

EXPLORING HOW GESTALT PLAY THERAPISTS ESTABLISH SENSORY  
CONTACT WITH CHILDREN WHO HAVE SENSORY INTEGRATION DISORDERS

by

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## **Declaration**

I declare that EXPLORING HOW GESTALT PLAY THERAPISTS ESTABLISH SENSORY CONTACT WITH CHILDREN WHO HAVE SENSORY INTEGRATION DISORDERS is my own work, that it has not been submitted before for any degree or assessment at any other university, and that all of the sources used or quoted have been indicated and acknowledged by means of a complete reference list.

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## **Abstract**

### EXPLORING HOW GESTALT PLAY THERAPISTS ESTABLISH SENSORY CONTACT WITH CHILDREN WHO HAVE SENSORY INTEGRATION DISORDERS

Children who have sensory integration disorders face many physical, social and emotional challenges. Unusual emotional and behavioural reactions to sensory stimuli are often displayed. These children are referred to professionals including Gestalt play therapists, although formal training in sensory integration is limited to the scope of occupational therapy. Gestalt play therapists routinely utilize sensory rich activities during therapy. This study sought to explore and describe how Gestalt play therapists establish sensory contact with children who have sensory integration disorders. A combined qualitative and quantitative approach was utilized. A questionnaire and semi-structured interviews were used to gain rich descriptive data. Participants felt that the therapeutic process with these children was markedly different than with other children. Participants who were aware of their own sensory difficulties demonstrated an increased ability to accommodate these children in therapy. A need for increased knowledge and/ or training in sensory integration was strongly expressed.

**Key terms:** Sensory integration, Sensory integration dysfunction, Gestalt play therapy, sensory contact.

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# Chapter 1

## Introduction to the study

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### **1.1. Introduction**

The human body is designed to live and function in the world as we know it. Our world is filled with countless colours, sounds, smells, movement and objects. We constantly interact with our sensory-saturated environment. What happens when a person is unable to make sense of sensory stimuli? What happens when sensory stimuli are incorrectly processed and perceived?

For children suffering from a sensory integration dysfunction, this sense-making process is a daily dilemma which often results in emotional and behavioural problems (Parham & Mailloux, 2006:365; Van Jaarsveld, 2005:369). A recent study indicated that children with sensory integration dysfunction are often referred for Gestalt play therapy (Geringer, 2009). What do Gestalt play therapists know about sensory integration dysfunction, and how do they apply this knowledge in therapy?

### **1.2. Rationale**

Gestalt therapy and play therapy alike emphasize the importance of sensation and sensory contact (Polster & Polster, 1974:213-222; Reynolds, 2005:159-163; Yontef, 2005). The importance can be explained by describing sensory contact in three ways within the Gestalt paradigm.

Firstly, bodily sensation and sensory contact form an integral part of awareness, which is considered to be an important vehicle of change in Gestalt therapy (Reynolds, 2005:161-163; Yontef, 2005:87-92; Blom, 2006:51, 57, 86-92). Full awareness is described by Yontef (1993:14) as "... the process of being in vigilant contact with the most important events in the individual/environment field with **full sensorimotor**, emotional, cognitive and energetic support" [own emphasis]. Blom

(2006:53) asserts that awareness in children implies full contact with themselves on a cognitive, sensory and affective level. Oaklander (2002:87) feels that “[w]hen the senses and the body is restricted, emotional expression and a strong sense of self will be negligible [sic]”. As awareness is a prerequisite for change, it is deemed one of the three goals of Gestalt play therapy. Promotion of self-supporting behaviour and promoting integration are the other two goals (Blom, 2006:51-54).

Secondly, sensation is seen as the first phase in the Gestalt contact cycle of experience, which depicts the phases a person moves through in order to satisfy an emergent need (see Figure 3.1.). All people have the ability to self-regulate in order to obtain homeostasis (Reynolds, 2005:159 Yontef & Fairfield, 2005:3). Whenever a need arises, it affects the child’s equilibrium and homeostasis. A sensation is experienced; the child becomes aware of the need; is mobilised by the building up of energy to act; acts and establishes contact with the environment to satisfy the need; assimilates the contact and meaning thereof; then withdraws from contact as the need is met and homeostasis regained (Zinker, 1977:90-103; Melnick & Nevis, 2005:103-105; Reynolds, 2005:159-163; Woldt & Toman, 2005:x). Sensation is thus a pre-requisite to maintain homeostasis.

Thirdly, sensory contact-making is an invaluable aspect of the second stage in the therapeutic process as described by Violet Oaklander and other Gestalt play therapists (Oaklander, 2002:86-87; Blom, 2006:89-102; Mortola, 2006:58). This stage comprises contact-making (sensory and bodily contact-making) and strengthening of the self. Sensory contact-making should also take place during every session, in every stage of therapy, in order to increase awareness (Blom, 2006:239). It is clear that sensation and sensory contact are interwoven with Gestalt theory and practice. It is actively facilitated by Gestalt play therapists as part of the therapeutic process in order to create the optimum atmosphere for change and growth.

Sensory integration (SI) is a term widely used by occupational therapists (OTs). A.J. Ayres developed the SI theory between the 1960s and 1980s (Van Jaarsveld, 2005:369). According to Ayres, SI is to organise sensations in order to use them purposefully (Parham & Mailloux, 2001:330). It describes the integration and

modulation of all the information received from the senses in order to make sense of the world. When this is done, the child is able to plan and execute an adaptive response (behaviour or interaction with the environment) that is appropriate to the demand posed by the environment (Van Jaarsveld, 2005:369-371).

Sensory integration disorders (SID) occur when effective SI is prohibited. SID refers to a group of disorders that reflect neural dysfunction in multisensory systems (Parham & Mailloux, 2001:349; Van Jaarsveld, 2005:369). SID can manifest in two ways: dyspraxia and sensory modulation disorders (SMD) (Bundy & Murray, 2002:9). For the purpose of this study, the term “sensory integration disorders” (SID) will be used when referring to dyspraxia and SMD.

A study performed at UNISA to determine the incidence of SID in children aged three to ten who received Gestalt play therapy in the Western Cape indicated that 24 out of the 28 studied children suffered from SID (Geringer, 2009:61). It is clear that children who present with SID are seen by Gestalt play therapists. The researcher is of the opinion that these children will pose a challenge to therapists, especially with regard to establishing sensory contact in therapy.

The researcher is an OT and presents with SID herself. This had a marked impact on her personal and professional development as an OT and play therapist. Having been introduced to SI theory at an undergraduate level, the researcher is also aware of the immense effect of SID on children’s functioning. As a student of Gestalt play therapy, awareness of the emotional effect of sensory impairment, restriction or neglect also became apparent to the researcher. This urged the researcher to perform a literature review of utilising SI concepts, principles or theory in Gestalt play therapy. However, little information was found. SI theory is deemed to be restricted to the field of OT, little information is provided as to how therapists in other professions should handle the child with SID in therapy. Speaking with fellow students and colleagues (OTs, psychologists and psychiatrists in Potchefstroom), the researcher identified a need for more documented information on this subject.

OT students are introduced to SI, but must undergo postgraduate training in order to diagnose and treat SID in therapy (Van Jaarsveld, 2005:370). The South African

Institute of Sensory Integration (SAISI) is affiliated with the Occupational Therapy Association of South Africa (OTASA) – and the only body through which official SI training can take place in South Africa. According to Stefanie Kruger (2010), Vice-Chairperson of SAISI, full SI training in South Africa is only available to OTs. Only three theory and/or foundation courses open to other professionals registered with the Health Professions Council of South Africa have been presented by SAISI since 2004.

Gestalt play therapy depends heavily on the ability to establish sensory contact and awareness in the child. However, children with SID may experience sensations as frightful and anxiety-provoking (Smith Roley, Blanche & Schaaf, 2001:15; Mackenzie, 2009:15). These children may present with emotional problems and are treated by Gestalt play therapists who do not necessarily have any theoretical knowledge of SI. This study sought to explore the following: How do Gestalt play therapists establish sensory contact in children with sensory integration disorders?

### **1.3. Problem statement**

According to Babbie and Mouton (2001:73), a clear formulation of the research problem is the starting point of all research. It includes selection of the unit of analysis (Fouché & De Vos, 2005a:103). Gestalt play therapists treat children who present with emotional and behavioural problems. Some of these children present with SID (Geringer, 2009:77). The researcher was of the opinion that the presence of SID would result in difficulty with contact-making and establishing relationships. The researcher agreed with Geringer (2009:2-5; 65) that it greatly influences the therapeutic relationship and the efficacy of the therapeutic process if the play therapist is unaware of SI theory. It is necessary to explore how Gestalt play therapists establish sensory contact with children who present with SID. Gestalt play therapists working with children in South Africa were the focus of the study.

## **1.4. Aim and objectives of the study**

### **1.4.1. Research question**

The purpose of the problem formulation is to define clear research questions. Subsequent parts of the research process are aimed at answering that research question (Fouché & De Vos, 2005a:100; Jansen, 2010:3). For the purpose of this study, the research question was defined as follows: How do Gestalt play therapists establish sensory contact with children who have SID?

### **1.4.2. Research goal**

Fouché and De Vos (2005a:105) regard research goals as being either basic or applied. The broad goal of this study was applied with exploratory objectives, as it aimed to generate basic information on how Gestalt play therapists establish sensory contact with children who present with SID. The study was also descriptive in nature as it provided a detailed examination and description of the research phenomenon. This was done with the intent of generating recommendations which may be practically applied in the Gestalt play therapeutic research and clinical fields (Babbie & Mouton, 2001:79-81; Fouché & De Vos, 2005a:106).

### **1.4.3. Objectives**

The objectives of this study were exploratory and descriptive, as they sought to generate both a basic insight into the way Gestalt play therapists establish contact in children with SID and a more detailed, phenomenological description of the researched phenomenon (Babbie & Mouton, 2001:80; Fouché & De Vos, 2005a:106).

Four specific objectives were identified:

- Undertaking a literature review to explore theoretical aspects of Gestalt therapy, Gestalt theory on sensory contact-making, contact cycle, phenomenology and awareness, and SI theory.
- Undertaking a pilot study during which a survey questionnaire will be completed by four Gestalt play therapists and feedback integrated to alter questions if deemed necessary.
- Undertaking an empirical study by means of a survey questionnaire, compiled by the researcher, as well as a focus group with randomly selected participants.
- To analyse the data from the questionnaire and focus group to make useful findings.
- Formulating recommendations to Gestalt play therapists and Gestalt play therapy training institutes regarding possible future studies to explore other aspects of the therapeutic process with the child who presents with SID.

The researcher planned to conduct a focus group in order to collect qualitative data from participants. However, due to logistical problems the researcher eventually conducted semi-structured, one-to-one interviews with four participants. (Please refer to Chapter 4, point 4.6.2.)

#### **1.4.4. Theoretical framework and paradigm**

This study was conducted from a Gestalt and SI theory perspective. Gestalt play therapists' phenomenological experience regarding therapy with children with SID was explored, with the focus on sensation and sensory contact-making. Sensory contact is an integral part of Gestalt theory (Oaklander, 2002:86-87; Blom, 2006:89-102; Mortola, 2006:58) and impacts the therapeutic process, awareness and the contact cycle within the therapeutic environment (Zinker, 1977:90-103; Melnick & Nevis, 2005:103-105; Reynolds, 2005:159-163; Woldt & Toman, 2005:x; Yontef,

2005:87-92; Blom, 2006:51, 57, 86-92). The presence of SID affects the child's field and may be a contributing factor to the reason for referral (Geringer, 2009:57).

## **1.5. Literature review and viability of the study**

A wealth of information on Gestalt theory, Gestalt therapy and Gestalt play therapy exists, and this was apparent to the researcher during the literature review. Similarly, information on SI theory could be located in various journals, books and electronic resources. As previously mentioned, authors in the field of SI widely recognise and comment on the emotional impact of SID on the child (Lane, 2002a:117; Van Jaarsveld, 2005:373; Geysers, 2009:11-12; Mackenzie, 2009:15-18). Although it is a well-known fact that children with SID often present with emotional and behavioural problems, there is little documented information on which interventions are used to combat the problem. Information regarding the use of play therapy with children who have SID was very limited. The researcher found some recent dissertations of similar scope. One dissertation focused on sensory strategies for children with ADHD, and whether these could be applied in play therapy (Raath, 2007), while another investigated the incidence of children with SID, aged three to ten, who received play therapy in the Western Cape (Geringer, 2009). A definite national and international knowledge gap concerning how Gestalt play therapists go about conducting therapy with these children was evident.

## **1.6. Research design and methods**

### **1.6.1. Research approach**

This study followed a combined research approach as it sought to explore and describe the phenomenon, whilst utilising both qualitative and quantitative data collection techniques (De Vos, 2005a:361; Fouché & Delport, 2005:73-74; Croswell & Zhang, 2009:612; Ivankova *et al.*, 2010:265; Niewenhuis, 2010a:51). According to Ivankova *et al.* (2010:265), both numerical and text data are collected in a mixed methods study. The survey questionnaire was used to generate quantitative and

qualitative data, as the majority of questions were open-ended. Additional qualitative data was obtained from the interviews. Gaining both quantitative and qualitative data allowed for an increased richness of understanding (Ivankova *et al.*, 2010:263, 265).

### **1.6.2. Research design**

An instrumental case study design was utilised. Fouché (2005:272) maintains that the case, which may refer to a group of individuals, facilitates the researcher's knowledge of the researched phenomenon. According to Niewenhuis (2010b:76), collected data in a case study design is mainly qualitative, although quantitative data may also be included. Furthermore, a non-experimental survey design was utilised to gain quantitative data (Babbie & Mouton, 2001:232; Fouché & De Vos, 2005b:137). The mixed method design was concurrent, as both data sets were collected and analysed during the same research phase. This enabled the researcher to examine how findings from both data sets corroborated, diverged or contradicted the other (Creswell & Zhang, 2009:614; Ivankova *et al.*, 2010:269).

## **1.7. Methodology**

### **1.7.1. Preparation for data collection**

The literature review for this study included literature on Gestalt therapy and Gestalt play therapy theory and SI theory. Available literature on utilising play therapy with children who present with SID was also scrutinised. According to Hofstee (2006:91), the literature review provides a theoretical base and indicates the context of the study. Following the literature review, a pilot study was conducted to establish the suitability and effectiveness of the questionnaire (Strydom, 2005a:210). Consent was obtained from participants and the interview schedule was finalised.

### **1.7.2. Sampling**

The term “universe” is described by Arkava and Lane, as cited by Strydom (2005b:193) as “all potential subjects who possess the attributes in which the researcher is interested”, while the population is composed of individuals within the universe who share specific characteristics (Babbie & Mouton, 2001:286; Strydom, 2005b:193; Niewenhuis, 2010b:79). For the purpose of this study, the universe comprised all Gestalt play therapists who had received Gestalt therapy training in South Africa. The population included all Gestalt play therapists indicated in the universe (excluding OTs – see inclusion criteria) who are currently practising Gestalt play therapy and who had treated children diagnosed with SID.

The researcher planned to make use of systematic, sequential sampling to select individuals from the population (Babbie & Mouton, 2001:190; Strydom, 2005b:194; Strydom & Delpont, 2005:330). However, due to difficulties with obtaining names and contact details, the researcher contacted all potential participants by e-mail to ascertain whether they complied with inclusion criteria (see Chapter 4, point 4.4.), thereby utilising purposive sampling (Babbie & Mouton, 2001:287; Strydom & Delpont, 2005:328). Snowball sampling was also used to increase the number of participants. Participants to be interviewed were randomly selected.

The following inclusion criteria were applicable to this study:

- Participants must practice Gestalt play therapy with children
- Participants may not be OTs, as OTs are introduced to SI at an undergraduate level and may have received further training in SI

Cases selected by participants had to meet the following criteria:

- The child should have been diagnosed with SID by an OT, prior to or during the Gestalt play therapeutic process. This criterion was altered to include children who were strongly suspected of suffering from SID. (Please refer to Chapter 4, point 4.9.1.1.)

- The child and therapist should have completed at least three therapy sessions, in order for the therapist to possess insight into the child's sensory contact-making style.

## **1.8. Data collection and analysis**

### **1.8.1. Data collection techniques**

A concurrent mixed method design was utilised, which implied that both quantitative and qualitative data sets were collected during the same research phase. A questionnaire was compiled by the researcher according to guidelines stipulated by Maree and Pietersen (2010:158-169) and Delport (2005:170-191). These include guidelines with regard to instructions, appearance, question sequence and wording. Care was taken to provide a user-friendly questionnaire with simple, clear instructions and questions. Biographical questions and questions relating to establishing sensory contact with children who have SID were included. Open-ended questions were included, which facilitated the generation of fundamentally qualitative data (Niewenhuis, 2010b:76).

Semi-structured interviews were also conducted during which the researcher made use of a pre-constructed interview schedule containing open-ended questions (Maree, 2010:87). The researcher used the interview schedule as a guide for questioning, but was also attentive to emerging ideas and themes. Interviews were audio-taped and field notes were kept during interviews to ensure meticulous data capturing (Babbie & Mouton, 2001:289; Greeff, 2005:296; Maree, 2010:87).

### **1.8.2. Managing data**

Seeing that a concurrent mixed method design was used, both data sets were coded and analysed during the same research phase, after completion of data collection (Creswell & Zhang, 2009:614; Ivankova, Creswell & Plano Clark, 2010:269). Completed questionnaires were printed out, assigned a participant number, coded

inductively by hand and analysed on the researcher's computer (Niewenhuis, 2010c:99). Interviews were also assigned participant numbers, copied onto writeable discs (CDs), and transcribed. Raw data, comprising printed questionnaires, audio tapes, field notes and written CDs, was kept in a locked cabinet accessible only to the researcher. Electronic data, comprising transcribed interviews and downloaded questionnaires, was also kept in a password-controlled file on the researcher's personal computer. Transcripts and questionnaires were reviewed repeatedly as the researcher immersed herself in the data, signifying the start of data analysis.

### **1.8.3. Data analysis**

Quantitative data obtained from the closed survey questions completed were coded and analysed statistically by means of univariate analysis (Babbie & Mouton, 2001:422; Kruger, De Vos, Fouché & Venter, 2005:222). Qualitative data obtained from open-ended survey questions and the interviews were coded and analysed by means of thematic analysis (Attridge-Stirling, 2001:387; Joffe & Yardley, 2004:57; De Vos, 2005a:338-339; Braun & Clarke, 2006:79). To ensure soundness, the researcher assessed findings against available literature, as well as the four constructs of trustworthiness: credibility, transferability, dependability and confirmability (Babbie & Mouton, 2001:276-277; Lincoln & Guba in De Vos, 2005a:346; Morrow, 2005:251-252). Please refer to Chapter 4 for a detailed description of the data analysis process.

## **1.9. Ethical considerations**

The necessity for ethical considerations is borne out of the researcher's interaction with participants (Babbie & Mouton, 2001:520). Ethical guidelines were implemented throughout the research process in recognition of the fact that participants can be vulnerable and should be protected from harm (Babbie & Mouton, 2001:520; Mouton, 2001:245; Haverkamp, 2005:146; Strydom, 2005c:56). The following measures provided by Strydom (2005c:58-66) were applicable to this study and were taken into careful consideration: avoidance of harm, informed consent, ensuring

confidentiality, actions and competence of the researcher, avoiding deception of participants, cooperation with contributors, and release of findings.

### **1.9.1. Avoidance of harm**

Mouton (2001:245) and Strydom (2005c:58) advocate that every possible care should be taken to avoid physical or emotional harm to participants. There was no danger of physical harm to participants during the course of this study. Participants may have experienced emotional discomfort during completion of the questionnaire or interviews. The subject of play therapy with children who have SID could have resulted in participants becoming aware of their deficiencies. Participants were, however, fully informed of the expectations and possible risks of discomfort, and could withdraw from the study at any time. One-to-one interviews were conducted, which decreased the probability of participants feeling embarrassed amongst their peers. No information that could lead to embarrassment or emotional harm was revealed at any time during this study (Babbie & Mouton, 2001:522; Mouton, 2001:245), as confidentiality was strictly maintained.

### **1.9.2. Informed consent**

Informed consent implies that participants have adequate knowledge of the research, i.e. the goal of the research, the research procedures, possible advantages and disadvantage, and the credibility of the researcher (Mouton, 2001:244; Haverkamp, 2005:154; Strydom, 2005c:59). Participants should also know that participation in the study is voluntary and that they can withdraw at any time (Babbie & Mouton, 2001:521; Mouton, 2001:244; Strydom, 2005c:59). Participants were given a letter of informed consent before participating in the study, stipulating all above aspects (see appendix A). Written consent to participate was obtained, as well as permission to quote written (survey) or transcribed (interview) data in the dissertation. Prior to interviews, verbal consent was once again obtained from participants to have the interviews audio-taped. Participants were assured of confidentiality.

### **1.9.3. Preventing deception of participants**

Participants were thoroughly informed of the goal and processes of this research study. No information was withheld or manipulated so as to coerce participants into participation (Babbie & Mouton, 2001:525; Strydom, 2005c:60). If it so happened that participants felt deceived in any way, the researcher was available to discuss and rectify the problem.

### **1.9.4. Confidentiality**

Haverkamp (2005:154) and Strydom (2005c:61) stress the importance of safeguarding participants' identity and privacy by means of confidentiality. Confidentiality was ensured throughout the research process. Once questionnaires were received and participants selected for interviews, any identifying information was removed and a participant number assigned (Mouton, 2001:244; Babbie & Mouton, 2005:523). A file in which the names and participant numbers were linked was kept and locked in a cabinet not accessible to any other persons. During the remainder of the research process participants were only identified by their participant numbers. No personal, identifying information regarding participants was made known. Furthermore, participants were asked to not provide any identifying information about the children in question. This was complied with.

### **1.9.5. Actions and competence of the researcher**

Researchers should bear the responsibility of ensuring that they are competent and possess the necessary skills to undertake the research investigation. In addition, the entire research process should be characterised by ethical decision making (Haverkamp, 2005:151; Strydom, 2005c:63). The researcher refrained from impressing her own values and morals upon the participants and from making value judgments about participants' views (Babbie & Mouton, 2001:64) (refer to Trustworthiness, Point 4.8). Prior to commencement of the study, the proposal was accepted by the Ethics Committee of Huguenot College. A competent supervisor kept an eye on all research proceedings.

### **1.9.6. Release or publication of findings**

All researchers are ethically obliged to make findings accessible to the scientific community (Babbie & Mouton, 2001:527; Mouton, 2001:239; Strydom, 2005c:65). Participants should also have free access to an objective account of findings, as the research process should also be a learning experience for them (Strydom, 2005c:67). This dissertation, once accepted, will be made available to the public, as it will appear in the library of UNISA.

## **1.10. Definition of key concepts**

### **1.10.1. Gestalt theory, Gestalt therapy and Gestalt play therapy**

Gestalt therapy is a humanistic, process psychotherapy based on phenomenology, existentialism and field theory (Bowman, 2005:6-12; Yontef & Fairfield, 2005:2; Blom, 2006:17). Phenomenology is concerned with subjective experiencing of the here and now experience (Zinker, 1977:84-88; Crocker, 2005:67; Yontef, 2007:18; Joyce & Sills, 2010:16). Gestalt theory, particularly the concept of phenomenology, underpins this research study, as participants' subjective experiences were explored.

Gestalt play therapy is a recent development in Gestalt therapy and shares many concepts of Gestalt therapy. It is process-oriented therapy aimed at helping children and adolescents to become aware of their processes instead of targeting behaviour change (Oaklander, 2007:46). Gestalt play therapy authors indicate that the play therapeutic process should start with relationship building and sensory contact making. This is followed by strengthening of the self, working with aggressive energy and projections, self-nurturing, handling persistent problems and termination (refer to Table 3.1). All participants were Gestalt play therapists.

### **1.10.2. Occupational therapy**

“Occupational therapy uses the client’s active engagement in meaningful, purposeful and socio-culturally approved activities to remediate occupational dysfunction precipitated by illness, injury, developmental delay, lack of environmental resources and opportunity.” (OTASA, 2003.) It is concerned with health and well-being through participation in occupations. The primary goal of occupational therapy (OT) is to enable people to participate in everyday life activities by enhancing their ability to participate or by modifying the environment to better support participation (WFOT, 2004). Occupational therapists (OTs) may receive specialised training in sensory integration, which enables them to diagnose and treat SID (Kruger, 2010; Van Jaarsveld, 2005:370).

### **1.10.3. Sensory integration**

Sensory integration (SI) is a neurological process whereby the sensations from one’s own body and the environment are organised, enabling the effective use of the body in the environment. SI encompasses the entire sequence of central nervous system events – from reception by the sensory organs, to the display of an adaptive environmental interaction (Bundy *et al.*, 2002:479).

### **1.10.4. Sensory integration dysfunction**

Sensory integration dysfunction (SID) refers to difficulty with central nervous system processing of sensation. Of particular interest to occupational therapists is processing of vestibular, tactile or proprioceptive sensory input. Dysfunction manifests as praxis or modulation disorders, or both (Bundy *et al.*, 2002:479).

## **1.11. Outline of the research report**

Chapter 1 provides a brief overview of the study. It is concerned with providing an introduction into the rationale, research problem, research question, aims, objectives, design, method, data collection and ethical considerations of the study.

Chapter 2 introduces the reader to sensory integration and sensory integration disorders. The impact of sensory integration disorders on the child is highlighted.

Chapter 3 includes a discussion on Gestalt therapy, Gestalt play therapy and concepts related to this study. Aspects central to sensory contact-making are described and related to the child who suffers from a sensory integration disorder.

Chapter 4 describes the empirical research process, data analysis and findings. Findings are discussed against the backdrop of available literature.

Chapter 5 presents an evaluation of the research process, summary of findings and conclusions. Recommendations for further research are made.

## **1.12. Limitations of the study**

The researcher expected the research sample to be small, due to the assumption that Gestalt play therapists are not generally aware of SI theory or SID and would therefore not be sure whether they had treated children with SID. Inclusion criteria were thus expanded in two ways:

- They study included Gestalt play therapists who had treated children strongly suspected of having a diagnosis of SID. Findings cannot be applied exclusively to children with a confirmed diagnosis of SID, but rather to children who have sensory contact-making difficulties in general.
- No limit with regard to children's age, race or gender was imposed, as this would have diminished the research sample even further. The children's

emotional responses or behaviour could have been influenced by these factors.

This research study did not aim to produce findings that can be generalised to all populations and circumstances.

### **1.13. Conclusion**

This chapter demonstrated the rationale for this study. It introduced the reader to the research problem, aim, objectives, approach, design and method. The following chapter is dedicated to a discussion on sensory integration.

# Chapter 2

## Theoretical considerations relating to sensory integration

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### **2.1. Introduction**

The world in which we live abounds with sensory information. Throughout life, every person's central nervous system is continuously bombarded with incoming sensory stimuli from the environment and the body itself. This information is used to make sense of the world and to act in a purposeful manner to meet environmental challenges. Sensory integration (SI) is the process whereby this potentially confusing assortment of sensory information is processed, modulated and integrated to be made clear and useful in everyday life.

The goal of this chapter is to provide the reader with an introduction into the fascinating science of SI and the intricate impact thereof on the child's functioning within the field. SI was developed from within the scope of occupational therapy (OT). The functional implications of SI from an OT paradigm will provide a backdrop for this discussion. Sensory systems will be reviewed, after which SI, sensory integrative dysfunction (SID) and other concepts of interest will follow. Some concepts will be related to Gestalt theory. However, Gestalt theory will be thoroughly discussed in Chapter 3.

The researcher wishes to present said information in an understandable manner. In order to facilitate clear comprehension of SI and OT theory, important terminology needs to be defined and elaborated upon. The following terms will be discussed: adaptive response, arousal, hyperresponsiveness, hyporesponsiveness, modulation, neurological threshold, praxis, sensory integration, sensory integrative dysfunction and sensory processing.

## **2.2. Terminology**

**Adaptive response** is the interaction between the environment and the individual, where the individual is able to meet the demands posed by the environment (Parham & Mailloux, 2005:410). An adaptive response is considered a visible, behavioural response to challenges posed by the environment.

**Arousal** is the level of neuron excitability, which influences the central nervous system's ability to maintain alertness, focus and concentration (Dahl Reeves, 2001:89). An optimum level of arousal is needed to ensure a calm-alert state. Under- or over-arousal can lead to disorganisation and dysregulation (Smith Roley, 2008:18). Sensory stimuli can have a facilitative effect on the level of arousal, implying that the level of arousal is increased. Sensory stimuli can also be calming, thus lowering the level of arousal.

**Hyperresponsiveness** is defined as a disorder of modulation, where the individual reacts strongly and defensively to normal sensory input as a result of a lowered neurological threshold. It is often used interchangeably with the terms "over-responsiveness" or "defensiveness" (Parham & Mailloux, 2005:410).

**Hyporesponsiveness** is a disorder of modulation, where the individual tends to be relatively unaffected by normal sensory input as a result of a higher neurological threshold. It is often used interchangeably with "under-responsiveness" (Parham & Mailloux, 2005:410).

**Modulation** refers to the ability to react to sensory input in an appropriately regulated manner, neither overreacting nor under-reacting to sensory input (Bundy et al., 2002:481; Parham & Mailloux, 2005:410).

**Neurological threshold** is the level at which stimuli are barely perceptible (Bundy et al., 2002:480). Children who are hyporesponsive to sensory stimuli are said to have a high neurological threshold. A higher level of stimuli is required to elicit a response. Children who are hyperresponsive have a low neurological threshold. A lowered level of stimuli is needed in order to elicit a response (Lane, 2002a:108).

**Praxis** is the ability to ideate (conceptualise), plan (organise) and execute non-habitual movements. Praxis includes cognitive and motor processes (Parham & Mailloux, 2005:410-411).

**Sensory integration (SI)** is “the organisation of sensory input for use” (Ayres, in Smith Roley *et al*, 2001:5). SI is a neurological process whereby the sensations from one’s own body and the environment is organised, enabling the effective use of the body in the environment. SI encompasses the entire sequence of central nervous system events from reception by the sensory organs, to the display of an adaptive environmental interaction (Bundy *et al.*, 2002:479).

**Sensory integrative dysfunction (SMD)** refers to difficulty with central nervous system processing of sensation. Of particular interest to occupational therapists is processing of vestibular, tactile or proprioceptive sensory input. Dysfunction manifests as praxis or modulation disorders, or both (Bundy *et al.*, 2002:479).

**Sensory processing** refers to the handling of sensory information by sensory receptors and the central nervous systems. It includes reception, modulation, integration and organisation of stimuli, as well as the behavioural responses to stimuli (Parham & Mailloux, 2005:410).

### **2.3. Sensory systems**

The human body encompasses seven sensory systems: the visual, auditory, gustatory (taste), olfactory (smell), tactile (touch), proprioceptive (awareness of joint position) and vestibular systems (Bentzel, 2002:160; Parham & Mailloux, 2005:357; Lombard, 2007:11). Sensory stimuli can affect the excitability of the central nervous system, affecting the level of arousal. Arousal levels can range from sleep on one extreme, to over-stimulation and irritability on the other. The ideal state for learning and contact with the environmental field is the calm-alert state, which can be found in the centre of the two said extremes. In this state, the child is able to concentrate optimally (Dahl Reeves, 2001:93; Faure & Richardson, 2010:18). Each of the seven

senses will be discussed briefly. Examples of inhibitory and excitatory sensory stimuli will be provided.

### **2.3.1. Visual system**

Vision and hearing are distant senses, as they allow a person to receive information from the environment outside the body. The primary function of the visual system is to transmit visual stimuli to the brain, where they are interpreted, coded and associated with past experiences (Schneck, 2005:413). Vision is used to make sense of the relationships between people and objects and to obtain information regarding distance, movement, spatial organisation, size, shape and colour, to name but a few (Russel & Nagaishi, 2005:828). Interpretation of visual stimuli is a mental process which takes place in the primary visual cortex of the brain (Meyer, Van Papendorp, Meij & Viljoen, 2002:8.9).

Bright or contrasting colours, bright or flashing light, a disorderly environment and fast moving objects have a facilitating nature and increase arousal (Labuschagne, 2005:563). An environment rich in visual stimuli can distract a child with attention difficulties, or provide a facilitative effect for children who are hyporesponsive to stimuli. Muted light with soft, natural colours in an organised environment is calming and provides a better environment for children who are hyperresponsive to visual stimuli (Faure & Richardson, 2010:19).

### **2.3.2. Auditory system**

Hearing is the sense that conveys sound from the environment. Sound provides information about the distance and direction of the stimulus (Russel & Nagaishi, 2005:828). Hearing is especially used to receive communication from people and objects in the environment.

Unpredictable noises, high or fluctuating pitch or loud noises have a facilitating nature and can increase the state of arousal. Children who are hyperresponsive to auditory stimuli may experience background music or noises as loud and disturbing.

“White noise”, rhythmic, soft and familiar sounds have a calming effect on the central nervous system (Faure & Richardson, 2010:19).

### **2.3.3. Gustatory system**

Taste and smell are associated with food and the digestive system (Meyer *et al.*, 2002:8.17). The tongue is used to taste food. Strong, sour, bitter or salty tastes are facilitative, while mild, sweet tastes are calming (Faure & Richardson, 2010:19).

### **2.3.4. Olfactory system**

Literature indicates that smells are often associated with emotions. Certain smells may be linked to memories and are a powerful facilitator in re-experiencing emotions linked to those experiences (Blom, 2006:91). Olfactory impulses are transmitted to the primary olfactory cortex situated in the limbic lobe of the cerebral cortex. The limbic system is concerned with emotional responses (Meyer *et al.*, 2002:8.18).

Strong, pungent smells such as perfume, chemicals or smoke have a facilitative effect on the nervous system. Neutral smells and smells associated with positive experiences have a calming effect (Faure & Richardson, 2010:19).

### **2.3.5. Tactile system**

The sense of touch encompasses the sensing of temperature, pain, light touch, deep pressure and vibration on the skin as well as inside the mouth (Bentzel, 2002:161). In sensory integration theory, touch and the tactile system are considered to be a significant determinant of behaviour (Lane, 2002b:51).

Light touch (such as tickling), unpredictable touch, touch on the front of the body and face, mixed textures and extreme temperatures are facilitating in nature. Deep pressure (firm touch or massaging), touch to the back, neutral warmth, smooth and soft textures and touch in and around the mouth are generally calming and are better tolerated by tactile defensive children (Faure & Richardson, 2010:19).

### **2.3.6. Proprioceptive system**

Some authors classify proprioception under the sense of touch (Bentzel, 2002:161). However it is classified, it is important to distinguish between touch and proprioception. Proprioception is the awareness of the positioning and movements of the body. It is the result of the person's own movement and is sensed by receptors in the muscles, tendons and joints (Lane, 2002b:47; Meyer *et al.*, 2002:7.1-7.3). The tactile system, however, provides information regarding the location of an external stimulus which is in contact with the skin (Lane, 2002b:48).

Proprioceptive stimuli exert a regulatory influence over other sensory systems. The modulating effects of proprioceptive stimuli help to decrease hyperresponsiveness to sensory stimuli from other systems. It generally has a modulating effect on the level of arousal, facilitating a calm and alert state (Blanche & Schaaf, 2001:113). In occupational therapy (OT), proprioceptive input is mostly introduced by facilitating adaptive behaviour against resistance and traction or compression through the muscles and joints (Blanche & Schaaf, 2001:121; Lane, 2002b:47). Activities such as tug-of-war, wheelbarrow walking, pushing objects, pulling and kneading play-dough all provide proprioceptive input (Blanche & Schaaf, 2001:121).

### **2.3.7. Vestibular system**

The receptors and structures of the vestibular system are located in the inner ear. The information obtained from the receptors is used to detect head and body position in space and movement of the head. It includes detection of the changes and speed of rotation, acceleration and deceleration of the head (Lane, 2002b:53-56).

Fast, irregular, angular and spinning movements have a facilitating nature. Slow, rhythmical, linear movements have a calming effect (Faure & Richardson, 2010:19).

The above information introduced the reader to the notion that sensory stimuli will either have a facilitating or modulating effect on the child's neural system and level of arousal. The playroom and all sensory stimuli gained from the therapeutic

environment will thus either facilitate or decrease the child's level of arousal during Gestalt play therapy. When the therapist is knowledgeable on the effect of sensory stimuli she can use it to the child's advantage. For example, when the child has an already high level of arousal (such as an over-active, distractible child), the sensory environment can be altered to assist the child with moving to a calm-alert state.

A higher level of arousal will usually be seen during specific stages of the therapeutic process, particularly during the expression of aggressive energy. A lower level of arousal may present after the completion of the Gestalt contact cycle when all foreground needs have been met, or when the child is satisfied but tired after a session. The calm-alert state is, however, considered to be the desired state for learning and useful interaction with the environment (Dahl Reeves, 2001:93; Faure & Richardson, 2010:18).

Gestalt play therapists routinely use sensory contact-making (the provision of sensory stimuli) in order to raise the child's sensory awareness levels (Blom, 2006:90-100; Oaklander, 2007:24-25). When this is done, the level of arousal is either facilitated or decreased. Right at that moment, a child with sensory integration difficulties may become confused, irritable or withdrawn (Lane, 2002a:108; Parham & Mailloux, 2005:378; Van Jaarsveld, 2005:373). The researcher strongly holds that if the play therapist is aware of which stimuli are needed in order to shift to a calm-alert state, sensory contact-making can prove to be a much more powerful tool in Gestalt play therapy.

The brain constantly receives sensory information from all seven sensory systems. This information needs to be processed and modulated in order to provide the human body with useful, clear information about the environment. This process is referred to as sensory integration.

## **2.4. Sensory integration**

SI is used to describe the integration of all the information received from the senses, configuring it into an understandable whole. A.J. Ayres, an occupational therapist

(OT), developed sensory integration theory between the late 1960s and the 1980s (Van Jaarsveld, 2005:369). According to Ayres, sensory integration is to organise sensations in order to use them purposefully (Parham & Mailloux, 2005:357).

The concept of SI can be explained by means of a vignette. Imagine a little girl playing outside in the garden with her brother. It is a delightfully sunny afternoon. A soft breeze is blowing, carrying the aroma of delicious food being prepared by their mother. Occasionally, cars and people pass by. The little girl now attempts to master riding a bicycle. The environmental sensory stimuli that are registered by her senses may consist of the following:

- **Hearing:** Her brother playing and making noises in the background, cars roaring by in the street, birds singing, droning of a lawn mower further down the road, a teenager playing loud music next door, the sound of the television inside the house, her mother calling her.
- **Sight:** The sight of the path on which she is riding, her feet and hands as she looks at them, the pretty bright floral dress she is wearing, her brother in the background, the garden and everything in it, people walking by in the street and birds fluttering skyward.
- **Touch:** The feeling of sitting on the saddle, her hands gripping the handles, her feet on the pedals or touching the ground, the gentle tickle of the sun on her face, the touch of her clothes against her body, that irritating label sewn into the back of her dress, the brushing of her hair against her neck, the wind blowing and the pain of a scraped knee that was acquired on a previous bicycle riding attempt.
- **Smell:** The smell of food wafting from the house, blooming flowers, the smell of the detergent used to wash her clothes and the smell of shampoo in her hair.
- **Taste:** The taste of sweat or tears or the lingering taste of the sweet she ate a few minutes ago.

- **Proprioception (awareness of the position of body parts):** The awkward, unfamiliar position and movements of her limbs in relation to one other while she is pedalling, steering and balancing simultaneously.
- **Vestibular:** The feeling of moving forward, riding over a bump in the driveway, accelerating and decelerating, stopping, the feeling that she is about to lose her balance, falling sideways or forward.

In the midst of all these potentially confusing sensations the little girl has to concentrate on the single need of mastering the novel, complicated skill of riding a bicycle. She is attempting to meet the challenges of riding the bicycle by planning and executing the necessary movements. The girl also needs to balance, steer the bicycle in the right direction and maintain the correct pedalling speed.

The little girl's brain has to select, process and focus on only the most relevant sensory information for each passing moment in order for her attempt to be successful. If she is falling sideways, vestibular and proprioceptive information will take precedence over other senses such as smell or taste. It will assist her in either correcting her balance or bracing for the fall. The brain can also select the most important information from each sensory system. The girl cannot concentrate on how pretty the garden is looking, but will rather look intensely at where she is going with the bicycle.

This ability to process, organise and integrate sensations refers to SI. When SI results in the ability to plan and execute the necessary behavioural response, it is termed the *adaptive response* (Parham & Mailloux, 2005:358; Van Jaarsveld, 2005:371). If the child's brain and neural system are unable to perform sensory integration correctly, SI dysfunction (SID) will occur. Unimportant sensory information will distract her, resulting in an inability to focus on the task at hand or plan the necessary movements with her body. The process of SI and the execution of an adaptive response thus play an enormously important role in learning, coping with demands from the environment and the child's own body, as well as general behaviour and functioning (Van Jaarsveld 2005:369).

The process of SI is not a passive one. An adaptive response is always elicited. The success of the adaptive response is an indication of whether efficient sensory SI is taking place.

## **2.5. Adaptive response**

A child does not passively absorb all sensory stimuli from the environment. As previously mentioned, the term SI depicts an active process whereby incoming sensations are purposefully selected and organised in a useful fashion. When this is achieved, the child can organise and execute a useful, goal-directed action or response to the environment, termed the *adaptive response* (Spitzer & Smith Roley, 2001:8; Parham & Mailloux, 2005:358). The importance of an adaptive response is twofold: firstly, the adaptive response enables the child to overcome challenges posed by the environment; secondly, the adaptive response promotes development as it facilitates the organised state of the brain, giving way to more complex adaptive responses (Parham & Mailloux, 2005:358).

The adaptive response is what sets SI apart from other theories or applications such as *sensory stimulation*. Sensory stimulation is a therapeutic process often applied in the treatment of preterm neonates, patients with an altered state of consciousness or patients suffering from traumatic brain injuries (Radomski, 2002:863-866; Hunter, 2005:713-717). Carefully selected sensory stimulation is provided to the individual who passively receives it. The individual is not expected to integrate and organise incoming sensory information in order to actively produce an adaptive response, as is the case with sensory integration (Spitzer & Smith Roley, 2001:8).

Children who find it difficult to initiate and execute an adaptive response often struggle with the process of self-regulation and maintaining homeostasis. Smith Roley (2008) maintains that dysregulation can take on many forms, one of which relates to SID.

The researcher believes that internal self-regulation is strongly dependent on sensory integration abilities. Internal self-regulation is often linked to a visible

behaviour. When a child has a need to play with her friends on the jungle gym, her internal self-regulation abilities mobilise her to go to them and engage in play. When the child suffers from sensory integrative dysfunction she may not be able to climb successfully onto the jungle gym or engage in socially appropriate play with her friends. The researcher maintains that sensory integrative dysfunction can often be the factor which inhibits children's abilities to self-regulate and achieve homeostasis.

## **2.6. Sensory integration disorders**

When a problem in SI occurs, the child may experience stress during the performance of everyday tasks (Parham & Mailloux, 2005:365; Schaaf & Miller, 2005:143). The child may, for example, find it difficult to dress, eat, join in physical games with friends or maintain attention in class. According to Parham and Mailloux (2005:365), the child will become aware of these difficulties and will become frustrated by repeated failure. Consequently, many children with SID tend to avoid simple sensory or motor challenges. When this becomes a pattern, the child misses out on important activities and learning opportunities which develop motor skills, a sense of mastery and flexible social skills. Problems which are frequently reported in children with SID include behavioural, social, motor coordination and academic impairments (Lombard, 2004:14; Geysler, 2009:9-13; Mackenzie, 2009:15).

The researcher always utilises basic SI principles when treating children during both OT and Gestalt play therapy. In the researcher's experience, children who are referred to OT for academic problems not only experience developmental delays but also SID and self-esteem problems. As a result of unsuccessful contact with the environment, a diminished sense of self occurs. When the SI problems are addressed, the child is able to produce effective adaptive responses which provide a platform for the assuagement of other difficulties. In many cases, the child's sense of self improved, negating the need for play therapeutic intervention.

The term SID is an umbrella term used to describe various SI disorders. Van Jaarsveld (2005) describes SID by mentioning two categories: sensory modulation disorders and practic disorders. Sensory modulation and practic disorders will be

discussed below to provide the reader with a better understanding of these dysfunctions. It will enable the reader to construct a mental image of how the child with SID may behave in therapy. It will provide an insightful view of the difficulties these children are faced with every day. Readers may also be surprised to find themselves identifying with some aspects of these dysfunctions, as all people can experience sensory problems at times. According to Lombard (2004; 2007), sensory modulation is an ongoing process in every person's life, and everyone experiences poor modulation at times. However, dysfunction is determined by the frequency and intensity of these occurrences (Lombard, 2004:20; Lombard, 2007:33).

### **2.6.1. Sensory modulation disorders**

Sensory modulation is defined by Lombard (2004:14) as “the ability of the nervous system to regulate, organise, and prioritise incoming sensory information, inhibiting or suppressing irrelevant information and prioritising and helping a person to focus on relevant information.” An individual whose nervous system is well modulated is able to adapt his behaviour to changes or challenges in the environment, sustain attention towards a task, ignore irrelevant incoming sensory information and respond in an appropriate manner towards the degree and proportion of the sensory information (Miller, Reisman, McIntosh & Simon, 2001:57; Lombard, 2004:14).

This process is disturbed when dysfunction in sensory modulation occurs. Sensory modulation dysfunction (SMD) is defined as:

*. . . [A] problem in regulating and organizing the degree, intensity and nature of responses to sensory input in a graded manner. SMD disrupts an individual's ability to achieve and maintain an optimal range of performance, and to adapt to challenges in daily life. (Miller et al., 2001:57).*

Individuals suffering from SMD demonstrate hyperresponsiveness, hypo-responsiveness or lability when faced with incoming sensory information (Miller *et al.*, 2001:58; Lane, 2002a:108). It interferes with the ability to organise behaviour to be appropriate and effective in terms of the challenge posed by the environment. In addition, children with SMD are continuously distracted by changes in the sensory environment as they are unable to filter irrelevant sensory information (Lane, 2002a:104; Van Jaarsveld, 2005:372).

SMD can manifest in several ways. Four types of SMD have been identified in sensory integration theory. These disorders will be discussed below.

#### **2.6.1.1. Sensory defensiveness**

Sensory defensiveness is a hyperresponse to sensory input. It is often linked to inadequate limbic or reticular processing in the brain. Intense fight-or-flight reactions are elicited when the child experiences sensory stimuli which others would regard as non-noxious (Parham & Mailloux, 2005:378; Van Jaarsveld, 2005:373). Children with sensory defensiveness react more intensely to sensory input than what is considered normal within a population. They often experience anxiety, fear and aggression when exposed to the sensation to which they are defensive, leading to withdrawal and avoidance of activities or situations which will expose them to it (Lane, 2002a:108; Van Jaarsveld, 2005:373). Sensory defensiveness can occur in one or more sensory systems, or in reaction to all types of sensory input (Parham & Mailloux, 2005:378).

Lane (2002a:117) put forth hypotheses which link sensory defensiveness with too little or too much behavioural inhibition, resulting in behavioural and secondary emotional problems such as irregular emotional tone, lability, extreme need for personal space and disruption in personal care. A child with sensory defensiveness may experience a myriad of secondary deficits which can manifest in problems with relationships, learning and functioning at school, self-care and play (Lane, 2002a:117; Van Jaarsveld, 2005:373; Geysers, 2009:11-12; Mackenzie, 2009:15-18). These can also manifest in the playroom. Some examples of problem behaviour include:

- Avoidance of certain clothing fabrics or an unusual preference for certain styles of clothing such as long-sleeved shirts or soft materials (refer to Chapter 4, point 9.2.1.4.). These children may dislike playing “dress up” during therapy, as they may have to handle and wear clothes with textures to which they have an aversion. Additionally, dress-up clothes may have unusual odours from old age or prolonged storing.

- Preference for standing at the end of the line in order to avoid physical contact with others, or lashing out at other children who accidentally bump into the child.
- Pulling away or avoiding anticipated touch or physical interaction with others; struggling when being cuddled or picked up; responding with aggression to light touch to the face, arms and legs. This may also apply to the therapeutic situation where the therapist makes physical contact in the form of hugs, a touch to the hair or physical assistance during an art or play activity.
- Avoidance of play activities that involve body contact with others, which can manifest in a preference for solitary play.
- Aversion of certain self-care tasks such as bathing, brushing teeth, cutting fingernails, brushing hair and washing the face.
- Aversion to art materials or play equipment such as sand, finger paint and pastes, which may result in refusal to participate in such activities. This is particularly applicable to play therapy as therapists often use such activities to facilitate sensory awareness during therapy.
- Moving away from background noise; becoming aggressive or frustrated in noisy settings. When background music is played during therapy, the child with an aversion to auditory stimuli may become completely over-aroused, leading to frustration and anger.
- Being unable to concentrate in class, as a result of background noise.
- Avoiding food with certain textures or tastes; in some cases preferring only a small selection of bland or pureed food, which can result in dietary problems.

#### **2.6.1.2. Gravitational insecurity**

Gravitational insecurity is linked to otolith processing, which forms part of the vestibular system. Children with gravitational insecurity fear everyday movements

that involve changes in head position or having their feet lifted off the ground (Lane, 2002a:118; Parham & Mailloux, 2005:378-379; Van Jaarsveld, 2005:373). The response to said movements is excessive and disproportionate to the stimulus. According to Lane (2002a:118) and Parham and Mailloux (2005:379), simple tasks such as getting into and out of a car, stepping off a curb, riding in an elevator, on an escalator or navigating uneven surfaces can present anxious moments for children with gravitational insecurity. Other common childhood activities such as using playground equipment, bicycle riding, swinging and ice-skating pose a big challenge to these children and often result in avoidance of the activity.

During play therapy, the child with gravitational insecurity may resist being picked up, wearing masks or being blindfolded as they are scared of falling, swinging, participating in games such as ring-a-rosy where they have to “fall down” fast or any other instance where uneven surfaces or climbing equipment plays a role.

#### **2.6.1.3. Aversive response to movement**

According to Lane (2002a:119) and Van Jaarsveld (2005:373-374), an aversive response to movement reflects poor processing of the information obtained from the semi-circular canals in the vestibular system. It is characterised by sympathetic autonomic nervous system reactions such as nausea, vomiting, dizziness and discomfort. Children with an aversive response to movement or gravitational insecurity tend to be fearful of unfamiliar movements. As a result, they avoid participating in activities such as rough-and-tumble play, sport or outdoor activities or going on rides in amusement parks. They often find themselves socially isolated and left out of these activities (Lane, 2002a:119; Van Jaarsveld, 2005:373-374). As with the child with gravitational insecurity, the child with an aversive response to movement will have an aversion to games which require a lot of big movement or change in position of the body and head.

#### **2.6.1.4. Hyperresponsiveness**

Each of the mentioned sensory modulation disorders pertain to hyperresponsivity with regard to certain sensory stimuli. According to van Jaarsveld (2005:374) some

children may present with hyporesponsivity or underresponsiveness. These children display a response to sensory stimuli which is far less intense than normally expected. Underresponsive children do not seem to notice sensory stimuli and can appear to be lethargic and daydreaming. Attention problems occur as these children need an increased amount of sensory input to maintain their attention.

It is important to realise the impact of the sensory environment created by the play therapist. Aversive, aggressive or withdrawal behaviour during therapy may have a neurological origin rather than an emotional one. Although practic dysfunction does not imply a direct behavioural response to sensory stimuli, it also gives rise to emotional experiences and behavioural responses.

### **2.6.2. Practic dysfunctions**

Another group of sensory integrative dysfunctions is practic dysfunctions, which are disorders of praxis. Parham and Mailloux (2005:382) refer to praxis as the ability to conceptualise, plan and execute new or unknown movements. Children with practic disorders are usually deemed to be clumsy and awkward. They experience difficulty with organising tasks (Van Jaarsveld, 2005:374). Moving from one position to the other, performing novel tasks and sequencing and timing the actions involved in a task are performed with great difficulty, often resulting in failure. Children with practic dysfunction experience difficulty with imitating other people's movements and directing their bodies correctly towards objects. Oral praxis may be affected, resulting in difficulties with eating or word articulation (Parham & Mailloux, 2005:382).

Some children with practic dysfunction have problems with ideation, which is the ability to generate ideas of what to do in novel circumstances. Of particular interest to the play therapist is the impact on the child's ability to initiate play. Parham and Mailloux (2005:382-383) explain that if a child with practic dysfunction is asked to play, without being given specific instructions, the child may have difficulty with organising and initiating the task. Examples of typical responses include: wandering around aimlessly, performing repetitive actions such as touching or patting objects,

randomly piling objects without a specific plan, or observing others at play and then trying to imitate them instead of initiating their own play activity. These examples provide the play therapist with insight into how sensory integration disorder affects the completion of the contact cycle of experience during daily life, as well as during therapy.

## **2.7. Conclusion**

Sensory integration provides a neural background for the process of adaptive behaviour to take place (Parham & Mailloux, 2005:358). SID inhibits or distorts this process and impacts the child's life in various areas: social development, interpersonal relationships, development of motor skills, meeting academic demands, performing daily self-care activities and play (Lombard, 2004:14; Geysler, 2009:9-13; Mackenzie, 2009:15; Van Jaarsveld, 2005:372-376;). In this chapter, the reader was provided with basic introductory knowledge regarding SID. The impact of SID on the child's daily life was highlighted, with some examples of how this may manifest during Gestalt play therapeutic intervention. The researcher will continue with a discussion of the Gestalt play therapy and its relation to SI in the following chapter.

# Chapter 3

## Theoretical framework

### Gestalt play therapy

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#### **3.1. Introduction**

In the previous chapter, the reader was introduced to sensory integration (SI) theory. In this chapter, the researcher wishes to present the reader with a take on Gestalt therapy, Gestalt play therapy and its entwinement with SI theory. The study focuses on how sensory contact is established with children who present with sensory integration disorders (SID). Therefore, discussion of sensory contact and related concepts will be the focus of this chapter.

#### **3.2. Gestalt therapy**

Gestalt therapy was primarily developed by Frederick and Laura Perls and Paul Goodman (Bowman, 2005:6; Yontef & Fairfield, 2005:2). During the 1940s, Frederick Perls laid the foundations for the development of Gestalt theory through his frustrated efforts to modify psychoanalysis. Perls attempted to shift the focus of psychotherapy from analysis (by the therapist) to the client's own phenomenological experience. Perls' efforts would ultimately cause a paradigm shift from the traditional "vertical" relationship between the patient and therapist to a "horizontal" one where therapist meets client in a phenomenological I-Thou encounter (Yontef & Fairfield, 2005:2).

Later influenced by thinkers in psychoanalysis, existentialism, Gestalt psychology and eastern philosophies, Gestalt therapy is known today as a humanistic, process psychotherapy based on phenomenology, existentialism and field theory (Bowman, 2005:6-12; Yontef & Fairfield, 2005:2; Blom, 2006:17). The immediate goal in Gestalt therapy is not to change behaviour but rather to restore awareness of the client's life

(field) and himself functioning as part of the field. When awareness is increased, attention can be fixed upon alternative, novel ways of contact or interaction with the field (Naranjo, S.a:2; Yontef & Fairfield, 2005:2-10; Joyce & Sills, 2010:31). Considering that being aware is the central goal of Gestalt therapy, all elements of awareness should receive prime attention during the Gestalt therapeutic process. Being sensorily aware is a central element of awareness and is linked with the process of establishing sensory contact during therapy. This will be elaborated upon in this chapter.

Gestalt play therapy is, as its name suggests, Gestalt therapy with the distinct focus of intervention with children. It is a relatively recent development in Gestalt therapy. Many authors and therapists are grateful for the pioneering work of Dr Violet Oaklander in this regard (Tudor, 2002:150; Wheeler, 2002:23).

### **3.3. Gestalt play therapy**

Dr Violet Oaklander describes her journey of working with children in the preface of *The heart of development, volume 1* (Wheeler & McConville, 2002). Oaklander started to apply Gestalt therapy in her work with children in 1970. Feeling frustrated with the lack of literature available on Gestalt therapy with children, Oaklander started to experiment with techniques and applying Gestalt theoretical concepts to her interaction with students in her class where she was teaching. Following this, she left the school setting and moved into private practice where she continued her studies and work with children. In 1978, her first book on Gestalt play therapy was published. Many authors consider Oaklander to be the pioneer of Gestalt play therapy (Tudor, 2002:150; Wheeler, 2002:23).

Blom (2006:22) asserts that some concepts of Gestalt therapy are also applicable to Gestalt play therapy: holism, homeostasis and organismic self-regulation, means of self-regulation, figure ground, process of gestalt formation and destruction, contact and contact boundary disturbances, polarities and structure of the personality. Although Blom does not list awareness as a central aspect, it is mentioned and described in her book. In her work, Oaklander (2007) frequently points out the

significance of a non-judgmental stance of phenomenology. The researcher will continue to discuss concepts that are of particular interest to this study and that apply to both Gestalt therapy and Gestalt play therapy. Links will be drawn between Gestalt play therapy and SI theory.

### **3.4. Important concepts of Gestalt therapy and Gestalt play therapy**

#### **3.4.1. Awareness**

Awareness is a vital feature of both Gestalt therapy and Gestalt play therapy. Yontef (2005:87) categorically states that “[a]wareness is the very heart of the Gestalt therapy philosophy and methodology”. Awareness encompasses being in contact with internal and external processes of the self. It is to be mindful of the self on sensory, psychomotor, emotional and cognitive levels and being aware of the interaction between the self and the environment (Benevento, 2002:291; Yontef, 2005:87; Blom, 2006:52-53). As awareness increases during the therapeutic process, the child comes in contact with who he is and how he relates to the field. The child becomes aware of his own needs, expectations, wishes, actions, thoughts and attitudes. A heightened sense of choice and possibilities for alternative contacting ensues. He is enabled to exert ownership in making choices and taking responsibility for his actions unto the environment. This leads to experimenting with new behaviour and creative adjustment (Blom, 2005:53; Melnick & Nevis, 2005:104; Yontef & Fairfield, 2005:7). In their classic publication, Polster and Polster (1974:211) describe awareness as a “. . . continuous means of keeping up to date with one’s self”. Simply put, awareness is all about understanding what is going on inside, and knowing what the person can do to make it feel better (Zinker, 1977:90).

In Gestalt play therapy, awareness is deemed one of the three main objectives. Promoting self-supporting behaviour and integration constitute the other two (Blom, 2006:52-53). As mentioned, awareness is to be in contact with the self on sensory, emotional and cognitive levels. Zinker (1977:78) aptly states that awareness, which is experiencing the here and now, begins with sensation. Interestingly, sensory

integration (SI) theory and Gestalt theory agree on the importance and possible consequences of sensation. Sensory integration theory holds that the process of integrating the senses is linked with emotional reactions and behaviour (Parham & Mailloux, 2005:358; Van Jaarsveld, 2005:371). Yontef (2005:88) agrees that sensory data is used to orient and organise the internal process of the self, including urges, impulses and needs. Sensation co-exists with action, serving as the starting point for action to take place but also as the means by which the person becomes aware of the action (Polster & Polster, 1974:214; Melnick & Nevis, 2005:103-104). Sensation is therefore considered the first step in the Gestalt contact cycle of experience or homeostasis cycle, which will be elaborated upon at a later stage in this chapter.

Another concept central to Gestalt play therapy is phenomenology. Paired with the quest to facilitate awareness, the purpose of therapy is for the child to experience and embody his own, unique phenomenological awareness.

### **3.4.2. Phenomenology**

Field theory advocates that all perception is relative and subjective. Perception holds no universal truth. Every person perceives and interprets the field from a subjective stance, which becomes the way the world is seen (Parlett, 2005:47, Yontef, 2005:94; Joyce & Sills, 2010:17). During therapy, the viewpoint of the child and the therapist may vary greatly, but neither is seen as the absolute, more important truth.

Phenomenology supplements this stance by promoting the shared experience in therapy and exploring *what* is happening, rather than *why* it is happening. Phenomenology is about the description of the here and now experience, rather than interpretation and judging thereof (Zinker, 1977:84-88; Crocker, 2005:67; Yontef, 2007:18; Joyce & Sills, 2010:16). Although the therapist has his own opinion and ideas about the world, it is momentarily put aside in order to surrender to the phenomenological experience of what is happening in the here and now (Yontef, 2005:94; Yontef, 2007:19; Joyce & Sills, 2010:19). The Gestalt play therapist is curious about what the child is experiencing, and not at all concerned about why it is experienced. The therapist may frequently ask the child what he is feeling right now,

attending to sensory, bodily and emotional cues. Together, the sensory and emotional awareness is continuously explored to increase awareness and make sense of what is happening (Zinker, 1977:124; Tervo, 2002:123; Yontef, 2005:94).

Since Gestalt theory is deeply rooted in phenomenology, it prepares the Gestalt play therapist to accept the child and his experiences in totality (Oaklander, 2002:86; Blom, 2006:56). The I-Thou relationship, concerned with meeting the child on an equal level, is always applicable. In Gestalt play therapy, neither person is considered more important than the other. Since the child is genuinely accepted by the therapist, therapy is not aimed at changing the child in any way but rather to facilitate awareness of the child's self in the present situation (Oaklander, 2002:86; Yontef & Fairfield, 2005:2; Blom, 2006:53). The child who suffers from SID often feels misunderstood and rejected by others (Gutman, McCreedy & Heisler, 2004:11; Parham & Mailloux, 2005:383). Keeping a phenomenological stance enables the Gestalt play therapist to enter the child's world with judgement-free, warm acceptance. The researcher regards an authentic, phenomenological stance to be the key to therapy with a child with SID, whether it be in Gestalt play therapy or any other therapy.

The phenomenological stance of the therapist is functionally utilised to establish contact with the child, and to explore the many facets of the child's habitual contact patterns with the field. When contact is drenched with awareness, growth can take place.

### **3.4.3. Contact**

Children have the ability to self-regulate, therefore maintaining homeostasis by fulfilling their needs. Contact between the child and environment takes place as soon as the child uses the environment in order to satisfy a need (Reynolds, 2005:159; Blom, 2006:29). Contact is thus the vehicle which enables the child to maintain homeostasis, and is the place where all psychological growth occurs (Benevento, 2002:290). In Gestalt therapy, contact is also viewed as the function of the self. Spagnuolo Lobb (2005:31) states that "[t]he self is defined by the process of contact

and withdrawal from contact, in which the self is drawn to the contact boundary with the environment and, after the fullness of the encounter, withdraws". The contact boundary is the point where the child meets the environment: "I am" versus "I am not". A permeable contact boundary is needed to assure healthy contact. It permits contact and flow between the child and the environment, which is needed in order to have the child's needs met. Conversely, it also maintains the separate entities of self and the environment which is needed in order to establish and maintain a healthy sense of self (Oaklander, 2002:87; Reynolds, 2005:161; Blom, 2006:29-30).

Oaklander (2007:5) stresses the importance of contact:

*What brings children into therapy? . . . Most of the children I have seen in therapy over the years have had two basic problems. For one, they have difficulty making good contact: contact with teachers, parents, peers, books. Secondly, they generally have a poor sense of self.*

Children who have difficulty making contact are susceptible to the development of emotional or behavioural problems, indicating intervention such as Gestalt play therapy.

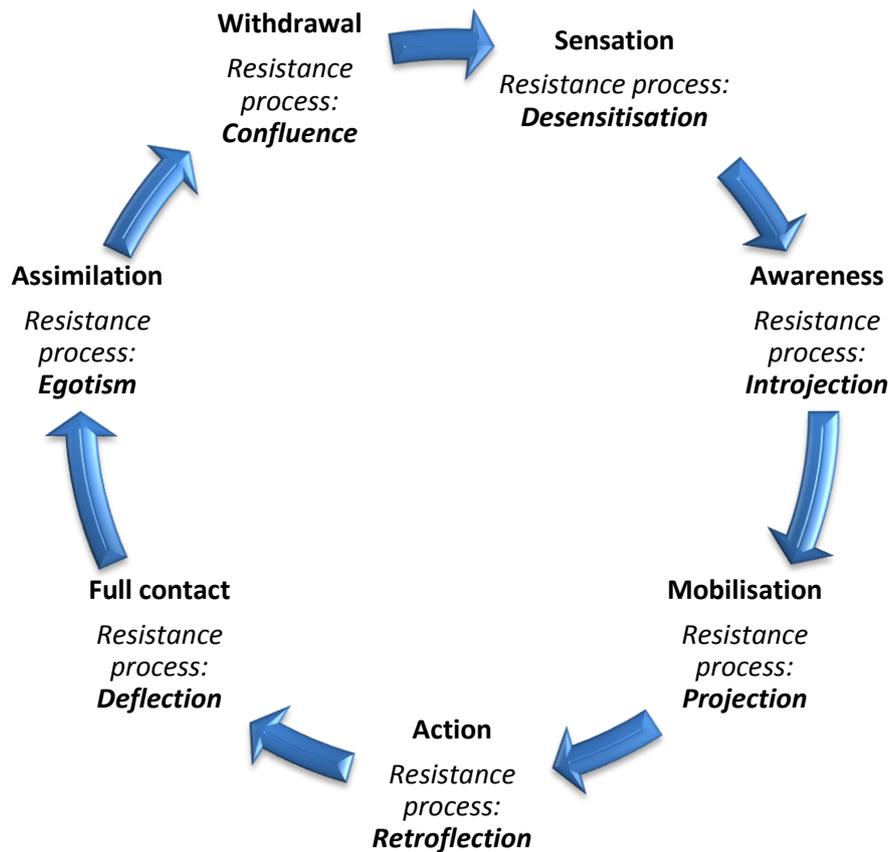
In order to make healthy contact, the child needs to use his senses, body, intellect and appropriate emotional expression (Blom, 2006:29). Polster and Polster (1973:128-129) speak about contact functions, which is the means of making contact with others and the environment. They assert that contact functions consist of touching, seeing, hearing, smelling, tasting, talking and moving. Similarly, Oaklander (2002:87) makes mention of contact skills, which she regards as the "how" of contact. These include touching, looking and seeing, listening and hearing, tasting, smelling, speaking, sound, gestures, language and moving in the environment. Oaklander (2002:87) maintains that contact skills are the pathways by which contact takes place. The researcher regards these contact functions or skills as the utilisation of the seven sensory systems, coupled with the process of sensory integration. When a person experiences touch, the physical sensation as well as the processing and integration of touch with other senses at that time constitute the awareness, meaning and emotional response to touching something or being touched by another.

According to Blom (2006:91) and Oaklander (2002:87), good sensory contact is imperative for establishing emotional contact, a strong sense of self and emotional expression. Children who suffer from SID often experience sensory contact as frightful, disorganising, confusing or anxiety-provoking. These children's patterns of contact-making are influenced, causing excessive sensory-seeking or sensory-avoiding behaviour (Parham & Mailloux, 2005:378; Van Jaarsveld, 2005:372-374). It is clear that children with SID have difficulty with establishing good sensory contact in the affected sensory systems. The fact that SID affects the child's emotional well-being has already been widely recognised and described in SI publications (Smith Roley *et al*, 2001; Bundy, Lane & Murray, 2002; Gutman, McCreedy & Heisler, 2004; Parham & Mailloux, 2005; Van Jaarsveld, 2005; Brett-Green, Miller, Schoen & Nielsen, 2010). A recent study performed in the Western Cape also indicated that a large percentage of children seen in therapy by Gestalt play therapists were suffering from SID (Geringer, 2009:52).

When a child suffers from SID, sensory contact during the play therapeutic process may also be disturbing, anxiety-provoking, unsettling, etc. for the child, as is the case in that child's daily life. At the very least, the play therapist will be challenged in finding inventive ways of facilitating good, effective sensory contact with the child. If unsuccessful, these efforts can result in poor emotional contact and awareness, leading to ineffective therapeutic intervention. At the worst, the sensory experiences provided during play therapy as an attempt to establish sensory contact can add to the child's emotional distress and further impair his sense of self.

#### **3.4.4. Gestalt cycle of experience and homeostasis cycle**

A child suffering from SID can find incoming sensory information confusing or anxiety-provoking (Parham & Mailloux, 2005:378; Van Jaarsveld, 2005:373). SID causes a disruption in sensory awareness as the child has difficulty with processing and organising sensory information (Bundy *et al.*, 2002:479; Parham & Mailloux, 2005:365). In Gestalt therapy, the disruptions to sensory awareness are best explained by the Gestalt cycle of experience and Homeostasis cycle.



**Figure 3.1: The Gestalt cycle of experience depicting primary contacting and resistance processes. Adapted from the Cycle of experience in Woldt & Toman, 2005:x and the Gestalt homeostasis cycle (Woldt, 1984) in Reynolds (2005:160).**

The Gestalt cycle of experience was developed around 1960 by the faculty of the Gestalt Institute of Cleveland with the intention to be used in Gestalt teaching institutes. It is currently used by teaching institutes and practitioners worldwide (Gaffney, 2010:8). Woldt (1984, 1993) developed the Gestalt homeostasis cycle, which is an elaboration on the Gestalt cycle of experience (Reynolds, 2005:161). In this cycle, the seven contact-making functions and the seven contact boundary disturbances are paired. Desensitisation is indicated to be the resistance process to the sensation phase which is concerned with sensory awareness or contact (see Figure 3.1.). Desensitisation is a contact boundary process whereby the child inhibits the effective functioning of sensory systems, thereby blocking incoming sensory information and numbing the self (Reynolds, 2005:163; Blom, 2006:37). The child seemingly becomes hyporesponsive to sensory stimuli as though it is not noticed or

the intensity at which it is experienced is far less than the actual intensity at which it was provided. Gestalt theory depicts this process of desensitisation as developing over time, starting as a resistance style but later changing into a rigid contact-making pattern. Similar examples provided in Blom (2006:37) and Joyce and Sills (2010:38) propose that a person who is exposed to physical abuse for an extended period of time will become desensitised to the pain of beatings. Contrary to this view, SID does not occur as a result of a single environmental influence such as physical abuse. SI theory holds that SID occurs as a result of many influences. It includes intra-uterine environmental influences, abnormal development particularly during the first seven years of life, genetic predisposition and pathology such as autism and mental retardation (Bundy & Murray, 2002:11; Parham & Mailloux, 2005:360; Van Jaarsveld, 2005:369-370; Lombard, 2007:34; Geysler, 2009:10).

No theory or model can be all-encompassing, allowing for every possibility and exception. In the researcher's opinion, a shortfall in the Gestalt cycle of experience and homeostasis cycle is that it does not account for children who are hyperresponsive to sensory stimuli. When considering the cycles, attention is only paid to children who make use of desensitisation as a resistance process during the sensation phase. Some children who suffer from SID are hypersensitive (hyperresponsive) to stimuli. As discussed in Chapter 2, children who are hyperresponsive to sensory stimuli display fear, aggression or anxiety when presented with sensory stimuli considered normal by other people. This often results in withdrawal or acting out behaviour (Lane, 2002a:108; Parham & Mailloux, 2005:378; Van Jaarsveld, 2005:373).

Let us revisit the vignette in Chapter 2:

*Imagine a little girl playing outside in the garden with her brother. It is a delightfully sunny afternoon. A soft breeze is blowing, carrying the aroma of delicious food being prepared by their mother. Occasionally, cars and people pass by. The little girl now attempts to master riding a bicycle.*

Let us suppose that this little girl was suffering from gravitational insecurity. Children who suffer from gravitational insecurity have an insecure relationship with movement against gravity and display excessive fear during everyday movement activities. They are hyperresponsive to sensory stimuli from otholitic processing (Parham &

Mailloux, 2005:378). For children who are gravitationally insecure, mastering the art of riding a bicycle will be no easy feat. The girl in our vignette may have trouble with getting on the bicycle as lifting a leg and maintaining balance may be a problem. When she has achieved this, the act of balancing and moving with the bicycle will be the next big obstacle. She will try to balance herself on the bicycle and then become extremely fearful once her feet are lifted from the ground. She will most likely put her feet right down again to ensure contact with the ground, feeling anxious and unable to lift her feet and try again. As a result of being fearful of movement, she will probably get off the bicycle, tearful and anxious even before she has really attempted to ride it.

From the vignette and the discussion in Chapter 2, it is clear that children with sensory integrative dysfunction, particularly those who are hyperresponsive to sensory stimuli, display resistance to sensory stimuli. This resistance can, however, not always be linked to desensitisation as the Cycle of experience would suggest, but rather to “oversensitisation”. As a result of being overly sensitised to sensory stimuli, deflection occurs even before full contact had taken place. Polster and Polster (1973:136) had already mentioned this fact in their classic work, stating that sometimes it is necessary to “take the edge off much personal contact” by means of deflection. They provide the example of a person who is scared by (overly sensitised to) visual images in a movie and looks away to avoid visual overload. Interestingly, Polster and Polster coupled sensory overload with an emotional response (fear or anxiety), akin to the intense fight/flight emotional response of an individual who is hyperresponsive to sensory stimuli (Parham & Mailloux, 2005:378; Van Jaarsveld, 2005:372). When considering a disruption in the sensation phase of the contact cycle, the possibility of being overly sensitised should also be considered.

Resistances and disruptions in contact will have profound effects on the child’s life, particularly when this disruption takes place regularly as is the case with children who have a sensory integrative disorder. When satisfying contact cannot be made, self-regulation will be impeded.

### **3.4.5. Self-regulation and homeostasis**

The concept of self-regulation is a central precept in Gestalt therapy and Gestalt play therapy (Blom, 2006:24; Kenofer, 2010:54) and is also mentioned in the field of OT with referral to infants or individuals with SI difficulties (Hunter, 2005:708; Smith Roley, 2008). Yontef (2005:86) and Crocker (2005:73) state that self-regulation has to do with creative adjustment in the present situation. Creative behaviour or adjustment refers to an action being taken to satisfy a need (Blom, 2006:24, Oaklander, 2007:13). It is akin to the adaptive response, an SI theory term which is discussed in Chapter 2, as both creative adjustment and the adaptive response are actions taken as a result of a challenge or need posed by the environment. Smith Roley (2008:12) affirms this:

*Sensory integration theory is built upon the premise that individuals must process information rapidly and accurately from their body and the environment in order to effectively figure out what to do and how to do it in real time and space. The speed, intensity and quality of the multiple sensations at any given moment must be processed and integrated for perceptual awareness that **guides resulting actions and interactions with gravity, surroundings, objects, and people**. These experiences then guide future plans. [Own emphasis.]*

The effectiveness of self-regulation depends on the awareness of current field conditions. When awareness is interrupted or creative behaviour is not activated, healthy self-regulation is negated (Reynolds, 2005:161; Yontef, 2005:90). The presence of an SID interrupts both processes necessary for self-regulation: sensory awareness is distorted and the planning and execution of the creative adjustment (adaptive response) is consequently hampered, thwarting the efficacy of healthy self-regulation.

As previously mentioned, self-support is one of the three main goals of Gestalt play therapy. Self-support is facilitated by promoting effective self-regulation and creative adaptation (Blom, 2006:52). Effective self-regulation is imperative for moving smoothly along the therapeutic process.

### **3.5. The Gestalt play therapy process**

Violet Oaklander, Hannie Schoeman and Rinda Blom are widely respected Gestalt play therapists and authors. Each had developed a play therapeutic process to provide the Gestalt play therapist with a guideline for therapy. These are not steps that have to be followed in a specific order, but rather an indication of the natural progression of the therapeutic process. Although each author made a unique contribution and each process differs somewhat from the others, some aspects or stages are shared in every process.

One of these aspects is sensory modalities, or sensory contact-making. It is clear that these authors consider sensory contact-making to be a non-negotiable part of Gestalt play therapy. All three processes indicate that sensory contact should be facilitated at the starting phases of the therapeutic process. Interestingly, all three authors also agree that sensory contact-making should take place during each and every therapy session, regardless of the phase of the therapeutic process. (Oaklander, 2002:85-112; Blom, 2004:89-97; Mortola, 2006:63; Schoeman, 2006:18-30). This serves to confirm the importance of establishing sensory contact in Gestalt play therapy.

The play therapeutic processes are indicated in the table below.

**Table 3.1: An overview of the Gestalt play therapeutic processes by Oaklander, Blom and Schoeman.**

Processes relating to sensory contact-making are highlighted in bold.

Oaklander's therapeutic process	Aspects that should be addressed	Schoeman working model	Aspects that should be addressed	Blom's therapeutic process	Aspects that should be addressed
Relationship	Authenticity, not placing expectations on the child, acceptance, being present. Working with transference and counter-transference, handling resistance.	Relationship	Presence, safety in the relationship, dialogue, respect, responsibility, non-verbal communication, confidentiality, boundaries.	Therapeutic relationship, assessment, treatment planning	Establish relationship, responsibilities, techniques and activities that focus on experience and discovery, handling resistance, boundaries and limitations, assessment, treatment planning.
<b>Working with contact</b>	<b>Being fully present with senses</b> , body, emotional expression and intellect. <b>Contact skills: touching, seeing, listening, tasting, smelling, speaking, sound, gestures, moving.</b>	<b>Sensory modalities</b>	<b>Sensory awareness</b> , focus in the here and now, relaxation and body work.	<b>Contact-making</b> and strengthening the self	<b>Sensory contact-making</b> , bodily contact-making, strengthening the self
Strengthening the self	<b>Sensory</b> and bodily experiences, mastery, choices, self-statements, power/ control.	Process of the child	Assessment of the child's process.	Emotional expression	Expression of aggressive energy, expression of emotions
Aggressive energy work	Expressing aggressive energy with the child in a safe place, having a spirit of fun and playfulness, exaggerated play.	Projection	Projection in the here and now, owning of the projection	Self nurturing	Contact-making with unacceptable part in the self, gain skills to nurture parts to integrate all parts.
Emotional expression	Expressive, projective techniques. Become aware of body reactions on emotion, ways of appropriate emotional expression.	Alternatives	Look at alternatives relating to the past, present and future.	Handling persistent inappropriate process	Awareness of own process and behaviour, make choices and take responsibility, learn handling strategies for problems.
Self-nurturing work	Identifying hateful parts of self, integrating hateful parts of self.	Clarification	Clarifying or summarising the issue.	Termination	Evaluation to determine suitable time, and preparation for termination.
Addressing persistent problems	Follow paradoxical theory of change principles. Experiments to direct awareness towards behaviour.	Empowering	Building self-image, providing realistic feedback.		
Closing and termination	Consider variety of factors to decide on the best time. Last session is a "rite of passage", honouring past sessions.	Evaluation	Help the child identify what has been learnt and what work is still necessary.		
		Self-nurturing	Integrating polarities between desired and undesired parts of self.		

Taken and summarised from: Oaklander (2002:85-112); Blom (2004:237-238); Mortola (2006:63); Schoeman (2006:7-50).

## **3.6. Sensory contact**

### **3.6.1. Sensory systems**

The seven sensory systems of the body were described in Chapter 2. Please refer to Chapter 2 for information on the sensory systems, as well as definitions of terminology.

Gestalt therapy and Gestalt play therapy focus on all the bodily senses. Body work, focusing on sensory systems, breathing exercises, dance, drama, movement, art and music are all utilised during therapy to heighten sensory and bodily awareness (Polster & Polster, 1974; Zinker, 1977; Amendt-Lyon, 2001; Oaklander, 2002; Tervo, 2002; Blom, 2006).

An activity rarely involves only one sensory system at a time. While dancing, a child experiences touch stimuli (feet touching the ground or hands brushing against the body), proprioception (the feel of the body and the limbs as it move), vestibular stimuli (change of position or linear and circular movement of the head), sight (looking at the environment and others who might also be dancing) and auditory stimuli (listening to the music or hearing the shuffling of feet on the ground). Even a simple activity such as drawing with crayons includes the senses of touch, proprioception and vision. Blom (2006:92) affirms that it is difficult to facilitate sensory awareness in only one specific sensory system. Therapists may thus find it impossible to “work around” or exclude the affected sensory system during therapy with a child who suffers from SID. Being knowledgeable of SI theory and the child’s diagnosis will empower the Gestalt play therapist to select or adapt activities in order to be more specifically suited to the child’s sensory contact needs.

### **3.6.2. Establishing sensory contact**

Oaklander (2007:24-25) and Blom (2006:90-100) provide a wealth of activity ideas to facilitate sensory contact-making. Particular mention is made of touch, sight, hearing, taste, smell and body awareness through breathing. During the sensory contact

phase of therapy, whole sessions may be constituted of sensory-rich activities. During other phases of the process, such as strengthening of the self, these activities may still be included, especially at the start of the session to increase general awareness (Blom, 2006:92; Schoeman, 2006:49). Some activity examples from Blom (2006) to facilitate awareness of touch are provided:

- Finger or foot painting.
- Playing with clay or sand.
- Playing with wet clay or sand.
- Walking over various surfaces.
- The therapist and child touching their own face, arms, legs or other body parts, and describing the feeling.

The Gestalt play therapist suggests these activities to the child with the therapeutic aim of facilitating sensory awareness. However, Lane (2002a:117) warns that the child who is hyperresponsive to touch stimuli (tactile defensive) will display a collection of the following behavioural responses to touch: avoidance of touch, having an aversive response to touch or displaying atypical emotional responses. Examples provided by Lane of the child's reaction to touch activities include:

- Avoidance of play activities that involve body contact, sometimes manifesting in a preference for solitary play.
- Aversion to art materials including finger paint, paste and sand.
- Responding with aggression to light touch to the body.
- Refusing to walk barefoot.
- Increased stress and anxiety when being physically close to people.

Parham and Mailloux (2005:378) add that "common irritants" to the tactile defensive child include light touch, certain clothing textures, grass or sand against bare skin, glue or paint on the skin, the light brush of another person passing by or being close

to them, having hair or teeth brushed and certain food textures. Contrary to these negative reactions to touch stimuli, the child who is hyporesponsive to touch stimuli may display sensory-seeking behaviour, thus seeking large quantities of sensory input. These children will probably love participating in above-mentioned activities, in fact, seeking more intense stimuli in ways that can be disruptive or socially unacceptable (Lane, 2002a:108; Parham & Mailloux, 2005:376-378). Caution should be taken when introducing a child with SID to sensory-loaded activities, as it may have various adverse behavioural and emotional effects. It is therefore essential for the play therapist to be knowledgeable of the child's diagnosis or sensory difficulties and how to handle these during therapy.

When considering field theory, it is a simple act to deduct that the presence of an SID will affect the Gestalt play therapeutic process. The therapeutic field is regarded as the entire situation including the therapist, the child and everything that goes on between them. All aspects are interrelated and mutually influence each other. Meaning can only be derived from considering the entire situation, not scattered fragments or facts (Parlett, 2005:43; Yontef, 2006:93; Joyce & Sills, 2010:28 ). When entering the therapeutic setting, both the therapist and the child bring their total being (including sensory difficulties) to the table.

### **3.7. The impact of SID on the Gestalt play therapeutic process**

Assessment and treatment planning are essential and usually take place at the start of the Gestalt therapeutic process. Assessment is done in the here and now; the therapist can only work with what the child is displaying (Blom, 2006:66; Oaklander, 2007:98; Joyce & Sills, 2010:53). Joyce and Sills (2010:54-57) state that assessment is essential for the following reasons: finding out things about each other is the natural way people relate to others; assessment is vital for generating a competent professional response and contracting with the client; it allows useful communication with other professionals; it helps to build the working alliance between client and therapist; and it helps to make decisions about suitability (whether Gestalt therapy is suitable for the client and whether the therapist is suitable for the client). Assessment

should be holistic and usually includes gathering background information and consultation with parents (Blom, 2006:66).

Currently, assessment tools for diagnosing SIDs include standardised questionnaires such as the Winnie Dunn Sensory Profiles and a test battery, the Sensory Integration and Praxis Test (SIPT), which may only be administered by OTs who have received specialised SI training (SAISI, 2008:10; Van Jaarsveld, 2009:23). However, the play therapist can devise a questionnaire or interview schedule containing pertinent questions related to sensory processing and modulation. This can be done by perusing available literature on SI theory, consulting with an OT, attending training sessions on SI, etc. Such an assessment tool can alert the therapist to possible sensory problems in order to facilitate early referral and diagnosis of the problem.

Information provided in Chapter 2 and 3 served to highlight the characteristic strengths and pitfalls of Gestalt play therapy with children suffering from SID. The reader might suppose the potential of play therapy with these children to be meager. However, play therapists can do much to improve their knowledge and practical skills on handling the child with SID in therapy. Parents and teachers are often taught basic *sensory strategies* by OTs, comprising of practical tips for creating the optimal sensory environment and handling the child with SID (Parham & Mailloux, 2005:395; Raath, 2007:87). Such strategies may also be found in literature, of which excellent examples are “*The out of sync child*” and “*The out of sync child has fun*” (Kranowitz, 2005, 2006).

The Alert Program is a very useful tool in assisting the child with assessing his own sensory processes and difficulties. It empowers children to manage their level of arousal themselves by identifying and implementing sensory strategies (Shellenberger & Williams, 2002:342-345). Training on the Alert Program is not limited to OT's. However, the program is essentially intended to be used by a treatment team, of which at least one team member should be trained in SI (Shellenberger & Williams, 2002:345; Parham & Mailloux, 2005:395; Raath, 2007:99).

Finally the researcher urges play therapists to become knowledgeable of their own sensory processes and difficulties. This can be done in various ways including consultation with a SI qualified OT or completing self-questionnaires found in literature. In this regard the researcher found *Sensory intelligence: Why it matters more than EQ and IQ* (Lombard, 2007) to be an excellent, easily readable source. Participants also indicated a need for training in SI theory (see Point 4.9.2.3.3.).

### **3.8. Conclusion**

In this chapter, the reader was introduced to Gestalt therapy, Gestalt play therapy and the significant role that sensory contact-making plays in the Gestalt play therapeutic process. Ways in which the presence of an SID can affect the process were also explored. Children who suffer from SIDs display extreme reactions to certain sensory stimuli, whether during therapy sessions or in daily life. This poses a significant problem to Gestalt play therapists, as they depend heavily on sensory activities during the entire process of play therapy. It serves to highlight the research question, which seems to be uttered now with an even greater urgency than before: How do Gestalt play therapists establish sensory contact with children suffering from sensory integrative disorders?

In the following chapter, the researcher will elaborate on the empirical research process. Findings will be presented and discussed, after which conclusions and recommendations will follow in the final chapter.

# Chapter 4

## Empirical analysis and findings

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### **4.1. Introduction**

In the previous two chapters, the reader was introduced to SI and Gestalt play therapy theory, both of which gave rise to the theoretical enquiry of this study. In this chapter, the researcher will discuss the research approach, design, methodology and data analysis. Findings will be presented by means of tables, graphs and discussions of emergent themes.

### **4.2. Research approach**

Qualitative research is an enquiry process aimed at developing a rich, holistic understanding, rather than an explanation or a prediction, of individuals' experiences. It is performed from an idiographic perspective within a constructivist or interpretive position, which allows for the emergence of multiple meanings of the individuals' experience in their unique situations (Fouché & Delpont, 2005:74; Terre Blanche, Kelly & Durrheim, 2006:278; Ivankova *et al*, 2010:261; Niewenhuis, 2010a:51). Qualitative research, with its epistemological roots in phenomenology and existentialism, is concerned with non-statistical methods and small, purposively selected samples in order to construct a detailed description of the studied phenomenon (Babbie & Mouton, 2001:58; Fouché & Delpont, 2005:74,75). Research designs are often malleable, allowing for deviation from the original design (Fouché & Delpont, 2005:75; Kelly, 2006:286).

In contrast, quantitative research is more formalised and explicitly controlled, with a more exactly defined range and design than a qualitative approach. Findings are regarded as nomothetic and should facilitate objective measuring, testing of hypothesis, prediction and control of the researched phenomenon (Babbie & Mouton, 2001:272; Fouché & Delpont, 2005:73; Ponterotto, 2005:128). Quantitative

data is obtained in a systematical, standardised manner and analysed with statistical procedures. Data collection methods include questionnaires, checklists and indexes (Delpont, 2005:166,179; Fouché & Delpont, 2005:74; Durrheim, 2006:47; Ivankova *et al.*, 2010:257).

This study followed a mixed-method design, as both qualitative and quantitative data collection techniques and data analysis methods were drawn upon (De Vos, 2005a:361; Croswell & Zhang, 2009:612; Ivankova *et al.*, 2010:265; Niewenhuis, 2010a:51). It was regarded as applied research with an exploratory and descriptive nature. This study was aimed at gaining basic knowledge and insight regarding how Gestalt play therapists establish sensory contact with children suffering from SID (exploratory research). The researcher was also intent on providing a detailed examination and description of this knowledge (descriptive research) in order to generate recommendations which may be practically applied in the Gestalt play therapeutic research and clinical fields (Babbie & Mouton, 2001:79-81; Fouché & De Vos, 2005a:106). Although combined in nature, this study followed an ideographic strategy classically associated with qualitative research studies. It was concerned with understanding the particular researched phenomenon within its own context (Babbie & Mouton, 2001:272; Fouché & Delpont, 2005:74; Ponterotto, 2005:128; Niewenhuis, 2010a:51).

### **4.3. Research design**

#### **4.3.1. Quantitative design and methodology**

This research study is of an exploratory and descriptive nature, and utilised a non-experimental survey design in order to gain descriptive quantitative data (Babbie & Mouton, 2001:232; Fouché & De Vos, 2005b:137). The researcher made use of a self-compiled, pilot-tested (Babbie & Mouton, 2001:244) survey questionnaire.

### **4.3.2. Qualitative design and methodology**

An extensive choice of qualitative designs is available to the researcher. Among those is the case study design (Fouché 2005:269). Case study designs are characterised by the investigation of a single unit, which may comprise a person, group, community, process, activity, event or programme (Babbie & Mouton, 2001:281; Fouché, 2005:272). For the purpose of this research study, an instrumental case study design was utilised, as the researcher was intent on elaborating on a specific phenomenon experienced by the study sample (Fouché, 2005:272). One-on-one, semi-structured interviews were conducted with four participants who had also completed the questionnaire (see Appendix B). Participants were Gestalt play therapists who indicated that they had treated a child or children with SID. The researcher was intent on gaining rich descriptive data regarding participants' phenomenological experience of establishing sensory contact with these children.

### **4.3.3. Mixed-method design and methodology**

Mixed-method designs possess four inherent components: They involve data collection and analysis of both qualitative and quantitative data; both qualitative and quantitative processes should be rigorous; both types of data are integrated (called *mixing*) and data collection procedures can take place either concurrently or sequentially (Johnson & Onwuegbuzie, 2004:17; Creswell & Zhang, 2009:613; Ivankova *et al.*, 2010:265).

A concurrent design (also referred to as triangulation or parallel design) was followed, as both data sets were collected during roughly the same research period and in the same research phase. The aim of a concurrent design is to examine how the findings in both data sets serve to corroborate, diverge, or contradict the other (Creswell & Zhang, 2009:614; Ivankova *et al.*, 2010:269). This research study utilised merging as a mixing process whereby the distinctiveness of data sets dissolve as they are merged in the discussion section (Creswell & Zhang, 2009:613). The quantitative (closed questions in questionnaire) data was presented first, after

which qualitative data (open-ended questions in questionnaire and transcribed interviews) followed. However, data was merged during the discussion and summation of findings. The two data sets mostly served to corroborate the other (see Point 4.9.2.2.2. as an example).

#### **4.3.4. Paradigmatic perspective**

All research is conducted from a paradigmatic perspective (De Vos, 2005b:40). This refers to the underlying philosophical perspective from which the study is undertaken, and provides the researcher with a conceptual base for selecting research tools, methods and participants (Ponterotto, 2005:127-128; Niewenhuis, 2010a:47-48).

The researcher selected Gestalt theory as a paradigmatic framework, which furnished this study with a phenomenological core and placed the focus on the participants' experiences. The researcher was concerned with exploring how Gestalt play therapists establish sensory contact with children who were diagnosed with a sensory integration disorder (SID). However, soon after the study was launched and the researcher contacted potential participants, it became apparent that the theoretical field of sensory integration (SI) was largely unknown to the research population (Louw, 2010; Strydom, 2010; Visagie, 2010). Only five participants had treated children with a confirmed diagnosis of SID. Moreover, confusion as to what exactly constitutes an SID became clear. However, all participants reported cases where significant problems regarding sensory contact were experienced (refer to Table 4.2). The focus of Gestalt theory is not on formal diagnosis and pathology but rather on meeting the client on a horizontal level, working with what is given in the here-and-now moment (Yontef & Fairfield, 2005:2; Joyce & Sills, 2010:53).

Seeing that the researcher employed a Gestalt phenomenological stance throughout the research process, her initial inclusion criteria were somewhat relaxed to include participants who had treated children with severe sensory contact-making difficulties whom they strongly suspected of suffering from SID. The researcher is of the opinion that this provided the study with a broader base of enquiry. It also provided the

researcher with additional insight into the participants' phenomenological experience of SID and related sensory problems.

#### **4.4. Sampling and selection of participants**

The processes of sampling in the qualitative approach differ from those associated with quantitative approaches, largely because of the less structured nature of a qualitative design (Babbie & Mouton, 2001:287; Strydom & Delpont, 2005:328). Sampling largely occurs only after the circumstances surrounding the study have been established, thus influencing sample size, and may continue until saturation of data is reached (Niewenhuis, 2010b:79). There are no prerequisites regarding qualitative study samples, as is the case with quantitative study samples, which include being statistically representative of a population (Strydom, 2005b:196; Strydom & Delpont, 2005:328; Durrheim, 2006:49).

The universe refers to all potential subjects that possess traits deemed necessary by the researcher (Strydom, 2005b:193). The population is the group of individuals within the universe who possess specifically defined characteristics and from which the sample will be drawn (Babbie & Mouton, 2001:286; Strydom, 2005b:193; Niewenhuis, 2010b:79). For the purpose of this study, the universe comprised all Gestalt play therapists in South Africa. The population included all Gestalt play therapists who were practising Gestalt play therapy and who had experience in working with children aged three to ten years. The following added criteria were applicable to the research sample: These therapists may not be occupational therapists (OTs), as OTs are generally introduced to SI theory on an undergraduate level. The Gestalt play therapists should have had at least one case where the child suffered from significant sensory problems, or a diagnosis of SID.

Seeing that the size of the universe was not previously known to the researcher and a small research population was expected because of applicable inclusion criteria, the researcher made use of purposive sampling (Babbie & Mouton, 2001:287; Strydom & Delpont, 2005:328). The researcher found it difficult to obtain names and contact details of practising Gestalt play therapists as there was no such national

database. The researcher requested lists of names and contact details of previous students from different Gestalt play therapeutic training institutes in South Africa. Only one list, with a total number of 43 names, could be obtained. The researcher contacted these persons via e-mail to determine whether they were willing to participate in the study and meet inclusion criteria. Following minimal success, the researcher telephonically contacted friends, colleagues and fellow students, who complied with inclusion criteria and requested contact details of additional persons from them (snowball sampling). These persons were also contacted by telephone. Letters of informed consent and questionnaires were sent to all participants via e-mail. Ultimately, the sample that completed survey questionnaires comprised ten participants. Of these, four participants were purposively selected. They subsequently agreed to semi-structured, one-to-one interviews.

#### **4.5. Context**

Ten participants took part in the study. All participants (100%) were female and had either completed their master's degree in Gestalt play therapy or were in the process of doing so. Participants who were interviewed are indicated in gray blocks in the table below. They disclosed information about their clinical context, which was added to the table. Two participants indicated that they were knowledgeable of their own sensory profile.<sup>1</sup> From analysed data, it became apparent that these participants were more sensitive to the child's sensory difficulties (see point 9.2.3.1).

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<sup>1</sup> The term "sensory profile" refers to a person's unique SI make-up. Standardised questionnaires (Winnie Dunn's Adult/Adolescent Sensory Profile and Caregiver Sensory Profile) can be used to determine a person's sensory profile (Dunn, 1999).

**Table 4.1: Biographical data of participants**

<b>Participant number</b>	<b>Previous studies</b>	<b>Years experience in Gestalt play therapy</b>	<b>Knowledge level of SI theory</b>
1	Psychology	Between 2 and 5 years.	None
2	Psychology and social work	Less than 2 years.	Have read and talked about SI.
3	Psychology	Less than 2 years.	None.
4	Psychology	Less than 2 years.	Have read and talked about SI.
5	Psychology	Between 5 and 10 years. Works in private practice; good contact between multidisciplinary team members.	Have read and talked about SI.
6	Teaching	Less than 2 years. Works at a school; minimal contact between team members. Aware of own sensory profile.	Have read and talked about SI.
7	Psychology, teaching	Between 5 and 10 years	Have talked about SI with a knowledgeable person.
8	Social work	Between 2 and 5 years. Working in private practice with multi-disciplinary team.	Have talked about SI with a knowledgeable person.
9	Social work	More than 10 years	Have talked about SI and attended therapy sessions facilitated by an SI-trained therapist.
10	Psychology	Between 2 and 5 years. Currently working in private practice, and a school where there is no OT. Aware of own sensory profile.	Have read and talked about SI with knowledgeable person.

The sample consisted of four (40%) therapists who had less than two years experience in the field of Gestalt play therapy. Three (30%) participants had two to

five years experience in the field. This can be ascribed to the fact that the initial list received from the training institute contained names of recently graduated or currently enrolled master's degree students. Two (20%) participants had five to ten years experience, and one (10%) had more than 10 years experience.

## **4.6. Data collection**

This study made use of concurrent data collection whereby quantitative and qualitative data were collected during a single research phase. The researcher will continue to elaborate on the quantitative and qualitative data collection procedures followed during this study.

### **4.6.1. Quantitative data collection**

A questionnaire compiled by the researcher in view of guidelines stipulated by Maree and Pietersen (2010:158-169) and Delport (2005:170-191) was used during the collection of quantitative data. The questionnaire was compiled in English. All participants had received training in Gestalt play therapy and had either already obtained their master's degree or were in the process of doing so. It was thus assumed that all participants would be able to read and understand questions relating to Gestalt theory in English. Questions regarding biographical information were limited. For instance, the researcher did not include questions regarding race, culture, age or spiritual beliefs. The focus of the study was not to formulate hypotheses or to study the relationship between said factors and the therapists' experience of establishing sensory contact in therapy. The researcher was more concerned about participants' previous studies (such as psychology) and knowledge of SI theory, as these factors could possibly influence the way in which sensory contact was established in therapy. Questions were mostly open-ended, which facilitated the generation of fundamentally qualitative data.

After the questionnaire was compiled, it was pilot tested by persons from the universe applicable to this study. As the researcher expected the sample size to be small, four persons who did not meet inclusion criteria were asked to pilot test the

questionnaire (Strydom, 2005b:206) (refer to Appendix C). The questionnaire, together with a letter of informed consent, was e-mailed to potential participants. After consent was given, completed questionnaires were e-mailed back to the researcher. The researcher assigned a number to each participant. During the remainder of the study, the researcher only referred to participants' assigned numbers in order to ensure confidentiality and minimise personal bias.

The utilisation of surveys – particularly self-administered electronic surveys (Babbie & Mouton, 2001:259) as is the case in the present study – does impose certain limitations. The following limitations were applicable to this study:

- Respondents may misinterpret complex questions or leave them unanswered when a field worker is not available on site (Delpont, 2005:167). The researcher attempted to minimise this by asking simple, clear questions. However, not all participants were knowledgeable of SI theory, and consequently may have had difficulty with the interpretation of some questions relating to it.
- Mailed questionnaires are usually associated with a low response rate (Delpont, 2005:167). The researcher also found this to be the case in the research study – the total response rate was 20%. The fact that SI theory was relatively unknown to the research population possibly played a significant role (see point 4.9.1.1). Babbie and Mouton (2001:260) suggest the use of follow-up mailings or contact in order to encourage participants to complete the questionnaire. This was not initially done. However, after snowball sampling had taken place, all potential participants were contacted by telephone prior to sending out an initial e-mail, which ensured a much improved response rate.
- Surveys may limit the degree of depth and complexity in which a topic is covered. It is also inflexible as all questions remain the same and new emergent variables cannot be pursued (Babbie & Mouton, 2001:263). After completion of data analysis, the researcher found that interviews as collection method supplied much more in-depth and contextually rich information than data obtained from completed questionnaires.

Some strengths, which agree with literature, also became apparent:

- Survey studies generally limit costs (Delport, 2005:167). In this particular case, the researcher would have had to travel significant distances in South Africa if she wanted to conduct one-to-one interviews with all participants – or spend many hours conducting telephone interviews.
- The same questions were posed to all participants and were answered without the influence of a field worker (De Vos, 2010:167; Maree & Pietersen, 2010:157), which aided with generating information unaffected by external sources.
- The self-administered questionnaire provided participants with general freedom as to the time and duration of completion. Participants could also access information such as process notes of therapy sessions, which could aid with completing questions (Delport, 2005:167; Maree & Pietersen, 2010:157).

After questionnaires were received, the researcher randomly selected four participants for one-to-one interviews. This step signified the start of qualitative data collection.

#### **4.6.2. Qualitative data collection**

Semi-structured, one-to-one interviews were conducted with four randomly selected participants. The aim of the interviews was to gain a phenomenological view of the researchers' experience regarding the research topic, and to explore how the qualitative and quantitative data corroborated, diverged from or contradicted the other (Creswell & Zhang, 2009:614; Ivankova *et al.*, 2010:269). Seeing that this study followed a corroborative mixed-method design, data obtained from the questionnaires was not analysed prior to the commencement of the interviews.

Procedures and useful guidelines for interviewing as set out in Niewenhuis (2010b:88-89), Kelly (2006:297-300) and Greeff (2005:287-297) were utilised. According to Niewenhuis (2010b:87), the semi-structured interview can be utilised to

corroborate information which emerges from other sources. It is also used to obtain rich, descriptive data regarding the researched phenomenon, as the interview is of a more flowing nature than a structured interview. The participant is encouraged to share insights, thoughts, beliefs and accounts regarding the research phenomenon (Babbie & Mouton, 2001:289; Greeff, 2005:296). It requires the participant to answer a predetermined set of questions, although it allows for probing and clarification of answers (Babbie & Mouton, 2001:289; Greeff, 2005:296; Niewenhuis, 2010b:87).

The researcher compiled an interview schedule (see Appendix B), which was used as a guideline during the interviews. Participants gave verbal and written consent to have interviews audio-taped and transcribed, and were assured of confidentiality. Interviews were conducted in Afrikaans or English, depending on the participant's preference. The researcher kept field notes during interviews, noting non-verbal cues and keywords for follow-up questions (Greeff, 2005:298; Niewenhuis, 2010b:89). (see Appendix D).

Limitations to semi-structured one-to-one interviews as provided in the literature (Greeff, 2010:299) include that cooperation is needed from participants, as this type of interview depends on personal interaction. Participants may also be unwilling to share, or provide misconstrued or untruthful accounts. Furthermore, researchers run the risk of turning the interviewing relationship into a therapeutic one. Fortunately, none of these limits applied to this study.

Certain strengths of semi-structured one-to-one interviews were evident in this study:

- Participants shared their personal and professional thoughts and experiences regarding therapy – particularly establishing sensory contact with children who suffer from sensory problems or SID. This enriched the data's descriptive and exploratory nature (Greeff, 2005:299; Niewenhuis, 2010b:87).
- Seeing that interviews were semi-structured, the researcher could utilise the interview schedule as a guide for questioning. She was also able to probe and clarify thoughts or pursue emergent ideas (Niewenhuis, 2010b:87).

Following the four interviews, the researcher reviewed the raw data, searching for initial themes and ideas. After ascertaining that data saturation had taken place, the researcher prepared for data analysis.

## **4.7. Data analysis**

### **4.7.1. Procedure of quantitative analysis**

Analysis is defined by Kruger, De Vos, Fouché and Venter (2005:218) as the process of “categorising, ordering, manipulating and summarising of data to obtain answers to research questions”. Pietersen and Maree (2010:183) add that descriptive statistics represent a collection of statistical methods aimed at organising and summarising data in a meaningful way. The researcher made use of univariate analysis, where one variable is analysed at a time, with a view to describe it (Babbie & Mouton, 2001:422; Kruger *et al.*, 2005:222). Though the researcher utilised a questionnaire (usually associated with quantitative data) to collect information, questions were mostly open-ended, which produced data of a qualitative nature (Johnson & Turner, 2003:298-300; Delpont, 2005:166; Maree & Pietersen, 2010:167). During the process of quantitative analysis, the researcher categorised (coded) qualitative data from the questionnaire and utilised thematic analysis to produce findings.

### **4.7.2. Procedure of qualitative analysis**

The researcher transcribed and analysed the interview audio tapes shortly after each interview was conducted (Greeff, 2005:299). Both data sets (qualitative data obtained from questionnaires and data obtained from interviews) were analysed separately by means of thematic analysis. Thematic analysis is defined by Braun and Clarke (2006:79) as a method for identifying, analysing and reporting patterns within qualitative data in order to be described and interpreted. Attridge-Stirling (2001:387) states that thematic analysis “seeks to unearth the themes salient in a text at different levels”. It sets the stage for a systematic process often associated

with content analysis, while also providing the opportunity to interpret data within context, thus adding richness and complexity to the study (Joffe & Yardley, 2004:57; Braun & Clarke, 2006:78). The researcher made use of inductive coding by identifying themes which emerged from the raw data itself (Joffe & Yardley, 2004:57; Braun & Clarke, 2006:83; Niewenhuis, 2010c:107). The researcher followed six phases of performing thematic analysis, provided by Braun and Clarke (2006), in analysing the qualitative data.

- **Phase 1: Familiarising yourself with your data.** The researcher immersed (Terre Blanche, Durrheim & Kelly, 2006:322) herself in the data by reading and re-reading all data, while starting to search for patterns and meanings. Notes and ideas were jotted down, which provided a platform for starting phase two.
- **Phase 2: Generating initial codes.** The researcher worked through her list of initial ideas, dividing the data into meaningful segments, coding them accordingly (Attridge-Stirling, 2001:391; Niewenhuis, 2010c:105). The researcher once again read through all data, adding any other codes of interesting data fragments. The researcher coded data inclusively, taking into account the context of surrounding data (Braun & Clarke, 2006:89). At the end of this phase, the researcher had compiled a list containing all codes.
- **Phase 3: Searching for themes.** Related codes were combined and organised to establish themes by taking into account the relationship between codes and the applicability of codes to the research question (Braun & Clarke, 2006:89; Niewenhuis, 2010c:109). The researcher continued to work inductively, allowing themes to emerge from the data itself. A thematic map (see Appendix E) was drawn to explore the relationship and hierarchy of themes and codes (Braun & Clarke, 2006:89).
- **Phase 4: Reviewing themes.** The researcher refined the themes by taking into account internal homogeneity and external heterogeneity (Braun & Clarke, 2006:89). Themes and codes were assessed in terms of their validity against the entire data set. The researcher compared themes that emerged

from both data sets in order to indicate whether they served to affirm or contradict the other (Creswell & Zhang, 2009:614; Ivankova *et al.*, 2010:269).

- **Phase 5: Defining and naming themes.** After reviewing themes, they were named and defined by identifying the central essence of each (Braun & Clarke, 2006:92). Data within themes was analysed for coherency and internal consistency, ensuring that the researcher could indicate the scope of each theme. The researcher conducted a detailed analysis of each theme (see Empirical Results, point 9).
- **Phase 6: Producing the report.** The researcher continued to produce the final write-up of the data, which included findings. Findings from the quantitative data set were merged with those from the qualitative data set in the discussion section (Creswell & Zhang, 2009:613).

#### **4.8. Trustworthiness**

Authors on social research consider the work of Lincoln and Guba (1985) to be highly influential in clarifying the quality control measures in qualitative studies (Babbie & Mouton, 2001:276; De Vos, 2005a:346). They propose four constructs against which the trustworthiness of a study should be measured: credibility, transferability, dependability, confirmability.

Credibility is linked with internal validity in quantitative research designs (Babbie & Mouton, 2001:276; Morrow, 2005:251). Credibility was maximised by “staying in the field until data saturation occurs” (Babbie & Mouton, 2001:277). The researcher conducted interviews with participants until data saturation was reached. Triangulation was ensured by collecting data by means of the survey questionnaire and interviews. Peer reviewing also took place by discussing the study with colleagues in Potchefstroom and Klerksdorp.

Transferability is linked with external validity in quantitative designs (Morrow, 2005: 252). However, in qualitative studies the researcher cannot claim that findings will

necessarily be relevant to another context, population or time frame. The obligation for demonstrating transferability rests upon the reader (or another researcher who wishes to apply findings to another setting) (Babbie & Mouton, 2001:277; De Vos, 2005a:346; Morrow, 2005:252). Once again, it is indicated that triangulation may facilitate transferability (De Vos, 2005a:346). Contextual descriptions about the research context and participants were also provided (Babbie & Mouton, 2001:277; Morrow, 2005:252).

Dependability corresponds with reliability (Morrow, 2005:252) and is aimed at assuring the reader that replication of the study in similar conditions will lead to similar findings (Babbie & Mouton, 2001:278; De Vos, 2005a:346; Morrow, 2005:252). The concept of replication is problematic in qualitative studies (De Vos, 2005a:347), although the researcher can account for it by describing the research process explicitly (Morrow, 2005:252), which was done in this study.

Confirmability is related to objectivity (Morrow, 2005:252) and questions whether findings could be confirmed by another person. The integrity of the findings should lie in the data itself, not in the subjectivity of the researcher (De Vos, 2005a:347). The researcher's personal history placed her at risk for bias, as she suffers from SID herself. Personal bias can influence the confirmability of a study (Morrow, 2005:252). Throughout the research process, the researcher kept this in mind and minimized bias through various strategies. These included: Peer reviewing, revisiting objective theory, planning and conducting data collection according to high objective (See Appendix D)

#### **4.9. Empirical results**

The researcher will continue to present the research findings, starting with quantitative data and followed by qualitative data generated from open-ended survey questions and interviews. Please note that all questions regarding therapy in both the questionnaire and interviews pertain to Gestalt play therapy, unless otherwise stated. Participants were asked to answer all questions bearing in mind a child or children who they had treated who was/were either strongly suspected (by the

participant) of suffering from SID or who had a confirmed diagnosis of SID. In order to aid concise descriptions, the researcher will refer to all sensory difficulties collectively as SID.

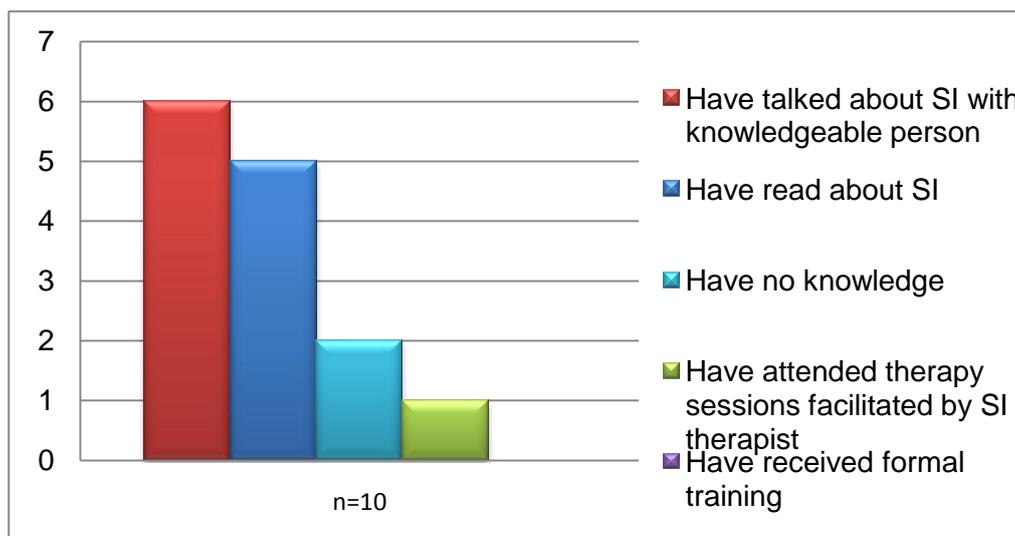
#### **4.9.1. Quantitative (closed question) survey results: All participants**

Closed questions included biographical questions and questions regarding the child with SID in Gestalt play therapy. Biographical information of the participants is indicated in Table 4.1. It was important to determine participants' knowledge level of SI theory, as it could have some bearing on their approach to children with SID. The researcher wished to explore participants' phenomenological experience and approach unclouded by formal training in SI.

##### **4.9.1.1. Knowledge level of sensory integration**

Participants were asked to indicate their previous exposure to SI, which influenced their knowledge level. Participants could indicate all applicable options.

**Graph 4.1: Participants' knowledge level of SI theory**



None of the participants had previously received any formal training in SI theory. Two participants (20%) indicated that they had no theoretical knowledge of SI whatsoever, while 8 (80%) indicated that they had some basic knowledge of SI. The majority of participants (60%) indicated that they had talked about SI with a knowledgeable person and 5 (50%) indicated that they had read about it before. Only one participant (10%) had witnessed therapy sessions facilitated by an SI-trained therapist.

Given the irrefutable link between SI, the impact thereof on the child's sensory contact-making abilities, and how heavily the Gestalt play therapeutic process relies on the ability to establish sensory contact (Oaklander, 2002:87; Blom, 2006:53, 89-102; Mortola, 2006:58), these results were unsettling – albeit expected. As already mentioned in Chapter 1, the South African Institute of Sensory Integration (SAISI) is the national body through which SI training takes place in South Africa. Formal training to become an SI-qualified therapist is only accessible to OTs, and only three introductory/foundation courses open to professionals other than OTs have been presented by SAISI since 2004 (Kruger, 2010). During telephone interviews with potential participants, before undertaking the empirical study, the researcher also noted that there was a general lack of knowledge regarding SI. Some therapists became aware of SI after being personally affected by it (for example, after having their own children treated for SID), or after working with an OT trained in SI. Therapists also found it difficult to obtain knowledge regarding SI training possibilities (Faul, 2010; Louw, 2010; Strydom, 2010; Visagie, 2010).

In this research sample, 80% of participants had been exposed to SI theory and possessed various levels of basic knowledge of it. Participants' approach to children with SID can therefore not be solely attributed to their knowledge (or lack of knowledge) of SI theory. It can also be attributed to factors such as previous education, training as Gestalt play therapist, experience, or personal factors such as awareness of their own sensory needs and difficulties (refer to points 4.9.2.1.1 and 4.9.2.3.1).

Another important question, which also reflected inclusion criteria, was whether participants had treated children with SID before. As already mentioned, initial

inclusion criteria were relaxed so as to include participants who had treated children strongly suspected of having SID.

#### 4.9.1.2. History of treating children with a diagnosis of SID

Participants were asked to indicate whether they had ever treated a child with a confirmed or a suspected diagnosis of SID.

**Table 4.2: Participants who had treated children with confirmed and suspected diagnoses of SID.**

Category	Frequency	Percentage
Participants who had treated a child with a confirmed diagnosis of SID	5	50%
Participants who had never treated a child with a confirmed diagnosis of SID	5	50%
<b>Total</b>	<b>10</b>	<b>100%</b>
Participants who had treated a child with a suspected diagnosis of SID	10	100%
Participants who had never treated a child with a suspected diagnosis of SID	0	0%
<b>Total</b>	<b>10</b>	<b>100%</b>

From these results, it was clear that all participants had treated children with severe sensory difficulties in therapy, although a diagnosis of SID was known in only 50% of cases. These results are not generalisable to the general population, because this variable (the presence of SID or SI difficulties) reflected inclusion criteria of the study. However, the confirmed incidence of SID in this study pales in comparison to a recent study conducted in the Western Cape. Geringer (2009:61) found that 24 out of 28 (85.7%) children who were being treated by Gestalt play therapists were suffering from SID.

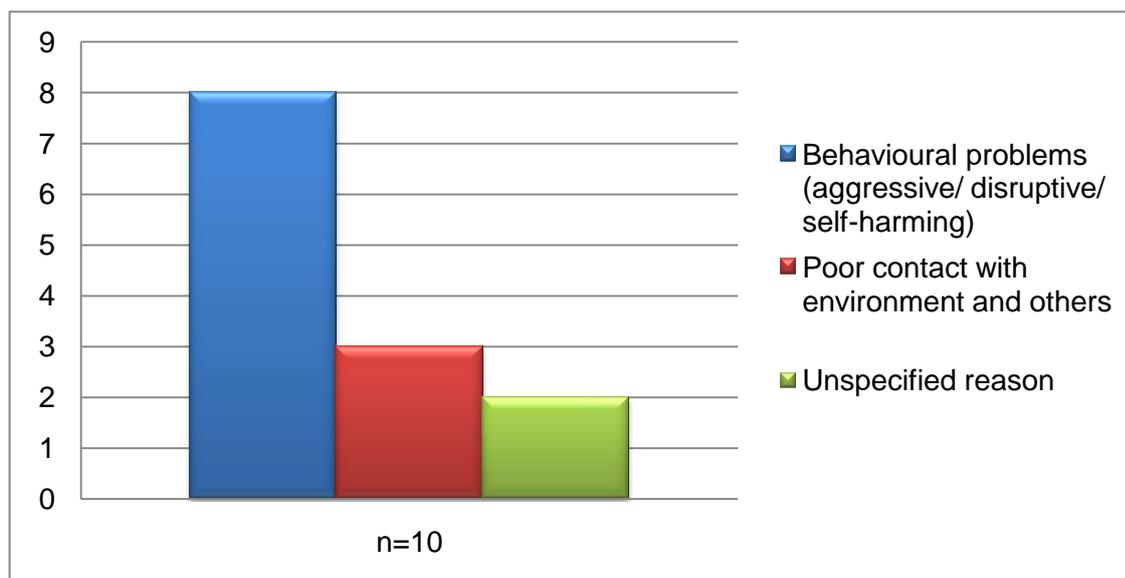
Although participants did not generally possess a high level of knowledge regarding SI and were not necessarily able to identify theoretical “red flags” for SID, they were

aware that these children experienced much more difficulty with establishing sensory contact than others. This difficulty was generally described by means of behavioural manifestation, which correlated well with those described in SI literature (see point 4.9.2.2). SI-trained OTs use observation of and questions about behaviour and emotional responses to identify possible SI difficulties. An example of a standardised questionnaire focusing on behavioural and emotional responses is the Winnie Dunn Caregiver Questionnaire (Dunn, 1999).

#### 4.9.1.3. Reason(s) for referral of children

Participants were asked to indicate the reasons why the children were referred for Gestalt play therapy. Participants could indicate more than one reason for referral.

**Graph 4.2: Reason(s) for referral**

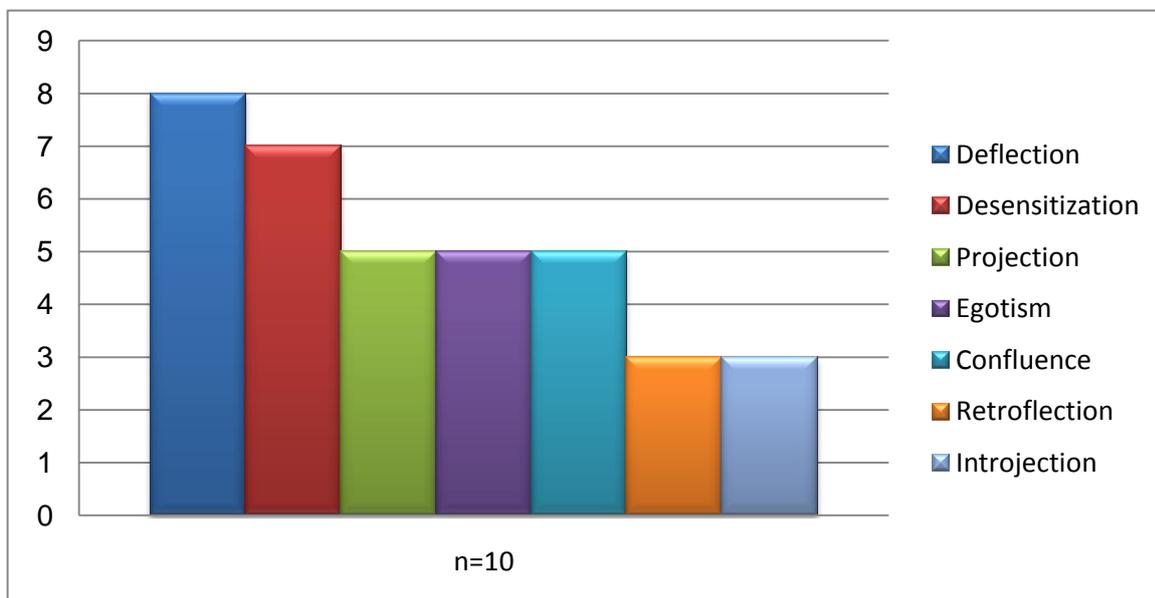


Behavioural problems accounted for 8 (80%) of the referral reasons, whereas poor contact constituted another 30%. In some children, both reasons were indicated. Non-specific, unspecified reasons accounted for 2 (20%) of the cases. In answer to this question, no specific mention was made of sensory contact difficulties, but rather of the behavioural manifestation which children displayed. Thus, children were not referred because they had SID, but because of behavioural or contact problems.

#### 4.9.1.4. Contact boundary disturbances displayed by children in therapy sessions

Participants were asked to identify which contact disturbances were utilised by children during therapy. As mentioned in Chapter 3, children suffering from SID will have difficulty with establishing sensory contact in the affected sensory systems, therefore displaying contact boundary disturbances. It was therefore assumed that contact boundary disturbances would occur.

**Graph 4.3: Contact boundary disturbances displayed by children**



Participants were asked to indicate all applicable options. Most of the children were indicated to display more than one contact boundary disturbance. The graph illustrates that deflection was indicated in 8 (80%) instances and desensitisation in 7 (70%) instances. Projection, egotism and confluence were each indicated in 5 (50%) instances, and retroflexion and introjection in 3 (30%) instances.

Literature on SI indicates that children who suffer from SID, particularly those who are overresponsive to sensory stimuli, may habitually display social withdrawal, solitary play and relationship difficulties (Lane, 2002a:108; Parham & Mailloux, 2005:378; Van Jaarsveld, 2005:373; Geysers, 2009:11-12; Mackenzie, 2009:15-18). Data obtained from particular questionnaires and interviews served to confirm this. It

was indicated that deflection manifested in withdrawal behaviour (especially ignoring the therapist, covering ears and avoiding eye contact). Please refer to point 9.2.2.2 for an elaboration on behavioural manifestation.

Desensitisation also emerged as a prominent contact boundary disturbance in these children. Participants indicated that some of these children were “numb” and unaware of their surroundings. These findings correlate with SI literature on children who are underresponsive to sensory stimuli and need additional sensory input before reacting to it. These children seem to be living “in their own world” (Van Jaarsveld, 2005:374).

The quantitative data obtained from this study was indicated and described above. The researcher will continue with a discussion on qualitative data obtained.

#### **4.9.2. Qualitative (open-ended survey questions and interview) data results**

Following data analysis as previously described (Point 6.2), themes which emerged from qualitative data were identified:

1. Effect of SID on Gestalt play therapeutic intervention
2. Effect of SID on the child
3. Effect of SID on the Gestalt play therapist
4. Working alliance with parents and team members

The researcher will discuss each theme and their sub-themes by providing examples from transcriptions (Appendix D) and codes generated from the questionnaire (Appendix C). Themes and sub-themes will be described and checked against literature.

#### **4.9.2.1. Theme1: Effect of SID on play therapeutic intervention**

In Chapter 3, the researcher demonstrated that SID will affect various aspects of the Gestalt play therapeutic intervention. Special reference was made to establishing contact (especially sensory contact), the Gestalt play therapeutic process and assessment (refer to Chapter 3, points 3.3.3, 3.5 and 3.6). Sub-themes which emerged from the data served to confirm the researcher's opinion.

##### ***4.9.2.1.1. Knowledge of SI theory and awareness of SI difficulties influenced participants' approach and activity choices***

As illustrated in Graph 4.1, none of the participants had received any formal training on SI theory. However, 80% of participants did possess basic knowledge of SI. Participants indicated that their approach to children with SID was different from their approach to other children: Participants were cautious of challenging the child or "pushing" for premature trust or disclosure.

- "... ek fokus... baie meer op bemeesting [tydens terapie met 'n kind met SID], so aanvanklik fokus ek op dinge waarvan... [die kind] hou en nie te veel challenge nie, want die verdedigings is al klaar so baie, die oomblik wat jy hulle challenge, verloor jy hulle heeltemal."<sup>2</sup> (Participant 5, p132.)
- "I suppose maybe I go a bit softer with them because I know that because of their high sensitivity I wouldn't necessarily push them." (Participant 6, p149). "You can't rush the highly sensitive, because they need to get confident in you and you can't push them more than they need." (p150). "The sessions needed to be more non directive..." (Participant 6, survey question 8.)

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<sup>2</sup> "I focus... a lot more on mastering [during therapy with a child who presents with SID], so initially I focus on things which...[the child] likes and [not on too many] challenges, Because of the many protective mechanisms [which the child has]; the moment you challenge them, you lose them."(Freely translated)

- “Soos hierdie seuntjie is tassensitief. Ek kan nie... verwag dat hy die eerste keer wat hy my sien, vir my ’n drukkies gaan gee of in die sand gaan speel... nie.”<sup>3</sup> (Participant 10, p165.)

Participants also indicated that activity choice was affected. Specific mention was made of avoiding activities to which the child displayed resistance, especially at the beginning of the therapeutic process. The general feeling was that the child with SID cannot be “pushed” into doing activities which he or she does not want to do, as the child’s trust and willingness to participate will be diminished. This reflects well on play therapists’ phenomenological I-Thou approach which advocates that the child should be accepted in totality by respecting the child’s phenomenological experiences (Oaklander, 2002:86; Blom, 2006:56). Participants 6 and 10, who were aware of their own sensory profiles, demonstrated particular sensitivity for the children’s SI difficulties (refer to point 4.9.2.3.1).

- “So ek probeer definitief om eers daar rondom te beweeg [aktiwiteite wat frustrasie veroorsaak], sodat [die terapeut en die kind] kan kontak maak op ’n ander vlak... want anders, jy verloor die kind heeltemal.”<sup>4</sup> (Participant 5, p126.)
- “I don’t do any strange sensory smells with him... because he has got smell issues and taste issues.” (Participant 6, p140.)
- “I would also try and encourage it [putting stickers on the child’s hands] just to get him used to the idea, but when we came to that resistance of tearfulness, I didn’t really push it.” (Participant 8, p158.)

Interestingly, the participants did not mention that activities to which the child was resistant could perhaps be adapted to be more suitable and enjoyable to the child. A simple example would be for the child to don gloves during art, painting, sand tray or clay work.

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<sup>3</sup> “For example, this boy is tactile defensive. I cannot... expect that he will hug me the first time he sees me, or that he will play in the sand.”(Freely translated)

<sup>4</sup> “I definitely try to avoid it [activities which cause frustration] at first, so that [the therapist and child] can establish contact on another level first... because otherwise you totally lose the child.” (Freely translated)

Participants mostly mentioned activities which focused on tactile, visual, smell and taste stimuli. Little mention was made of vestibular and proprioceptive stimuli, which, if applied correctly, have a powerful regulatory effect on the central nervous system (see Chapter 2, point 3.6).

#### **4.9.2.1.2. Good sensory contact-making was more challenging and influenced the level of emotional contact with the child**

Participants indicated that the children struggled more with establishing sensory and emotional contact. This influenced the therapeutic process, as participants had to spend more time on sensory awareness.

- “... asof hierdie defensiwiteit en daai geïrriteerdheid op grond van die sensoriese integrasieprobleme 'n muurtjie bou tussen hulle en die buitewêreld, en jy kan amper nie kontak maak met hulle nie.”<sup>5</sup> (Participant 5, p129.)
- “... I have to obviously work more on a sensory awareness level, because it's a lot more difficult to, uh, go into emotional awareness if I don't actually first deal with the sensory awareness.” (Participant 8, p153.)
- “[The child] finds it difficult to show any kind of emotional response, sensitive to sensory stimulus—touch, sand/clay. Loud noise in classroom—blocks his ears. He became withdrawn, did not speak and started to hurt himself by scraping with sharp object his inner part of upper leg.” (Participant 2, survey question 7.)
- “It was difficult to get him to join in conversation. He did not like to touch or smell different things and got upset with ‘strange’ sensory stimuli.” (Participant 3, survey question 7.)

The fact that children with SID will struggle with establishing and maintaining good sensory (therefore also emotional) contact emerged from SI theory and Gestalt literature. It was thoroughly discussed in Chapter 3.

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<sup>5</sup> “. . . as if that defensiveness and irritability in terms of the sensory integration problems becomes a little wall between them and the outside world, and one can almost not establish contact with them.” (Freely translated)

#### **4.9.2.1.3. Therapeutic process took longer to complete**

Participants indicated that the therapeutic process with children suffering from SID took much longer in comparison to other children. This was due to the fact that the children struggled more with sensory and emotional contact, which leads to a diminished ability to trust in others.

- “[V]an die begin af weet ek dit [die terapeutiese proses] gaan stadiger wees.<sup>6</sup>” (Participant 5, p132.)
- “It took me a lot longer... to get to the emotional and social side of things...” (Participant 8, p153.)
- “You can’t rush the highly sensitive, because they need to get confident in you and you can’t push them more than they need.” (Participant 6, p150.)
- “[The] therapist [referring to herself] had to concentrate first on building a trusting relationship which took longer than the normal intervention for children.” (Participant 2, survey question 8.)

Following from the discussion on the sensory process, participants highlighted the need for the assessment of sensory problems.

#### **4.9.2.1.4. Assessment of sensory problems / diagnosis necessary**

Participants indicated that it was important to assess children’s sensory systems, as this provided an indication of how and when to intervene with sensory work. This agrees with literature, especially in Blom’s therapeutic process where assessment procedures in Gestalt play therapy are set out in great detail (2006:51-68). Participants who had some knowledge on SI were able to identify factors which could point to an SID.

- “... en ek het agtergekom hy kon glad nie die sand hanteer nie... ek het eintlik gedink dat hy iets soos tasdefensief is.”<sup>7</sup> (Participant 5, p126.)

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<sup>6</sup> “[F]rom the start I know that it [the therapeutic process] will take longer to complete.” (Freely translated)

- “I noticed that he was wearing a jersey and it was like the hottest day in February. So I knew something wasn’t right.” (Participant 6, p136.)
- “... because I gained those information [about the child’s sensory needs] from the parents, I knew how to work with the child.” (Participant 8, p159.)
- “Hy het ’n groot behoefte aan sensoriese input ook... [E]k probeer hom nog steeds blootstel aan dit, en kyk hoe hy reageer.”<sup>8</sup> (Participant 10, p166.)

Participants 5 and 6 indicated that they were knowledgeable of typical behaviour which could indicate tactile defensiveness. As mentioned in Chapter 2, children who are tactile defensive may display an uncommon preference to long-sleeved clothing, or be uncomfortable with touching sand. Following from the discussion on the impact of SID on the therapeutic relationship, the effect on the child also became apparent.

#### **4.9.2.2. Theme 2: The effect of SID on the child**

From the literature review, it was evident that the presence of SID in a child’s life will have an intricate impact on various areas of the child’s environment or field. Areas of special interest to this study were that of the child himself (behavioural and emotional manifestation) and the child’s relationships.

##### **4.9.2.2.1. Establishing trusting relationships**

When any child is treated by a therapist, some form of therapeutic relationship needs to be established. This is especially true for the Gestalt play therapist who regards the therapeutic relationship as the start of the therapeutic process of therapy (refer to Chapter 3). The researcher sought to explore and describe how and whether the therapeutic relationship with a child who has SID differs from the therapeutic relationship with other children.

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<sup>7</sup> “... and I realised that he could not handle [playing with] sand... I actually thought that he was something like tactile defensive.” (Freely translated)

<sup>8</sup> “He also has a great need for sensory input... I try to expose him to [sensory input] and watch his reaction.” (Free translation)

As discussed in Chapter 2, children with SID are often reported to have difficulty with functioning in various areas of their lives, including interpersonal relationships (Lane, 2002a:117; Lombard, 2004:14; Van Jaarsveld, 2005:373; Geysers, 2009:11-13; Mackenzie, 2009:15-18). Participants realised that the children with SID had difficulty with establishing trusting relationships, particularly with friends and the therapist.

- “[Die kind] wil graag met die ander maatjies speel, maar... hulle raak aan hom op maniere waarvan hy nie hou nie... en dan raak hy aggressief.”<sup>9</sup> (Participant 5, p130.)
- “You can’t rush the highly sensitive because they need to get confident in you and you can’t push them more than they need.” (Participant 6, p150.)
- “It takes them [children with different types of SID] both longer to build trust.” (Participant 8, p159.)
- “[The] therapist [referring to herself] had to concentrate first on building a trusting relationship which took longer than the normal intervention with children.” (Participant 2, survey question 8.)

#### **4.9.2.2.2. Behavioural manifestation**

The children displayed very specific behavioural patterns, which strongly linked with Gestalt and SI literature (see discussion below). Participants mostly reflected on how children reacted in terms of tactile stimuli.

- “Hy sal die mannetjies [in die sand] insit en dan sal hy weer sy hande afskud... Met die klei het hy letterlik gegril... hy het vir my gesê dit laat hom dink aan gwel.” (Participant 5, p125.) “... dat hy by die skool geïrriteerd geraak het met maatjies wat te naby aan hom was... en dat hy hulle dan begin boelie het.”<sup>10</sup> (p127.)

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<sup>9</sup> “[The child] also wants to play with his friends... but they touch him in ways which he doesn’t like... and then becomes aggressive.” (Freely translated)

<sup>10</sup> “He would insert the plastic figures [into the sand] after which he would shake [the sand] off his hands... With the play-dough he literally become revolted by it... he told me that it reminded him of

- “And when I put cream on him it was like I had put some vile pestilence on him”. (Participant 6, p136). “... [H]e gets tantrums, he hits people without warning. He tried to strangle someone and throw him out the window... Because [the sensory overload] was just too much for him...” (p141.)
- “A hug to greet. His arms would be down and you would have to do the hugging and put your arms around his body, whereas he would just sort of lean his body against you, and that is as far as he would go.” (Participant 8, p157.) “He really didn’t want stickers on his body or writing on his body either... He would still be... very fearful in a sense, of it, and result in being teary.” (p161.)

These examples illustrate avoidant behaviour and fight/flight responses elicited in children who were overresponsive to sensory stimuli (Parham & Mailloux, 2005:378; Van Jaarsveld, 2005:373). In Gestalt terms, these examples are most often likened to deflection (Blom, 2006:37). When asked which contact boundary disturbances were utilised by the children, participants mostly indicated deflection (80%) and desensitisation (70%) (refer to point 4.9.1.3).

Below are meaningful examples of children who displayed sensory-seeking behaviour. They struggled with withdrawal from contact (indicating confluence as a contact boundary disturbance):

- “And the little girl, she is sensory seeking in many ways... She’s busy always with art... She’s very busy with that. Then I will bring in music and she will sing and she’ll play with the video camera... There has to be limits, like ‘don’t paint the floor’, or ‘only two papers please instead of a hundred’, otherwise she will go through all of them and staple all of them.” (Participant 6, p144.)
- “Wat interessant was van hom, was dat hy mal was oor die sensoriese. Ons het vir weke lank sensoriese goed gedoen... Elke week wou hy dit

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slime... [He told me] that he became irritated with friends who were [standing] too close to him... and that he then started to bully them.” (Freely translated)

[sensoriese werk] doen. Hy het 'n groot behoefte aan sensoriese input..."<sup>11</sup>  
(Participant 10, p166.)

An example of how a child's inconsistent sensory preferences resulted in confusion in the participant is indicated below.

- "... [the child] was more resistant to like stickers on his hand and um, [pictures] drawn on his hand and stuff like that. Um... Although he wouldn't mind painting and messing himself with paint. So it was very contradictory... So it's kind of... strange for me." (Participant 8, p155.)

Therapists should be cautious when generalising behavioural manifestations into "typical" behaviour (for example, thinking that all tactile defensive children dislike messing with paint), as every person's sensory make-up is unique (Lombard, 2007:33). An additional factor which may cause confusion, but was not mentioned by any of the participants, is that children with SID may be labile in their response to sensory stimuli. They can be underresponsive to stimuli at times, and overresponsive at other times (Lane, 2002a:109).

#### **4.9.2.2.3. Emotional manifestation**

Participants reported children to exhibit irritation, anger, becoming "upset", control issues and an impaired sense of self.

- "... jy kon sien sy gesig raak geïrriteerd [wanneer hy met die sand speel]..." (Participant 5, p127) "Dit is... asof daar verdedigingsmeganismes opgaan." (p129). "... ek weet dat [kinders met SID] nie sommer maklik in 'n nuwe situasie inbeweeg nie..." <sup>12</sup>(p132.)
- "He liked more structured games and he would liked to be prepared in advance what we are going to do and what is expected of him... [H]e had a very low sense of self." (Participant 8, p161.)

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<sup>11</sup> "What was interesting about him was that he loved the sensory [input]. We did sensory work for weeks... He wanted to do it [sensory work] every week. He had a great need for sensory input." (Freely translated)

<sup>12</sup> "...one could see by the look of his face that he became irritated [when playing the the sand]. . . It is... as though defence mechanisms went up. . . . I know that [children with SID] struggle with moving into new situations." (Freely translated)

- “He did not like to touch or smell different things and got upset with ‘strange’ sensory stimuli.” (Participant 3, survey question 7.)
- “I felt waves of nervous energy and anxiety coming from this child. He was very irritated and angry a lot of the time.” (Participant 4, survey question 11.)

The researcher was mindful of the fact that these children were referred for play therapy because of a myriad of reasons (see Graph 4.2); therefore, SID was not the only variable which could cause specific emotional manifestations. However, participants commented on the children’s emotional responses after being confronted with sensory stimuli in an attempt to establish sensory contact with them.

The previous sub-themes elaborated on the effect of SID on the child. As mentioned in Chapters 2 and 3, children with SID display definite behavioural, emotional and relationship difficulties. As established by Geringer (2009), children with SID are often referred for play therapy. Gestalt play therapists therefore need to establish whether they are equipped to handle children with SID in therapy.

#### **4.9.2.3. Theme 3: Effect of SID on the play therapist**

As the research study was conducted from a Gestalt paradigm, principles of field theory were taken into account. Field theory advocates that a change in one part of the field will affect other parts of the field (Yontef, 2002:19). Therefore, treating a child with SID will inevitably affect the therapist, as she and the child are entering each other’s fields, co-creating a new, emergent field between them.

##### ***4.9.2.3.1. Participants who were aware of their own sensory needs/difficulties, realised how these impacted the field***

Every person possesses inherent neurological thresholds and a unique sensory profile, indicating sensory needs and difficulties (Lombard, 2007:33). The researcher wanted to establish whether participants were aware of their own sensory needs and difficulties and how these impacted the therapeutic field. Participants 6 and 10 in

particular indicated in the interviews that they were aware of their own sensory difficulties and that these difficulties impacted the therapeutic field.

- “I brought an aerosol because the room smells of, um... and I’m highly sensitive. I notice the smells. So she [the child] comes in and sprays the room with the aerosol.” (Participant 6, p144.)
- “... there would always be that, um, space [between us], which is not an issue for me because I don’t like anyone in my space... [H]e once actually sat right next to me. And I was like [showing surprise] and I noticed it because of my personal [space issue]... and I allowed it, and it was nice...” (Participant 6, p138.)
- As ek aan myself dink, weet ek dat ek sintuie het wat ek weet maklik oorgestimuleer raak... [E]k moet ook maar leer om my wêreld te organiseer... Gehoor is nogal iets waarin ek maklik my levels bereik. Met so ’n [raserige, besige] kind sal ek probeer, as dit moontlik is, om hulle vroeër in die dag te sien... Maar dit is moeilik [om my wêreld te organiseer], want jy moet by die kind hou (al het jy nie meer energie oor nie), en dan join jy maar... Ek kan maar na die tyd op die bank gaan uitpass. Dis nou maar hoe dit is. Vir my gaan dit oor die kind.”<sup>13</sup> (Participant 10, p169.)

These participants indicated that they were aware of their own sensory difficulties and had already taken measures to implement sensory strategies to modulate themselves (refer to Chapter 3, point 3.7). This facilitated the ability to bracket their own sensory difficulties during therapy, which enabled the child to continue with what he or she wished. The researcher is of the opinion that the participants’ own sensory awareness led them to being more sensitive to the child’s sensory difficulties.

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<sup>13</sup> “When I think about myself, I know that I also have senses which become over stimulated easily... I also have to learn how to organise my world... Hearing is definitely [a sensory system] which easily reaches [too high stimulation] levels. I will try to see a [busy, loud] child earlier in the day, if possible... But it [organising your world] is difficult because you have to stay with the child, even if you don’t have any energy left, you have to join [in activity with the child]. I can go and pass out on the couch after therapy. That is the way it is for me. The child is important.” (Freely translated)

#### **4.9.2.3.2. Participants were empowered by knowledge of SI**

Although none of the participants had attended any courses on SI or received formal training, they felt empowered by learning of SI and could employ sensory strategies in play therapy. Participants who possessed some knowledge of SI adapted their approach and activity choices.

- “Ek dink dit [kennis oor SI] help jou in terapie. Ek het al ’n bietjie gaan oplees daaroor op my eie, so dit help om die kind beter te verstaan.”<sup>14</sup>(Participant 5, p133.)
- “He comes in[to the therapy room]... it’s sensory, optimal arousal, optimal level of stimulation I think it’s called? So then he comes in, it’s quiet... he can play with the toys he knows... So I think with him [what he needs is] stability, routine, it’s quiet...” (Participant 6, p139)
- “... because I gained those information [about the child’s sensory needs] from the parents I knew how to work with the child.” (Participant 8, p159.)
- “... [E]k het myself beter leer ken toe ek die boek [*Sensory Intelligence*] ge lees het en nou verstaan ek myself beter... Die boek het vir my ’n breër uitkyk gegee oor die sensoriese belewenis. Ek dink dit is hoekom ek meer ruimte laat daarvoor in terapie.”<sup>15</sup> (Participant 10, p173.)

#### **4.9.2.3.3. Participants regarded an increased knowledge of SI to be beneficial**

Linking with the previous sub-theme, participants indicated that an increased knowledge of SI would be greatly beneficial to them. Therapists were not concerned with doing SI therapy (meaning, to treat SID as SI-trained OTs do) but rather with understanding and handling the child better during therapy. Also, participants wanted to know when to refer the child.

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<sup>14</sup> “I think it [knowledge of SI] is very helpful for therapy. I have read up a little about the subject on my own, so it helps me to better understand the child.” (Freely translated)

<sup>15</sup> “I came to know myself better when I read the book [*Sensory intelligence*] and now I also understand myself better.. . The book provided me with an expanded outlook on the sensory experience. I think that is why I leave more room for it during therapy.” (Freely translated)

- “Beslis [sal opleiding in SI voordelig wees]. Nie om dit self te hanteer nie... om presies te kan weet maar wat is die kriteria wanneer mens dan nou eventueel moet verwys.”<sup>16</sup> (Participant 5, p133). “More knowledge [on SI] would have helped me to understand what was going on better and being able to identify the problem quicker.” (Participant 5, survey question 13.)
- (After speaking about contradictory behaviour from child.) “That’s why I say, maybe I don’t know about sensory integration and I need more knowledge on it to be able to know how to actually work with it.” (Participant 8, p155.)
- “I personally think that there is not enough focus on sensory work in the Gestalt course and how to intervene. Practical examples would have been helpful with the sensory integration process.” (Participant 2, survey question 13.)
- “[If I had more knowledge on SI] I would have been able to recognise or diagnose his problem. Instead I referred him to an expert...” (Participant 3, survey question 13.)

As mentioned under the previous sub-theme, participants who possessed some knowledge regarding SI thought themselves to be empowered by it. It became apparent that participants also regard it as important that parents be made aware of their children’s sensory needs and problems.

#### **4.9.2.4. Theme 4: Working alliance with parents and team members**

Participants indicated that play therapeutic intervention with a child with SID was not optimal if it took place in isolation. Participants particularly stressed the importance of a working alliance with OTs and children’s parents.

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<sup>16</sup> “[Training in SI] would definitely be an advantage. Not to handle it by myself... [but to] know exactly what the criteria for eventual referral is.” (Freely translated)

#### **4.9.2.4.1. Parents' awareness and knowledge of SI difficulties influenced their willingness to accommodate the child and work with the team**

- “I explained to the mom that if he doesn't like the Handy Andy, [she should] just go to the shop with him, let him smell all the detergents and find the one he likes... the mom is able to now more or less understand, you know, this [sensory defensiveness] is a problem.” (Participant 6, p.141.) “[The mother] actually phoned me and I explained this is what the problem is. She was willing to accommodate him.” (p146.)
- “... the parents are very knowledgeable of what he's got... So she [the mother] knows that he needs... say, a hammock in his room. And so they did that. So they accommodate those things that he needs.” (Participant 8, p159.) “[P]arents that... don't do the [exercises and suggestions given by the OT and play therapists]... then it's not gonna work. That's probably another reason why it takes longer also in the therapy sessions.” (p163.)
- “[Die ouers] het hom al vir arbeidsterapie gevat nog vóór spel terapie. So hulle het besef hier is 'n probleem. En dan is hulle ook meer oop daarvoor om hom te akkommodeer... en dit te maak werk vir hulle.”<sup>17</sup> (Participant 10, p170.)

Participants felt the need to inform parents of their children's difficulties. Participants indicated that informed parents were better able to accommodate their children's sensory needs and difficulties and that it further facilitated progress in therapy. Informing and educating parents seemed to be regarded largely as the OT's role (see sub-theme below).

#### **4.9.2.4.2. OTs and Gestalt play therapists have unique roles to fulfil**

Participants felt that they were equipped to deal with children's emotional, social and behavioural difficulties, whereas OTs were especially well equipped to treat SID. Participants indicated that play therapists and OTs were dependent on the work of the other.

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<sup>17</sup> “Even before play therapy the parents took him for OT. So they realised that there was a problem. They were then more willing to accommodate him and to make it work for them.” (Freely translated)

- “...dis iets wat die spelterapeute nie noodwendig op hulle eie kan doen nie. Die arbeidsterapeut is nodig om haar deeltjie daar te doen voor jou proses kan vorder.”<sup>18</sup> (Participant 5, p131.)
- “... I can work on the emotional and social and behavioural side of the child, but... I think [the OT] still need to give a lot more knowledge on about how to deal with these SI [problems].” (Participant 8, p 162.)
- “So dit was vir my interessant om te sien van waar af hy gekom het en wat die arbeidsterapie ook doen... Ek wil amper sê, wat mens saam kan doen as arbeidsterapeut en spelterapeut.” (Participant 10, p1646)

#### **4.9.2.4.3. Referral to team members, correct diagnosis**

Participants discussed the importance of referral to the appropriate team member, including the question of when to refer. Participants also expected the OT to inform them of the child’s diagnosis and how to handle it in therapy.

- “Ek het hom toe vir ’n arbeidsterapie-evaluasie verwys omdat ek so iets [SID] vermoed het... Daar was toe ’n sensoriese probleem... hy [het toe ook] arbeidsterapie [gekry] en soos dit gevorder het, het dit ook vir my makliker geword om met die emosionele goedjies te werk...”<sup>19</sup> (Participant 5, p126.) “A guideline for psychologists to identify SID in order to know when to refer to OT [is needed].” (Participant 5, survey question 14.)
- “... it’s important [that] the OT who, say, does diagnose [the child] with SI, needs to inform [the play therapist] and work as a team with the play therapist...” (Participant 8, p162.)
- “... [P]arents and therapists need to be knowledgeable of SI, and hopefully it is diagnosed properly as [an] SI [problem].” (Participant 8, p162.)

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<sup>18</sup> “...this is something that play therapists cannot necessarily do on their own. The OT is needed to do her bit before the [play therapy process] can progress.” (Freely translated)

<sup>19</sup> “I then referred him for an OT evaluation because I suspected it [SID]... there was indeed a sensory problem... he then received OT intervention and as it progressed it became easier for me to work on emotional things...” (Freely translated)

- “Kinders word dikwels na spelterapeute verwys as gevolg van emosionele blokkasies. Baie keer is dit eerder sensoriese integrasieprobleme wat eers aandag moet kry.” (Participant 9, survey question 13.)

The above mentioned four themes were generated from qualitative data. Insightful findings were generated, and these will be discussed in Chapter 5.

#### **4.10. Conclusion**

In this chapter, the research approach, design and methodology were discussed. In addition, the researcher presented the empirical findings and discussed them against the backdrop of available literature on the topic. Four main themes with sub-themes were identified and elaborated upon: the effect of SID on Gestalt play therapeutic intervention; the effect of SID on the child; the effect of SID on the Gestalt play therapist, and working alliance with parents and team members.

In the next chapter, a summary of findings will be presented. This will be followed by an evaluation, limitations of the study, conclusions and recommendations

# Chapter 5

## Evaluation and Conclusion

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### **5.1. Introduction**

The researcher regards this final chapter of the dissertation as the most important, as it represents the culmination of the entire research process. An evaluation and summary of the research process will be presented, followed by a summary of findings, conclusions and recommendations.

### **5.2. Answering the research question**

The question posed by the researcher was the following: How do Gestalt play therapists establish sensory contact with children suffering from SID? This question guided the researcher in establishing the research approach, design, data collection techniques and data analysis. Rich explorative and descriptive data was obtained, which resulted in a deeper phenomenological insight into the research phenomenon.

### **5.3. Accomplishment of the aim and objectives of this study**

This research study had an applied goal, which was to explore how Gestalt play therapists establish sensory contact with children suffering from SID. Five objectives were stipulated, which enabled the researcher to meet the goal.

#### **5.3.1. Undertaking a literature review: Gestalt and SI theory**

This objective was achieved in Chapters 2 and 3, where the researcher provided insight into both SI theory and the theoretical framework of Gestalt play therapy. Various theoretical aspects applicable to this study were explored and discussed.

The literature review provided an integrated theoretical backdrop against which the empirical study could take place.

### **5.3.2. Undertaking a pilot study given to four Gestalt play therapists and altered if necessary**

The researcher met this objective by asking four Gestalt play therapists to complete the questionnaire and provide feedback regarding the general appearance, coherence and clarity of questions. Feedback provided by therapists included that the questionnaire should be saved in a compatible file format to enable ease of access to participants with both older and newer computer programs. This was done by the researcher. After completion of the pilot study, the empirical study commenced.

### **5.3.3. Undertaking an empirical study by use of survey questionnaire and focus group**

This objective to undertake the empirical study was achieved. The researcher made use of a self-compiled, pilot-tested questionnaire. As mentioned in Chapter 4, the researcher chose to conduct semi-structured interviews with four participants, as logistics and travel distances rendered a focus group impossible. Rich, descriptive qualitative data was collected through the interviews.

### **5.3.4. Analyse data to make useful findings**

Interviews were transcribed verbatim. Thematic analysis was used to analyse qualitative data obtained from the questionnaire and interviews. Univariate analysis was used to analyse quantitative data from the questionnaire. After the data was analysed, findings were presented to the reader in Chapter 4.

### **5.3.5. Formulating recommendations to Gestalt play therapists and training institutes regarding further studies**

This objective will be met in Chapter 5. Refer to point 5.8.

The research objectives were duly met, resulting in a successful journey of exploration and description of the researched phenomenon. Meeting research objectives also enabled the researcher to identify the need for further studies on the subject.

## **5.4. Chapter summaries**

Chapter 1 presented an overview of the study by clearly indicating the rationale, research problem, research question, aim and objectives. The researcher commented on ethical aspects applicable to this study.

In Chapter 2, the reader was introduced to the fascinating science of SI theory. The sensory systems, sensory integration, adaptive response and sensory integration disorders were discussed. The complex nature of SID and the impact thereof on the child were highlighted.

Chapter 3 included a discussion of Gestalt therapy and Gestalt play therapy. Awareness, phenomenology, contact, Gestalt cycle of experience, self-regulation and homeostasis, the Gestalt play therapy process, sensory contact and the impact of SID on the Gestalt play therapeutic process were discussed and integrated with SI theory.

Chapter 4 was dedicated to the empirical research process, data analysis and presentation of findings. Identified themes and sub-themes were discussed and checked against literature.

## **5.5. Summary of findings**

### **5.5.1. Biographical data**

The absence of a national database of Gestalt play therapists made obtaining a research sample a very difficult task. A list of current or recently graduated master's degree students was obtained. This signified the start of sampling. Ultimately, ten participants responded. Four (40%) participants had less than two years experience in the field of Gestalt play therapy, followed by 30% with two to five years experience.

There was a general lack of knowledge regarding SI among the population (please refer to Chapter 4, point 9.1.1), which may have played a role in the low response rate. Formal SI training open to disciplines other than OTs seemed to be limited; most participants indicated that they had talked about SI with a knowledgeable person or read about it. None of the participants had received any formal training in SI and two (20%) indicated that they had no knowledge of SI.

### **5.5.2. Quantitative data**

All participants had treated children strongly suspected of suffering from SID, but a diagnosis was confirmed in only 50% of cases. Reasons for referral included behavioural problems and diminished ability to make contact. None of the children were referred for play therapy because of sensory difficulties. Participants indicated that the children mostly displayed deflection (80%) and desensitisation (70%) as contact boundary disturbances, which agreed with Gestalt and SI literature.

### **5.5.3. Qualitative data**

#### **5.5.3.1. Theme 1: The effect of SID on Gestalt play therapeutic intervention**

Participants indicated that their therapeutic approach to children with SID was different from their approach to other children. Participants altered their approach

and activity choices, especially if they were knowledgeable of the child's sensory difficulties. Sensory and emotional contact-making were more challenging. Participants also felt that the therapeutic process took longer to complete. Participants indicated that it was important to assess and/or diagnose sensory difficulties.

***5.5.3.1.1. Knowledge of SI theory and awareness of SI difficulties influenced participants' approach and activity choices***

Participants indicated that they were cautious of "pushing" or challenging the child. Activity choice was also strongly affected. Participants would rather avoid activities to which the child was resistant than try to adapt them to be more acceptable to the child. When discussing activities to which children were resistant, participants mostly mentioned tactile activities such as sand or clay work. Little mention was made of vestibular/movement/proprioceptive activities, which could have powerful regulatory influences on sensory systems and may prove to be more acceptable to the child.

***5.5.3.1.2. Good sensory contact-making was more challenging and influenced the level of emotional contact with the child***

Participants indicated that children with SID clearly struggled with establishing sensory and emotional contact, and that more time had to be spent on sensory work. The presence of an SID also affected the ability to establish trusting relationships.

***5.5.3.1.3. Therapeutic process took longer to complete***

The therapeutic process took longer with children who suffered from SID. This was mainly due to diminished sensory and emotional contact (leading to diminished trust) with others. Participants made particular mention of how this affected children's ability to trust the therapist and peers.

#### **5.5.3.1.4. Assessment of sensory problems / diagnosis**

Assessment of sensory problems and diagnosing SID were important to participants, as this assisted them with knowing how and when to intervene with sensory work.

#### **5.5.3.2. Theme 2: The effect of SID on the child**

Findings served to stress that the presence of SID affected the child in various ways. This manifested in emotional, behavioural and social difficulties.

##### **5.5.3.2.1. Establishing trusting relationships**

Children with SID were reported to experience difficulty with establishing trusting relationships. Particularly relationships with peers and the play therapist were indicated to be affected.

##### **5.5.3.2.2. Behavioural manifestation**

Sensory difficulties became evident after witnessing children's behavioural responses. Avoidant behaviour and the fight/flight response (aggression and frustration) were described by participants, which indicated the use of deflection and desensitisation. Some participants described sensory-seeking behaviour, indicating confluence as a contact boundary disturbance.

##### **5.5.3.2.3. Emotional manifestation**

Participants described how children's sensory difficulties presented emotionally. Irritation, anger, wanting to be in control and poor sense of self were observed in these children.

### **5.5.3.3. Theme 3: Effect of SID on the play therapist**

Not only the children but also participants were impacted by the co-created therapeutic field. Some participants deemed themselves to be more sensitive to the child's needs because they were aware of their own sensory difficulties. Participants who had some knowledge of SI were empowered by it and thought that they could handle the child with SID more effectively. Participants pointed out that an increased knowledge of SI would be beneficial and improve their therapeutic skills.

#### ***5.5.3.3.1. Participants who were aware of their own sensory needs/difficulties realised how these impacted the field***

Two participants were knowledgeable of their own sensory profiles/needs and difficulties. These participants were also aware of how their preferences impacted the therapeutic field and were thus more sensitive to children's needs.

#### ***5.5.3.3.2. Participants were empowered by knowledge of SI***

Participants who were knowledgeable of SI theory or children's specific diagnosis and sensory needs felt empowered by that knowledge. This knowledge guided their activity choices and their approach to the children.

#### ***5.5.3.3.3. Participants thought that an increased knowledge of SI would be beneficial***

Participants indicated that an increased knowledge of SI would facilitate a better understanding of the child. Also, it would enable participants to know when to refer the child, and to recognise sensory difficulties sooner.

#### **5.5.3.4. Theme 4: Working alliance with parents and team members**

Participants indicated that teamwork was important when treating a child suffering from SID. The important role of parents and team members (specifically the OT) was stressed.

##### ***5.5.3.4.1. Parents' awareness and knowledge of SI difficulties influenced their willingness to accommodate the child and work with the team***

Participants felt the need to educate and inform parents if they were not already informed of the child's sensory problems. Working together with parents seemed to facilitate the therapeutic speed and process.

##### ***5.5.3.4.2. OTs and Gestalt play therapists have unique roles to fulfil***

Participants indicated that they were especially equipped to deal with children's emotional, behavioural and social difficulties, whereas OTs were trained to deal with SI problems. Gestalt play therapists and OTs both have their own roles to fulfil and are mutually dependent.

##### ***5.5.3.4.3. Referral to team members and correct diagnosing***

The importance of early referral and correct diagnosing was stressed. This would be aided by an increased knowledge of SI, as participants would then know when to refer the child to an SI-trained OT.

## **5.6. Conclusions**

Several conclusions were drawn after facts from literature and research findings were taken into account. These findings cannot be generalised to other contexts.

The main conclusions are presented below:

- There was a general lack of knowledge regarding SI among Gestalt play therapists, particularly in the broader study population. This was due to various reasons, including the lack of available training opportunities for professional persons other than OTs, and the lack of exposure to SI theory during training as a Gestalt play therapist. Gestalt play therapists were generally informed of SI through contact with OTs.
- Participants' approach to children with SID was markedly different from the approach to other children. It was affected by:
  - their level of knowledge of SI theory;
  - the knowledge that the child has a confirmed diagnosis of SID;
  - the awareness that the child is struggling with sensory contact, although not necessarily having been diagnosed with SID;
  - the participants' awareness of their own sensory profile (sensory needs and difficulties); and
  - training as a Gestalt play therapist, which advocated a phenomenological I-Thou approach
- Participants' approach to children with SID was characterised by the notion that the child cannot be "pushed" into performing activities to which he or she is resistant, or rushed into trusting the therapist.
- Participants suspected a diagnosis of SID on the grounds of behavioural manifestation when the child was faced with sensory stimuli. Inconsistent behaviour, paired with inadequate knowledge of SI theory, posed a challenge to participants.
- The reason why children with SID were referred to participants often linked to behavioural problems and not sensory difficulties. If the Gestalt play therapist is unaware of SI theory, the child may never be diagnosed, referred to an SI-

trained OT or treated for SID. Knowledge of SI theory is therefore essential to all play therapists.

- Participants tended to avoid activities to which children were resistant and did not consider the possibility of adapting activities. This restricted the free use of activities and limited participants in their activity choices.
- Participants focused on the five visible, well-known senses and stimulated these senses with general awareness during therapy. They were unaware of the powerful effect of proprioceptive and vestibular stimuli, therefore stimulating these senses without being aware of the possible positive or negative impact on the child's sensory processing and level of arousal.
- Children with SID struggled with establishing sensory contact, emotional contact and trusting relationships with the therapist and their friends.
- Participants generally indicated that the therapeutic process with children suffering from SID took longer to complete.
- The assessment of sensory systems and difficulties was considered imperative to aid with referral when necessary, as well as with correct diagnosing of SID.
- Children who suffer from SID are referred for Gestalt play therapy. Gestalt play therapists need to establish whether they are equipped to handle SID in therapy, and equip themselves if knowledge is found lacking.
- Participants who were aware of their own sensory profiles demonstrated an improved ability to bracket their sensory difficulties. They implemented basic sensory strategies to facilitate in modulating their sensory systems. These participants were more sensitive to the difficulties faced by children with SID.
- Participants who possessed some knowledge of SI considered themselves empowered by it. They could successfully apply basic sensory strategies with the children.

- Participants held that parents who were informed of their children's sensory difficulties were more willing to accommodate the child. The same went for participants: Willingness to accommodate the child in therapy was increased by knowledge of the child's difficulties.
- Participants were not concerned with treating SID, but rather with handling it in therapy, knowing when to refer to an SI-trained OT and being able to assist parents with implementing sensory strategies at home. The particular roles of the play therapist and the OT came to the fore.
- Gestalt play therapists and OTs are deemed to have unique, interdependent roles to fulfil with regard to children suffering from SID. These children should preferably receive intervention from both parties.

## **5.7. Limitations of the study**

Particular circumstances posed limitations to this study. The main limitations applicable to this study were the following:

- Literature on SI and Gestalt theory abounds. However, very little information was found on treating the child with SID in Gestalt play therapy.
- This study explored and described the phenomenological experience of ten participants who had treated children with a confirmed or suspected diagnosis of SID. Findings cannot be generalised to other contexts. More in-depth findings could have been generated by employing a longitudinal study, describing participants' experience as therapy with said children progressed.
- Inclusion criteria ultimately included participants who strongly suspected a diagnosis of SID in a child who was treated. Although this increased the number of participants and enriched collected data, findings cannot be applied exclusively to children who have a confirmed diagnosis of SID. Findings are therefore applicable to Gestalt play therapy with children who have any sensory difficulty, which, according to participants' discretion, could be an SID.

- The absence of a national names database of Gestalt play therapists caused significant delay in this study, as the researcher had to painstakingly search for names and contact details. If such a list were available, a greater sample could have participated in this research study.

## **5.8. Recommendations**

After completing the process of data collection, analysis and identifying main findings, the researcher was able to generate various recommendations. One of the main concerns was the general lack of awareness and knowledge of SI theory. Awareness is considered the epicentre of Gestalt play therapy, and sensory contact-making is a crucial aspect of awareness. Seeing that SID vastly impacts sensory contact-making, Gestalt play therapy cannot afford to be ignorant of it. The following recommendations are applicable to Gestalt play therapy training programmes and institutes:

- It is strongly recommended that a basic introduction to SI theory should form part of the curriculum when Gestalt play therapy is studied. The focus is not on formal diagnosing or SI treatment, but on learning how to efficiently handle these children in therapy. Theoretical aspects covered should focus on identifying possible SIDs (so that the child can be referred) and learning how to implement sensory strategies practically in play therapy to make the most of sensory work. The vast impact of SID on the child's field should be explored so that therapists can gain a holistic understanding of SID and of their role in assisting the child. The function of the OT in treating SID should also be taught and possibilities of working together as a team can be explored.
- Furthermore, it is strongly recommended that Gestalt play therapists be aware and knowledgeable of their own sensory profile, indicating their unique strengths and weaknesses with regard to sensory processing. Participants who were aware of their own sensory profiles were able to handle children with SID more effectively in therapy, thus increasing their therapeutic skill.

Play therapists may become knowledgeable of their sensory profiles by consulting with an SI-trained OT, or by completing self-questionnaires as found in books such as *Sensory intelligence: why it matters more than IQ and EQ*, written by Annemarie Lombard (2007). Whenever the introduction to SI is given to play therapy students, self-profiling may be included in the lectures.

The following recommendations are applicable to Gestalt play therapists and OTs who treat children:

- The theme of interdependent teamwork between OTs and play therapists was prominent throughout data sets. It is recommended that OTs and Gestalt play therapists continue to recognise this fact and that a sustained effort be made to consult with the other whenever a child with SID is treated by either party. OTs should take responsibility for informing the play therapist of the child's diagnosis and continue to give advice on important sensory strategies which can be implemented by parents and the play therapist. It is imperative that the play therapist continue to search for information and training opportunities regarding SI theory and the practical application thereof.
- Parents who are knowledgeable of their children's diagnosis tend to be more willing to accommodate the child and work with the multidisciplinary team. Both OTs and Gestalt play therapists should focus on informing parents about the child's diagnosis and sensory strategies which may be applied by them.

This study specifically focused on how play therapists established sensory contact with children suffering from SID. Participants comprised a small group of Gestalt play therapists. Further studies that can add value to the knowledge base of play therapy with children who have SID include:

- The benefits of play therapeutic intervention with children who have SID.
- Sensory strategies which can be utilised by play therapists to increase the effectiveness of sensory contact-making with children who suffer from SID.

- Exploring the interplay between sensory profiles of the play therapist and her clients, and how this affects the therapeutic process.
- Investigating the effect of multi-disciplinary teamwork in treating children with SID.

## **5.9. Conclusion**

This research study was a journey of exploring Gestalt play therapists' phenomenological experience of establishing sensory contact with children who have SID. Meaningful findings were obtained. Participants did not regard SID as an insurmountable problem, but rather as a challenge best tackled when equipped with knowledge. Findings ultimately serve to bring a sense of urgency to Gestalt play therapists and training institutes regarding the importance of becoming knowledgeable of sensory integration.

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## **Appendix A: Letter of informed consent**

### **HUGUENOT COLLEGE**

#### **GESTALT PLAY THERAPIST CONSENT TO PARTICIPATE IN RESEARCH**

**Research title:** Exploring how Gestalt play therapists establish sensory contact with children who have sensory integration disorders.

*You are asked to participate in a research study conducted by Elsie Wilhelmina van Zyl from the Institute for Child, Youth and Family Studies at Huguenot College and UNISA. This study will be in fulfilment of a M.Diac degree in Play Therapy.*

#### **1. PURPOSE OF THE STUDY**

The researcher wishes to explore how Gestalt play therapists establish sensory contact with children who have sensory integration disorders. The findings will be used to make recommendations to Gestalt play therapists regarding further research on the area of interest, or to Gestalt play therapy training institutes regarding the possibility of introducing sensory integration theory during training.

#### **2. PROCEDURES**

Gestalt play therapists who received training in South Africa will be identified and asked to participate in the study. You will be asked to identify children from your current/ recent caseload who have been diagnosed with a sensory integration disorder by an occupational therapist. You will be asked to complete a questionnaire regarding therapeutic processes with these specific children. This will especially pertain to how sensory contact was established in therapy with each child. You will be required to e-mail the completed questionnaire back to the researcher who will analyze the data. If requested, information regarding treatment of sensory integration disorders will be made available to you, such as contact details of sensory integration trained occupational therapists in your area. All data will be kept strictly confidential and stored in a locked cabinet which is only accessible by the researcher. You may also be asked to be interviewed by the researcher by means of a semi-structured, one-to-one interview which will be audio taped.

### **3. POTENTIAL RISKS AND DISCOMFORTS**

No participant will be exposed to any risks or unnecessary discomforts. However, completing the questionnaire may take some time (around 30 minutes) and may raise more questions regarding the children's behaviour and sensory integration functions. If you are selected and give consent to be interviewed, the interview may also take 30 minutes to an hour.

### **4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY**

No direct benefits to you are expected from this research study.

### **5. PAYMENT FOR PARTICIPATION**

No participants will be remunerated for participation in this study.

### **6. CONFIDENTIALITY**

Any personal information which can lead to identification of participants will remain confidential and will only be disclosed with permission or if required by law. As a participant you will receive a respondent number which will be used throughout the study. Your chosen cases will also be allocated a number in order to ensure anonymity. Data will be labeled according to codes and stored in a locked cabinet or electronically on a computer, protected by a password which only the researcher is knowledgeable of. The researcher's supervisor will have access to the data which have already been coded and only after numbers have been assigned. The final research report will be published at Huguenot College.

### **7. PARTICIPATION AND WITHDRAWAL**

You may choose to withdraw from the study at any time with no penalty raised against you.

### **8. IDENTIFICATION OF INVESTIGATORS**

Please phone Elmien van Zyl (researcher) by telephone (084 835 8368) or e-mail (elmien\_vanzyl@yahoo.com) or dr Susanne Jacobs (study leader) by telephone (082 783 7474) if you have any questions or concerns regarding the study.

## 9. RIGHTS OF RESEARCH SUBJECTS

You may withdraw from participation in this study at any time. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your or your child's rights as a research participant, contact Dr Retha Bloem, head at the Institute for Child, Youth and Family studies at Huguenot College.

Research participant
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The information above was described to [me / the subject/ the participant] by Elmien van Zyl in English and [I am/the subject is/the participant is] in command of this language or it was satisfactorily translated to [me/him/her] in Afrikaans. [I/the participant/the subject] was given the opportunity to ask questions and these questions were answered to [my/his/her] satisfaction.

[I hereby consent voluntarily to participate in this study/I hereby consent that the subject/participant may participate in this study.] I have been given a copy of this form.

---

Name of participant

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Signature of participant

---

Date

Researcher

I declare that I explained the information given in this document to \_\_\_\_\_ [*name of /participant/*]. [*He/she*] was encouraged and given ample time to ask me any questions. This conversation was conducted in English and [*no translator was used/this conversation was translated into Afrikaans by the researcher*].

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date

## **Appendix B: Interview schedule**

1. You have identified a case (or cases) where the child you have been seeing in therapy had been diagnosed with sensory integration disorder. Was the child diagnosed during or prior to the play therapeutic process?
2. How did the knowledge of the child's diagnosis influence you and/ or the therapeutic process?
3. Please describe the child's behaviour and/ or contact making disturbances when sensory contact was attempted during therapy.
4. How did these difficulties influence the child's field and relationship with you and/ or others outside therapy?
5. Which activities/ strategies did you find helpful in assisting the child with establishing sensory contact during therapy sessions?
6. How did the presence of SID influence the overall therapeutic process?

## Appendix C: Questionnaire

### Gestalt play therapy Research Questionnaire

#### Section A: Background information

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Please indicate your answer by typing the **number/ numbers** of your desired response in the "response" column.

					<b>Response</b>
1. What did you study prior to Gestalt play therapy?					
1. Psychology	2. Social work	3. Teaching	4. Other: Please specify in this block		
2. How many years practical experience do you have in Gestalt play therapy?					
1. Between 1 month and 2 years	2. Between 2 years 1 month and 5 years	3. Between 5 years 1 month and 10 years	4. More than 10 years		
3. Do you possess theoretical knowledge regarding sensory integration?					
1. Yes	2. No				

4. If yes, please indicate your knowledge level

1. I have read about the topic	
2. I have talked about it with a knowledgeable person	
3. I have attended therapy sessions facilitated by a trained sensory integration therapist	
4. I have received formal training in sensory integration theory	
5. Other: (Please specify)	

### Section B: Therapeutic experience

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*Please complete these questions as thoroughly as possible. These questions pertain specifically to children who had been diagnosed with a sensory integration disorder, or children who you suspect of having a sensory integration disorder.*

*Please try to provide specific, clear answers. When applicable, indicate the number of your desired response in the "response" column.*

		<b>Response</b>		
1.	Have you ever treated a child in Gestalt play therapy who had been diagnosed with a sensory integration disorder by an occupational therapist?			
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">1. Yes</td> <td style="width: 50%; padding: 2px;">2. No</td> </tr> </table>	1. Yes	2. No	<input style="width: 80px; height: 25px;" type="text"/>
1. Yes	2. No			
2.	Have you ever treated a child in Gestalt play therapy who you suspect of having a sensory integration disorder?			
	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 2px;">1. Yes</td> <td style="width: 50%; padding: 2px;">2. No</td> </tr> </table>	1. Yes	2. No	<input style="width: 80px; height: 25px;" type="text"/>
1. Yes	2. No			

3. Why was Gestalt play therapy initiated with the child?

--

4. With which aspects does/ did this child struggle with in therapy?

--

5. Which contact boundary disturbances does/did the child display often? You may indicate all applicable options.

1. Deflection
2. Introjection
3. Retroflection
4. Desensitization
5. Projection
6. Egotism
7. Confluence

--

6. Do/ did you find it difficult to establish sensory contact with this child?

1. Yes	2. No
--------	-------

--

7. If you answered **yes**, please discuss the possible reason(s):

8. If you answered **yes** at question 6: How did this difficulty to establish sensory contact influence the therapeutic process?

9. What behaviour does/ did the child exhibit when sensory contact was attempted?

10. What activities or strategies do/ did you find helpful when attempting sensory contact with this child?

11. Describe the thoughts, feelings and experiences which you became aware of during therapy with this child.

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12. Do you think that theoretical knowledge of, or training in Sensory Integration would have helped you to establish sensory contact with this child?

1. Yes	2. No
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13. If you answered **yes**, please discuss the reason(s) why.

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14. Please provide any additional information which you feel might be of importance.

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***Thank you!***

## Appendix D: Analysed transcriptions and field notes

Transcription of interview with participant #5		
Field notes and additional thoughts	Verbatim transcript	Codes
	<i>(Researcher) Jy het gevalle identifiseer waar kinders reeds gediagnoseer is met sensoriese integrasie</i>	
	<i>(Participant) Of waar dit vermoed is...</i>	
	<i>(Researcher) Ja. Hoe het jy dit agtergekome?</i>	
Participant seems confident. Good eye contact. Calm, confident voice.	<i>(Participant) Um, van die outjies... Hoe ons hier werk is dat die arbeidsterapeut sal verwys en as ek hoor dit is 'n arbeidsterapeut wat verwys sal ek altyd eerste met haar kontak maak en uitvind wat is die redes en so.</i>	Origin of referral Teamwork
	<i>So dit is of op daardie manier, dat sy noem sy werk daaraan en daar is probleempies daar, of die spesifieke geval waaraan ek gedink het met die vraelys is 'n seuntjie wat by my aangemeld is met aggressie en lae frustrasie toleransie en</i>	Origin of referral Teamwork Reason for referral
	<i>ek het agtergekome hy kon glad nie die sand hanteer nie, hy het glad nie met die sand gespeel nie en het gesukkel met kleiwerk aanvanklik en hy was oor die algemeen 'n redelik geïrriteerde outjie gewees. Ek het hom toe vir 'n arbeidsterapie evaluasie verwys omdat ek so iets vermoed het.</i>	Assessment of sensory systems Teamwork/ cross referral Knowledge of SI theory

	Ek het eintlik gedink dat hy is iets soos tasdefensief is.	
	<i>Is dit toe bevestig dat daar 'n sensoriese probleem is?</i>	
	Ja. Daar was toe 'n sensoriese probleem. Wat toe nou gebeur het is dat hy in arbeidsterapie ook in en soos wat dit gevorder het, het dit ook vir my eventueel makliker geword om met die emosionele goedjies te werk so die kontakmaking het makliker geword.	Role of OT Role of play therapist Therapeutic process
	<i>Hoe beïnvloed die kennis/ vermoede dat daar 'n sensoriese probleem is, jou denkwysse as die kind in die terapie kamer instap? Beïnvloed dit die terapeutiese proses?</i>	
	As ek gaan dink aan die voorbereiding vir so 'n sessie, probeer ek altyd die goed waarmee hulle sukkel in ag neem. Ek sal nie byvoorbeeld soos in hierdie kind se geval, sandmedium vir die sessie beplan as ek weet dat dit vir hom frustrasie oplewer nie en aanvanklik probeer ek glad nie met daardie goed... ek probeer op ander manier, byvoorbeeld reuke of teksture voel, goed waaroor hy beheer het, jy weet, en kan wegtrek as hy wil. So ek probeer definitief om eers daar rondom te beweeg, sodat mens kan kontak maak op 'n ander vlak, voordat mens in daardie situasie inbeweeg, want anders, jy verloor jy die kind heeltemal. Hulle onttrek net.	Knowledge of SI Approach to child with SID Adapting approach/ activity preference Resistance to sensory stimuli
	<i>Hoe sal jy die kind se gedrag beskryf wanneer hy nie 'n aktiwiteit wou doen nie?</i>	

	<p>Met die sand? Hy het redelik geïrriteerd geraak en hy sal die hele tyd dit doen (klap hande teen mekaar om te demonstreer hoe dit kind die sand “afvryf”). Hy sal die mannetjies insit en dan sal hy weer sy hande afskud.</p>	<p>Behavioural manifestation Emotional manifestation Resistance to sensory stimuli</p>
	<p>Ek gebruik met die meeste outjies seesand wat ek van Richardsbaai af gebring het en hulle is meestal mal daarvoor. Hulle grawe in dit en hy wou dit glad nie doen nie. Hy sou dit heelyd op die kant gesit het, wat baie abnormaal vir 'n seuntjie is. Hulle probeer gewoonlik kyk of kan hulle die sand uit die sandbak kry. So dit was die een ding.</p>	<p>Behavioural manifestation</p>
	<p>Met die klei het hy letterlik gegril. Hy het vir my gesê “ek wil nie, ek kan nie daaraan vat nie” dit laat hom gril. Um...(lag) hy, daardie spesifieke seuntjie het vir my gesê dit laat hom dink aan gwel. Toe verstaan ek hoekom hy so grillerig daarvoor voel toe hy daardie woorde gebruik. So dit is die gedrag wat ek... grillerig, en dan het hy dadelik onttrek. Sy gesigs...ek is nogal ingestel op gesigsuitdrukkings...jy kon sien sy gesig raak geïrriteerd, jy weet. Soos in: “hoekom MOET ek dit doen”. Um..</p>	<p>Emotional manifestation Behavioural manifestation Resistance to sensory stimuli Approach to child</p>
	<p>En dit is ook wat die aanmelding van die, toe sy mamma-hulle hom na my gebring het was die probleem dan ook dat hy by die skool geïrriteerd geraak het met maatjies wat te naby aan hom was, jy weet, en dat hy dan, dat hy hulle begin boelie het. En hulle het toe gedink dis lae frustrasie toleransie.</p>	<p>Effect of SID on child's relationships Reason for referral</p>

	<p><i>Die kinders wat jy sien en wat ook deur die arbeidsterapeut gesien het, is daar 'n paar algemene goed wat jy gesien het waarmee hierdie kinders oor die algemeen sukkel?</i></p>	
	<p>Um, weet jy, die algemene goedjies wat ek maar oor die algemeen, as ons saampraat, is dat hulle sukkel om te fokus. Jy weet, dis amper asof, soos 'n ADD aandaggebrek, die aandag is heelyd op 'n ander plek, so hulle sukkel om gefokus te bly. By my sukkel hulle om emosioneel; dat ons by die emosionele issues uitkom want hulle is so gefokus op dit wat rond.. en dat hulle nie geïrriteerd is nie, moet net nie aan dit vat nie, jy weet, en klanke ook.</p>	<p>Behavioural manifestation Therapists' awareness Emotional manifestation Reason for referral Knowledge of SI Effect of SID on awareness</p>
	<p>Ek het op 'n stadium 'n dogtertjie gesien wat die geringste, as iemand anders se aircon aangaan, of as daar 'n geluid buite in die pad is, weet, dat, gehoortotse en alles en op die ou end het sy ook maar by die arbeidsterapeut geëindig</p>	<p>Teamwork/ referral Role of play therapist and OT</p>
	<p>. So... maar die goedjies waarmee ek die meeste sukkel is om kontak te maak met hulle, vir hulle om gefokus te bly met dit wat ons doen, en om by die emosionele kwessies uit te kom. Dis vir my amper, en jy sal dalk nou beter kan sê, maar dis amper asof hierdie defensiwiteit en daai geïrriteerdheid op grond van die sensoriese integrasie probleme 'n muurtjie bou tussen hulle en die buitewêreld, en jy kan amper nie kontak maak met hulle nie.</p>	<p>Contact boundary disturbances Effect of SID on awareness and relationships Knowledge of SI</p>

	<i>So jy sal sê die feit dat sensoriese kontakmaking moeilik is, definitief emosionele kontakmaking dan ook bemoelijk?</i>	
	Beslis. Dit is amper vir my asof daar verdedigingsmeganismes opgaan. Seker maar om jousef te beskerm, um, en dan kan jy nie by die emosies uitkom nie.	Contact boundary disturbances Self regulation
	<i>Sal jy dit dan defleksie noem?</i>	
	Defleksie, definitief ontkenning ook. Ek het 'n paar outjies gehad wat sal, sal projekteer, jy weet, ek sal byvoorbeeld, as ek byvoorbeeld iets in die sand gaan doen het sal hy sê: "maar jy gaan gril vir die sand", jy weet, of so iets. So ja, ek het 'n paar keer dit gekry (lag).	Contact boundary disturbances Resistances Behavioural manifestation
	<i>Hoe dink jy beïnvloed dit die verhouding van die kind met ander persone in sy lewe?</i>	
	Ek dink dit moet vir hulle baie moeilik wees. Die spesifieke outjie wat, toe ons eventueel uitgekome het op 'n punt wat ons kontak gemaak het, jy weet, waar hy nou regtig in die terapeutiese proses begin werk het, het ons agtergekome dat ons, ek agtergekome dat ons wil graag met die ander maatjies speel, maar dis vir hom so sleg om met hulle te speel want hulle raak aan hom op maniere waarvan hy nie hou nie, jy weet, en.. ja.. dit maak hom seer en dan raak hy aggressief, jy weet, en hy stamp hulle weg om homself te beskerm en hy word gesien as 'n boelie. Ek dink dit is vir hulle baie moeilik in daardie situasie.	Emotional manifestation Behavioural manifestation Effect on child and relationships

	<i>As jy met so 'n kind terapie doen, waarvan raak jy bewus in jouself?</i>	
Therapist does not feel that she needs to “push” the child but rather stay “with” the child. When therapist did not know much about SID she felt helpless. Became empowered by knowledge.	Um, kyk, ek hou van 'n challenge, so jou eerste twee sessies is maar gewoonlik assessee, so die oomblik as dit gebeur is my eerste vraag altyd “hoe anders kan ek met hierdie kind kontak maak?” want vanuit die Gestalt veld is jou eerste stap maar gewoonlik sensoriese kontakmaking, nè, so dan moet ek na ander goedjies gaan kyk	Assessment Adapt Approach to child Therapists' awareness
	want die proses kan nie aangaan sonder dit gebeur nie. Partykeer, die eerste paar kere toe ek nou nog nie so baie van hierdie goed geweet het nie, baie saam met die arbeidsterapeute gewerk het nie, raak mens nogal, um, moedeloos,	Therapeutic process Knowledge from SI originate from OTs Teamwork
	want 'n proses wat met 'n ander kind dalk vinnig begin en jy sien vinnig vordering, gebeur nie met hulle nie en ek weet nie altyd waar die fout is nie, maar ek probeer bewus wees van dat dit dalk regtig 'n probleem ... en dat mens dan daar rondom kan werk.	Effect on therapeutic process Approach
	<i>So jy voel nie dat dit 'n onoorkombare probleem is nie.</i>	
	Ek dink definitief dat mens daardeur kan werk, maar wat ek wel agtergekom het is dat, en dis waar 'n multidissiplinêre span inkom, is dat, dis iets wat die spelterapeute nie noodwendig op hulle eie kan doen nie. Die arbeidsterapeut is nodig om haar deeltjie daar te doen voor jou proses verder kan voer.	OTs role Play therapists' role
	<i>Dink jy dat kinders wat SI probleem het, ook nie net deur 'n</i>	

	<i>arbeidsterapeut gesien moet word nie, dat dit 'n saamwerkproses is?</i>	
	Ek dink beslis so, tensy die arbeidsterapeut ook opgelei is in spel terapie om na die emosionele kan te gaan kyk, maar dit hang af van die ouderdom van die outjie, as mens hiervan bewus word. Sê nou maar hierdie outjie is 8 of 9 as jy die eerste keer daarvan bewus word of dit gediagnoseer word, is daar baie emosionele prosesse wat hy dalk mee agter is as gevolg van die verdediging wat hy gehad het.	OT's role Play therapists' role Emotional effect of SID on child
	<i>Jy het nou klaar genoem dat jy die aktiwiteit waarmee hulle sukkel, sal vermy. Is daar enige iets anders wat jy sou, enige ander strategieë wat jy sou probeer?</i>	
	Meeste van die outjies wat...um...jy soek nou iets anders, ne. um... ek gebruik baie projeksietegnieke waar ek dan nou net glad nie van enige sensoriese modaliteite gebruik maak nie, en wanneer mens dan van die emosies daarso bewus word, jy weet, is dit makliker om dit deur te vat, jy weet. Hierdie outjie het toe ook later toe die, die Roberts persepsie toets mee gedoen, en daaruit agtergekome,....ek moes dit eintlik vir jou gewys het... dis twee seuntjies wat baklei en die een lê op die grond en die ander een staan so en dit lyk of hy hom gestamp het, waar my vir my verduidelik het "dit maak my seer, dit maak die seuntjie seer as hulle aan hom stamp en toe stamp hy hulle weg". Toe kon ons so daarby uitkom...jy weet, en so oor dit praat.	Projection Adapt to child Awareness Approach to child

	<i>Amper soos 'n projeksie oor die sensasie.</i>	
	Dis reg, ja.	
	<i>As 'n kind dan so 'n probleem het, hoe beïnvloed dit die spel-terapeutiese proses in die geheel?</i>	
	Um...van die begin af weet ek dit gaan stadiger wees (lag) en ek noem dit dan vir mamma-hulle ook, dit gaan tien teen een stadiger wees.	Effect of SID on therapeutic process Working alliance with parents
	Um, ek probeer meer fokus op, ons doen dit altyd maar met hulle baie meer, op bemeestering, so aanvanklik fokus op dinge waarvan jy hou en nie te veel te challenge nie, want die verdedigings is al klaar so baie, die oomblik wat jy hulle challenge verloor jy hulle heeltemal.	Approach Relationship Trust Emotional impact Awareness
	Goed waarmee hulle gemaklik is, werk ek, probeer ek eerste mee werk en, um, soos wat hulle gemakliker raak en meer oopmaak en makliker waag, ek weet dat hulle nie sommer in 'n nuwe situasie inbeweeg nie, vra ek toestemming “kan ons maar aangaan met dit”, “kan ons vandag so 'n klein bietjie dit probeer doen?” so die proses is definitief stadiger. En dan is ek die heelyd bewus van daardie verdedigingsmeganismes.	Approach Knowledge of SI Contact boundary disturbances Trust Therapist's awareness
	<i>Dink jy dat as jy kan opleiding kry in SI dat dit vir jou van hulp sal wees?</i>	

	<p>Beslis. Nie om dit self te hanteer nie, maar um, soos wat ek in die vraelys ook gesê het, om presies te kan weet maar wat is die kriteria wanneer mens dan nou eventueel moet verwys.</p>	<p>Empowered by knowledge Diagnosing of SID Referral</p>
	<p>Want ek vind dit maak dit vir my baie makliker wanneer die arbeidsterapeut met my iemand verwys en sê “weet jy, hierdie outjie by my sukkel met, um, kan nie mislukkings hanteer nie, sukkel met selfvertroue”, so as ek kan verwys en sê ek vermoed daar is sensoriese integrasie probleme, dan weet sy klaar waar om te begin fokus. Um.</p>	<p>Teamwork Referral</p>
	<p>En ek dink dit help jou in terapie. Ek het al bietjie gaan oplees daaroor op my eie, so dit help om die kind beter te verstaan.</p>	<p>Effect of knowledge on therapy and therapist</p>

Transcription of interview with participant #6		
Field notes and additional thoughts	Verbatim transcript	Code
	<i>(Researcher) Are there specific cases where you knew that the child had a diagnosis of sensory integrative disorder, where it was confirmed by an OT?</i>	
Describing the setting.	(Participant) No. You know, where I'm working... it's an inner city, no money, um, school. And there were no OTs around. So we get OTs once a year from the TUKS university to come, but it was the beginning of the year that I noticed this and, um, you know most of these children, you know, there were so many other problems. You know, you're kind of on a waiting list for an OT. Um, so, those, I had two who had seriously... some sort of sensory integration problem. With no diagnosis.	Knowledge of SI Working without input from the team
	<i>(Researcher) Okay. So know formal diagnosis, but according to your knowledge...</i>	
	(Participant) Ja.	
Researcher is trying to establish whether the children in question showed signs of an SID.	<i>With therapy with these kids, how did that sensory problem manifest in terms of behaviour? What did they physically do for you to see that they had sensory problems?</i>	

Therapist is at ease.	One kid I had, um, she... was completely desensitized. So, um, she... it was just like blank stares, there was nothing there. She was not in her body.	Contact boundary disturbances Behavioural manifestation
	And, um, the reason I saw, when I actually saw growth in her, was the first session she took off her shoes. And, um, that carpet was very rough. And I think it was session four she had put her shoes back on. So I realized that there was obviously, there was a reason she was keeping her shoes on and taking them off.	Desensitization changing to sensitization Origin of knowledge of SID in child Assessment of sensory systems Behavioural and emotional manifestation Effect of SI on awareness
	Um, and also, she couldn't... like if I threw some balls at her or something like balloons... she used to bounce into walls and she used to...um... she... just things like that. She couldn't see things, like the carpet. When we were playing in, like, the passage, you know, she was pouring stuff all over and I had to keep on reminding her, you know, "don't mess on the carpet", and I had to pick up her stuff and put it on the plastic. So she actually couldn't... it was almost as if she couldn't see it. And she wouldn't... I think she couldn't really answer my questions because she wasn't really there. She had conversations	Desensitization Knowledge of SI Growth Adapting activities Approach to child Behavioural manifestation

	about what she was interested in. And I noticed with like pepper... I had pepper and she didn't notice it on her skin. Um, and I think by session four she had realized that something was bothering... she became aware of what was bothering her.	
	Because I think by session two I'd say "you are sneezing because of the pepper" and then she'd carry on with it... And then I'd use lemon and um she got lemon all over her, like you know, hair and everything, and I think I had to like sort of pluck it out for her. And then also like about session four or five she kind of realized that "oh, I've got lemon..." and would sort of wash it off. So, um, that was the one kid.	Effect of SID on awareness Growth Behavioural manifestation
Becomes puzzled when talking about the child's spatial problems.	The other one, the second one I had, he was from Venda. And um I did like the formal sensory work like we were told to do, and I gave him chips and I gave him sweets and he would swallow the sweets whole and with the chips I thought he was gonna die. But I noticed that he was wearing a jersey and it was like the hottest day in February. So I knew something wasn't right. And um, and when I put cream on him it was like I had put some vile, um, pestilence on him.	Effect on therapist Knowledge of SI Behavioural manifestation Approach Effect on awareness Knowledge of SI impacting assessment
	And... so those were my two. With him it was almost like a spatial problem as well. I couldn't really figure out. He kept on... he kept on like bumping... not bumping into walls but no matter what I did he always ended up working towards the wall. I figured...and um, I didn't know that	Behavioural manifestation Approach Effect on awareness Knowledge of SI

	<p>it was a problem, like a strategy problem or a spatial problem, but it was probably like a sensory... He kept on moving towards the wall. I would put toys in the middle and he would end up towards the outside. I ended up putting boxes on, against the wall so at least I could move the boxes away and he didn't seem to have any, um, ability, to, like sort of regulate ... You know, I had to remind him "you are going against the wall, you know, let's make a plan" and eventually, probably like session 12 or something, um, I said to him "come to the middle" and that's when he finally realized "oh okay, that is what I need to do, I need to come into the middle" but he couldn't make his own plans he'd sort of bump into the door.</p>	
	<p><i>Was he also unaware of the personal space between you two?</i></p>	
<p>Why did she see them for two years? Amazed at change.</p>	<p>Initially he, there was always a big amount of space between him and me. And actually now, sometimes he comes right up, not like there (indicating space in front of face), but probably on like...(indicating space). I kept on seeing those two for probably two years.</p>	<p>Growth Relationship/ trust Therapeutic process</p>
	<p>And now he can sort of come near me, like sometimes I'm like "wow". You know, he would show me things and sit right next to me. And um, you know, I taught him how to tie his shoelaces and he was eleven then, so ja. That was the first time that I actually got close to him.</p>	<p>Growth, behavioural manifestation</p>

	<p>Before then there would always be that, um, that space, which is not an issue for me because I don't like anyone in my space. Our space has definitely become closer. If I recall... with him he once actually sat right next to me. And I was like (showing surprise) and I noticed it because of my personal... and I allowed it and it was nice that he, he felt comfortable enough to sit right next to me like that.</p>	<p>Therapist impacting therapy/ field Effect on therapist Relationship/ trust Therapist's awareness regarding own SI difficulties</p>
	<p><i>Wow. That's wonderful. And what do you think the reasons are for therapy taking such a long time? Like you said, you have been seeing them for two years.</i></p>	
	<p>Those two were very bad. The one, the girl, um, was severely abused, and in a situation I think is not that much better. And she will never be... My personal opinion is that she will never be okay. Brain damage, it's... (indicating the sign of being "mentally confused" by pointing to head). It's my theory.</p>	<p>Diagnosis of SID Misdiagnosis</p>
	<p>The other kid, he is also very very bad. He ended up in a mental hospital, basically on a list of medications of like twelve or fourteen you know like vicious stuff. And the mom... So obviously misdiagnosed severely and it was most probably all sensory integration that caused him to have all of that.</p>	<p>Misdiagnosis Role of therapist in SID Effect of SID on behaviour Knowledge of SID</p>

	<p>So you know if I go and see him, I think what I basically do is I go and regulate him. He comes to me once a week. I have gone periods where I haven't seen him for like a month or two but, um, his behaviour in class starts getting a little bit anxious. So now he enjoys it, I enjoy it. I have the luxury because I'm, like, employed full time by the school, to take him once a week and, you know, he has really benefitted from it and he is growing. He needs that time to just like de-overload and he gets it.</p>	<p>Self-regulation Awareness Approach</p>
	<p><i>What is it that he then does to de-overload?</i></p>	
<p>Not pushing child to do activities that he does not want to. Staying with what child gives.</p>	<p>With him, um, he does what he wants to do. He comes in... it's sensory, optimal arousal, optimal level of stimulation I think it is called? So then he comes in, it is quiet, you know, he can play with the toys he knows and with him it's always the toys he knows. I've had them since last year. So with him I don't dare move toys or the toys must stay where they are, they must be the toys that he knows, you know he can tell me exactly how many lions there are and how many dogs there are and you know I have to make sure that those are there for him. So I think with him it's for stability, routine, it's quiet and I think I'm the only person who actually listens to him, because he comes from a big family.</p>	<p>Self-regulation Knowledge of SI Approach to child Adapt to child Activity preference Relationship Trust Effect of SID on child Effect of SID on awareness</p>

	Um, I don't do any strange sensory smells with him, or... because he has got smell issues and taste issues. I have brought lunch for him but it's like crackers and uh... because he wouldn't eat for like three or four sessions, or like for a long time. And it kept coming up in his projections because he doesn't verbalize it. He can't. He kept bringing in this hungry animal. And I asked him one day, are you hungry? No. And eventually he said, "yes, I'm hungry". But he wouldn't eat there.	Approach to child Assessment of sensory systems Trust; effect of SID on child
	And there's not a lot of money, and eventually I got the mum to bring like pies for him. And now he's eating bread but it has to be like say, specific bread, you know like Sasko 2 in 1. You know It can't be... it can't be... like both to me would look like white bread. It's not like a fancy kind and a rubbish kind of bread and only one brand, I'm not sure which one, he will eat. And uh now he's complaining about I think Handy Andy in the bath.	Working alliance with parents Behavioural manifestation
	<i>So he is highly sensitive, he can taste the difference?</i>	
	Yes.	
Researcher checking for other signs of SID.	<i>and is he sensitive towards certain textures on the bread, like say for instance crunchy peanut butter or peanut butter?</i>	
	I'm sure	
	<i>you know, things like maybe yoghurt with fruit pieces in or things like that?</i>	

	<p>I haven't checked that specifically. But when I spoke to the mom recently she said to me he went without meat for about two months for no reason, and then suddenly he's back on it. So I've explained to the mom what I think the problem is. It is a certain sensory high sensitivity, probably sensory integration.</p>	<p>Working alliance with parents  Knowledge of parents  Origin of knowledge of SID  Child's inconsistent behaviour</p>
	<p>But he is coping at the moment so I don't suppose he needs further intervention. But um he is not interested. So I tried to explain to him this is... (sensory sensitivity) so avoid this or avoid that but he...uh, not.. there's something in him that's just not... he doesn't want to know.</p>	<p>Approach  Effect on awareness</p>
	<p>And so I explained to the mom that if he doesn't like the Handy Andy just to go the shop with him, let him smell all the detergents and find one that he likes (smiles).</p>	<p>Parent's approach  Practical application of tips  Knowledge of SI</p>
	<p>So at least the mom is able to now more or less understand, you know, this is a problem. I think it was the sensory overload because he came from Venda and now he's suddenly in a new environment completely and he became overstimulated, completely overloaded and basically went beserk.</p>	<p>Knowledge of SI  Working alliance with parents</p>
	<p><i>When he goes beserk like that, what kind of behaviour does he show?</i></p>	
	<p>Allegedly, I didn't see it... he gets tantrums, he hits people without warning. He um, he tried to strangle someone and throw him out the</p>	<p>Behavioural manifestation  Effect on child</p>

	<p>window but that was before. That was why he was eventually sent to the mental hospital. Because it was just too much for him, he couldn't handle it... he didn't have verbal skills. He still doesn't really have verbal skills. Like I think he is normal, he just can't verbalize what is wrong with him. So up to about session ten he never ever verbalized. He never verbalized with me, what is bothering with him.</p>	<p>Effect on therapeutic relationship Psychological manifestation</p>
	<p><i>Alright. You already mentioned things which you adapted in therapy, because you know that he doesn't like weird tastes and smells so you tried to take that away. You tried not to pressurize him.</i></p>	
	<p>Yes. Correct.</p>	
	<p><i>Is there anything else that you've noticed that you do differently with him to accommodate him in therapy?</i></p>	
	<p>With him I make sure that everything is the same (smile) and I make sure that everything is predictable. I let him do what he needs to do. I don't... I might show him something.</p>	<p>Approach to child Practical application Therapeutic relationship</p>
	<p>But he is actually usually the first to notice that I've brought in a new, um, toy. He will be the first one to notice it and the first one to try and figure out a new way of playing creatively with it. And in his class work he is not the same. He is not creative at all. So that is quite interesting that he is showing completely different sides of himself. Um...</p>	<p>Behavioural manifestation Inconsistency of behaviour Activity preference Effect on awareness</p>

	<p>But generally I just let him be. I don't, I don't have the radio on with him. I have brought clay with me and he had actually played with it once and it worked very well with him, with the clay.</p>	<p>Approach to child Practical application of knowledge Adapting to child</p>
	<p>But once he was finished he was done with it. You know a lot of the children from Venda get brought up with the clay, so it brought up a lot of things in him which was very nice. A lot of the children from Venda come there with... I don't know if its sensory issues, but ja, it is sensory issues. They miss the clay, they miss the... the cow dung. And with him, I brought in lots of animals and he responded to like the pigs. Like, the pigs he sort of nurtured and he responded to the, um, the sheep because they were from home. So even though it was, um, plastic models of the animals that he was used to, it obviously brought in sensory awareness or stimulation from home.</p>	<p>Knowledge of SI Adapting to child</p>
	<p>And the little girl, she is sensory seeking in many ways, now. I bring in... she is the first person to notice if I bring my school lunch and I forget to put it in my little locker. She will be the first person to notice the new bags, and she will open it, and I let her, um, and then she will find my school lunch or she will... and she will grab it and break it and use it and um...</p>	<p>Growth Behavioural manifestation Approach</p>

	<p>I brought in an aerosol because the room smells of, um... and I'm highly sensitive. I notice the smells. So she comes in and sprays the room with the aerosol. She's from the Kongo so she doesn't know things like aerosols.</p>	<p>Effect on therapist Therapist own SI difficulties Therapist's own awareness impacting the field Therapist's</p>
	<p>She's busy always with art. Um she likes to do art. So if she does art you know she will eat a biscuit then write then colour. She's very busy with that. Then I will bring in music and she will sing and she'll play with the video camera. And she's very... you know if she comes right she'll be like an artist or a hairdresser or a flower arranger. She's got lovely sense of colour and texture. Within boundaries, within limits.... There has to be limits, like don't paint the floor, or only two papers please instead of a hundred otherwise she will go through all of them and paint all of them and staple all of them and ja.</p>	<p>Behavioural manifestation Approach to child</p>
	<p><i>It is as if she wants more and more sensory input.</i></p>	
	<p>Yes. By session five with her we started with art and from then on she was always busy busy busy, with like the make-up, like all over... If I had make-up she would put on make-up all over. It was like the first four sessions she was totally cuckoo, like not there, and from then on she</p>	<p>Behavioural manifestation Knowledge of SI Growth Awareness</p>

	was into everything. And she was able to walk in a straight line and she was there in the body and after about a year she knew how old she was.	
	<i>She wasn't in contact with anything.</i>	
	No. And like session five, she drew a face. There were three eyes, there were four eyelashes, the head was in the crotch, you know, anyway, whatever. And I think by September of that year, a couple of months later, she drew a perfect face with ears and eyes and... so she really, you could see her resensitize. I explain her like a, a mirror that has been shattered. You would have like the eye there and the nose there and the mouth there. It's just not making sense. So she's got A there, B there, C there, F there. I haven't been able to get her to piece the puzzle together.	Projections showing SID/ growth
	And I don't know if it's... I do an inkblot thing. Actually, it was very interesting. With the boy I gave him the inkblot test. He came there and he drew a mouth. It doesn't really look like a mouth but anyway, they perceive in it what they perceive in it. He drew a mouth, he drew a nose, he drew a snake and, um something else.	Projections Self-regulation Awareness
	But basically, that was the first time and that was this year. I saw in his projections that he didn't like smells and he didn't like tastes. And I saw it in his projections, never ever in his games. Because his play always tells me what is going on. I never know what's going on but he knows it	Assessment of sensory systems Diagnosis Self-regulation

	<p>and he's fixed it with his games. After like in three sessions he sorted it out, whatever the problem was. And so in his inkblot I see it.</p>	
	<p>Then with this other kid I did the inkblot I thought ag let me do an inkblot with her and she said there's an eye, there's the nose, mouth, there's an ear, there's the other ear. And it looked sort of like an eye and the mouth and an ear and another ear. And I realized that's how she sees... just this fragmented... it doesn't make sense. It was... It's shattered.</p>	<p>Effect of SID on child</p>
	<p><i>How do you think these sensory problems affect the relationship with their parents?</i></p>	
	<p>Um, with the boy, I think it was very difficult. He's got a huge family and, um, you know, I've heard that he actually sits behind the couch while everyone else is there. I think it's probably like a one bedroom flat or two, but they're about six or seven people or whatever and they're all noisy, according to the mom. And the mom clearly doesn't... I don't think she's a bad person but she clearly doesn't understand the kid because she doesn't have those issues. She doesn't see it. She is just oblivious. So I think... I think that poor kid is just there. They are just oblivious to him. But at least the mom, she actually phoned me and I explained that this is what the problem is. She was willing to accommodate him. She was willing to go and spend more money than she has on pies to try and accommodate the child.</p>	<p>Parental working alliance Getting info from parents Parents' knowledge</p>

	<i>Even though she doesn't know why</i>	
Therapist linking self-regulation to self-modulation	Yes, she doesn't understand, no. And so this has also helped the mom to try and understand the child. There's nothing wrong with him in the big picture. So I hope that through my therapy and my explaining his sensory issues, it helps her understand how to relate to the child and how not to worry about the child. He is gonna be okay. And I think he is gonna be okay when he is older and willing to accept he will learn to self-regulate. You know, learn how to self-modulate? He will learn how to.	Empowering parents Awareness Self-regulation
	With the girl... I don't know... it's difficult. No-one really knows how to... like I said, she's cuckoo. So, I mean, fortunately they seem to be quite tolerant though I don't know how educated they are. So she just fits into that family and they all just....	
Therapist notice sensitivity from own intuition. Does not necessarily get background info from parents but rather ask the child himself.	But what I tend to do, because I'm doing my research on high sensitivity... if children come in there that I love because they are sensory sensitive, you know, like emotionally sensitive, I will start asking them. I get the feeling that they are highly sensitive. And if they are highly sensitive they most likely have sensory issues. And then I'll ask them, tell me... do you... Because some of the questions are "do you notice socks? Do you notice strange smells?" And then you know if I pick up that maybe they are highly sensitive or yes, they are highly	Emotional manifestation Assessment Approach Knowledge of SI impact process Therapist's own SI difficulties

	sensitive then I know also to be more sensory aware so as not to give them... Then I will ask them, would you prefer a toy or would you prefer play-dough? You know If I sense in them that they have that sensitivity, then I would say “would you like to have something soft or would you like something hard?” so then I start giving them choices. But it’s more, it’s an intuition from my work that makes me realize that these people are probably highly sensitive.	
	<i>...so you notice that this bothers them but maybe that will suit them better (referring to activity choices)</i>	
	Exactly that, yes.	
	<i>It’s wonderful that you can do that because I don’t think other people have that idea.</i>	
Opening up about her own SI difficulties.	Yes. But it’s because of me. It’s um, I’m also highly sensitive and probably, when I was growing up, probably might have been diagnosed with sensory integration problems. Not like a disorder but problems. I am very sensitive to touch and smells, um. So I am sensitive to others; that they might be sensitive.	Therapist’s process and own SI influence therapeutic approach
	<i>Yes. Okay.... What do you think... Do you think the fact that the sensory issues are present, that it influences the therapeutic process in the whole?</i>	

<p>Therapist's growth.          Learned to be more patient.          Becoming surprised/          concerned when talking about the sensitive girl/</p>	<p>Look, let me put it this way. I don't feel, that it has affected me. It has affected me in the sense that the cases that I have are extraordinary. So I can't.... Those are not the norm. Those are where you just work with what you have and I've done really well, you know, with them. The others... I suppose maybe I go a bit softer with them because I know that because of their high sensitivity I wouldn't necessarily push them. So that might be where... I haven't really thought about what you are saying but maybe intuitively I let them feel comfortable with me.</p>	<p>Effect on therapist          Approach to child          Therapist's awareness          Effect on therapist and therapeutic process</p>
	<p>Because in my situation I've, um, got a waiting list of a gazillion so it's crazy. I have, to be honest, tried to rush the process... say, to help more people so that I can, um, you know, see the rest. And one of the children I know was referred to me for high sensitivity. So I sat the child down in front of me and I said "okay, so you're highly sensitive, this is your problem". And she looked at me like I was... like "excuse me, who are you and why are you talking to me like this?"</p>	<p>SID=reason for referral          Trust          Behavioural manifestation          Impact of not having knowledge of diagnosis          Behavioural manifestation          Impact on relationship</p>
	<p>So I realized actually because of those children that they are more withdrawn. So you have to let them really become safe and um before they will open up things that they are not comfortable with. I saw another kid and again, she was slightly older. I gave her the inkblot and I, you know, I sometimes forget how powerful that is. And she was also highly sensitive but I was not aware of it, at the time. And suddenly she saw</p>	<p>Knowledge of SID          Emotional and behavioural manifestation          Therapists' awareness          Therapeutic process          Approach to child</p>

	<p>this and she saw things in the inkblot, not things that she shouldn't have seen, but a normal child would not have seen. And she immediately withdrew. And then like the following week I said "I'm sorry about the inkblot, we will take it more slowly. Have you seen something in the inkblot or the sand tray?" and she said "yes I've seen it" and I asked "would you like to talk about it", she said no. So I make sure that they know about it, what they don't have to... but I sort of actually realized but also knowing that you can't rush the process.</p>	
	<p>You can't rush the highly sensitive, because they need to get confident in you and you can't push them more than they need.</p>	<p>Trust Therapeutic relationship and process Approach to child</p>
	<p><i>Do you think that they have trust issues in general? Do you think that it's more difficult for them to trust you in the therapeutic relationship than another kid?</i></p>	
	<p>Yes. It's withdrawal. It's an evolutionary survival strategy. The way I explain it is by talking about fishes. You've got the shark and then you've got 5 fishes. The one fish, the highly sensitive, it is evolutionarily necessary for it to stay behind and to be careful. The other four will go ahead and they will be eaten by the shark. It's how God made us. So we, I, them, are evolutionarily programmed to survive. So they will</p>	

	evolutionarily withdraw to make sure that I'm safe.	
	<i>If you speak in terms of contact boundary disturbances, what do you think they use?</i>	
	Deflection and desensitization	Resistances

Transcription of interview with participant #8		
Field notes and additional thoughts	Verbatim transcript	Code
Therapist seems unsure and slightly anxious	<i>(Researcher) Did the diagnosing of the problem usually take place while you were busy with play therapy or beforehand,</i>	
	<i>(Participant) No</i>	
	<i>(Researcher) ..that the child came in and you knew there was a sensory issue?</i>	
Talking slowly to get the facts straight	<i>(Participant) Ja. Um... It got done by an occupational therapist. When the child was referred to me it was referred, uh, by the teacher to the parent and the parent came in contact with me and then when I do a background check with the parent, the parent tells me about, uh, that they've gone to OT and this is what they have identified.</i>	Origin of knowledge re SI came from parents. Method of referral. Knowledge of parents—SI
	<i>Yes</i>	
	<i>That's how I found out.</i>	
	<i>Okay. So it is a specific case now that we are talking about. One child.</i>	
	<i>I think I've got two, and when I say "I think", um, I remember the parent mentioning sensory integration.</i>	Origin of knowledge of SID
	<i>OK. That's fine. When you knew that this child had sensory issues, how did it affect your thinking when you went into therapy with this child?</i>	
	<i>I never really knew what... I still don't really have... I have a vague idea of</i>	Limited knowledge of SI.

	<p>what sensory integration is. Um, but, um, it, it doesn't affect it in a negative way. I just know that I have to obviously work more on a sensory awareness level, um, because it's a lot more difficult to, uh, go into emotional awareness, uh, if I don't actually first deal with the sensory awareness. So, ja. It took me a lot longer, and sometimes I still struggle, to get to the emotional and social side of things with the child, because the child is on a sensory awareness level a little bit lower, slower in development or stuff like that. Ja.</p>	<p>Applying (limited) knowledge to Gestalt theory/ approach to SI. Doesn't see SID to impact therapy in a negative way. Effect on therapy. Process of therapy.</p>
	<p><i>So when you attend to sensory awareness during a session, do you feel that the response to... do they take longer to react to the sensory stimuli?... or what do you think... is there a resistance to it or why does it take longer to get to that sensory awareness?</i></p>	
<p>Referring to herself in the third person. Unsure of what SID entails: how it presents and how it affects the child.</p>	<p>I think there could be a resistance, yes. Um... there can be a resistance. I know of one case there was resistance. Um, so, therefore one did take a while to get into the emotional side of things. Then there's almost like a blockage, or a resistance as you say.</p>	<p>Resistance to sensory stimuli. Effect of SID on therapy/ therapeutic process. Knowledge of SI</p>
	<p>Um, they don't communicate it or verbalize it as well, put it that way. Um, the other case, um, I think the child is probably more on, um, a slower age development. In other words, you know... Therefore not able to... He is a five-year old but he doesn't communicate very well. So he needs a lot</p>	<p>Effect of SID on child SI problems vary Activities needed, vary</p>

	more sensory, um, contact and activities. So it does, sort of varies, the two that I'm thinking of. Um, so they reached it at different levels but in different ways as well...so, ja.	
	<i>Okay. In the first case you said that there was a resistance to it. If you have to, if you can describe it to me... like for instance was it when you suggested particular activities and the child didn't want to do it?</i>	
	Yes. Exactly that.	
	<i>What kind of activities did the child not want to do?</i>	
Participant is relaxing more now. Feels that she doesn't have enough knowledge of SI to effectively work with it.	Um, okay, the one particular one, the one with slower development... um, say for example, wouldn't do, um.... Wouldn't necessarily do games, board games, that kind of visual sensory awareness.	Behavioural manifestation Activity preference
	Um, whereas the other child, uh, was more resistant to contact like stickers and um, drawn on his hand, stuff like that. Um. Although he wouldn't mind painting and messing himself with paint. So it was very contradictory, because I was like thinking, okay, you don't like stickers and you don't like say, writing on your hand, if we're to say write your telephone number on... so you would be resistant to that but, say for example, he could go easily play in mud. Or he could go easily... uh... mess around with paint with his hands.	Inconsistency in activity preference/ behaviour

	<p>So it's kind of... strange for me. That's why I say, maybe I don't know about sensory integration and I need more knowledge on it to be able to know how to actually work with it. But that was the resistance I got. So I would do those kind of activities. With the other child who was of a slower development, I needed to do more physical, really hard, pounding type of physical exercises with him.</p>	<p>Knowledge of SI Effect of SI on therapist Approach to child with SID</p>
	<p><i>Why do you think you needed to do that?</i></p>	
<p>Almost as if participant realizes for the first time that there are discrepancies, and now wonders whether it can happen that way. Confusion. Researcher wants to find out what the participant knows about SI.</p>	<p>From what I understand and from what I know, the um, the "messages" need to get across into the brain. So um, we did like those big Pilates balls. We would um literally push hard and kick hard. And he would find it hilarious! Or we would play sword games and bash-bash-bash... you know, not each other, but the swords. So, that kind of force contact we would have. You see the other child's resistance was contact. He needed space around him, whereas the other one needed that hard force contact. So it was very different.</p>	<p>Knowledge of SI influence therapy Activities needed, vary Child enjoyed sensory correct activities</p>
	<p>Yes.</p>	
<p>Therapist feels empowered by increased knowledge of SI.</p>	<p>Can that happen?</p>	
	<p>Yes!</p>	

	So you can have sensory integration that varies?	
	<i>Yes. A child can even be sensory avoidant or defensive at times and sensory seeking at other times. (Researcher continues to explain a bit about the categories in the Winnie Dunn profile. Participant listens with interest)</i>	
	<i>When you spoke about the one who was more defensive, the one that didn't.</i>	
	The one who needed his space.	
	<i>Yes. If you can put his resistance in terms of a contact boundary disturbance, how would you put it? What did the child utilize?</i>	
	What did he do to avoid that contact?	
	Yes.	
Reflecting on visible behavioural response, not contact boundary disturbance. Therapist still initiated hugs even though child did not like it.	He was very tearful. He would be very tearful. Um... ja. He didn't like... and it would remind him of things...(sigh). It sounds very psychological but, say, uh, for example, he wouldn't, say, kick the ball against the wall because he now psychologically pre-empted that if he accidentally kicked his foot against the wall, he would hurt his toe and it would bleed. So see, it was a very psychological thing. So he pre-empted those consequences long in advance. His avoidance would just be not to do it, and if I would try encourage it he would start.. (makes a face)... and then he would get tearful. So he would be tearful. And he wouldn't really... say for example,	Behavioural manifestation Psychological manifestation Approach to child with SID Effect of SID on child

	<p>a hug. A hug to greet. His arms would be down and you would have to do the hugging and put your arms around his body, whereas, uh he would just sort of lean his body against you and that is as far as he would go. That would be his resistance.</p>	
	<p><i>And with those two children, how did the sensory issues affect the therapeutic relationship with you, but also the knowledge that you have of the relationship with others in his life like his parents?</i></p>	
	<p>Um... you know what, okay. The one who has avoidance, that one. The relationship I had with him, wasn't a bad relationship, um, even though he would resist, say, a hug, or he may have resisted certain activities which, uh, was related to touch, and stuff. He was able to still communicate, uh, verbalize his emotion, to a certain extent. Um, 'cause I think they... he wasn't sure how to explain it. I think because he is not so in sensory contact it would be difficult to explain... cause he is not, concretely in contact with himself. Um, um... so the relationship we had was good, and I think it was, in comparison to the parents, pretty much the same. From the feedback I got from the parents, um, I realized that what I was getting from the child, that kind of resistance, the same thing was happening at home.</p>	<p>Effect on therapeutic relationship Effect of SID on relationships Effect of SI on awareness Parents' approach to child Behavioural manifestation Approach to child</p>
	<p><i>Hmm</i></p>	
<p>Unsure. Participant might</p>	<p>The same thing was happening at home. Um... I think maybe the parents</p>	<p>Effect of SID on</p>

<p>think that parents did not push but they should have, vs: Therapist realized when she couldn't push the child.</p>	<p>just probably gave in a bit more. You know... they live with him every day. So, say, to avoid stress or complications or whatever, they would probably give in a little more and understand him better, or they can pre-empt it a little bit better and then they know, okay, we're not going to give him this because he doesn't like it. So for example, we won't put stickers on him or we won't write on him. They did try it, and they do try to encourage it but, um, there were times that they wouldn't push it or force it. So the same thing really happened with myself in the sessions. I would also try and encourage it just to get him used to the idea, but when we came to that resistance of tearfulness, I didn't really push it.</p>	<p>relationships Activity preference Approach to child</p>
	<p>Yes</p>	
<p>Therapist gained information from parents on how to work with child, which helped her. Did she feel unsure of how to handle this child before gaining this information?</p>	<p>With regards to the other child who is, seeking, um... very good relationship... um... let me try and see... uh, the relationship in comparison with myself and the parents, right? I think, you see, the parents are very knowledgeable in terms of what he's got. And I think in terms of the one parent, the mother especially, knows exactly how he feels and stuff, because I think she is experiencing similar issues when she was younger, she also experienced those sensory tactile stuff. So, um, she understands him. And so, she knows how he feels and so she won't push it. Or she knows that he needs more, um, stern talk or he needs, say, a swing in his room, or a hammock in his room. And so they did that. They</p>	<p>Effect on other relationships Parents' approach to child Parents' knowledge of SID Knowledge of SI Parent and therapist working alliance Effect of SID on therapeutic relationship</p>

	<p>built those things. So they accommodate those things that he needs. Um, and because I gained those information from the parents I knew how to work with the child. So it wasn't too difficult, we had a lot more sessions with that child, but, um, because he is at a lower level of development it took a lot longer. That's why.</p>	
	<p><i>OK. Do you feel that trust came easily with those children, if you compare them with other children who doesn't have sensory issues?</i></p>	
<p>Unsure at first. Sudden clarification as she continues talking.</p>	<p>I'm trying to compare now in my head... Um... Maybe the one that was avoiding took a while to develop the trust levels, I think because he was avoiding, that part of sensory integration. But the child who, say for example, is more seeking, I had to play his type of game a lot longer for him to gain trust and for him to gain trust in me. Um, so, ja, that's the difference. I think it takes a bit longer for them to build trust, put it that way. For both of them. It takes them both longer to build trust. Ja.</p>	<p>Effect of SID on therapeutic relationship Approach to child Effect on therapeutic process</p>
	<p><i>Okay. Then, I think you already answered this question but just to make sure that you don't have any other ideas... I want to know whether you used any strategies in order to get the child to do sensory activities, like with the one you said you had to use lots of bouncy, bashful kind of activities with the one child. Were there any special kind of activities that you tried with the other child, to make sure that he still got sensory awareness, um, by maybe changing the activity to something that is fine</i></p>	

	<i>for him?</i>	
	You are talking about the avoidant one? The one who the stickers?	
	Yes	
Did not understand my question.	What other type of activities did I do that related to stickers and stuff like that?	
	<i>Yes. Or, for example, you said that he didn't like stickers but he enjoyed painting, so you suggested something else. Was there any other kind of plan that you had in your head, like if he doesn't like this I'm going to go that way.</i>	
	To try and instigate that?	
	Yes	
It was important for the therapist that the child be OK with stickers and writing.	Uh, we did shaving cream, which he liked as well. I think it's very similar to paint. So we sort of put shaving cream on his hands, you know it didn't only land on his hands, we'd sort of touched each other type of thing, we did that. Um. What else did we do...um... I really tried to put stickers, say for example, putting stickers on a doll, saying that it's got chicken pox or something like that, and like let us now play doctor doctor and now we also have chicken pox... but like, resistance again. So we did shaving cream, we did paint, um, and we even like incorporated a lot of stuff in the shaving cream so then we had different textures and different items in there. And we even incorporated doctor play tools, like injections and stuff	Adapting activities/ approach Activity preference Child enjoyed sensory correct activities Behavioural manifestation Adapting activities Knowledge of SI "fixing" SID Psychological

	<p>like that, because I thought, um, he had a bit of a difficult trauma when he was born and as a baby he had eczema, very bad eczema, um, and, um, that I think could have been a trauma in his life and could have caused for him to be resistant to the stickers and stuff... and that contact. So we tried to do a lot of that. So that's what I did and we repeated it a few times but to no avail. Stickers really... to no avail. He didn't really want stickers on his body or writing on his body either. Even when saying "wow, you did something really great, let me draw a star on your hand"... you know, not really. He would still "no no no"... be very fearful in a sense, of it, and result in being teary.</p>	<p>manifestation Approach to child.</p>
<p>Therapist feels that SID caused child to have low sense of self.</p>	<p>He liked more structured games and he would liked more to be prepared in advance as to what we are going to do and what is expected of him. He was a very, in play therapy, he had a very low sense of self. So, I think because he never had that contact and concrete and sensory ability, uh, or that tactile deficiency, that's why probably he had that low sense of self.</p>	<p>Effect of SID on therapeutic relationship Approach to child Psychological manifestation</p>
	<p><i>Do you think that he felt that he needed to be in control of the situation?</i></p>	
	<p>Ja, and he needed to be informed and what exactly... and what is the consequence of, in other words, what will happen after that activity... will I be safe. That kind of thing.</p>	
	<p><i>OK. There was a question that I wanted to ask, but I think you already answered that, I wanted to know how the sensory problems affected the</i></p>	

	<i>therapeutic process. Like you said, it took longer.</i>	
	Hmmm (nods in agreement).	
	<i>You said that it took longer to reach sensory awareness. Was there anything else that you think it had an impact on?</i>	
	(thinking)... um... I'm not... at the moment I can't think of anything.	
	<i>Okay, that's fine, my questions are finished. Is there anything else you would like to add or say?</i>	
Therapist feels that OT should provide parents and play therapists with guidelines. Therapist feels that she can only do her part; cannot handle SI on her own.	You know what... um, I suppose the other resistance would be, um... I think parents and therapists need to be knowledgeable of sensory integration, um, and hopefully it is diagnosed properly as sensory integration. Um, and then, I always think it is important for the occupational therapist, who, say, does diagnose with sensory integration, needs to inform and work as a team with the play therapist or the speech therapist or whatever, because now as I've said to you, I can work on the emotional and social and behavioural side of the child, but (and we deal in play therapy a lot with sensory awareness) but, um, I think that... I think we still need to give a lot more knowledge on, oh, okay, about how do I deal with these sensory integration. And not just with the therapist but the parents as well need to be taught how to deal with it at home as well. So I think maybe the other resistance would be that, say, the parents that don't work with their children that have that, and they don't do the exercises that they	<p>Knowledge of SI</p> <p>Diagnosing SI</p> <p>Teamwork with OT/ speech therapist</p> <p>Working alliance with parents</p> <p>SI does not equal sensory work</p> <p>Practical application</p> <p>If parents do not work to accommodate child, process may take longer</p>

	<p>are given by the OT, or the suggestions that are given by the play therapist to do at home and they don't do it, then it's not gonna work. That's probably another reason why it takes longer also in the therapy sessions. So ja, that's what I would add.</p>	
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Transcript of interview with participant #10		
Field notes and additional thoughts	Verbatim transcript	Code
Researcher used this as starting point to initiate conversation.	<i>(Researcher) Baie dankie dat jy ingestem het tot die onderhoud. Ek het gesukkel om terapeute in die hande te kry wat al kinders gesien het met sensoriese integrasie probleme... dit lyk my spelterapeute weet oor die algemeen nie van sensoriese integrasie nie</i>	
	(Participant) Dis vir my vreemd dat want ons vertrekpunt is tog sensories. Maar, ek dink dit het baie te doen met hoe ons opgelei is. En ek praat nou soos hoe ek opgelei is met Gestalt en speltherapie... en ek weet nie of dit al verander het nie, maar dit was hierdie model, en dit is wat jy doen. En dit is nie hoe dit werk op die ou end nie. Jy gebruik nogsteeds alles. In ses tot agt sessies moet jy terapie werk doen.	Training
	(Participant) Die hele sensoriese ding is vir my deel van die bewusmakingsproses van myself, van wie is ek... hoe funksioneer ek, waarvan hou ek, waarvan hou ek nie. En as jy nie dit deeglik gedoen is nie kan jy nie aanbeweeg. Kyk, dit is ook nie altyd moontlik om daardie goed 100% uit te sorteer nie. Want, as ek reg verstaan het ons maar almal verskillende "thresholds" in verskillende sintuie, en jy is maar met sommige sintuie meer sensitief as met ander. Jy sal nooit noodwendig	Awareness Therapeutic process "fixing" SID Role of therapist in SID Knowledge of SID

	die kind kan “fix” nie, maar om hulle ten minste op ‘n punt by hulle bewustheid daaroor te kry...want tien teen een is speel dit ‘n groot rol in hoe hulle hulle emosionele goed beleef.	
	Jy kan die kind help om strategieë te kry om emosionele goed te hanteer, wat insluit: hoe cope ek met sensoriese goed.	Effect of SID on child and therapy
	<i>(Researcher) Het jy al ‘n kind gesien wat jy weet gediagnoseer is met sensoriese integrasieprobleme?</i>	
	Ja, ek het byvoorbeeld nou spesifiek een seuntjie, um, wat nou al ook arbeidsterapie kry vir sensoriese integrasie, en dan was daar al ‘n paar gewees, veral by die skool was daar verseker sensoriese probleme gewees, maar omdat dit so ‘n armoedige omgewing is en die arbeidsterapeut wat daar gewerk het, het bedank. So dan is dit moeilik en jy moet maar die beste van die saak maak.	Origin of referral Knowledge of SI Working in absence of team members
	<i>Die kind wat jy geweet het het ‘n diagnose, het dit jou beïnvloed in die manier wat jy voorberei het vir sessies met die kind, jou denkwyse aan die gang gesit?</i>	
Staying with child even though information presented/ assumed regarding child’s diagnosis may present confusion.	Ek dink op die ou end van die dag wil ek as terapeut my kind 100% respekteer en dit moet ook insluit die sintuie. Soos hierdie seuntjie is tassensitief. So ek kan hom nie gaan sien en verwag dat hy die eerste keer wat hy my sien, vir my ‘n drukkie gaan gee of in die sand speel of ‘n sandtoneel maak of hy gaan noodwendig van die klei en van	Approach to child Knowledge of SI Influence on therapy Adapting Practical application

	<p>daardie tipe van goed hou nie. Dis nie noodwendig iets waarvoor ek 100% voorberei daarvoor nie maar dit is iets wat jy in jou agterkop hou en deurentyd onthou dat hy tassensitief is. Ek sal nogsteeds, interviews en ek sal vra “okay, wat hiervan?” en dan sal ek kyk, wil hy of wil hy nie? Want dit bly sy keuse op die ou end van die dag. Wat interessant was van hom was dat hy mal was oor die sensoriese. Ons het vir weke lank sensoriese goed gedoen. En dan was dit van goedjies wat ons kan eet meng ons deurmekaar. Goedjies wat dan eetbaar is, wil hy proe, en dan is dit die hele ding van, hoe voel dit op jou tong? Watter vorm is dit? En is dit sag of is dit grof? Dit was ongelooflik om te sien watter sensoriese pad hy gestap het. Elke week wou hy dit doen. Hy het ‘n groot behoefte aan sensoriese input ook. So ja, ek probeer dit maar net in gedagte hou en ek probeer nogsteeds hom blootstel aan dit en kyk hoe hy reageer. Want op die ou end van die dag is dit lekker as jy kan weet dit is vir hom lekker, dit is beter... dit is lekker om te besef dit is nie meer vir hom ‘n issue om in die sand te speel nie. So dit was vir my baie interessant om te sien van waar hy af gekom het en wat die arbeidsterapie ook doen. Hy was nog nie lank vir arbeidsterapie nie. Ek wil amper sê, wat mens kan saam doen as arbeidsterapeut en spelterapeut.</p>	<p>Assessment  Approach  Inconsistency of sensory needs  Growth  Effect on therapist, child, process  Role of OT  Teamwork</p>
	<p><i>Aan die begin, toe hy begin het met terapie, hoe kon jy sien dat hy ‘n</i></p>	

	<i>probleem het met sensoriese integrasie?</i>	
Staying with the child	<p>Wel, met hom het ek byvoorbeeld geweet, want met die ouer-onderhoud het sy mamma gesê dat hy arbeidsterapie kry vir spesifiek vir sensoriese integrasie probleme, onder andere. Maar met die meeste van die kinders gooi ek maar sensoriese goed tussenin, en dan kyk ek maar hoe hanteer hulle dit. En mens probeer maar tussendeur kyk watter aktiwiteite probeer hulle uit hulle eie uit doen. Sal hulle uit hulle eie uit met die sand speel, of sal hulle uit hulle eie uit aan iets vat met 'n tekstuur, of, um, sal hulle byvoorbeeld 'n opmerking maak oor die kar wat verbygery het. Jy weet, so jy probeer maar kyk oor die algemeen, wat sien hierdie kind, hoe reageer hy op sy sensoriese wêreld, sonder om dit noodwendig spesifiek te assesseer "hier is 'n dingetjie, wat voel jy, hier is 'n dingetjie, wat ruik jy, watter kleur sien jy, van watter kleure hou jy?" ens. So ek probeer oor die algemeen eers kyk wat gee hulle, kyk wat doen hulle, hoe reageer hulle in die speelkamer. En dan sal ek weet watter vrae om te vrae om agter te kom, bv hoor jy die waaier, jy weet, so iets.</p>	<p>Origin of info of SID diagnosis</p> <p>Assessment and how knowledge of SID influences it</p> <p>Behavioural manifestation</p>
	<i>Wanneer jy 'n kind sien in terapie wat sukkel met sensoriese probleme, hoe verander jy die aktiwiteite om vir hulle meer aanvaarbaar te wees?</i>	
	<p>Gelukkig is daar so baie goed. Ek dink op die ou end van die dag moet jy as terapeut eers agterkom... want as jy net sand en klei het, dan sit</p>	<p>Effect on relationship</p> <p>Adapt to child</p>

	<p>jy. Want dit is alles tassintuig. So net daar sal ek dan...dis okay. Vir my gaan dit oor hoe beleef hulle dit. Is hulle bewus daarvan en verstaan hulle hoekom is dit so. En verstaan hulle dat hulle nogsteeds kan leer om dit beter te maak, om met meer verskillende ... En as ek sien hulle verstaan dit, dan maak dit nie saak nie. Dan kan jy enigeiets doen, om nogsteeds 'n lekker game daaruit te maak. As dit 'n speletjie is kan jy daardie mastery ervaring gee of deursetting leer, of soms net as dit pret is, sodat hulle kan voel hoe dit is om lekker pret te hê. Dan moet jy nogsteeds sensitief wees (oor wat jy gebruik). Ek haal partykeer 'n klomp goed uit en dan moet die kind kies. So ja, ek dink op die ou end van die dag, as ek aan myself dink, het ek ook sekere sintue wat ek weet maklik oorgestimuleer raak. En dit is nie iets wat noodwendig kan drasties verander nie. So ek moet ook maar leer om my wêreld te organiseer.</p>	<p>Approach Awareness Strengthening of the self Role of therapist Therapists' awareness and own SID Empowered through knowledge of SI</p>
	<p><i>Kan jy jou eie sensitiwiteit bracket wanneer jy met 'n kind werk wat bv altyd harde geraas maak?</i></p>	
<p>Therapist disown her own needs while busy with therapy as the child's needs come first.</p>	<p>Dit is nie altyd maklik nie want gehoor is nogal iets waarin ek maklik my... levels bereik. Met so 'n kind sal ek probeer, as dit moontlik is, sal ek probeer om hulle vroeër in die dag te sien. Veral as dit 'n vol dag is, probeer ek hulle vroeër sien. Dis nie altyd moontlik nie maar ek probeer sodat ek 'n rustiger kind aan die einde van die dag kan sien,</p>	<p>Therapist's own awareness Adapting Relationship Therapist impacting the</p>

	<p>wanneer jy nie meer regtig baie energie oor het nie.... Maar dit is moeilik want jy moet by die kind hou, en dan join jy maar. Want op die ou end van die dag gaan dit oor wat daardie sensory awareness vir daardie kind beteken. En hulle moet ervaar: in die uur wat ek hierso was het die tannie alles saam met my gedoen. Sy het nie gemoan oor ek te veel raas nie of weet jy wat, ek wou buite speel maar ons het nie of wat ookal. Dit gaan vir my oor wat is die kind se ervaring van daardie uur en dat dit vir die kind 'n positiewe ervaring was. Ek kan maar na die tyd op die bank gaan uitpass. Dit is nou maar hoe dit is. Vir my gaan dit oor die kind.</p>	<p>field Therapeutic process</p>
	<p><i>Die kind wat jy gesien het: dink jy sy sensoriese probleme het 'n impak gehad op julle twee se terapeutiese verhouding?</i></p>	
	<p>Nee... nee, want ek dink dit het ons so 'n unieke vertrekpunt gegee. Um, en veral met hom, hy is 'n kind wat heeltemal in sy eie wêreld is. Hy hou van Egipte en hy kan vir jou alles van Egipte vertel: van die Egiptenare en die Israëliete en van Moses en die piramiedes en al daardie goed. Hy weet genuïene alles van Egipte en hy is maar net 5 jaar oud. So behalwe vir sy tansensitiwiteit was daar soveel ander goed wat hy regtig kon voel: "Hierdie tannie hoor wat ek sê. Hierdie tannie luister saam en wil meer weet van Egipte. En as ek vir haar 'n prentjie wil teken van dinosour wat ek nie eers amper kan doen nie,</p>	<p>Impact of SID on therapeutic process/ relationship Adapting</p>

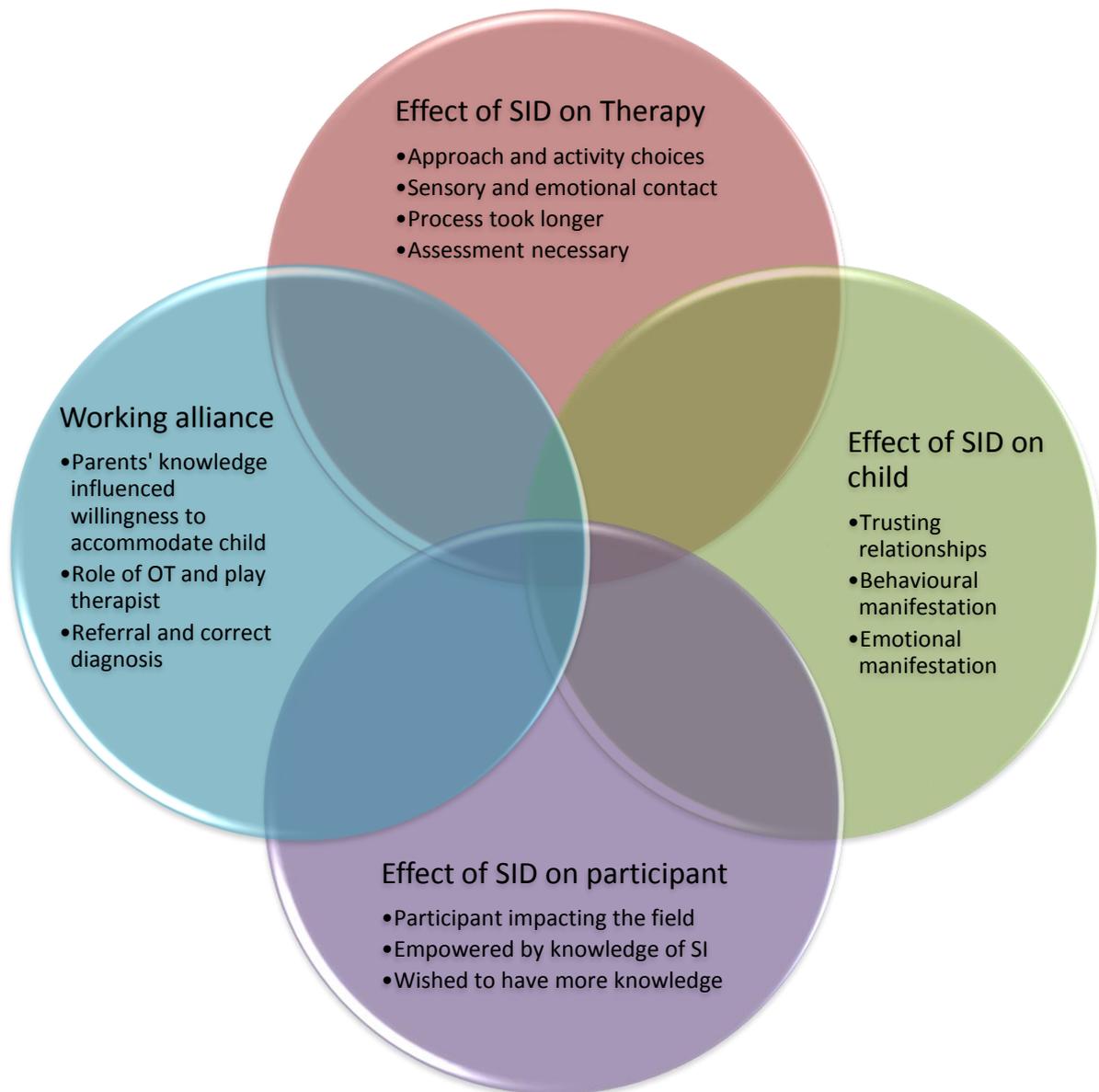
	<p>dan moedig sy my aan.” So, nee. Ek dink daar is genoeg ander goed wat jy kan inwerk om ‘n verhouding met die kind te bou as om net te fokus op die sensoriese. Ek het nog nie ‘n kind gehad wat heeltemal sensories... Soos op ‘n skaal van 0 tot 100 wat ‘n verskriklike lae threshold vir alles het en maklik oorstimuleer word nie, maar my ervaring met kinders met sensoriese uitvalle is ...(inaudible) En dat hulle sien: Dit is okay. As hulle nie ‘n drukkies wil gee nie is dit okay... as hulle nie die radio wil aan hê nie is dit okay.</p>	
	<p><i>Dink jy dit het ‘n invloed op die verhouding met die ouers?</i></p>	
	<p>Ek kan dink... ek kan dink dat dit ‘n invloed kan hê. Ek bedoel, as die ouers bereid is om te werk daaraan... soos met hierdie seuntjie. Hulle het hom al gevat vir die arbeidsterapie nog voor speltherapie. So hulle het besef hier is ‘n probleem. En dan is hulle ook baie meer oop daarvoor om hom te akkommodeer .... en dit te maak werk vir hulle. Maar ek kan dink dat dit ‘n uitdaging kan wees in jou verhouding met jou kind, veral as sensoriese profiele seker maar baie verskil. So dit kan wees... So ek dink dit verskil gaan inkom ook of die ouers bereid is om daardie aanpassings te maak en ‘n ouer wat sê “dis nie my probleem nie, die kind moet maar regkom.”</p>	<p>Parents’ approach Parents’ knowledge Working alliance</p>
	<p><i>Watter kontakgrensversteurings het hierdie kind gebruik in terapie?</i></p>	
	<p>Seker maar defleksie, want hy sou my ignoreer as ek iets voorstel, en</p>	<p>Resistance</p>

	dan seker maar resistance.	Behavioural manifestation
	<i>Dink jy die teenwoordigheid van sensoriese integrasieprobleme beïnvloed die terapeutiese proses in die algemeen?</i>	
	Ja, as die kind nie bewus is daarvan nie... Die kind weet iets is nie lekker nie, maar hy weet nie regtig wat nie. So ek dink die oomblik wat jy die kind kan kry om bewus te raak... soos wat jy met hulle deur die sensoriese aktiwiteite werk met hulle, sê jy vir hulle “ek sien jy hou nie hiervan nie en dit is okay” of “ek sien jy is mal hieroor”, um, net om daardie bewustheid te skep. Want dan weet hy, ek hou hiervan, ek hou nie van hierdie nie, of ek nie hierdie nie, ek soek daardie. En dan kan jy met emosionele goed lekker saam met dit uitpluis en kyk hoe hanteer jy hierdie situasie. Kom ons sê byvoorbeeld ‘n nuwe babatjie in die huis en die kind is gehoorsensitief. En dit is dalk een van die redes hoekom die kind in terapie is, oor die nuwe babatjie. En dat jy dit dan intrek by die planne wat jy maak oor hierdie ding waarmee die kind nie cope nie, die nuwe babatjie. Wat kan jy doen as die babatjie te veel huil? Gaan na nou kamer toe. Kom ons maak ‘n lekker tent in jou kamer ‘n “den” of so iets. Kom ons hang ‘n kombes daaroor om die klank te demp. So ja, dat jy die sensoriese goed deelmaak van die planne wat jy saam met die kind maak om daardie emosionele kwessie te hanteer.	Awareness Impact of SID on therapeutic process Practical application Knowledge of SI Behavioural and emotional manifestation

<p>Wants child to enjoy the process</p>	<p>Ek voel regtig dat die tyd wat daardie kind by my in terapie is, ten spyte daarvan dat ons op die ou end van die dag met emosionele goed gewerk het wat nie vir hulle lekker is nie, maar dat hulle algehele ervaring positief is. Dit is vir my persoonlik nogal 'n pad om te stap van hierdie van die absolute direktief wat ons geleer is, om 'n bietjie meer flexible te wees om 'n gemaklike ruimte vir die kind te skep. In plaas daarvan om te sê “vandag gaan ons hierdie en hierdie oefeninkies doen” vir sensories, probeer ek dit so half deel maak van die sessie. So ek sal baiekeer nogsteeds sê, okay, hier is vir jou 'n mandjie met goedjies in wat ons bietjie gaan voel en kyk, of vandag gaan ons ruik, of kom ons gaan in die tuin in en kyk watse blomme sien ons... Maar ek probeer dit op so 'n manier doen dat dit vir die kind amper soos 'n ontdekkingsreis is.</p>	<p>Therapist's awareness Growth Training Adapting</p>
	<p><i>Hoe weet jy van sensoriese integrasie?</i></p>	
	<p>Toe ek net klaar geswot het was daar 'n arbeidsterapeut by ons skool gewees. Maar die bewustheid daarvan het seker maar begin met jou studies want sensories is hoe jy jou wêreld ervaar en hoe jy dan uiteindelik betekenis daaruit opbou. So dit is waar dit begin het. En dan soos wat jy werk kom jy agter, selfs op die ou manier deur te sê “vandag doen ons sensories” kom jy agter maar die kind hou nie noodwendig van hierdie nie, of hulle vrek oor hierdie goed en is altyd</p>	<p>Origin of info regarding Si theory Training Awareness Therapists' growth Knowledge of SI impact therapy</p>

	<p>daarmee besig. So ja, soos wat mens maar met die kinders gewerk het, so het my bewustheid maar gegroei. Maar ek hou ook van lees, so as ek 'n boek of 'n ding sien wat basies iets te doen het met werk met kinders of..... Sensory intelligence... ek het myself beter leer ken toe ek die boek gelees het en nou verstaan ek myself beter. Dit voel partyker vir my, nadat ons familie saamgekuier het, ek wil net huis toe gaan. En nou weet ek die mense wil net nooit ophou praat nie. En hoe meer hulle kan sê, hoe beter, en hoe harder hulle kan praat, hoe beter. Dan wil ek huis toe gaan! Die boek het vir my baie beteken en 'n breër uitkyk gegee oor die sensoriese belewenis. Ek dink dit is hoekom ek meer ruimte daarvoor laat in terapie. Ek besef ons almal het maar sekere voor- en afkeure wat daarmee saamgaan en dit is deel van wie jy is, so ek dink net soos alles anders kan jy leer hoe om dit te manage maar jy gaan dit nie noodwendig dit kan "cure" nie.</p>	<p>Fixing SID</p>
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## Appendix E: Thematic map indicating main themes and sub-themes



## **Appendix F: Language editing**

WH Cloete

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TAALVERSORGING VAN E.W. VAN ZYL SE VERHANDELING:  
EXPLORING HOW GESTALT PLAY THERAPISTS ESTABLISH SENSORY  
CONTACT WITH CHILDREN WHO HAVE SENSORY INTEGRATION DISORDERS

Ek, WH Cloete, is 'n geakkrediteerde lid van die Suid-Afrikaanse Vertalersinstituut (lidnr. 1000520) en bevestig hiermee dat ek Elmien van Zyl se verhandeling taalversorg het.



WH CLOETE

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