-style-type: none"> <li>• Health care</li> <li>• Durable equipment</li> <li>• Support groups</li> </ul>
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The National Institute of Health (2001:62) suggested some areas of assessment and questions (Table 2.3), which can be used to guide planning for transition services. At particular ages, certain areas of development and intervention will become more important. The researcher used some of these assessment areas during therapy sessions with learners that have Spina Bifida.

Table 2.3: Areas of Assessment and Planning for Transition to Adulthood (The National Institute of Health, 2001:62)

<b>Activities of Daily Living</b>	
<ul style="list-style-type: none"> <li>• What self-care skills (such as for personal hygiene and dressing) does the young person have?</li> <li>• What might be learned?</li> <li>• What supports and resources are available?</li> <li>• What housekeeping skills does the young person have for meal planning; shopping and cooking; keeping the living quarters clean and maintained; cleaning and maintaining clothing; and dealing with emergencies?</li> </ul>	<ul style="list-style-type: none"> <li>• For what activities does the person need help during the day?</li> <li>• What resources are available to provide this help and how might they be funded?</li> </ul>
<b>Mobility</b>	
<ul style="list-style-type: none"> <li>• What ability does the person have to walk or roll within all parts of buildings used for daily activities and between buildings?</li> <li>• Are buildings that the person wishes to enter for education, employment and recreation accessible?</li> </ul>	<ul style="list-style-type: none"> <li>• What adaptations might reasonably be made?</li> </ul>
<b>Transportation</b>	
<ul style="list-style-type: none"> <li>• What abilities does the person have to access public transportation, special transportation options in the community?</li> <li>• Is the person able to access and complete driver's education to become a licensed driver?</li> <li>• What vehicle adaptations would be required?</li> </ul>	<ul style="list-style-type: none"> <li>• What adaptation services are available in the person's community?</li> <li>• How can they be funded?</li> </ul>
<b>Health Care</b>	
<ul style="list-style-type: none"> <li>• What does the young person know about his disabilities?</li> </ul>	<ul style="list-style-type: none"> <li>• What is the person's source of primary care for general health monitoring and education</li> </ul>

<ul style="list-style-type: none"> <li>• What skills does he have and/or need to learn to monitor physical and/or psychological conditions?</li> <li>• Does he participate in therapies and administer own medications with knowledge of regimen and side effects?</li> <li>• Does the person communicate with health care providers?</li> <li>• What supports would assist the person to do these things, such as educational programs, assistive technology, equipment, supplies, therapies, personal attendants, public health nursing and/or home nursing assistance?</li> <li>• Where are these available, and how can they be funded?</li> </ul>	<p>such as normal development, immunizations, diet, exercise, substance use and abuse, risk taking behaviours and safety issues, and sexuality education and supports?</p> <ul style="list-style-type: none"> <li>• Does the person receive regular dental care?</li> <li>• What specialty medical care is available from paediatric and adult health care providers knowledgeable or willing to learn about the particular problems?</li> <li>• What planning is in process for transition from paediatric primary and specialty care providers to adult health care providers?</li> <li>• What options are available in the community? What funding is available?</li> </ul>
<b>Living Arrangements</b>	
<ul style="list-style-type: none"> <li>• Where does the young person wish to live – apartment, house, dorm, city, country?</li> <li>• With who will the young person live – family, friends, independently, supported living?</li> <li>• What are the options in the person’s community?</li> <li>• Where is the best place to live to be able to go to school, work and participate in the community?</li> </ul>	<ul style="list-style-type: none"> <li>• What is needed to live more independently – housekeeping skills, transportation, and personal assistance?</li> <li>• Is help available to learn these?</li> <li>• What are the effects of decisions about living arrangement on the family?</li> </ul>
<b>Housing</b>	
<ul style="list-style-type: none"> <li>• What adaptations such as ramps, railings, wider doorways, bathroom configuration, and kitchen adaptations are needed to support independence?</li> </ul>	<ul style="list-style-type: none"> <li>• What home maintenance skills does the person have or can learn and what help is available?</li> </ul>
<b>Recreation and Leisure</b>	
<ul style="list-style-type: none"> <li>• What does the person like to do for fun and physical and mental fitness?</li> <li>• What skills does he have?</li> <li>• What is available in the community for sports, shopping, watching or viewing, visiting?</li> </ul>	<ul style="list-style-type: none"> <li>• What things would the person like to learn to do and what might be available in the community to assist in learning?</li> </ul>

## 2.10 CONCERNS OF ADOLESCENTS WITH SPINA BIFIDA

In a study undertaken by McGavin (1998:74), the following aspects were found to be concerns for adolescents that have Spina Bifida:

### **2.10.1 Selfcare**

The main concerns regarding selfcare were:

- tub and shower transfers
- endurance
- stability
- safety when walking outdoors

### **2.10.2 Productivity**

Concerns regarding productivity were:

- household management, particularly kitchen-based activities
- academic problems
- problems related to personal time organization
- having friends at school
- being treated like other children

### **2.10.3 Leisure**

Main concerns regarding leisure were:

- more availability of disabled sport activities
- socialization

In another study done by Holmbeck (2003:793), it was found that children with Spina Bifida tended to be socially immature and more dependent on adults, less likely to initiate social contacts, less scholastically competent in the school setting, less physically active, less likely to make independent decisions, more likely to exhibit attention difficulties and more passive and less engaged during observed family interactions.

## **2.11 PHYSICAL ENVIRONMENT**

During the researcher's contact with children that have Spina Bifida at Astra School for the Physically Disabled, one aspect was evident for each of these children namely their physical environment. In an article regarding the impact of poverty on quality of life in families of children with disabilities, Park (2002:151) stated that when children have a disability and also live in poverty, the impact of poverty might be more significant. Poverty restricts opportunities for family members to play, exercise and socialize in sound recreational activities. The physical surroundings of a family home are the physical environment. This domain encompasses the human factors related to family life (neighbours, community culture) as well as the physical factors. The indicators of this domain include space, safety, and order of home, work, school, community and environment.

Throughout the article of Park, it became clear to the researcher that poverty impacts on the home environment, and in turn, the home environment impacts on the productivity, emotional well-being and health of all family members.

## **2.12 IMPACT ON EMOTIONAL WELL-BEING**

Emotional well-being as stated by Park (2002:158), embraces the emotional aspects of family quality of life, such as adaptability, positive thinking, identity, happiness and stress/exhaustion. Stress, adaptability and self-esteem are the main themes in the literature regarding the impact of poverty on families' emotional well-being.

When the family has a child with disabilities, more stress is added to the strain already caused by poverty and more coping strategies will be needed by the family. In an article by Park (2002:163), information was gained regarding 25 recent studies. Researchers examined stress and coping in families of children with disabilities to find out how stress and adaptability in families of children with disabilities are different according to many family variables. They found that families with higher incomes have more choices available to help them cope and also demonstrated higher paternal and maternal satisfaction.

With reference to the above and the researchers' contact with learners that have Spina Bifida who come from low socio-economic backgrounds, it became evident that there is a big need for help and support to the family with a disabled child. Some parents are unemployed and uneducated. In some cases there is a lack of parental support, as well as the knowledge and money to help their disabled child. Through Gestalt play therapy the researcher aimed to guide and help the disabled child to become more independent.

### **2.13 SELF-ESTEEM AND BODY SELF-IMAGE**

When individuals are confined to a wheelchair and no longer capable of caring for themselves, how they feel about themselves will be the determining factor in their quality of life. Rowley-Kelly (1993:40) mentioned that a child's self-esteem grows as progress is made in gaining peer acceptance, learning to speak for himself, learning to function with a minimum of dependence on adults, achieving academic progress and learning new skills in a variety of areas. Self-esteem also grows as the learner gains competence in dealing effectively with other medical routines. The relationship between these factors is not that of simple cause and effect: Progress in any area promotes self-esteem and, in turn, gains in self-esteem promote progress in every other area.

Adolescents are painfully conscious of their appearance and tend to see their flaws in exaggerated proportions. The child with Spina Bifida may view himself primarily in terms of the differences in his appearance. Such a child's self-definition may be stated primarily in terms of disabilities rather than abilities. Rowley-Kelly (1993:47) is of opinion that school children are frequently cruel in their honesty, so they make derogatory remarks about a child who is different. It seems that teasing has a lasting effect. According to various studies done by Rowley-Kelly, people who were teased as children were less satisfied with their bodies as adults. The "ugly" child remembered his misery long into adulthood. Thus, the school experience may either reinforce or weaken the child's feelings about himself as a unique, important person with specific talents or abilities.

### **2.14 SUMMARY**

It is evident that Spina Bifida – the most common Neural Tube Defect – is one of the most devastating of all birth defects. Because of the paralysis resulting from the damage to the spinal cord, people born with Spina Bifida may need surgery and other extensive therapeutic intervention. Some children may have difficulty with paying attention, expressing or understanding language, organizing sequencing and grasping reading and math. Early intervention can help considerably to prepare these children for school. Children with Spina Bifida need to learn mobility skills, and often with the use of crutches, braces or wheelchairs can achieve more independence.

The next chapter will focus on Gestalt play therapy and a discussion on concepts, to explain what Gestalt play therapy is. The researcher will look at the different mediums of play that were used during contact with learners that have Spina Bifida.

## **CHAPTER 3: GESTALT PLAY THERAPY**

### **3.1 INTRODUCTION**

This chapter will consist of general elements and discussions regarding Gestalt play therapy. The researcher will look at various Gestalt concepts. Some of these concepts

are: relationship building, awareness, the role of the past, play therapy techniques, forms of play as well as a discussion regarding Schoeman's model.

### **3.2 EXPLAINING HOW GESTALT THERAPY WORKS**

To explain what Gestalt therapy consists of and how it works, the researcher would like to refer to Joyce and Sills (2003:7). According to them Gestalt therapists believe that people potentially have all the necessary abilities to solve their problems or face their difficulties. However, sometimes people get stuck and need some assistance. The role of the therapist will be to assist the client to see more clearly what the situation is, find out how the client is part of it and experiment with finding new solutions or ways to face the difficulty. Gestalt therapy is a humanistic/existential therapy, which believes that people are born with the resources and ability to be in rewarding contact with other human beings, and lead a satisfying, creative life. However, often during childhood and sometimes later on, something interrupts this process and the person becomes stuck in fixed patterns and beliefs about himself that get in the way. Gestalt aims to investigate and uncover how these patterns are still active and affecting a person's present life. Gestalt therapy can therefore be seen as a journey into the unknown.

Another view on Gestalt therapy according to Kaduson and Schaefer (2000:28) is that it is a humanistic, process-oriented mode of therapy that focuses attention on the healthy, integrated functioning of the total organism, comprised of the senses, the body, the emotions and the intellect. The following are a few of the most salient principles of Gestalt therapy.

#### **3.2.1 The relationship**

The Relationship is a particular type of relationship based on the philosophical writings of Martin Buber (in Kaduson & Schaefer, 2000:28), often referred to as the I-Thou relationship. Some of the pertinent fundamental principles of this relationship are highly significant in working with children. The therapist is cognizant of the fact

that, despite differences in age, experience and education, she is not superior to the client; both are equally entitled. It is a relationship where two people come together in a dialogical stance. The therapist meets the child; however he or she presents the self, without judgement and with respect and honour. The therapist does not play a role. She is congruent and genuine, while at the same time respecting her own limits and boundaries, never losing herself to the child, but willing to be affected by the child. The therapist holds no expectations, yet maintains an attitude that supports the full, healthy potential of the child. The therapist is involved, contactful and often interactive.

According to the researcher, the relationship is very important and it will influence the therapy process either positively or negatively. From the first moment of contact, the researcher creates an environment of safety and will never push the child beyond his or her capabilities or consent. The relationship itself is therapeutic; often, it provides an experience for the child that is new and unique.

### **3.2.2 Contact and resistance**

Contact involves the ability to be fully present in a particular situation, with all the aspects of the organism vital and available. Healthy contact involves the use of the senses (looking, listening, touching, tasting, smelling), awareness and appropriate use of aspects of the body, the ability to express emotions in a healthy way, the use of the intellect in its various forms as learning, expressing ideas, thoughts, curiosities, wants, needs and resentments. When any of those modalities are inhibited, restricted or blocked, good contact suffers. Fragmentation, rather than integration occurs. Children who have troubles, who are grieving, worried, anxious, frightened or angry, will armour and restrict themselves, pull themselves in, inhibit themselves and block healthy expression. Healthy contact involves a feeling of security with oneself, a fearlessness of standing alone. We make good contact with others from the edge of ourselves – from the boundary of the self. The contact boundary is the point at which one experiences the ‘me’ in relation to that which is not me and through this contact, both are more clearly experienced. If the self is weak and undefined, the boundary is fuzzy and contact suffers. Good contact is fluid and involves a rhythm of withdrawal. The child who maintains a fixed contact posture, as requiring constant attention, never

able to play alone, or talking constantly, shows evidence of a fragile sense of the self (Kaduson & Schaefer, 2000:28).

Resistance is a healthy response and good contact involves some level of resistance. The researcher agrees that some resistance can be expected and it must be recognized as the child's ally. As the child begins to feel safe in the sessions, the resistance will soften. However, resistance comes up over and over again. The above-mentioned writers further state that when the child has experienced or divulged as much as he can handle or has inside support for, the resistance will come up again and must be honoured. It is the child's signal that she/he has reached the limit of capability at this particular time. Resistance can be viewed as a manifestation of energy as well as an indication of the contact level of the child. When the energy fades and the contact shifts, this is evidence of resistance.

Again the researcher would like to agree that it is important not to push through this resistance quickly, forcefully or mechanically. If the relationship is strong, the therapist can use all of her skills to gently override some of the resistance. It is a tenuous matter. Inappropriate behaviours are often viewed as resistances or contact boundary disturbances. As the child struggles to grow up, survive and cope with life, he may manifest a variety of inappropriate behaviours and symptoms that serve to avoid contact and protect the self.

### **3.2.3 Sense of self**

Helping the child develop a strong sense of self is a prelude to emotional expression, an important step in the healing process. Kaduson and Schaefer (2000:30) are of opinion that when children restrict and inhibit an aspect of the organism, the self is diminished. Strengthening the skills of contact play is an important part in this process. These skills – looking, listening, smelling, tasting, touching, moving in the environment, expressing thoughts, ideas, opinions and defining the self – give the support necessary for expressing deep emotions that block healthy functioning and integration.

The researcher is of opinion that the 'Building a Self-Image-Oaklander Approach' is a very effective and useful approach when working with children. Schoeman (2002:8) stated the following aspects regarding the above approach:

- A child needs space to orientate himself.
- Assign responsibilities.
- Give the child independence.
- Give the child freedom to choose.
- Involve the child in problem solving and decision making.
- Respect the child's feelings, needs, desires, suggestions and wisdom.
- Allow the child to experiment (within certain boundaries).
- The unique nature of each child is extremely important.
- Do not condemn the child.
- Respect the child's opinion/remarks.
- Do not try to change negative feelings/remarks into positive feelings.
- Acknowledge the feelings only and do not sanction negative action.
- Changes occur when the child is allowed to become what he really is.
- The therapist must be in contact with herself to be in contact with the child.
- The child must learn to be in contact with himself.

#### **3.2.4 Awareness and experience**

As mentioned above, Gestalt therapy is considered to be a process therapy. Kaduson and Schaefer (2000:30) state that attention is paid to the 'what' and 'how' of behaviours rather than the 'why'. When the therapist can help the client to become more aware of what he or she is doing that causes dissatisfaction, the client then has the choice to make changes. Awareness encompasses many aspects of life. One can become aware of one's process, sensations, feelings, wants, needs, thought processes and actions. As the child moves through the therapy experience, he becomes more aware of who he is, what he feels, what he needs and what he wants. Some older children as well as adolescents often become cognizant of unsatisfactory ways of being, experience them fully with the guidance of the therapist and begin to make

conscious choices for new behaviours. This is beyond the scope of younger children. For these children, experience is the key to awareness.

The above researchers are also of opinion that, providing varied experiences for children is an essential component of the therapeutic process. These experiences may be with aspects of themselves that are blocked, such as one or more of their sensory modalities. They might experience that experiment with parts of the self that have been kept dormant. All of these experiences serve to strengthen the child's self and promote good contact functioning, culminating in healing emotional expression and in general facilitating new and more satisfying ways of being in the world. Many creative, expressive and projective techniques are used to further the therapeutic experience.

These techniques serve as bridges to the child's inner self and often provide the means to discover, renew or strengthen aspects of the self. The techniques include the use of graphic arts in many forms, such as drawing, painting and collage, as well as pottery clay, puppets, music in many forms, creative dramatics, sensory and body experiences, various games, books and storytelling, the sand tray, fantasy, imagery and the use of metaphors. These techniques are very powerful in the context of Gestalt therapy and the relationship that develops with the therapist.

Zinker (1994:65) refers to the Gestalt Experience Cycle. See Figure 3.1 below. On an intrapsychic level, we are grounded in awareness of what is relevant at the moment, what grabs our attention and stands out intellectually and/or emotionally. This interest is invested with energy without which we would be unable to act. Ideally, our awareness is clear and rich. When awareness is sufficiently heightened by energy, we are able to move decisively toward what we want. Actions lead to contact with the environment and are followed by a sense of satisfaction, resolution and closure. We are able to withdraw from the situation, relax and let go. Withdrawal, when clean and complete, allows us to turn to a fresh experience without feeling the 'drag' of something unfinished. A new awareness then comes to the foreground and the cycle begins again.

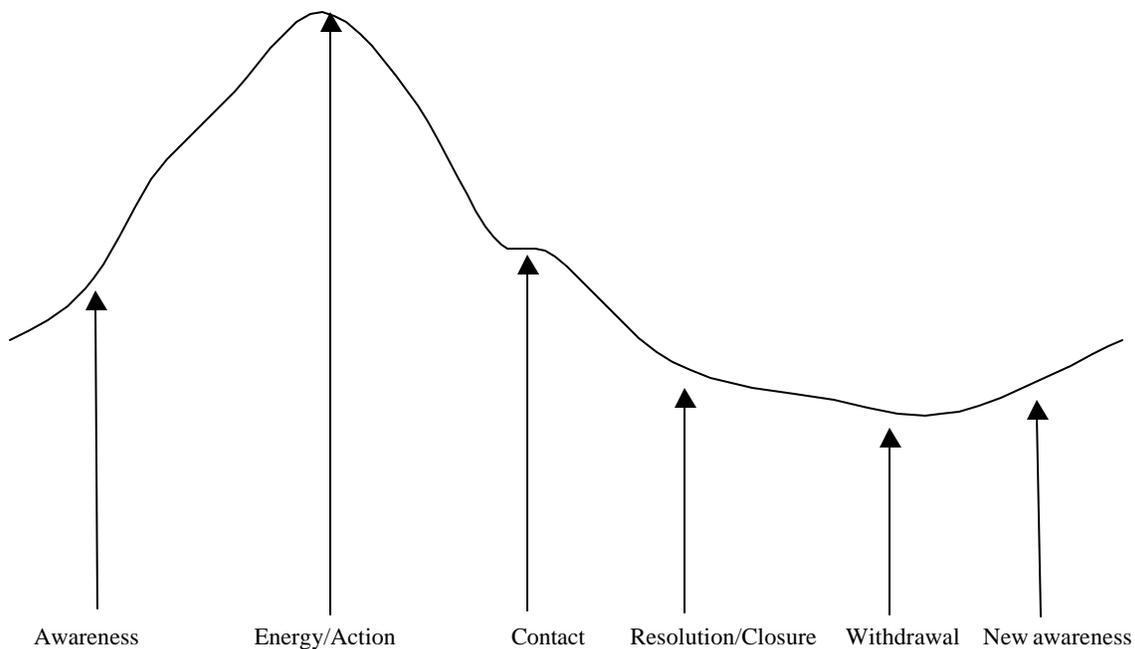


Figure 3.1 Gestalt Experience Cycle (Zinker, 1994:65)

### 3.2.5 Polarities

Polarities are being used to establish an awareness of opposites. According to Schoeman (2001:90), people tend to flounder at times between existing, natural dichotomies in their lives such as body/mind, self/external world, emotional/real, infantile/mature, spontaneous/deliberate, personal/social, love/aggression and conscious/unconscious. Much of everyday living seems to be involved in resolving conflicts:

- Physical polarities: masculinity/femininity.
- Emotional polarities: pleasure/pain, excitement/depression, love/hate.
- Mental polarities: parent/child, eros (feeling)/logos (reason), topdog (should do)/underdog (want to do).
- Spiritual polarities: intellectual doubt/dogmatism.
- Inter-individual polarities: man/woman, black/white, Christian/Jew.

It confuses a child when he experiences feelings of love and hate for the same person. According to Schoeman (2002:10), a child fears contradictions in his life and in the lives of those he loves. Children experience parts they do not like as very difficult. It

is important for a child to experience positive and negative aspects as facts of life, to assist with integrated development.

### **3.2.6 Perls's five-layer model of working through neurosis**

The impasse is a neurotic state, which forms the central layer in Perls's five layer model of working through neurosis. In order to understand and discuss this model in more detail, the researcher will first clarify what is meant by neurosis. Schoeman (2001:92) stated that neurosis refers to a growth disorder or disturbance in development that hinders the process of maturing. Maturity involves the transition from environmental support to self-support. Self-support involves contact with other people through the maintenance of the ego functions that allow the process of creative adjustment. Ego functions refer to the polar process of identification and alienation as the individual makes continual choices relating to the self within the organism/environment field. The loss of ego functions, or loss of choice, forms the basis of neurosis. The neurotic individual avoids actual pains as well as imaginary hurts, and also avoids taking reasonable risks. The individual learns to manipulate his environment through various games and manoeuvres in order to maintain the status quo and avoid becoming aware of his actual experience.

Perls (1969:64) identifies five layers of neurosis as a representation of how people fragment their lives and prevent themselves from succeeding and maturing. Each layer acts as a defence against moving to the next layer, resulting in the formation of a scab that obscures authentic and spontaneous functioning. These layers form the benchmarks of the Gestalt therapeutic process. The layers are consecutive and discrete and need to be worked through in order. However, it is felt that while the layers do represent a series of counselling stages, overlap is inevitable as the person may move backwards and forwards across layers in accordance with anxiety. The layers are as follows:

#### **3.2.6.1 Phoney layer/Cliché layer**

This is the outermost level of relating at a level of shallow, superficial contact and may include handshakes, greetings, small talk and other tokens of meeting. Some people find such casual contact difficult and in such situations, the therapeutic method should model the type of relationship the client needs to experiment with. As therapist, our engagement in more profound work must similarly be based on an ability just to be interested in each other on a less intensive level. However, clichés become problematic in therapy when they manifest as an avoidance of contact or as a deflection of the anxiety associated with a particular unfinished gestalt. Schoeman (2001:92) states that many people find themselves trapped in trying to be what they are not. The phoney layer is characterised by many conflicts that are never resolved.

### **3.2.6.2 Phobic layer/Role-playing or “As If” layer**

In this layer, one is trapped into playing phoney games in pursuit of being what one is not and hiding from one’s fears and dislikes. It can be described as splitting, where we show only a part of how we can be, but then act as if this is us. There is a loss of ego functions and the self is reduced to the self-concept. Through the maintenance of this social veneer, the rawness of spontaneous contact, and its subsequent anxiety, is avoided. Schoeman (2001:92) was of opinion that as people become aware of their phoney games, they become aware of their fears that maintain the games. This is often a frightening experience.

### **3.2.6.3 Impasse layer**

The impasse is marked by an awareness of the loss of ego functions. This results in anxiety as the game playing, roles and facades of one’s previous existence are removed and one’s fears, dislikes and seemingly unresolvable conflicts are exposed. The synthetic existence is replaced by the anti-existence – an experience of nothingness and emptiness. It is a static phase characterised by the phobic attitude of avoidance. We want to avoid suffering, frustration and the pains of growing towards maturity. As long as we avoid feeling and experiencing fully, we remain stuck – in an impasse. According to Schoeman (2001:92) this layer is reached when people shed the environmental support of their games and find themselves not knowing a better

way to cope with their fears and dislikes. People often get stuck here and refuse to move on.

#### **3.2.6.4 Implosive layer/Death layer**

This fourth layer appears as death or as the fear of death because of the paralysis of opposing forces. The client is now ready to move forward and regains and mobilises energy for that move, but does not have the necessary direction or knowledge of what the right thing is to do. This stage can be compared to the concept of the “grenzsituation” or limit situation, namely, a cul de sac where the person can go neither forward nor backward, forcing the person back on his or her resources. This layer is an ‘abandonment depression’ which is central in Gestalt therapy, not as an end point, but as a doorway to authenticity. Schoeman (2001:93) states the people become aware of how they limit themselves, and they begin to experiment with new behaviours.

#### **3.2.6.5 Explosive layer**

Here the implosion becomes explosion as the death layer comes to life. The individual discovers his authentic needs and interests in the environment, learns to experience and express his emotions and chooses to direct his energy into the process of creative re-adjustment. If experiments with new behaviours are successful, people are able to reach the explosive layer, where they find much un-used energy that had been tied up in maintaining a phoney existence.

#### **3.2.7 The role of the past**

Gestalt therapy sees people as holistic, consisting of different parts that make up the individual. When we start off we are more or less “together” or “a whole”, but as we grow and develop, we encounter experiences, feelings and fears in our lives that cause us to lose parts of ourselves or cause us to lose our balance between our different parts. These parts must be regained if we are to live intentional, self-actualized lives. Therefore, Gestalt Therapy is centrally concerned with integrating our parts that are not in balance, into a whole person (Yontef, 1993:3).

Gestalt therapy also focuses on the person in every form, in relation to every system that the person interacts with. Therefore looking at past experiences and bringing those experiences to the here and now is emphasized as a way to integrate people in relation to themselves, others and the world. This view is emphasized by Yontef (1993:3) where he states that Gestalt therapists work with the here and now and are sensitive to how the here and now includes residues of the past, such as body posture, habits and beliefs. Perls (1969:64) points out that in Gestalt therapy we start with what is, and see which abstraction, which context, which situation is to be found to relate to the figure, the foreground experiences, to the background, to the content, to the perspective, the situation and together they form the gestalt. Meaning is the relationship of the foreground figure to its background.

In working with the here and now, past experiences that are of present importance are dealt with but for the researcher it can only be dealt with in a therapeutic relationship if the following core elements have been established:

### **3.2.7.1 Field theory and the past**

According to the field theory, the field is everything out there, everything that exists; your interaction with the field is everyone and everything: religion, education, employment, family, friends, and nature Yontef (1993:3). Everything is of the field and cannot be separated from the field. The person in his life space constitutes the field. The field has a past and as the person interacts with the field the field becomes part of the person's past and likewise will be part of the person's future. The therapist needs to take cognizance of the relationship the client has with the fields and to draw on issues from the field and to bring it to the here and now.

### **3.2.7.2 Dialogue in relation to the role of the past**

Dialogue is the verbal and non-verbal communication that exists between client and therapist. Yontef (1993:3) states that the relationship grows out of contact and through contact people form identities. The Gestalt therapist works by engaging rather than by manipulating the client towards some therapeutic goal. Such contact is

marked by straightforward caring, warmth, acceptance and self-responsibility. The latter is also reinforcing by the ABC-structure for building the therapeutic relationship, developed by Schoeman (2001:6). See 3.3.2.1.

### **3.2.7.3 Awareness and the role of the past**

Yontef (1993:14) believes that in Gestalt therapy, the only goal is to be aware. Within therapy the therapist needs to be aware of everything. Especially to be aware of the client and how he interacts with the world. Perls (1969:53) states that awareness covers awareness of the self, awareness of the world and awareness of what is in between the intermediate zone of the fantasy that prevents a person from being in touch with either himself or the world.

In Gestalt therapy the focus is always to work with the here and now. Yontef (1993:11) states that the act of awareness is always here and now, although the content of awareness is not now. The act of remembering is now, but what is remembered is not now. When the situation calls for an awareness of the past or anticipation of the future, effective awareness takes this into account. Effective awareness thus also provides for previous experiences to be brought to the here and now if it is on the client's foreground figure.

The researcher is of opinion that to conclude the role of the past, when working with the here and now, the foreground experiences are often related to past experiences. Past experiences are dealt with only if it is of importance to here and now situations. In bringing these past experiences to here and now, the therapist should have established a therapeutic relationship where core elements of dialogue, awareness and understanding the client within the field have been integrated in understanding the client's process.

In the following paragraphs, the researcher will discuss what play therapy is as well as the different forms of play. According to the researcher, it is important to keep in mind the concepts as discussed above, while working with the child using play therapy.

## **3.3 PLAY THERAPY**

Play, as a means of self-expression, is an opportunity given to the child to 'play out' feelings and problems just as an adult might 'talk out' difficulties. Kaduson and Schaefer (2000:57) mention the following basic principles of play therapy created by Axline.

- The therapist must develop a warm friendly relationship with the child, in which good rapport is established as soon as possible.
- The therapist unconditionally accepts the child.
- The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to express his feelings completely.
- The therapist is quick to recognize the feelings the child is expressing and interprets those feelings for the child in an insightful manner to gain insight into the behaviour.
- The therapist maintains a deep respect for the child's ability to solve problems once given an opportunity to do so. It is the child's responsibility to make choices and to institute change.
- The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way and the therapist follows.
- The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognized as such by the therapist.
- The therapist establishes only those limitations that are necessary to anchor therapy to the world reality, and makes the child aware of responsibility in the relationship.

Play, according to Oaklander (1988:160), is the child's form of improvisational dramatics. Playing is how the child tries out his world and learns about this world, and it is therefore essential to his healthy development. For the 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 conflicts are often worked through. Through the safety of play every child can try out his 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 make of it. Play also serves as a language for the child – a symbolism/substitute for words. The

child experiences much in life he cannot as yet express in language, and so he uses play to formulate and assimilate what he experiences.

For the purpose of this study, the researcher will only discuss the forms of play that were implemented during the therapy sessions with high school learners that have Spina Bifida.

### **3.3.1 Forms of play**

There are different forms of play. The following are the forms of play, as indicated by Schoeman (2001:109 - 112), that are applicable to this study.

#### **3.3.1.1 Dramatic play**

Dramatic play refers to when the child plays out certain situations or experiences. There are different mediums of dramatic play. Some mediums are:

- Role playing
- Hand puppets

#### **3.3.1.2 Creative play**

Through creative play the child communicates what he can't express verbally. It refers to the making of an object that reflects something that might be too painful to talk about. Some mediums are:

- Clay work
- Drawings
- Letters

The following is an example of how to use the object that was created by the child during creative play:

- Give the object a name.
- Give the object emotions, wishes, needs, characteristics, likes and dislikes.
- Explain how the above can be compared with the child's own experience or situation.
- Give the opportunity for the child to own the emotions.
- Give the opportunity to express the emotions/play out the emotions.
- Encourage unloading.
- Evaluate the emotions.
- Explain why unloading of emotions is important.
- Empower the child.
- Allow self-nurturing.

### **3.3.1.3 Biblio play**

Biblio play refers to the creative use of written words, which can be directed to the past, future or present situation. Some mediums are:

- Diary
- Poetry

### **3.3.1.4 Gestalt techniques**

Together with the forms of play, the following techniques, as discussed by Schoeman (2001:109 – 112), can be used:

- Rosebush technique: With this technique the child pretends to be a rosebush. The child is then asked to consider the following points:
  - Type of rosebush – strong or weak?
  - Root system – deep or shallow?
  - Number of roses – too many or too few?
  - Number of thorns – too many or too few?
  - Environment – bad or good for growing?
  - Does your rosebush stand out?

- Does it have enough room?
  - How does it get along with the other plants?
  - Does it have a good future?
  - Which of the above aspects can be applied to the child's own life?
- **Monster technique:** According to Schoeman (1996:68), unfinished business may become 'monsters' in a child's life. Because of unfinished business the child is unable to establish organismic self-regulation. The child is asked to identify the monsters in his life. When the therapist deals with the monster in the life of the child, the following steps can be followed:
    - The child must create a monster that deals with his life situation.
    - Start a discussion with the child, asking him the following:
      - \* For how long has the monster existed?
      - \* Are there other people who know about the monster?
      - \* Is there something about the monster that scares him?
      - \* Is he prepared to have the monster in his life and live with it?
      - \* Can he name his monster?
      - \* How old was he when he got the monster?
      - \* Is it possible to draw or make the feelings about the monster in clay?
      - \* Ask the child to talk to the monster.

During the researcher's contact with high school learners that have Spina Bifida, the above techniques were found to be very effective while attending to the incomplete gestalts of these learners.

### **3.3.2 Schoeman's model**

For the purpose of this study the researcher focused on Schoeman's model (Schoeman, 2003) during play therapy sessions. Schoeman's model follows a logical sequence, which the researcher will be elaborating on. This working model in play therapy is based on Gestalt therapy. It provides a good outline and structure for therapy sessions. Even though the model provides the above, it also allows some room for flexibility. The researcher is of opinion that the child in the therapy session

will influence the structure and form of the therapy. It is important to work with what the child gives you, and not to be stuck in a fixed structure of therapy. The model will not necessarily be applied or implemented in the sequence as discussed below, but the different aspects can overlap with each other throughout the sessions.

The researcher will discuss all the different concepts applicable to Schoeman's model in the paragraphs below.

### **3.3.2.1 Building of a therapeutic relationship**

In Schoeman's model, she strongly emphasises the establishment of a therapeutic relationship. Building a relationship means an opportunity is provided for client and therapist to get to know each other and determining each other's boundaries and limitations. Schoeman further states that some children will initially be resistant which is to be expected. It is important though that his resistance be accepted and respected. This is the client's way of protecting himself. With the growing of the relationship with the client, the resistance will occur again as new topics are being explored, meaning the client's boundaries moved (Schoeman, 2001:76).

The first moment of contact between therapist and client has great impact on the relationship. According to Axline (1993:73) the initial contact is of great importance for success in therapy. It is important for the therapist to develop a warm, friendly relationship with the child, in which a good rapport is established as soon as possible.

The researcher thus concludes that a good relationship with the client will result in the formation of a positive therapeutic relationship. The researcher is also of opinion that the client should feel accepted, which will result in feelings of security and comfort. The client will then feel free to share feelings and thoughts. A relationship can be established by playing informally with the client, in a relaxed, safe, comfortable environment where the client feels accepted. The therapist must allow the client to provide the guidance. Table 3.1 provides the ABC-structure for building the therapeutic relationship, developed by Schoeman (2001:6).

Table 3.1. ABC-framework for building a therapeutic relationship (Schoeman, 2001:6)

<b>Alphabetical grouping</b>	<b>Description</b>
A – “Awareness”	Making the child aware of his behaviour and emotions.
B – “Bidding One’s Time”	Do not rush the therapy – let the child know that you have time for him.
C – “Clichés And Confluence”	Allow the child to be himself – do not attempt to change the child.
D – “Dialogue”	Communication is very important from both the therapist and child – allow the child to express himself without judgement.
E – “Equilibrium”	Be aware of the child’s developmental stage – sometimes children act to please others, instead of being their true selves.
F – “Friendship”	Be a true friend to the child – communicate on the same level and not as if the therapist is there to look after the child.
G – “Guardianship”	Create an atmosphere where the child feels safe and relaxed.
H – “Humility”	Be true and interact with respect and on the same level as the child.
I – “Information”	Only share information if the child is ready for it – prepare the child for a situation he might not be aware of or understand.
J – “Joy”	It is important for the child to enjoy the sessions, so that he wants to come again – make sure you choose the activities according to each child’s needs.
K – “Kindness And Honesty”	Always be friendly and honest – don’t ever lie to the child.
L – “Laughter”	Laugh a lot and have fun – be aware not to laugh at the child, but with him.
M – “Making Contact”	Be aware of the child’s process – see the child as a whole.
N – “Concept Of Now”	Be aware of the ‘here and now’ – what is happening now – what is on the child’s foreground.
O- “Organismic Self-Regulation”	In organismic self-regulation, choosing and learning happens holistically, with a natural integration of mind and body, thought and feeling, spontaneity and deliberateness.
P – “Polarities”	Make sure the child understands the meaning of polarities – for example good/bad.
Q – “Critic”	Do not criticize the child – only the behaviour.
R – “Responsibilities”	Encourage responsibility – let the child take responsibility for his actions and emotions.
S – “Sincerity”	Always be sincere.
T – “Transference”	Be aware of the possibility of transference – if therapist reminds child of something, work through it and discuss uniqueness.
U – “Unfinished Business”	Be aware of unfinished business – it can influence the therapeutic process.
V – “Violence”	Give the child with aggression opportunity to unload.
W – “Warmth”	Create a warm and loving atmosphere.
X – “X-Ray Vision”	Be aware of all the information the child gives – verbal and non-verbal.
Y – “Yes, I Can”	Help the child to create an ‘I can’ attitude.
Z – “Zest”	Be enthusiastic and energetic.

### 3.3.2.2 Sensory modalities

Once the therapeutic relationship is established the next important aspect is to test whether the client is sensory intact. Schoeman (2003:15) regards this as another important aspect. She is of opinion that if the client is not sensory intact, he will also not be emotionally mature; emotional immaturity meaning the client's inability to understand / identify / recognize feelings. Schoeman also strongly recommends that the necessary referral be made if the client is not intact.

From conception onwards the baby experiences different sense that influence the way he perceives life. Schoeman (2003:16) states that perception is the ability to recognize and discriminate sensory stimuli, to interpret these stimuli by associating them with previous experiences and reacting appropriately thereon. Perception is the way in which the brain makes contact with the outside world. Different sense organs receive sensory impressions but the recognition of these impressions takes place in the brain. Perception is the interaction between the senses and the central organizing process.

The researcher concludes with the following. Through the developmental years the human being experiences various sensory stimuli and reacts on it, resulting in physical, cognitive and emotional growth. If however, the client is found not to be sensory intact it will hamper him. Emotional immaturity means lack of insight (emotional and intellectual) explaining why therapy will not be successful. Sensory intactness can be tested by allowing the client to smell various fragrances, tastes various flavours, listen to various sounds, and see various colours, figures and movements. Testing sensory intactness can be done directly (asking the child to smell containers with different fragrances and discussing it) or indirectly (playing with dough or clay and asking the child what it smells or feels like).

### **3.3.2.3 The child's process**

According to Schoeman (2003:6) the child's process is the means by which he interacts with the world around him and how he uses previous experiences as a measuring tool. She suggests that you can determine the child's process by using an obstruction. She also believes that each person has his own process and it does change.

Axline (1993:73) agrees that the individual is constantly changing. The dynamics of life are such that every experience and attitude and thought of every individual is constantly changing in relation to the interplay of psychological and environmental forces upon each and every individual. The child's process is being influenced by whether his basic needs are met or not. Each individual has basic needs and constantly strives to satisfy those needs. When direct satisfaction is achieved it is said that the individual is well adjusted. When needs cannot be satisfied devious paths are taken to bring about satisfaction and the individual is said to be maladjusted.

The researcher agrees that therapy cannot start unless you know the child's process, getting to know the child's thinking processes and know how he reacts in and handle situations. The therapist in turn uses this information to make the client aware of feelings, to prevent manipulation and to set boundaries and limitations where necessary. By knowing the child's process the therapist will know what she needs to reach in the client and find why this child needs the help of the therapist.

#### **3.3.2.4 Projection**

The researcher includes the following definitions of projection, as stated by Schoeman (1996:64). Projection, defined by Yontef, is a confusion of self and other that results from attributing to the outside something that is truly self. More simply stated, projection is imagining that our own (unwanted) feelings belong to someone else - it contributes to the development of artistic and creative qualities; it is at the same time a primitive defence mechanism, used when one cannot accept his feelings and actions because one should not feel or act that way."

According to Schoeman (1996:64), healthy projection is an art; pathological projection, on the other hand, results from one's not being aware of and not accepting responsibility for that which is projected. It is therefore very harsh on a child to

confront him with a projection. He may feel robbed and unwilling to admit that a projection is part of him.

Schoeman also provides the following information regarding projection (1996:64-74).

Projection serves the following objectives in the life of the child:

- Projection gives the child the space to sort out the expectations with which the world confronts him.
- It is an attempt by the child to dispel that which he cannot yet handle.
- Projection offers the child a means of maintaining his self-respect.
- It offers an escape when the child is unready to accept criticism and rejection.

The steps in the projection are as follows:

- Use any medium that the child chooses.
- The child must describe his projection – using the following as indicators:
  - How old is the object?
  - What colour?
  - What emotions?
  - Where does it live?
  - Where does it work?
  - Tell me about its friends?
  - Anything else you can think of that is important to share regarding the object?
- The child must now be given the opportunity to own the projection. In other words, the child must tell you in what way the things he told you about the object can be applicable to his own life.
- Discuss the emotions regarding the above.

To conclude this discussion regarding projection, the researcher would like to summarize projection as the process where the child takes his own experience and puts it into another person or object. The other person or object serves as a video screen onto which he projects the aspect of himself that he cannot handle. The basic principle underlying this technique is that the child must use natural media to communicate his response, in cases where he would otherwise find it difficult to

respond. The child organises the material in terms of his own perceptions, motivations and attitudes to adapt to his own uniqueness. A projection is also a reflection of incompleteness. Axline (1993:73) states that there is frankness, honesty and vividness in the way children state themselves in a play situation. Their feelings, attitude and thoughts emerge.

### **3.3.2.5 Alternatives**

The alternative techniques entail the therapist helping the client to become aware of how problems were handled in the past, how the problem is handled presently and how the child is planning to deal with it in future (Axline, 1993:73). Often the child chooses alternatives but cannot execute it because of too low ego powers. The therapist then empowers the client by using the following technique:

- The empty chair: The Gestalt technique of the empty chair is often used to role-play a conflict between people or within a person. The child can sit on one chair and play his or her own part; then sitting on the other chair, the child can play out a projection of what the other person is saying or doing in response. Similarly, a child may sit on one chair and discuss the pros of making a decision and then argue the cons of the decision while sitting on the opposite chair (Schoeman, 2001: 94 – 95).

By looking at alternatives the child will have to make choices, which further creates responsibility. According to the researcher, it is important to note that the therapist cannot move on to alternatives if the child has not yet owned his feelings. During this phase in therapy, it is important for the child to make his own choices and therefore to take responsibility for the choices. This could be very empowering for the child to know that he is in charge of his life and that he is able to come up with an alternative (solution) himself.

### **3.3.2.6 Clarification**

By clarifying, according to Axline (1993:73), the therapist gives permission to the client to experience/to feel that specific emotion, giving the “OK”. In other words, that it is all right to have those feelings. The therapist also summarizes the child’s feelings, which provides a sense of security.

### **3.3.2.7 Empowerment**

According to the researcher, empowerment is a very important aspect during any contact with a child. Schoeman (2003:18) states that therapists often use empowerment to help the child feel in control and to provide confidence. It is crucial not to pretend or to be false in empowering a child. This must be a natural and ongoing process, no matter at what phase of the therapy session.

During the researcher’s contact with learners that have Spina Bifida, it became evident that these children are extremely receptive to empowerment. Because of the difficulties and low self-image of these learners, empowerment played a major role in building up self-confidence and also to realise that what they are experiencing is “OK”.

### **3.3.2.8 Evaluation**

Evaluation refers to the part of the therapy session where the therapist summarizes the session. This includes everything that was done or said since the beginning of the session – projection, emotions experienced, techniques implemented, alternatives, confirmation of the child’s situation (Axline, 1993:73). It allows the child to reflect and identify what aspects were dealt with.

### **3.3.2.9 Self-Nurturing**

The researcher is of opinion that in any therapy session, enough time must be spent regarding self-nurturing. It is important to find something that the child can do for himself to make him feel special and valued. According to Schoeman (2002:9), each child has a critical self. A child can take everything personally – everything reflects on the child – often does a better job of criticizing himself than his parents. Self-

acceptance develops from healthy self-maintenance. Each trauma takes its toll in terms of unexpressed, unfinished business and blaming the self. If the child accepts all parts and sides he can grow in peace. In other words, if the child is brought into contact with the 'dark' parts of his life and he nurtures it, the child experiences integration.

During the researcher's contact with learners that have Spina Bifida, self-nurturing was a big need for all learners. It became evident that they seldom receive any love, support and help from their families, which results in them not being able to understand or realise the need for nurturing themselves.

### **3.4 SUMMARY**

The basic assumption of Gestalt therapeutic approach is that people can adequately deal with their own life problems if they know what they are, and can bring all their abilities into action to solve them. This way people can strive towards restoring their balance. The task of the therapist is thus to unlock awareness by helping people to relax their retroflected energies, restore sensitivity, assimilate introjects and change projection into direct expression. Once in good touch with their real concerns and their real environment, the clients can be on their own and be strong enough to strive towards balance and healthy functioning.

The next chapter (chapter 4) will refer to an in depth discussion regarding the case studies where Gestalt play therapy techniques were implemented (therapy).

## **CHAPTER 4: EMPIRICAL STUDY**

## **4.1 INTRODUCTION**

A detailed literature outline was given in chapters 2 and 3, which included an overview of what Spina Bifida and Gestalt play therapy are. In this chapter, the researcher will present the empirical data, which was gained from the case studies. The researcher made use of individual therapeutic sessions, to gain the necessary information. Therapeutic intervention with four high school learners that have Spina Bifida, took place over a period of 2 months and therapeutic input within 6 sessions.

For the purpose of this chapter, the researcher will refer to herself as the therapist. In order to protect the identities of the learners that were involved in the study, the researcher will make use of pen names.

## **4.2 RESEARCH APPROACH AND METHOD**

In order to understand and put the gathering of empirical information into context of this study, it is important to look at the main goal and objectives of the study. The main goal of this study was to determine the value of Gestalt play therapy for high school learners with Spina Bifida. In order to reach this goal, the following objectives were set:

- To do a literature study regarding the child with Spina Bifida, as well as Gestalt play therapy, in order to determine what needs and difficulties these children experience and how Gestalt play therapy can be implemented to address these needs and difficulties.
- To determine the value of Gestalt play therapy for the high school learner with Spina Bifida, by using case studies.
- To draw conclusions and make recommendations in order to support and assist children with Spina Bifida, as well as their families, friends, educators and the broader community.

During this study, qualitative research was used in order to determine the needs and difficulties of learners that have Spina Bifida, as well as the value of Gestalt play therapy. For the purpose of this study, the universe was all high school learners with Spina Bifida. The population was all high school learners with Spina Bifida at Astra School for the Physically Disabled. The sample consisted of four high school learners with Spina Bifida at the above-mentioned school.

### **4.3 DISCUSSION OF CASE STUDIES**

In order to understand and put the gathering of information into context of this study, the researcher will first look at some aspects from the literature study, which were referred to during therapy sessions.

#### **4.3.1 Prior to the therapeutic sessions**

As mentioned in chapter 3 point 3.2.1, the relationship between the therapist and the learner is very important. From the first moment of contact, the therapist created an environment of safety and never pushed the learners beyond their capabilities or consent. Helping the child develop a strong sense of self is a prelude to emotional expression, an important step in the healing process. The researcher used the 'Building a Self-Image-Oaklander Approach' as discussed in chapter 3 point 3.2.3, as a guideline for interaction with learners.

It is important for the therapist to be aware of the field of each learner, as discussed in chapter 3 point 3.2.7.1. Everything is of the field and cannot be separated from the field. Another important guideline that was used during therapy sessions was the basic principles of play therapy as discussed in chapter 3 point 3.3.

#### **4.3.2 Using Schoeman's model during therapy sessions**

As mentioned in chapter 3 point 3.3.2, the therapist focused on Schoeman's model during therapy sessions. Some of the concepts in the model are:

#### **4.3.2.1 Building a therapeutic relationship**

The therapeutic relationship was monitored according to the ABC-framework for building a therapeutic relationship, as discussed in chapter 3 Table 3.1

#### **4.3.2.2 Sensory modalities**

As discussed in chapter 3 point 3.3.2.2, it is important for the child to be sensory intact. Sensory intactness can be tested by allowing the child to smell various fragrances, taste various flavours, listen to various sounds, and see various colours, figures and movements. Testing sensory intactness can be done directly or indirectly.

#### **4.3.2.3 Projection**

The therapist allowed each learner to make a projection, in order to create an opportunity where the child takes his own experience and puts it into another person or object. In chapter 3 point 3.3.2.4, it was mentioned that the other person or object serves as a video screen onto which he projects the aspect of himself that he cannot handle. The different steps when using projections, was used during therapy sessions.

#### **4.3.2.4 Alternatives**

As stated in chapter 3 point 3.3.2.5, alternative techniques entail the therapist helping the child to become aware of how problems were handled in the past, how the problem is handled presently and how the child is planning to deal with it in future. During this phase in therapy, it is important for the child to make his own choices and therefore take responsibility for the choices. This could be very empowering for the child to know that he is in charge of his life and that he is able to come up with an alternative (solution) himself.

#### **4.3.3 Areas of assessment**

In chapter 2 Table 2.3, areas of assessment and questions were suggested by The National Institute of Health (2001). The therapist used these assessment areas during therapy sessions. The information gained from these areas of assessments gave the researcher an indication of how dependent learners are, as well as the kind of support they would need to function independently. This will be discussed in this chapter, point 4.3.4.

#### **4.3.4 Case Discussions**

Therapeutic intervention with each learner will be discussed in the following paragraphs.

##### **4.3.4.1 Case Study 1**

###### **(a) Biographical information:**

Name:	Sammy
Date of birth:	1989-12-19
Age:	14
Gender:	Female
Address:	Hermanus (hostel placement)
Home language:	English
Number of children in family:	2

###### **(b) Therapeutic Intervention:**

###### **1. First Session**

- Form of play: Creative play
- Medium of play: Clay work
- Goal of therapeutic session: The goal of the first session was to meet Sammy - to introduce the therapist and therapeutic room in an informal and relaxed

manner. The therapist's main aim was to concentrate on building a therapeutic relationship.

### **Course of session**

Sammy was very eager in participating in the conversations with the therapist. Clay was handed out with no instructions. The therapist aimed to encourage dialogue through a non-threatening activity. Roles, expectations and the course of future sessions were discussed. Through the clay activity the therapist gained some information regarding likes and dislikes of Sammy. This is valuable information in planning future sessions and also to understand her process. Within this first session it was clear that Sammy's disability tends to be a big issue in her life, although she can walk with crutches and has most of her functioning in control. One thing that was mostly on her foreground was her relationship with her father. Her mother died 3 years ago, and left behind Sammy, her brother and father. She explained how she looks exactly like her mother, and how that influences her relationship with her dad. She seems very mature and aware regarding the reasons why her father doesn't often speak about her mom, or even visit her grave.

According to the information gained, the therapist realised that there is a huge need for Sammy to feel safe and needed within her environment – school or home. The therapist suggested that Sammy think of her “place of safety”. This is a place where she can go to – physically or fantasize about being there. There she can escape from her environment, or whatever unpleasant feelings she experiences. For Sammy, her place of safety was on a hill with lots of clouds and beautiful flowers – next to her mother's grave.

### **Evaluation**

Sammy presented as a strong, though needy young girl. She is prone to negative thoughts about herself and her life. There is still a lot of unfinished business regarding her mother's death and the circumstances at home. The relationship between the therapist and Sammy was already strong within this first session. Even

though it is still in the early stages of the therapeutic process, there is an indication that Sammy is willing to trust the therapist.

## 2. Second Session

- Form of play: Creative play
- Medium of play: Writing (unfinished sentences)
- Goal of therapeutic session: Through this session the therapist aims to gain information through the use of unfinished sentences. Attention will still be given to creating a positive and safe therapeutic environment. The therapist kept in mind the basic principles of play therapy, as discussed in chapter 3 point 3.3.

### Course of session

The therapist will first give a summary of the unfinished sentences and Sammy's feedback, before giving a short discussion on the information gained. The option was given that Sammy only needs to fill in those sentences she chooses to fill in.

Table 4.1: Unfinished Sentences: Sammy

I like...	Singing, dancing, eating, to sometimes be alone.
My saddest moment...	Was when my mom died.
I feel...	Unhappy most of the time.
When I'm in my bed at night...	I often think how things would have been if my mom was still here.
I really want to...	Use my talents to go far in life.
If I can afford it...	I will decorate and make my mother's grave look beautiful.
I can't stand...	People fighting and swearing at each other.
My dad...	Is often very hard, but also soft and I can always rely on him.
My biggest fear is...	That my dad would lose my brother and me.
My future...	Is sometimes dark, because I don't have my mom around.
When I was younger...	I was very happy and life was good when my mom was still here.
I will never forget...	How happy I was when I was younger.
Sometimes I wonder...	Why I'm in this situation.
I enjoy...	Life – sometimes.
I hate...	My disability.

I am...	A loving and caring person.
The only obstacle is...	My future.
I wish...	I can be a star.
I decided to...	Only think about things that are good.
There is nothing that...	Can bring me down.
Unfortunately there is...	My disability.
Most boys...	Make me feel like their sisters.
My biggest dream is...	To be a singer and to have my own family.

## Evaluation

With reference to the above information and the discussion with Sammy, the therapist was made aware of the 2 biggest issues in her life at the moment. **Firstly**, she still misses her mother and indicated a need for her to visit her grave often and to put flowers on when it is her birthday, Christmas or wedding anniversary. It is hard for Sammy to deal with it when she needs to go and visit the grave and her dad refuses to go immediately. According to her, he always has an excuse. She was able to identify with all the emotions regarding the above, and a discussion around ways to handle this situation took place. It was suggested that Sammy confronts her dad with the fact that she still needs to visit her mom's grave often and that she feels sad and angry when he refuses to take her there. The fact that Sammy realised that this was a possibility empowered her and gave her the courage to stand up for what she feels. This opened up her perspective of what the reasons might be for her dad to refuse to visit the grave or to talk about her mother. It was also suggested that she writes a letter to her mom, which – if she chooses to – she can either keep in a private place, or read it to her when she visits her grave. The fact that she still misses her mom and often cries about her not being in her life anymore, created an opportunity for the therapist to make Sammy realise that this was “ok” and that she is allowed to feel that way. A discussion around the mourning process took place.

**Secondly**, her disability creates barriers and brings feelings of uncertainty to the foreground. Although she realises that she has a lot of strengths and talent, she still feels held back in life, because of her disability. Discussions regarding her strengths took place, and it resulted in Sammy being more aware of the positive and creative characteristics she has. More time was spent on this during the next sessions.

It is evident that the therapeutic environment and relationship between Sammy and the therapist, is creating a safe and encouraging atmosphere for sharing and opening up.

### 3. Third Session

- Form of play: Creative play
- Medium of play: Writing (complete assessment questions)
- Goal of therapeutic session: The therapist aimed to concentrate on the disability (Spina Bifida), the effect it has on Sammy, her perspective of the disability, as well as her coping skills.

#### **Course of session**

During this session time was spent on an explanation regarding the following:

- The nature of Spina Bifida according to the literature in chapter 2 point 2.2.

Sammy wasn't completely informed, nor did she have the correct knowledge regarding the nature of her disability. According to the therapist it is very important for Sammy to fully understand her disability, to prevent any uncertainty and possible feelings of guilt.

- Secondary conditions associated with Spina Bifida according to the literature in chapter 2 point 2.3.

A discussion regarding Sammy's academic progress took place. She indicated that she struggles with some subjects, especially maths and languages. By using the literature, the therapist explained that this was one of the secondary conditions associated with Spina Bifida. Sammy's feelings regarding her struggle with these subjects were acknowledged. The therapist again made her aware of her strengths,

and the importance of focusing on that. It was suggested to perhaps look at an alternative subject or activity like computer skills, instead of maths.

- Treatment and prevention of Spina Bifida according to the literature in chapter 2 point 2.6 and 2.7.

As Sammy indicated some feelings of guilt regarding her having Spina Bifida, a discussion took place about what causes this disability and how to prevent it. This was a big relief for her to realise that she had nothing to do with the fact that she has Spina Bifida.

- Awareness of needs, limitations and goals.

The therapist again concentrated on working in polarities. This guided Sammy to become aware of her limitations, but also of what she can do and achieve.

The therapist used the following areas of assessment, as discussed in chapter 2 Table 2.3, to gain more information regarding Sammy’s disability and her coping skills.

Table 4.2: Areas of Assessment and Planning: Sammy

<b>Activities of Daily Living</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What self-care skills (such as for personal hygiene and dressing) does the young person have?</li> <li>• What might be learned?</li> <li>• What supports and resources are available?</li> <li>• What housekeeping skills does the young person have for meal planning; shopping and cooking; keeping the living quarters clean and maintained; cleaning and maintaining clothing; and dealing with emergencies?</li> <li>• For what activities does the person need help during the day?</li> <li>• What resources are available to provide this help and how might they be funded?</li> </ul>	<ul style="list-style-type: none"> <li>• Able to look after herself – can dress and care for herself.</li> <li>• Would like to learn how to cook.</li> <li>• Her dad and her brother.</li> <li>• She can cope with housekeeping and cooking, but needs assistance in going out (shops). In case of emergencies she would call her dad, brother, uncle or the police if none of the above can be reached.</li> <li>• Can cope independently with most activities.</li> <li>• Again she can depend on her family.</li> </ul>
<b>Mobility</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What ability does the person have to walk or</li> </ul>	<ul style="list-style-type: none"> <li>• Learner is mobile on crutches and does not</li> </ul>

<p>roll within all parts of buildings used for daily activities and between buildings?</p> <ul style="list-style-type: none"> <li>• Are buildings that the person wishes to enter for education, employment and recreation accessible?</li> <li>• What adaptations might reasonably be made?</li> </ul>	<p>have any mobility problems. She can use stairs, even if it takes her longer.</p>
<p><b>Transportation</b></p>	<p><b>Learner feedback</b></p>
<ul style="list-style-type: none"> <li>• What abilities does the person have to access public transportation, special transportation options in the community?</li> <li>• Is the person able to access and complete driver's education to become a licensed driver?</li> <li>• What vehicle adaptations would be required?</li> <li>• What adaptation services are available in the person's community?</li> <li>• How can they be funded?</li> </ul>	<ul style="list-style-type: none"> <li>• Transportation is easily accessible and she will cope with using any transportation within her community.</li> <li>• Yes</li> <li>• Would have to have an automatic car.</li> <li>• None are required.</li> </ul>
<p><b>Health Care</b></p>	<p><b>Learner feedback</b></p>
<ul style="list-style-type: none"> <li>• What does the young person know about the disabilities?</li> <li>• What skills does she have and/or need to learn to monitor physical and/or psychological conditions?</li> <li>• Does she participate in therapies and administer own medications with knowledge of regimen and side effects?</li> <li>• Does the person communicate with health care providers?</li> <li>• What supports would assist the person to do these things, such as educational programs, assistive technology, equipment, supplies, therapies, personal attendants, public health nursing and/or home nursing assistance?</li> <li>• Where are these available, and how can they be funded?</li> <li>• What is the person's source of primary care for general health monitoring and education such as normal development, immunizations, diet, exercise, substance use and abuse, risk taking behaviours and safety issues, and sexuality education and supports?</li> <li>• Does the person receive regular dental care?</li> </ul>	<ul style="list-style-type: none"> <li>• More informed after previous discussion.</li> <li>• Fully aware of her needs and condition.</li> <li>• Only requires physiotherapy occasionally and needs to get a check-up from the doctor. Able to organize the above independently.</li> <li>• Yes</li> <li>• Functions independently</li> <li>• Services available in community – receives grant to pay for these services when needed.</li> <li>• Fully aware – visits doctor for check-up when needed.</li> <li>• When needed.</li> </ul>
<p><b>Living Arrangements</b></p>	<p><b>Learner feedback</b></p>
<ul style="list-style-type: none"> <li>• Where does the young person wish to live –</li> </ul>	<ul style="list-style-type: none"> <li>• House</li> </ul>

<p>apartment, house, dorm, city, country?</p> <ul style="list-style-type: none"> <li>• With whom will the young person live – family, friends, independently, supported living?</li> <li>• What are the options in the person’s community?</li> <li>• Where is the best place to live to be able to go to school, work and participate in the community?</li> <li>• What is needed to live more independently – housekeeping skills, transportation, and personal assistance?</li> <li>• Is help available to learn these?</li> <li>• What are the effects of decisions about living arrangement on the family?</li> </ul>	<ul style="list-style-type: none"> <li>• Family</li> <li>• Lot of options – organisations and workshops.</li> <li>• Current place is suitable.</li> <li>• Transportation when old enough to get.</li> <li>• Yes</li> <li>• Family accepts and supports fully.</li> </ul>
<b>Housing</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What adaptations such as ramps, railings, wider doorways, bathroom configuration, and kitchen adaptations are needed to support independence?</li> <li>• What home maintenance skills does the person have or can she learn and what help is available?</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> <li>• Can do what is needed – if requires help, brother or father can assist.</li> </ul>
<b>Recreation and Leisure</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What does the person like to do for fun and physical and mental fitness?</li> <li>• What skills does he have?</li> <li>• What is available in the community for sports, shopping, watching or viewing, visiting?</li> <li>• What things would the person like to learn to do and what might be available in the community to assist in learning?</li> </ul>	<ul style="list-style-type: none"> <li>• Spending time with friends and singing.</li> <li>• Good singing and communication skills.</li> <li>• Lots of options available as well as accessibility.</li> <li>• Learn to drive when old enough – community does have resources available.</li> </ul>

## Evaluation

It is evident that Sammy has the skills to function independently most of the time. The only setback is her feelings around her disability. Although she copes quite well, there are times that she struggles to accept the fact that she can’t use her lower limbs in the way that all other people can. The therapist focused on all the positive aspects

of Sammy and guided her to become more aware of it. The therapeutic relationship is strong and interaction relaxed and non-threatening.

#### **4. Fourth Session**

- Form of play: Creative play
- Medium of play: Drawing
- Goal of therapeutic session: By using this projection technique, drawing a monster, as discussed in chapter 3 point 3.3.1.3, the therapist aimed to determine what the monster in Sammy's life is and how she can overcome or deal with that monster.

#### **Course of session**

Sammy was very eager, as always, to come to the session and participate in the activities. The relationship between the therapist and Sammy seems to be very strong, which leads to trust and willingness to share.

Sammy was given a piece of paper and asked to identify and draw the monster in her life. She drew the school/hostel. A discussion regarding the following took place:

\* For how long has the monster existed?

S: For 9 years.

\* Are there other people who know about the monster?

S: Only a few other people.

\* Is there something about the monster that scares her?

S: Yes, the fact that I need to stay another year.

\* Is she prepared to have the monster in her life and live with it?

S: No, I hope not.

\* Can she name her monster?

S: The jail of disabled people.

\* How old was she when she got the monster?

S: 6 years.

\* Ask her to talk to the monster.

S: Please let me go.

## **Evaluation**

Through this projection Sammy indicated her emotions and perceptions regarding the school. The latter was acknowledged, while time and opportunity was given to name and work through those emotions. As indicated above, Sammy doesn't want to stay another year to finish her gr. 9, but after a discussion she came to the decision to stay and to be "OK" with it. This alternative created a huge sense of empowerment. Sammy's attitude towards the school switched from negative to positive, and the fact that she made that choice on her own, made her very proud.

## **5. Fifth Session**

- Form of play: Creative Play
- Medium of play: Drawing
- Goal of therapeutic session: By using this projection technique, pretending to be a rosebush, as discussed in chapter 3 point 3.3.1.3, the therapist aimed to determine how Sammy sees herself and how she functions (as an individual, but also within her environment).

## **Course of session**

With this technique Sammy must pretend to be a rosebush. She was given a piece of paper and asked to draw a rosebush. The following points were considered and discussed:

\*Type of rosebush – strong or weak?

S: Weak

\*Root system – deep or shallow?

S: Deep

\*Number of thorns – too many or too few?

S: Has too many thorns.

\*Environment – bad or good for growing?

S: Environment is not good for growing.

\*Does your rosebush stand out?

S: Yes

\*Does it have enough room?

S: No

\*How does it get along with the other plants?

S: Yes, very good.

\*Does it have a good future?

S: Depends on all the bad things around the rose.

\*Which of the above aspects can be applied to Sammy's own life?

S: According to Sammy the rose is almost similar to her own life and experiences. Just as the rose she sees herself as a weak person, because of her disability. Her root system refers to her support network, which is her father in most cases. As discussed in previous sessions, she doesn't always feel that her father is there for her when she needs him to be. She indicated lots of thorns on her rosebush, and in her life she sees her mother's death and her disability as thorns hurting her all the time. According to her, her environment that refers to the school, tends not to be good for her (as discussed and indicated through the monster technique in previous session). Although Sammy indicates mostly negative similarities with her rosebush, she does believe that she stands out among other learners and her friends. She also indicated that she still needs a lot of room to grow, and that her future depends on the bad or good things that lie ahead.

## **Evaluation**

Through this projection Sammy indicated how she sees herself and how she functions (as an individual, but also within her environment). The latter was discussed, while time and opportunity were given to work through emotions and perceptions. For Sammy it was empowering to be aware of all the negative points in her life, but to also realise her strengths and good points.

## **6. Sixth Session**

- Goal of therapeutic session: Termination of the therapeutic process.

### **Course of session**

During the last session, the therapist focused on the termination of the therapy process. The session took place outside the therapy room – in a sunroom – where the therapist and Sammy shared something small to eat.

Sammy indicated that she learned a lot throughout the therapeutic process. She became more aware of her strengths, but also learned a lot about her disability and her limitations. She experienced the therapy as positive and a big help in dealing with a lot of unfinished business. She felt empowered and positive regarding her future.

### **Evaluation**

For the therapist it was important to empower and facilitate Sammy to fully understand her disability, and to create a sense of self-worthiness and control. Although Sammy felt empowered and had more courage to face whatever difficulties she still experiences, she requested that therapy sessions must continue. The researcher is of opinion that Sammy will need support and guidance for a longer time frame than only 6 sessions. Academic barriers will continue to affect her overall functioning within the school environment. It will be beneficial for her if her teachers could adapt her academic programme. Sammy has a beautiful singing talent, and it is suggested for her teachers to incorporate this into her school programme. This will not only empower her, but will increase her sense of self-worth that is an important step in the healing process. Sammy was able to quickly move from the phoney layer (as discussed in chapter 3 point 3.2.6) to the explosive layer. Although the therapist did not mention sensory modalities within session discussions, attention was given to various ways of making sure that Sammy was sensory intact.

#### 4.3.4.2 Case Study 2

##### (a) Biographical information:

Name:	Harry
Date of birth:	1987-10-22
Age:	16
Gender:	Male
Address:	Mitchell's Plain
Home language:	English
Number of children in family:	2

##### (b) Therapeutic Intervention:

#### 1. First Session

- Form of play: Creative play
- Medium of play: Clay work
- Goal of therapeutic session: The goal of the first session was to meet Harry - to introduce the therapist and therapeutic room in an informal and relaxed manner. The therapist's main aim was to concentrate on building a therapeutic relationship.

#### Course of session

Harry was, although quiet and reserved, very eager to participate in the conversations with the therapist. The therapist aimed to encourage dialogue through a non-threatening activity and decided to hand out clay with no instructions. Harry made several objects out of the clay, which he enjoyed a lot. He mentioned the fact that he liked the feeling of the clay in his hands. Attention was given to sensory modalities. Through the clay activity the therapist gained some information regarding likes and dislikes of Harry. This is valuable information in planning future sessions and also to understand his process. During this first session Harry indicated that his disability is

an issue in his life, although he can walk with crutches and has most of his functioning in control. According to the information gained, the therapist realised that although Harry functions independently in most areas of his life, there is still a need to feel safe and accepted within his environment – school or home. The therapist suggested that Harry think of his “place of safety”. This is a place where he can go to – physically or fantasize about being there. There he can escape from his environment, or whatever unpleasant feelings he experiences. For Harry, his place of safety was away from everybody without any disturbances or reminders of his disability. Roles, expectations and the course of future sessions were also discussed.

## **Evaluation**

Harry presented as a quiet but strong young man. He is sometimes prone to negative thoughts about himself, because of his disability. The relationship between the therapist and Harry was relaxed and comfortable within this first session.

## **2. Second Session**

- Form of play: Creative play
- Medium of play: Writing (unfinished sentences)
- Goal of therapeutic session: Through this session the therapist aims to gain information through the use of unfinished sentences. Attention will still be given to creating a positive and safe therapeutic environment. The therapist kept in mind the basic principles of play therapy, as discussed in chapter 3 point 3.3.

## **Course of session**

Before the researcher gives a short discussion on the information gained through the unfinished sentences, in Table 4.3 a summary of the unfinished sentences and Harry’s feedback is presented. The option was given that Harry only needs to fill in the sentences of his choice.

Table 4.3: Unfinished Sentences: Harry

I like...	To meet people.
Even my best friend told me...	That I can achieve anything I want to do.
I feel...	Sometimes unhappy when I wonder why I am disabled.
When I'm in my bed at night...	I often think about things I've done throughout the day.
I really want to...	Achieve all the goals I've set for myself.
If I can afford it...	I will make myself "normal". I would give money for charity.
I can't stand...	People who think they are better than other people.
Sometimes I imagine....	That I'm an actor – that life is a movie.
My biggest fear is...	What the future holds for me.
I cannot afford...	That my disability holds me back in life.
When I was younger...	I imagined I was Superman.
I will never forget...	How I grew up.
Sometimes I wonder...	What people think of me?
I enjoy...	To hang out with my friends.
I hate...	When people push disabled people away.
I am...	Sometimes in a "funny" mood.
The only obstacle is...	Myself
I wish...	I can travel all over the world one day.
I decided to...	Make my dreams come true.
There is nothing that...	Can make me feel so good, as when people say something nice about me.
My biggest dream is...	To have my own car and family one day.

## Evaluation

With reference to the above information and the discussion with Harry, the therapist was made aware that there is a need for Harry to get closure regarding his disability. He had a lot of unfinished business regarding the latter. He was able to identify with all the emotions regarding the above, and a discussion around ways to handle and address this need took place. It was suggested that Harry communicate his uncertainties to his parents. There was an indication that the relationship within their family would allow this conversation. He was very unsure of how they see him and how they feel about him, and the fact that they need to be stuck with a disabled child. The fact that Harry realised that addressing the above was a possibility, empowered him and gave him the courage to share what is on his mind. This opened up his

perspective of what the reasons might be for him to have these perceptions regarding his family.

His disability creates barriers and brings feelings of uncertainty to the foreground and although he realises that he has a lot of strengths and talent, he still feels held back in life, because of his disability. He indicated how lucky other abled learners are, and how many opportunities they have in comparison to disabled learners. Discussions regarding his strengths took place, and it resulted in Harry being more aware of the positive and creative characteristics that he has. More time will be spent on this during the next sessions. The therapeutic environment and the relationship between Harry and the therapist, are creating a safe and encouraging atmosphere for sharing and opening up.

### **3. Third Session**

- Form of play: Creative play
- Medium of play: Writing (complete assessment questions)
- Goal of therapeutic session: The therapist aimed to concentrate on the disability (Spina Bifida), the effect it has on Harry, his perspective of the disability as well as his coping skills.

#### **Course of session**

During this session time was spend on an explanation regarding the following:

- The nature of Spina Bifida according to the literature in chapter 2 point 2.2.

Harry wasn't completely informed, nor did he have the correct knowledge regarding the nature of his disability. According to the therapist it is very important for Harry to fully understand his disability, to prevent any uncertainty and possible feelings of guilt.

- Secondary conditions associated with Spina Bifida according to the literature in chapter 2 point 2.3.

A discussion regarding Harry’s academic progress took place. He indicated that he sometimes struggles with languages. By using the literature, the therapist explained that this was one of the secondary conditions associated with Spina Bifida. Harry’s feelings regarding his struggle with these subjects were acknowledged. The therapist again made him aware of his strengths, and the importance of focusing on that. It was suggested to perhaps look at an extra period and programme to assist him with his needs regarding his academic work.

- Treatment and prevention of Spina Bifida according to the literature in chapter 2 point 2.6 and 2.7.

As Harry indicated some feelings of guilt regarding him having Spina Bifida, a discussion took place about what causes this disability and how to prevent it. This was a big relief for him to realise that he had nothing to do with the fact that he has Spina Bifida.

- Awareness of needs, limitations and goals.

The therapist again concentrated on working in polarities. This guided Harry to become aware of his limitations, but also of what he can do and achieve.

The therapist used the following areas of assessment, as discussed in chapter 2 Table 2.3, to gain more information regarding Harry’s disability and his coping skills.

Table 4.4: Areas of Assessment and Planning: Harry

Activities of Daily Living	Learner feedback
<ul style="list-style-type: none"> <li>• What self-care skills (such as for personal hygiene and dressing) does the young person have?</li> <li>• What might be learned?</li> <li>• What supports and resources are available?</li> <li>• What housekeeping skills does the young</li> </ul>	<ul style="list-style-type: none"> <li>• Able to look after himself – can dress and care for himself.</li> <li>• Would like to learn how to cook.</li> <li>• His family and the neighbours.</li> <li>• He would depend on his family and friends to</li> </ul>

<p>person have for meal planning; shopping and cooking; keeping the living quarters clean and maintained; cleaning and maintaining clothing; and dealing with emergencies?</p> <ul style="list-style-type: none"> <li>• For what activities does the person need help during the day?</li> <li>• What resources are available to provide this help and how might they be funded?</li> </ul>	<p>assist him in gaining these skills. In case of emergencies he would call his parents, the neighbours or the police if none of the above can be reached.</p> <ul style="list-style-type: none"> <li>• Can cope in his own manner, but will need some support in making him more equipped to function more independently.</li> <li>• Again he can depend on his family.</li> </ul>
<b>Mobility</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What ability does the person have to walk or roll within all parts of buildings used for daily activities and between buildings?</li> <li>• Are buildings that the person wishes to enter for education, employment and recreation accessible?</li> <li>• What adaptations might reasonably be made?</li> </ul>	<ul style="list-style-type: none"> <li>• Learner is mobile in crutches and does not have any mobility problems. He can use stairs, even if it takes him longer.</li> </ul>
<b>Transportation</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What abilities does the person have to access public transportation, special transportation options in the community?</li> <li>• Is the person able to access and complete driver's education to become a licensed driver?</li> <li>• What vehicle adaptations would be required?</li> <li>• What adaptation services are available in the person's community?</li> </ul>	<ul style="list-style-type: none"> <li>• Transportation is easy accessible and he will cope with using any transportation within his community.</li> <li>• Yes</li> <li>• Would have to have an automatic car.</li> <li>• None are required.</li> </ul>
<b>Health Care</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What does the young person know about the disabilities?</li> <li>• What skills does he have and/or need to learn to monitor physical and/or psychological conditions?</li> <li>• Does he participate in therapies and administer own medications with knowledge of regimen and side effects?</li> <li>• Does the person communicate with health care providers?</li> <li>• What supports would assist the person to do these things, such as educational programs, assistive technology, equipment, supplies, therapies, personal attendants, public health nursing and/or home nursing assistance?</li> </ul>	<ul style="list-style-type: none"> <li>• More informed after previous discussion.</li> <li>• Fully aware of his needs and condition.</li> <li>• Only requires physiotherapy occasionally and needs to get a check-up from the doctor. Able to organize the above independently.</li> <li>• Yes</li> <li>• Functions independently</li> </ul>

<ul style="list-style-type: none"> <li>• Where are these available, and how can they be funded?</li> <li>• What is the person’s source of primary care for general health monitoring and education such as normal development, immunizations, diet, exercise, substance use and abuse, risk taking behaviours and safety issues, and sexuality education and supports?</li> <li>• Does the person receive regular dental care?</li> </ul>	<ul style="list-style-type: none"> <li>• Services available in community – receives grant to pay for these services when needed.</li> <li>• Fully aware – visits doctor for check-up when needed.</li> <li>• When needed.</li> </ul>
<b>Living Arrangements</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• Where does the young person wish to live – apartment, house, dorm, city, country?</li> <li>• With whom will the young person live – family, friends, independently, supported living?</li> <li>• What are the options in the person’s community?</li> <li>• Where is the best place to live to be able to go to school, work and participate in the community?</li> <li>• What is needed to live more independently – housekeeping skills, transportation, and personal assistance?</li> <li>• Is help available to learn these?</li> <li>• What are the effects of decisions about living arrangement on the family?</li> </ul>	<ul style="list-style-type: none"> <li>• House</li> <li>• Family</li> <li>• Lot of options – organisations and workshops.</li> <li>• Current place is suitable.</li> <li>• Transportation when old enough to get.</li> <li>• Yes</li> <li>• Family accepts and supports fully.</li> </ul>
<b>Housing</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What adaptations such as ramps, railings, wider doorways, bathroom configuration, and kitchen adaptations are needed to support independence?</li> <li>• What home maintenance skills does the person have or can he learn and what help is available?</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> <li>• Can do what is needed – if requires help, family can assist.</li> </ul>
<b>Recreation and Leisure</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What does the person like to do for fun and physical and mental fitness?</li> <li>• What skills does he have?</li> <li>• What is available in the community for sports, shopping, watching or viewing, visiting?</li> <li>• What things would the person like to learn to do and what might be available in the community to assist in learning?</li> </ul>	<ul style="list-style-type: none"> <li>• Spending time with friends and singing.</li> <li>• Good communication skills.</li> <li>• Lots of options available as well as accessibility.</li> <li>• Learn to drive when old enough – community does have resources available.</li> </ul>

## **Evaluation**

It is evident that Harry has the skills to function independently most of the time. The only setback is his feelings around his disability. Although he copes quite well with most things, there are times that he struggles to accept the fact that he must always make use of his crutches to move around. His emotions regarding the latter were acknowledged and the therapist guided Harry to focus on all the positive aspects to become more aware of it. The therapeutic relationship is strong and interaction relaxed and non-threatening.

### **4. Fourth Session**

- Form of play: Creative play
- Medium of play: Drawing
- Goal of therapeutic session: By using this projection technique, drawing a monster, as discussed in chapter 3 point 3.3.1.3, the therapist aimed to determine what the monster in Harry's life is and how he can overcome or deal with that monster.

### **Course of session**

Harry was given a piece of paper and asked to identify and draw the monster in his life. He drew himself in a wheelchair. A discussion regarding the following took place:

\* For how long has the monster existed?

H: My whole life.

\* Are there other people who know about the monster?

H: Perhaps.

\* Is there something about the monster that scares him?

H: Yes, everything.

\* Is he prepared to have the monster in his life and live with it?

H: No.

\* Can he name his monster?

H: Being cripple.

\* How old was he when he got the monster?

H: Since birth.

\* Ask him to talk to the monster.

H: You mess up my life.

## **Evaluation**

Through this projection Harry indicated his emotions and perceptions regarding his interpretation of his disability. Time and opportunity were given to name and work through those emotions. As indicated above, Harry struggles to accept his disability. A discussion around altering his thoughts about himself took place. This alternative interpretation option created some sense of empowerment. Harry's attitude towards himself and his environment created a sense of self for him.

## **5. Fifth Session**

- Form of play: Creative Play
- Medium of play: Drawing
- Goal of therapeutic session: By using this projection technique, pretending to be a rosebush, as discussed in chapter 3 point 3.3.1.3, the therapist aimed to determine how Harry sees himself and how he functions (as an individual, but also within his environment).

## **Course of session**

Harry was given a piece of paper and asked to draw a rosebush. The following points were considered and discussed:

\*Type of rosebush – strong or weak?

H: Strong

\*Root system – deep or shallow?

H: Deep

\*Number of thorns – too many or too few?

H: Has too many thorns.

\*Environment – bad or good for growing?

H: Environment is good for growing.

\*Does your rosebush stand out?

H: Yes

\*Does it have enough room?

H: No

\*How does it get along with the other plants?

H: Yes, very good.

\*Does it have a good future?

H: Yes.

\*Which of the above aspects can be applied to the Harry's own life?

H: According to Harry the rose is almost similar to his own life and experiences. Just as the rose he sees himself as a strong person, even though he is disabled. His root system refers to his support network, which is his family and friends. He indicated lots of thorns on his rosebush, and in his life he sees his disability as thorns hurting him all the time. According to him, his environment allows him to grow and be the person he strives to be. It is only the fact that he is disabled that puts him down sometimes (as discussed and indicated through the monster technique in previous session). He also indicated that he still needs a lot of room to grow, and that he would really work hard to achieve his goals in life.

## **Evaluation**

Through this projection Harry indicated how he sees himself and how he functions (as an individual, but also within his environment). Time and opportunity were given to work through emotions and perceptions. For the first time Harry realised the importance of believing in himself and to not sometimes hide behind his disability. He made a definite choice not to use this as an excuse, and to really work hard to not allow anything or anyone to put him back in life.

## 6. Sixth Session

- Goal of therapeutic session: Termination of the therapeutic process.

### **Course of session**

The therapist focused on the termination of the therapy process. A relaxing and informal atmosphere was created by having the session outside the therapy room – in a sunroom – where the therapist and Harry shared lunch.

Harry indicated that he learned a lot about himself, but also about his negative perceptions that often create a sense of helplessness. His awareness of his strengths made him realise that although he is disabled physically, he is still a human being like everyone else.

### **Evaluation**

Initially it was very difficult for Harry to realise how he often hides behind his disability. In Harry's case, it was important to allow some resistance within the first sessions. He had a lot of unfinished business regarding his aim in life, and most importantly within the school environment. With Harry the use of polarities (as discussed in chapter 3 point 3.2.5), was very effective. He also realised his responsibility towards himself and his happiness. The therapist is of opinion that for Harry, 6 sessions did not allow enough time to work through all the uncertainties and unfinished business. Harry also requested more sessions to guide and help him in this growing and healing process.

### **4.3.4.3 Case Study 3**

#### **(a) Biographical information:**

Name:	Eddie
Date of birth:	1990-04-21
Age:	14

Gender: Male  
Address: Mitchell's Plain  
Home language: English  
Number of children in family: 3

## **(b) Therapeutic Intervention:**

### **1. First Session**

- Form of play: Creative play
- Medium of play: Clay work
- Goal of therapeutic session: The goal of the first session was to meet Eddie - to introduce the therapist and therapeutic room in an informal and relaxed manner. The therapist's main aim was to concentrate on building a therapeutic relationship.

### **Course of session**

Eddie was quiet, shy, friendly and indicated some eagerness to participate, but also some sense of resistance. In order to encourage dialogue through a non-threatening activity, the therapist handed some clay to Eddie, while the roles, expectations and the course of future sessions were discussed. Eddie indicated that his disability creates some negative thoughts about himself, although he is fortunate to walk without any appliances. Eddie seems to function independently in most areas of his life, but he desires to feel safe, accepted and loved in spite of his disability. The therapist suggested that Eddie think of his "place of safety". This is a place where he can go to – physically or fantasize about being there. There he can escape from his environment, or whatever unpleasant feelings he experiences. For Eddie, his place of safety was away from anybody – playing soccer or any other activity he feels like – just to escape from his surroundings.

## Evaluation

Eddie presented as a quiet and shy young man. He is sometimes prone to negative thoughts about himself, because of his disability and the way his family treats him. Although people see him as independent and fortunate not to need any appliances to walk with, he experiences a desire to be loved and cared for by others. The therapy sessions created an atmosphere for Eddie to work through and understand all the unfinished business in his life.

## 2. Second Session

- Form of play: Creative play
- Medium of play: Writing (unfinished sentences)
- Goal of therapeutic session: Through this session the therapist aims to gain information through the use of unfinished sentences. Attention will still be given to creating a positive and safe therapeutic environment. The therapist kept in mind the basic principles of play therapy, as discussed in chapter 3 point 3.3.

## Course of session

The instruction was given to Eddie to complete some unfinished sentences. He could choose how many and which sentences he would like to complete. The therapist will first give a summary of the unfinished sentences and Eddie's feedback, before giving a short discussion on the information gained.

Table 4.5: Unfinished Sentences: Eddie

I like...	Basket ball.
I feel...	Happy to be here and to talk to the therapist.
I can't stand...	It when my mom makes me angry.
Sometimes I wonder...	What people think of me and how they see me
I wish...	I can have my own TV.

## **Evaluation**

With reference to the above information and the discussion with Eddie, the therapist was made aware that there is a need for Eddie to be given the opportunity to talk about his disability and to understand it. He had a lot of unfinished business regarding the latter. He was able to identify with all the emotions regarding the above and a discussion around ways to handle and address this need took place. It was suggested that Eddie communicate his uncertainties with his family. There was an indication that the relationship within their family would not allow this conversation. He was very unsure of how they see him and how they feel about him, and the fact that they need to be stuck with a disabled child. The fact that Eddie realised that there could be a possibility to discuss his concerns with his family, empowered him and gave him the courage to share what is on his mind. This opened up his perspective of what the reasons might be for him to have these feelings regarding his family.

His disability creates barriers and brings feelings of uncertainty to the foreground and although he realises that he has a lot of strengths and talent, he still feels held back in life, because of his disability. Discussions regarding his strengths took place, and it resulted in Eddie being more aware of the positive and creative characteristics he has. It is evident that the therapeutic environment and relationship between Eddie and the therapist, is creating a safe and encouraging atmosphere for sharing and opening up.

### **3. Third Session**

- Form of play: Creative play
- Medium of play: Writing (complete assessment questions)
- Goal of therapeutic session: The therapist aimed to concentrate on the disability (Spina Bifida), the effect it has on Eddie, his perspective of the disability as well as his coping skills.

## **Course of session**

During this session time was spend on an explanation regarding the following:

- The nature of Spina Bifida according to the literature in chapter 2 point 2.2.

Eddie wasn't completely informed, nor did he have the correct knowledge regarding the nature of his disability. According to the therapist it is very important for Eddie to fully understand his disability, to prevent any uncertainty and possible feelings of guilt.

- Secondary conditions associated with Spina Bifida according to the literature in chapter 2 point 2.3.

A discussion regarding Eddie's academic progress took place. He indicated that he really struggles with writing, reading and understanding languages. By using the literature, the therapist explained that this was one of the secondary conditions associated with Spina Bifida. Eddie's feelings regarding his struggle with the latter were acknowledged. The therapist again made him aware of his strengths, and the importance of focusing on that. It was suggested to perhaps look at an extra period and programme to assist him with his needs regarding his academic work.

- Treatment and prevention of Spina Bifida according to the literature in chapter 2 point 2.6 and 2.7.

As Eddie indicated some feelings of guilt regarding him having Spina Bifida, a discussion took place about what causes this disability and how to prevent it. This was a big relief for him to realise that he had nothing to do with the fact that he has Spina Bifida.

- Awareness of needs, limitations and goals.

The therapist again concentrated on working in polarities. This guided Eddie to become aware of his limitations, but also of what he can do and achieve.

The therapist used the following areas of assessment, as discussed in chapter 2 Table 2.3, to gain more information regarding Eddie’s disability and his coping skills.

Table 4.6: Areas of Assessment and Planning: Eddie

<b>Activities of Daily Living</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What self-care skills (such as for personal hygiene and dressing) does the young person have?</li> <li>• What might be learned?</li> <li>• What supports and resources are available?</li> <li>• What housekeeping skills does the young person have for meal planning; shopping and cooking; keeping the living quarters clean and maintained; cleaning and maintaining clothing; and dealing with emergencies?</li> <li>• For what activities does the person need help during the day?</li> <li>• What resources are available to provide this help and how might they be funded?</li> </ul>	<ul style="list-style-type: none"> <li>• Able to look after himself – can dress and care for himself.</li> <li>• Would like to learn how to cook.</li> <li>• His family and the neighbours.</li> <li>• He would depend on his family and friends to assist him in gaining these skills. In case of emergencies he would call his parents, other family members, the neighbours or the police if none of the above can be reached.</li> <li>• Can cope in his own manner.</li> <li>• Again he can depend on his family.</li> </ul>
<b>Mobility</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What ability does the person have to walk or roll within all parts of buildings used for daily activities and between buildings?</li> <li>• Are buildings that the person wishes to enter for education, employment and recreation accessible?</li> <li>• What adaptations might reasonably be made?</li> </ul>	<ul style="list-style-type: none"> <li>• Learner is fully mobile and does not have any mobility problems. He can use stairs, even if it takes him longer.</li> </ul>
<b>Transportation</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What abilities does the person have to access public transportation, special transportation options in the community?</li> <li>• Is the person able to access and complete driver’s education to become a licensed driver?</li> <li>• What vehicle adaptations would be required?</li> <li>• What adaptation services are available in the person’s community?</li> </ul>	<ul style="list-style-type: none"> <li>• Transportation is easy accessible and he will cope with using any transportation within his community.</li> <li>• Yes</li> <li>• Would have to have an automatic car.</li> <li>• None are required.</li> </ul>

<b>Health Care</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What does the young person know about the disabilities?</li> <li>• What skills does he have and/or need to learn to monitor physical and/or psychological conditions?</li> <li>• Does she participate in therapies and administer own medications with knowledge of regimen and side effects?</li> <li>• Does the person communicate with health care providers?</li> <li>• What supports would assist the person to do these things, such as educational programs, assistive technology, equipment, supplies, therapies, personal attendants, public health nursing and/or home nursing assistance?</li> <li>• Where are these available, and how can they be funded?</li> <li>• What is the person's source of primary care for general health monitoring and education such as normal development, immunizations, diet, exercise, substance use and abuse, risk taking behaviours and safety issues, and sexuality education and supports?</li> <li>• Does the person receive regular dental care?</li> </ul>	<ul style="list-style-type: none"> <li>• More informed after previous discussion.</li> <li>• Fully aware of his needs and condition.</li> <li>• Only requires physiotherapy occasionally and needs to get a check-up from the doctor. Able to organize the above independently.</li> <li>• Yes</li> <li>• Functions independently</li> <li>• Services available in community – receives grant to pay for these services when needed.</li> <li>• Fully aware – visits doctor for check-up when needed.</li> <li>• When needed.</li> </ul>
<b>Living Arrangements</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• Where does the young person wish to live – apartment, house, dorm, city, country?</li> <li>• With whom will the young person live – family, friends, independently, supported living?</li> <li>• What are the options in the person's community?</li> <li>• Where is the best place to live to be able to go to school, work and participate in the community?</li> <li>• What is needed to live more independently – housekeeping skills, transportation, and personal assistance?</li> <li>• Is help available to learn these?</li> <li>• What are the effects of decisions about living arrangement on the family?</li> </ul>	<ul style="list-style-type: none"> <li>• House</li> <li>• Family</li> <li>• Lots of options – organisations and workshops.</li> <li>• Current place is suitable.</li> <li>• Transportation when old enough to get.</li> <li>• Yes</li> <li>• Family accepts and supports fully.</li> </ul>

<b>Housing</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What adaptations such as ramps, railings, wider doorways, bathroom configuration, and kitchen adaptations are needed to support independence?</li> <li>• What home maintenance skills does the person have or can he learn and what help is available?</li> </ul>	<ul style="list-style-type: none"> <li>• None</li> <li>• Can do what is needed – if requires help, family can assist.</li> </ul>
<b>Recreation and Leisure</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What does the person like to do for fun and physical and mental fitness?</li> <li>• What skills does he have?</li> <li>• What is available in the community for sports, shopping, watching or viewing, visiting?</li> <li>• What things would the person like to learn to do and what might be available in the community to assist in learning?</li> </ul>	<ul style="list-style-type: none"> <li>• Spending time with friends and playing soccer.</li> <li>• Good communication skills and loves sport.</li> <li>• Lots of options available as well as accessibility.</li> <li>• Learn to drive when old enough – community does have resources available.</li> </ul>

## Evaluation

Eddie has the skills to function independently most of the time, but the only setback is his feelings around his disability. Although he copes quite well with most things, there are times that he struggles if he needs to move fast. His emotions regarding the latter were acknowledged and discussed. The discussion regarding these areas of assessment made Eddie more thankful and aware of his own unique abilities. It gave him some perspective on his life and his abilities, rather than his disabilities.

## 4. Fourth Session

- Form of play: Creative play
- Medium of play: Drawing
- Goal of therapeutic session: By using this projection technique, drawing a monster, as discussed in chapter 3 point 3.3.1.3, the therapist aimed to determine what the monster in Eddie's life is and how he can overcome or deal with that monster.

## **Course of session**

Within this 4<sup>th</sup> session Eddie already presented his realisation of his abilities and seemed to be more comfortable with himself.

Eddie was given a piece of paper and asked to identify and draw the monster in his life. He drew a teacher from school. A discussion regarding the following took place:

\* For how long has the monster existed?

E: Since I came to this school.

\* Are there other people who know about the monster?

E: Perhaps.

\* Is there something about the monster that scares him?

E: His way of being himself.

\* Is he prepared to have the monster in his life and live with it?

E: No.

\* Can he name the monster?

E: Mr Karl (pen name)

\* How old was he when he got the monster?

E: Since I started school.

\* Ask him to talk to the monster.

E: Please stop bugging me.

## **Evaluation**

Through this projection Eddie indicated his emotions and perceptions regarding one of his teachers. As indicated above, Eddie struggles with interacting with one of his teachers. A discussion around altering his thoughts and emotions about the way he thinks the teacher sees him, took place. The latter was acknowledged, while time and opportunity were given to name and work through all emotions and thoughts. This alternative interpretation option created a logical explanation regarding this teacher. Eddie's attitude towards himself and his environment created some peace of mind and acceptance towards the teacher.

## 5. Fifth Session

- Form of play: Creative Play
- Medium of play: Drawing
- Goal of therapeutic session: By using this projection technique, pretending to be a rosebush, as discussed in chapter 3 point 3.3.1.3, the therapist aimed to determine how Eddie see himself and how he functions (as an individual, but also within his environment).

### **Course of session**

Eddie was given a piece of paper and asked to draw a rosebush. With this technique he must pretend to be a rosebush. The following points were considered and discussed:

\*Type of rosebush – strong or weak?

E: Strong

\*Root system – deep or shallow?

E: Don't know.

\*Number of thorns – too many or too few?

E: Has no thorns.

\*Environment – bad or good for growing?

E: Environment is good for growing.

\*Does your rosebush stand out?

E: No

\*Does it have enough room?

E: Yes

\*How does it get along with the other plants?

E: Yes, very good.

\*Does it have a good future?

E: No

\*Which of the above aspects can be applied to the Eddie's own life?

E: According to Eddie the rose is almost similar to his own life and experiences. Just as the rose he sees himself as a strong person, even though he sometimes feels

uncertain because of the way other people treat him. His root system refers to his support network, which he feels unclear about as his family does not always show love and support. He indicated no thorns on his rosebush, as he feels that nothing can actually hold him back from being what he wants to be and that he can choose to be hurt or not. According to him, his environment is good for him, although his family doesn't always reflect this. It is only the fact that he is uncertain of people's perspective about him being disabled, which puts him down sometimes (as discussed and indicated through the monster technique in previous session). He also indicated that he still needs a lot of room to grow, and that he would really work hard to achieve his goals in life.

## **Evaluation**

Through this projection Eddie indicated how he sees himself and how he functions (as an individual, but also within his environment). The latter was discussed, while time and opportunity were given to work through emotions and perceptions. For Eddie it was empowering to be aware of the fact that sometimes he tends to let other people's thoughts and attitudes influence his view on life and his disability. He made a definite choice not to let this bring him down or influence the things he believes in.

## **6. Sixth Session**

- Goal of therapeutic session: Termination of the therapeutic process.

### **Course of session**

During the last session, the therapist focused on the termination of the therapy process. The session took place outside the therapy room where the therapist and Eddie interacted and shared something to eat.

Eddie experienced the therapy sessions as a big help in guiding him towards independence. Not only did the therapy alter his perceptions and thoughts about himself, but also about his perception of how he thinks other people sees him.

## **Evaluation**

For the therapist it was important to empower and facilitate Eddie, to fully understand his disability and to create an eagerness to not let anything or anyone put him down in life. By going through a discovering process of how he tends to let other people determine his happiness and views on life, Eddie grew to learn how he has the ability to control the latter. He left the therapy room with a huge sense of empowerment. Initially Eddie didn't reflect any knowledge of his disability, as well as the reasons why he experienced life and other people the way he did up till now. As Eddie's process did not allow fast growth towards healing and working through unfinished business, more sessions will be scheduled to accommodate his needs. It was amazing to see this young boy change from a shy, uncertain disabled learner to a relaxed and more easy-going learner with so much more self-confidence.

### **4.3.4.4 Case Study 4**

#### **(a) Biographical information:**

Name:	Jerry
Date of birth:	1989-12-19
Age:	14
Gender:	Male
Address:	Mitchell's Plain
Home language:	English
Number of children in family:	3

#### **(b) Therapeutic Intervention:**

##### **1. First Session**

- Form of play: Creative play
- Medium of play: Clay work

- Goal of therapeutic session: The goal of the first session was to meet Jerry - to introduce the therapist and therapeutic room in an informal and relaxed manner. The therapist's main aim was to concentrate on building a therapeutic relationship.

### **Course of session**

Jerry presented as a friendly and mature young boy, who was very eager to participate in all activities. As Jerry indicated his uncertainty regarding how exactly the sessions will work, the therapist first discussed roles, expectations and the course of future sessions. The therapist aimed to encourage dialogue through a non-threatening activity, and clay was handed out with no instructions. While handling the clay, the therapist attended to sensory modalities and made sure that Jerry was sensory intact. This was Jerry's first contact with clay, and he enjoyed playing with it. He did not make any clear objects, but just moved the clay with his hands and part of his arms. Through the clay activity the therapist gained some information regarding likes and dislikes of Jerry. He also indicated that his disability creates some negative thoughts about himself, as well as the relationship between his parents. Through the information gained, the therapist realised that although Jerry strives to function independently in most areas of his life, there is a need for support and to feel safe and accepted within his environment – school or home. The therapist suggested that Jerry think of his “place of safety”. This is a place where he can go to – physically or fantasize about being there. There he can escape from his environment, or whatever unpleasant feelings he experiences. For Jerry, his place of safety was away from everybody – especially home – where he can have peace and quiet all on his own.

### **Evaluation**

Jerry interacted in a mature and sensible manner. He is sometimes prone to negative thoughts about himself, because of his disability and the problems his parents experience in their marriage. The relationship between the therapist and Jerry was already strong within this first session.

## 2. Second Session

- Form of play: Creative play
- Medium of play: Writing (unfinished sentences)
- Goal of therapeutic session: Through this session the therapist aims to gain information through the use of unfinished sentences. Attention will still be given to creating a positive and safe therapeutic environment. The therapist kept in mind the basic principles of play therapy, as discussed in chapter 3 point 3.3.

### Course of session

The therapist will first give a summary of the unfinished sentences and Jerry's feedback, before giving a short discussion on the information gained. The option was given that Jerry only needs to fill in those sentences he chooses to fill in.

Table 4.7: Unfinished Sentences: Jerry

I like...	Wheelchair basketball.
My saddest moment...	Was when my grandpa died.
I feel...	Happy about myself.
When I'm in my bed at night...	I often think about my future.
I really want to...	Work with computers.
If I can afford it...	I will someday have my own computer business and design computer games.
Sometimes I wonder...	If I can achieve all the goals I've set.
I hate...	It when people hurt animals.
I am...	A loving and caring person.
The only obstacle is...	To get a wife.
I wish...	I can be rich.
My biggest dream is...	Is for my family to live in peace.

### Evaluation

With reference to the above information and the discussion with Jerry, the therapist was made aware that there is a need for Jerry to be given the opportunity to talk about

his disability and to understand it. He had a lot of unfinished business regarding the latter, as well as his parents having problems in their marriage. He was able to identify with all the emotions regarding the above and a discussion around ways to handle and address this took place. It was suggested that Jerry communicate his uncertainties with his family. There was an indication that the relationship within their family would allow this conversation. He was very troubled about all the fights between his parents, and indicated how that makes him feel guilty. He was very unsure of the reasons why his parents fight. The fact that Jerry realised that there could be a possibility to discuss his concerns with his family, empowered him and gave him the courage to share what is on his mind. This opened up his perspective of what the reasons might be for him having these feelings.

His disability creates barriers and brings feelings of uncertainty to the foreground and although he realises that he has a lot of strengths and talent, he still feels held back in life, because of his disability. Discussions regarding his strengths took place, and it resulted in Jerry being more aware of the positive and creative characteristics he has. More time will be spent on this during the next sessions.

It is evident that the therapeutic environment and relationship between Jerry and the therapist is creating a safe and encouraging atmosphere for sharing and opening up.

### **3. Third Session**

- Form of play: Creative play
- Medium of play: Writing (complete assessment questions)
- Goal of therapeutic session: The therapist aimed to concentrate on the disability (Spina Bifida), the effect it has on Jerry, his perspective of the disability as well as his coping skills.

#### **Course of session**

During this session time was spend on an explanation regarding the following:

- The nature of Spina Bifida according to the literature in chapter 2 point 2.2.

Jerry wasn't completely informed, nor did he have the correct knowledge regarding the nature of his disability. According to the therapist it is very important for Jerry to fully understand his disability, to prevent any uncertainty and possible feelings of guilt.

- Secondary conditions associated with Spina Bifida according to the literature in chapter 2 point 2.3.

A discussion regarding Jerry's academic progress took place. He indicated that he really struggles with maths. By using the literature, the therapist explained that this was one of the secondary conditions associated with Spina Bifida. Jerry's feelings regarding his struggle with the latter were acknowledged. The therapist again made him aware of his strengths, and the importance of focusing on that. It was suggested to perhaps look at an extra period and programme to assist him with his needs regarding his academic work.

- Treatment and prevention of Spina Bifida according to the literature in chapter 2 point 2.6 and 2.7.

As Jerry indicated some feelings of guilt regarding him having Spina Bifida, a discussion took place about what causes this disability and how to prevent it. This was a big relief for him to realise that he had nothing to do with the fact that he has Spina Bifida.

- Awareness of needs, limitations and goals.

The therapist again concentrated on working in polarities. This guided Jerry to become aware of his limitations, but also of what he can do and achieve.

The therapist used the following areas of assessment, as discussed in chapter 2 Table 2.3, to gain more information regarding Jerry's disability and his coping skills.

Table 4.8: Areas of Assessment and Planning: Jerry

<b>Activities of Daily Living</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What self-care skills (such as for personal hygiene and dressing) does the young person have?</li> <li>• What might be learned?</li> <li>• What supports and resources are available?</li> <li>• What housekeeping skills does the young person have for meal planning; shopping and cooking; keeping the living quarters clean and maintained; cleaning and maintaining clothing; and dealing with emergencies?</li> <li>• For what activities does the person need help during the day?</li> <li>• What resources are available to provide this help and how might they be funded?</li> </ul>	<ul style="list-style-type: none"> <li>• Able to look after himself – can dress and care for himself.</li> <li>• Would like to learn how to cook.</li> <li>• His family, friends and the neighbours.</li> <li>• He would depend on his family and friends to assist him in gaining these skills. In case of emergencies he would call his parents, other family members, the neighbours or the police if none of the above can be reached.</li> <li>• Can cope in his own manner.</li> <li>• Again he can depend on his family.</li> </ul>
<b>Mobility</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What ability does the person have to walk or roll within all parts of buildings used for daily activities and between buildings?</li> <li>• Are buildings that the person wishes to enter for education, employment and recreation accessible?</li> <li>• What adaptations might reasonably be made?</li> </ul>	<ul style="list-style-type: none"> <li>• Learner is in a wheelchair and certain adaptations or support is needed, regarding mobility.</li> <li>• Yes</li> </ul>
<b>Transportation</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What abilities does the person have to access public transportation, special transportation options in the community?</li> <li>• Is the person able to access and complete driver's education to become a licensed driver?</li> <li>• What vehicle adaptations would be required?</li> <li>• What adaptation services are available in the person's community?</li> </ul>	<ul style="list-style-type: none"> <li>• Transportation is easy accessible, but he would need some support and help with his wheelchair, if he makes use of public transport. Dial-a-Ride can be used, which caters for person in wheelchairs.</li> <li>• Yes</li> <li>• Would have to have an automatic car.</li> <li>• None are required.</li> </ul>
<b>Health Care</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What does the young person know about the disabilities?</li> <li>• What skills does he have and/or need to learn to monitor physical and/or psychological</li> </ul>	<ul style="list-style-type: none"> <li>• More informed after previous discussion.</li> <li>• Fully aware of his needs and condition.</li> </ul>

<p>conditions?</p> <ul style="list-style-type: none"> <li>• Does he participate in therapies and administer own medications with knowledge of regimen and side effects?</li> <li>• Does the person communicate with health care providers?</li> <li>• What supports would assist the person to do these things, such as educational programs, assistive technology, equipment, supplies, therapies, personal attendants, public health nursing and/or home nursing assistance?</li> <li>• Where are these available, and how can they be funded?</li> <li>• What is the person's source of primary care for general health monitoring and education such as normal development, immunizations, diet, exercise, substance use and abuse, risk taking behaviours and safety issues, and sexuality education and supports?</li> <li>• Does the person receive regular dental care?</li> </ul>	<ul style="list-style-type: none"> <li>• Only requires physiotherapy occasionally and needs to get a check-up by the doctor. Able to organize the above independently.</li> <li>• Yes</li> <li>• Functions independently</li> <li>• Services available in community – receives grant to pay for these services when needed.</li> <li>• Fully aware – visits doctor for check-up when needed.</li> <li>• When needed.</li> </ul>
<b>Living Arrangements</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• Where does the young person wish to live – apartment, house, dorm, city, country?</li> <li>• With whom will the young person live – family, friends, independently, supported living?</li> <li>• What are the options in the person's community?</li> <li>• Where is the best place to live to be able to go to school, work and participate in the community?</li> <li>• What is needed to live more independently – housekeeping skills, transportation, and personal assistance?</li> <li>• Is help available to learn these?</li> <li>• What are the effects of decisions about living arrangement on the family?</li> </ul>	<ul style="list-style-type: none"> <li>• House</li> <li>• Family</li> <li>• Lot of options – organisations and workshops.</li> <li>• Current place is suitable.</li> <li>• Transportation when old enough to get.</li> <li>• Yes</li> <li>• Family accepts and support fully.</li> </ul>
<b>Housing</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What adaptations such as ramps, railings, wider doorways, bathroom configuration, and kitchen adaptations are needed to support independence?</li> <li>• What home maintenance skills does the</li> </ul>	<ul style="list-style-type: none"> <li>• None – all in place currently.</li> <li>• Can do what is needed – if requires help,</li> </ul>

person have or can he learn and what help is available?	family can assist.
<b>Recreation and Leisure</b>	<b>Learner feedback</b>
<ul style="list-style-type: none"> <li>• What does the person like to do for fun and physical and mental fitness?</li> <li>• What skills does he have?</li> <li>• What is available in the community for sports, shopping, watching or viewing, visiting?</li> <li>• What things would the person like to learn to do and what might be available in the community to assist in learning?</li> </ul>	<ul style="list-style-type: none"> <li>• Spending time with friends and playing basketball or tennis.</li> <li>• Good communication skills and loves sport.</li> <li>• Lots of options available as well as accessibility.</li> <li>• Learn to drive when old enough – community does have resources available.</li> </ul>

## Evaluation

It is evident that Jerry has the skills to function independently most of the time. The only setback is his feelings about being dependent on certain people with certain things. Although he copes quite well with most things, there are times that he struggles. The therapist focused on all the positive aspects of Jerry and guided him to become more aware of it. The therapeutic relationship is strong and interaction relaxed and non-threatening.

## 4. Fourth Session

- Form of play: Creative play
- Medium of play: Drawing
- Goal of therapeutic session: By using this projection technique, drawing a monster, as discussed in chapter 3 point 3.3.1.3, the therapist aimed to determine what the monster in Jerry's life is and how he can overcome or deal with that monster.

## Course of session

Jerry was very eager, as always, to come to the session and participate in the activities. The relationship between the therapist and Jerry seems to be very strong, which leads to trust and willingness to share.

Jerry was given a piece of paper and asked to identify and draw the monster in his life. He drew a teacher from school. A discussion regarding the following took place:

\* For how long has the monster existed?

J: 4 Years.

\* Are there other people who know about the monster?

J: The whole school.

\* Is there something about the monster that scares him?

J: He is very strict.

\* Is he prepared to have the monster in his life and live with it?

J: No.

\* Can he name the monster?

J: Mr Pearl (pen name)

\* How old was he when he got the monster?

J: 9 Years.

\* Ask him to talk to the monster.

J: I will tell him how I feel about him and disagree with most of the things he do.

## **Evaluation**

Through this projection Jerry indicated his emotions and perceptions regarding one of his teachers. The way this particular teacher treats him, creates a lot of negative feelings towards this teacher. The latter was acknowledged, while time and opportunity were given to name and work through all the possible reasons why this teacher reacts the way he does. Jerry struggles with interacting with this teacher. A discussion around some possibilities to address this matter took place. The alternative of making an appointment with this teacher and discuss the matter, was looked at as a possibility. It was suggested to write down his perceptions and thoughts regarding this matter, in order to get some perspective on it.

## **5. Fifth Session**

- Form of play: Creative Play

- Medium of play: Drawing
- Goal of therapeutic session: By using this projection technique, pretending to be a rosebush, as discussed in chapter 3 point 3.3.1.3, the therapist aimed to determine how Jerry sees himself and how he functions (as an individual, but also within his environment).

### **Course of session**

Jerry was given a piece of paper and asked to draw a rosebush. Jerry must pretend to be a rosebush. The following points were considered and discussed:

\*Type of rosebush – strong or weak?

J: Strong

\*Root system – deep or shallow?

J: Deep

\*Number of thorns – too many or too few?

J: Too few.

\*Environment – bad or good for growing?

J: Environment is good for growing.

\*Does your rosebush stand out?

J: Yes

\*Does it have enough room?

J: Yes

\*How does it get along with the other plants?

J: Yes, very good.

\*Does it have a good future?

J: Yes

\*Which of the above aspects can be applied to the Jerry's own life?

J: According to Jerry the rose is almost similar to his own life and experiences. Just as the rose he sees himself as a strong person, even though he sometimes feels uncertain because of his disability and his parents' marriage. His root system refers to his support network, which he feels is very good. Although his parents are having problems, they still support and love him. According to him, his environment is good

for him, although the circumstances at home do not always reflect this. The fact that he struggles to cope with being in a wheelchair also puts him down at times. He also indicated that he has enough room to grow, and believes that he has a lot of potential to achieve lots of goals.

## **Evaluation**

For Jerry it was empowering to be aware of the fact that sometimes he tends to let things like him being in a wheelchair and his parents' marriage, influence his view on life. He made a definite choice not to let this bring him down or influence the things he believes in. He became aware of the fact that he has control over what he thinks and feels. This empowered him to move towards different perceptions and emotions about himself and others.

## **6. Sixth Session**

- Goal of therapeutic session: Termination of the therapeutic process.

### **Course of session**

During the last session, the therapist focused on the termination of the therapy process. While sharing something to eat, the researcher discussed the termination of therapy with Jerry. He indicated that he learned a lot throughout the therapeutic process. He became more aware of his strengths, but also learned a lot about his disability and his limitations. He experienced the therapy as positive and a big help in dealing with a lot of unfinished business. He felt empowered and positive regarding his future, although he felt that he needed a few more sessions to support him in altering his goals in life.

## **Evaluation**

Jerry showed a lot of inner strength throughout the therapeutic process. Although he experienced life differently now, it took a lot of hard work and courage to actually move towards altering his perceptions of himself and others. Jerry moved quickly to

the explosive layer (as discussed in chapter 3 point 3.2.6). He was able to discover his needs and to express his emotions, in order to direct his energy into the process of creative re-adjustment. Before he tended to look at his life in different parts, but now he developed a more holistic view on life.

#### **4.4 EVALUATION OF THERAPY SESSIONS**

The above-mentioned empirical data are based on the information, which was gained through therapy sessions. During the exploration of each case study, the process, unfinished business, needs and difficulties of each learner with Spina Bifida were indicated. The way each learner experienced the therapeutic process and what they gained from it, are indicated throughout the sessions.

The therapeutic environment allowed the learners to feel safe and comfortable in sharing a part of themselves. Some resistance occurred, but overall the contact was positive and led to willingness to express emotions, ideas, thoughts, curiosities, wants, needs and resentments. As awareness encompasses many aspects of life, the therapist focused a lot on working towards the awareness of one's process, feelings, wants, needs, thought processes and actions.

By looking at the process of each learner, the following was noticed: (a) Sammy: She became more aware of her strengths, but also learned a lot about her disability and her limitations. She was able, for the first time, to address and work through the fact that her mom died and how that influenced her life and relationship with her father. She experienced the therapy as positive and as great help in dealing with a lot of unfinished business. She felt empowered and positive regarding her future. (b) Harry: He was able to fully understand his disability and to create an eagerness to not let anything or anyone put him down in life. This led to a sense of self-worthiness and control. (c) Eddie: By going through a discovering process of how he tends to let other people determine his happiness and views on life, Eddie grew to learn how he has the ability to control the latter. He left the therapy room with a huge sense of empowerment. (d) Jerry: He was empowered and facilitated, to fully understand his disability and to create an eagerness to not let anything or anyone discourage.

According to the researcher, the therapeutic process assisted the above-mentioned learners with some aspects like: (a) an understanding of the nature of their disability, (b) the occurrence of secondary conditions associated with Spina Bifida, (c) the treatment and prevention of Spina Bifida, (d) to be aware of limitations, needs and goals, and (e) acceptance of who I am. Throughout every session, each learner grew to become more emotionally aware of themselves as individuals, as well as young people with everyday life experiences. The sessions were of great therapeutic value, as each learner realised his potential to “survive” within his own world. It taught him ways of coping and finding support structures to assist when guidance and help is needed.

One important aspect each learner grew to become aware of is the fact that they could move from feelings like denial, anger, disappointment and unworthiness towards feelings like acceptance, understanding, self-worthiness and to feel empowered to determine their own future.

#### **4.5 SUMMARY**

Throughout this chapter it became evident that Gestalt play therapy techniques can be very effective and helpful in therapeutic intervention with high school learners that have Spina Bifida. For these learners there seems to be a lot of unfinished business and a lack of real support and understanding, because they are disabled. Initially none of the participants were fully informed regarding their disability. This led to more feelings of uncertainty and guilt. By exposing these learners to Gestalt play therapy, the therapist believes that all of them were guided towards a healthier and happier existence.

The following chapter will consist of a summary regarding the therapeutic process within the empirical study. Accordingly a conclusion and some recommendations for future studies will be given.

## **CHAPTER 5: SUMMARY, CONCLUSION AND RECOMMENDATIONS**

### **5.1 INTRODUCTION**

This chapter consists of a summary regarding a study about what value Gestalt play therapy had for high school learners with Spina Bifida. The needs and difficulties of these learners will be evident. The focus will also be on a conclusion and some recommendations.

### **5.2 SUMMARY OF RESEARCH**

For high school learners with Spina Bifida, gaining emotional as well as physical competence, is often quite difficult. Especially when it is further compromised by cognitive limitations, frustration with communication, lack of normal biologically expected development challenges, physical problems and coping with mobility.

It became evident that successful adaptation in adolescence requires not only the attachment of a positive outlook on one's disability, the use of competent stress processing and the appreciation of developmental maturation, but also an access to tangible services. For the learner with Spina Bifida, it is often hard to be part of society because of a gap in awareness and complete understanding of the "world" of a child with Spina Bifida. There are various needs, difficulties, personal barriers and other problems they need to deal with. Feelings of guilt and uncertainty are the two foreground emotions, when dealing with high school learners that have Spina Bifida. Due to a lack of proper information and guidance, the learner often dwells on reasons why he has the disability. In most cases he will blame himself and believe that it was because of something he did. Uncertainty regarding his future often comes to the foreground, as he gets older and needs to become more independent of friends and family.

Uncertainty is also experienced regarding leaving the school environment, where support and understanding are present on a daily basis – for example, physiotherapy, medical services as well as psychological services. The latter is a critical point in the life of a young person in the transition from a formal, structured school setting to the

world of higher education, employment and life as an adult. Therefore it is important that the individual with Spina Bifida should enter adolescence with the experience and understanding of his specific physical and psychosocial needs, as well as goals for independence in all aspects of life. Learners also indicated the need for acceptance, understanding and love. By focusing on strengths and positive characteristics, the researcher empowered each learner to realise his potential and the possibilities for the future.

### **5.2.1 Goal of study**

The goal of this study was formulated as:

To determine the value of Gestalt play therapy for high school learners with Spina Bifida.

This goal was reached by focusing on the various objectives. Each of the high school learners that have Spina Bifida, is of opinion that he received support, guidance and help. Not only did they become aware of their own abilities, but also of the influence they allow circumstances to have on them. For each of them, a healing process already started within the first sessions. Schoeman's model was very helpful in guiding all sessions. It became evident that the fact that they were uninformed regarding their disability, led to a lot of the unfinished business they experienced. After the therapy sessions the learners were more in control regarding their limitations, emotions and perceptions about being disabled and having to cope with their disability. Each learner was empowered to believe in himself and to focus and be aware of his strengths.

### **5.2.2 Objectives**

The objectives of this study and the way they were reached, are as follows:

## **Objective 1**

- To do a literature study (chapter 2) regarding high school learners with Spina Bifida, in order to gain information about their unique process, emotions and to determine what needs and difficulties these learners experience.

Information gained through this literature study, was very crucial for the researcher to be able to fully understand what the needs and difficulties are that these learners are faced with.

## **Objective 2**

- To do a literature study (chapter 3) regarding Gestalt play therapy and how it can be implemented to address the needs and difficulties of high school learners with Spina Bifida.

The researcher gave a review of various Gestalt concepts. Some of these concepts are: relationship building, awareness, the role of the past, play therapy techniques, forms of play as well as a discussion regarding Schoeman's model.

## **Objective 3**

- To determine the value of Gestalt play therapy for the high school learner with Spina Bifida, by using case studies (chapter 4).

By going through a therapeutic process with each of the case studies, it was possible for the researcher to determine what value and contributions Gestalt play therapy can have for learners with Spina Bifida. The techniques used, like the Rosebush and Monster, are very effective in establishing awareness regarding strengths and a positive self-esteem. It also made them aware of what barriers or negative issues in their lives hold them back from being what they strive to be. Each of them came to realise that they are in charge of their own emotions and perceptions on life – in other words, what they think, feel and how they perceive themselves.

### **5.2.3 Research methodology**

For the purpose of this study, the following aspects were important:

#### **5.2.3.1 Type of research**

For the purpose of this study applied research was used, which refers to gaining information to either solve a social problem or to make a contribution to real-life issues. Existing knowledge was explored to gain new knowledge, in order to determine what value Gestalt play therapy can have for high school learners with Spina Bifida. Therefore exploratory research was conducted to gain insight into the life of a high school learner with Spina Bifida.

#### **5.2.3.2 Work procedure**

As the researcher determined the value of Gestalt play therapy for high school learners with Spina Bifida, the main information collection method was therapy sessions. By going through a therapeutic process with each learner, the needs/difficulties/barriers became evident for each of the learners. By implementing various play therapy techniques, foreground issues were addressed and dealt with. This allowed the learners to get closure on various uncertainties. Each therapy session was very meaningful and special to each learner, as it created an opportunity to bring forward issues they never had the chance to do. By the end of the therapeutic process, each learner was more empowered as well as aware of the implications of his disability. As Gestalt play therapy techniques guided these learners to a new and healthy perspective, and the personal growth to be strong within themselves, it was very successful.

#### **5.2.3.3 Assumptions**

The assumption that was made before undertaking this study was that Gestalt play therapy would have some value for high school learners that have Spina Bifida. This assumption was confirmed, as mentioned above, by evaluating the therapeutic process of each learner. By giving the opportunity to become more aware of various

foreground issues and by dealing with unfinished business, each learner was empowered to deal with unpleasant circumstances in the here-and-now, but also in the future.

### **5.3 RECOMMENDATIONS**

Before conducting this research, one of the aims was to make conclusions and recommendations at the end of the study, in order to support and assist children with Spina Bifida, as well as their families, friends, educators and the broader community. Due to the time frame and extent of this study, it was not possible to involve all relevant role players in the study. For the purpose of future studies, it is recommended that the families, friends, educators and even the broader community must be included in an intervention programme to help and support learners with Spina Bifida. The education of families would be beneficial for these learners, as the support and guidance could come from home and the school environment. It is also suggested that a community-based project be established to involve these particular learners in developing skills to function independently – emotionally and financially.

This research can be used as an informative document for health care professionals, teachers and parents to assist them in understanding the child's physical capabilities and limitations. By informing and educating parents, neighbours, teachers and the general public who are involved in raising a child with Spina Bifida the researcher hopes - through this research study - that understanding and sympathy will be increased and that more assistance on a personal level, and perhaps on a much larger scale will result.

With reference to the above, the following general conclusions can be made:

- The therapeutic environment that was created and maintained within the Gestalt therapy framework, allows learners to feel safe and comfortable in sharing a part of themselves.
- Gestalt therapy techniques is useful when some resistance occurs within therapeutic sessions, as it can assist to guide contact to be positive and

therefore lead to willingness to express emotions, ideas, thoughts, curiosities, wants, needs and resentments.

- The therapeutic process assisted the learners with an understanding of the nature of their disability, the occurrence of secondary conditions associated with Spina Bifida as well as the treatment and prevention of a disability like Spina Bifida.
- The therapeutic process also assisted the learners to become more aware of limitations, needs, goals and the acceptance of who “I” am.
- Throughout every session, each learner grew to become emotionally more aware of themselves as individuals, and as a young adult experiencing various developmental and emotional difficulties.
- The sessions were of great therapeutic value, as each learner realised his potential to “survive” within his own world. It taught him ways of coping and finding support structures to assist when guidance and help is needed.

The following are some recommendations when working therapeutically with high school learners that have a physical disability like Spina Bifida:

- For these learners there is a great need for acceptance: They often experience feelings like rejection, discrimination and pitiableness, because they look different. It is important within a therapeutic relationship to deal with the latter, by treating these learners like any other learner in school. They have a need to be treated “normally” and to not be referred to as disabled. As soon as these learners experience a feeling of being “normal”, they tend to look beyond their disability and focus on their abilities.
- Schoeman’s model is very effective when working with these learners, but there must always be space for adapting some of the aspects. Each learner has a unique process and will experience the therapy in his own unique manner.
- Mediums of play like drawing (rose bush, monster technique) and clay work seemed to create dialogue through a non-threatening activity. This is very

effective, especially in the initial stages of therapy, when the learner is not ready or comfortable to share things about himself.

- Learners must be informed about their disability from the start. A lot of emotions and unfinished business is often caused by wrong and negative perceptions about the disability. The connection between their disability and academic progress must also be addressed. The latter must be handled with sensitivity, as this could contribute to more negative feelings.
- It is important for these learners to grow strong within themselves, so that they can function independently when they leave high school. Awareness regarding their own responsibility to be happy, must be encouraged.
- In addition, some adaptations must be made to the academic curriculum for learners that have Spina Bifida. As most of the learners with this disability experience various problems regarding their academic progress, assessment methods and criteria need to be established to accommodate these unique learning barriers.
- Regarding the prevention of Spina Bifida, women need to be informed about what can possibly cause this disability, and how a healthy diet can play a crucial role. Parents also need to be skilled in order to support and guide their children, who experience various needs/difficulties/barriers within all areas of life.

#### **5.4 FINAL CONCLUSION**

As indicated throughout this chapter, it is evident that for the high school learner with Spina Bifida, Gestalt play therapy is an effective and meaningful way to assist learners with the consequences of this disability. By using various forms and mediums of play, the researcher aimed to encourage dialogue through non-threatening activities. These non-directive ways of interaction made the learners more willing to open up and share things about themselves, without feeling uncomfortable or

threatened. By creating awareness of their perceptions of themselves and by guiding them towards a healthier and more realistic view on life, these learners were able to look at themselves more holistically. It became evident that the families of learners with Spina Bifida need to realise how important support, love, proper education regarding this disability and understanding are.

The researcher is therefore of opinion that Gestalt play therapy indeed has a value for high school learners with Spina Bifida. Not only did this specific therapy intervention have a value for these learners, but it also contributed to emotional, spiritual and intellectual growth.