THE HANDLING OF AGGRESSION IN THERAPY FROM A GESTALT PERSPECTIVE

by

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STATEMENT

Student number: 3591-458-0 (1)

I declare that **"THE HANDLING OF AGGRESSION IN THERAPY FROM A GESTALT PERSPECTIVE"**, is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

______________________________ ______________________________

NICOLA RICHARDSON **DATE**

DEDICATION

I dedicate this study to my parents for their endless support and encouragement. Their constant guidance and love have been an inspiration to me to achieve my goals and dreams.

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Herewith I would like to acknowledge and thank the following people:

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SUMMARY

This qualitative study aimed to explore how to handle aggression in therapy from a Gestalt perspective. In order to reach the aim of this study a conceptual framework was done exploring terms central to this project including aggression and Gestalt Play therapy. Unstructured, telephonic interviews were then conducted with seven Gestalt Play therapists working with children in the Western Cape exploring ways to handle and treat aggression in therapy. The data collected during these interviews were then analyzed and several themes were identified and explored by conducting a literature control. Guidelines were then formulated and written on how to handle aggression in therapy from a Gestalt perspective as part of the concluding chapter of this research report.

KEY WORDS

Aggression

Gestalt Perspective

Middle childhood

Play therapy

Handle

Qualitative

Therapeutic Relationship

Boundaries

Alternatives

Parental involvement

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CHAPTER ONE

INTRODUCTION TO RESEARCH

1.1. INTRODUCTION

Aggression is a worldwide occurrence with roots that reach deep into society. It has many faces and forms and may occur at the most unlikely of times. No one can be excluded from the frustrations of life or the anger one may feel when things don't go according to plan, but how a person reacts can have a great impact on one's way of life and those around them. Aggressive behaviours may range from a child pushing another child on the playground during recess to a man physically assaulting his wife. The importance of these behaviours in day to day living should not be underestimated, nor should their effects on the recipient's self-esteem, social status and happiness. (Sadock & Sadock, 2003:150.)

Baron and Byrne (2000:632) define aggression as behaviour directed toward the goal of harming another living being who is motivated to avoid such treatment. Others may refer to aggression as also including behaviour directed toward non-living organisms. For example, Oaklander (1988:206) defines aggressive acts, also called antisocial acts, as including destructive behaviours such as destroying property, stealing or setting fires. Whichever way it is directed, aggression can have a great impact on others and the environment around them. For this reason it is important that aggression is addressed by exploring its nature, causes, implications and possible preventative measures.

Research suggests that with violent behaviour having such profound effects on the youth, violence by young people has today become one of the most visible forms of violence (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002:25). Aggression

is, after all, alarmingly frequent and shockingly devastating in its consequences (Baron & Byrne, 2000:440).

When addressing aggression it is critical to explore how aggression manifests in our youth and how from a young age they can be taught to explore this emotion in a healthy manner. This positive behaviour can be taught to children in various forms including by example from those around the child or in therapeutic settings. This is why it can be said that in today's therapeutic setting, aggression has become one of the most frequent occurrences in child therapy. Therapists today find themselves frequently faced with the damaging impact of aggression and violence on the people exposed to it and it is for this reason that aggression has become of great concern to therapists (compare Louw & Edwards, 1997:470). For the purpose of this study the researcher focused on aggression displayed by children in a therapeutic setting.

Working with a child displaying aggression in the therapeutic setting can be trying and at times even harmful to the therapist. That is why the therapeutic relationship is built on mutual respect and physical injuries to the child or therapist must be prevented (Blom, 2004:63). For the purpose of this study, Gestalt play therapists were interviewed who have experience working with aggressive children in a therapeutic setting. This research aimed to explore how Gestalt play therapists handle and treat aggression by children in therapy and then based on this study provide the reader with basic recommendations on how to handle aggression in therapy.

1.2. RATIONALE FOR STUDY AND PROBLEM FORMULATION

The researcher is of the opinion that aggression displayed by the child in a therapeutic setting is a behaviour that needs to be addressed with the appropriate therapeutic actions so as not to cause further therapeutic obstacles

such as resistance or abuse towards the therapist. The best way of addressing this aggression in a therapeutic setting is dependant on various circumstances and the researcher is of the opinion that the therapist needs to be sensitive as well as aware of all possible approaches to follow when dealing with aggression in therapy. In the following section the researcher further explores the rationale for a study of this nature.

According to Louw and Edwards (1997:470) the destructive power of human aggression is one of the greatest social and political concerns of our time. The effects reach deep into the lives of the youth of today causing many further concerns. Aggression found in children that is not addressed in a healthy manner can lead to outbursts of rage and anger in the form of physical or verbal violence and one has only to look around to see the effects of this aggression.

It is important when addressing aggression in children to distinguish between healthy aggression and unhealthy aggression. This is especially necessary when addressing aggression in the middle-childhood years. During middle childhood, the period between five and 12, children gain basic tools, skills and motivations to become productive members of their society and failure to acquire these basic tools can lead to long-term consequences for children's future education, work and family life (Huston & Ripke, 2006). As a result of this, the researcher is of the opinion that the middle-childhood years is a time when children are beginning to assume a larger share of responsibility for their own behaviour in relation to parents, peers and others. It is also time when a child needs to learn to take responsibility for his/her emotions and how to express them. For this reason the researcher focused this study on children in their middle-childhood years expressing aggression in therapy.

Oaklander (1998:206) explains that sometimes a child is viewed as aggressive when they are simply expressing anger. For a child to feel angry is a function of the child's organism, leading him/her to satisfy needs. According to Schoeman

(1996:183) the expression of anger can be seen as serving the function of maintaining the child's health and growth in his/her best interest. This implies that in order for a child to function optimally, the child needs to learn to express anger through positive aggressive energy. This means to say that the difference between the healthy expression of aggression and antisocial displays of aggression need to be distinguished when referring to aggression in children.

Even though antisocial behaviour decreases with age for most children, those who are most physically aggressive maintain their relative standing over time (Mash & Wolfe, 2002:129). For this reason it is important that children who struggle to express their emotions in a healthy way are guided through therapy to ensure the avoidance of violence or harmful, unhealthy acts of aggression.

Aggression being the intentional infliction of some form of harm on others, has long been a topic of concern to many social psychologists (Baron & Byrne, 2000:440). Research conducted over the years relating to aggression in children has covered many aspects. For example, research on *The relationship between aggression and social skills* (Storm, 2001), *Aggression as a symptom of a child's learning problems* (Du Plooy, 1985) and *Aggression and levels of moral development* (Borsten, 1978) addressed the relationship between aggression and the developmental skills of the child. Research concerning aggression in play therapy has included *The effect of music on the aggressive primary school child from a Gestalt play therapy perspective* (Bestbier, 2005), and *Dealing with aggression in the mid-childhood boarding school child by using play therapeutic group work* (van der Lith, 1998). Other research has included *An investigation into social perspective taking of aggressive children* (Phangela, 1993) and *A narrative deconstruction of aggression in children* (Reid, 2003). Aggression in children has been researched from various perspectives over the past years but no research has been done on exploring how to handle and treat aggression in therapy from a Gestalt perspective.

The researcher is therefore of the opinion that therapists will benefit from further in-depth research on how Gestalt play therapists handle and treat aggression in a therapeutic setting. Psychotherapy with an aggressive child may require the imposition of rather firm limitations over aspects of the child's aggressive behaviour. It is important that during therapy boundaries with respect to aggressive behaviour be put into place. Blom (2004:63) states that no aggressive behaviour towards the therapist is allowed and any attack on the therapist must be stopped immediately. This implies that harmful aggression towards the therapist should not be tolerated in a therapeutic setting but how aggression is explored and should be handled in therapy to benefit not only the client but also the therapeutic process is not discussed. Although the researcher is aware of the different therapeutic approaches in addressing aggression, for the purpose of this study the researcher worked from a Gestalt perspective only.

With reference to the above literature the researcher formulated the following problem. Gestalt play therapists working with children are being faced with aggression in therapy on a daily basis, which poses many therapeutic obstacles including resistance and physical or verbal harm. As a result therapists, who are unsure of the best way to handle or treat this aggression, can be faced with a therapeutic block, causing great frustration and even creating a negative impact on all involved. Therefore, it is essential that the therapist be prepared as to how to handle and treat aggression in a therapeutic setting. Consequently it is the researcher's opinion that how to overcome aggression in a therapeutic setting needs to be addressed through research and that other therapists then faced with aggression in a therapeutic setting can benefit greatly from these findings.

- **AIM AND OBJECTIVES**

Fouché and De Vos (2005:104) describe the aim as an abstract conception of the end toward which effort or ambition is directed. The aim of this study was to explore how Gestalt play therapists handle and treat aggression in therapy. In

order to achieve this aim certain objectives needed to be addressed. Fouché and De Vos (2005:104) describe objectives as being the steps the researcher needs to take in order to reach his/her aim. For the purpose of this study the following objectives were applied:

⇒ To provide a conceptual framework describing aggression within the context of this study and discussing Gestalt play therapy and the significance of the therapeutic relationship.

⇒ To conduct an empirical study by means of unstructured, telephonic interviews to explore how Gestalt play therapists handle and treat aggression in therapy.

⇒ To analyze the data received from the empirical study and then conduct a literature control where existing literature is compared to the data obtained in this study.

⇒ To provide a summary and conclusion based on the research findings and formulate recommendations on how Gestalt play therapists can handle and treat aggression in therapy.

- **RESEARCH QUESTION**

The first step in any research is to formulate or work out the research question. The question is gradually refined until it becomes specific enough to give the researcher a clear direction for answering it. Developing the initial question is critical because it determines much of how the research should be conducted (Graziano & Raulin, 2004:60). For the purpose of this study the researcher developed the following research question: How do Gestalt play therapists handle and treat aggression in therapy?

1.3. RESEARCH APPROACH

At present there are two well-known and recognized approaches to research, namely the qualitative and the quantitative paradigms (Fouché & Delport, 2005:73). For the purpose of this study a qualitative approach was followed. Graziano and Raulin (2004:424) define qualitative research as a research approach that seeks to understand psychological operations by observing the broad, interconnected pattern of variables, rather than the strength of the statistical relationship of variables. The qualitative research paradigm in its broadest sense refers to research that elicits participant accounts of meaning, experience or perceptions (Fouché & Delport, 2005:74). This study aimed to explore and describe the experiences of respondents, namely Gestalt play therapists and how they handle and treat aggression in therapy. Qualitative studies give a kind of insight and understanding which not only reveals to the reader in an academic manner the psychological dimensions of what the respondents went through, but also communicates to fellow humans about the personal qualities of human experience (Louw & Edwards, 1997:36). Through this study the researcher aimed to gain insight and understanding of how the Gestalt play therapist handles and treats aggression in therapy.

- **TYPE OF RESEARCH**

Research can be categorized as being either applied or basic research. For the purpose of this study applied research was used. Research, which has immediate practical application, can be called applied research (Louw & Edwards, 1997:55). Fouché and De Vos (2005:105) describe applied research as being aimed at solving specific problems or at helping practitioners accomplish tasks. In this study the researcher intended to explore the experiences of the Gestalt play therapists when faced with aggression in therapy and to describe how they handle or solve this specific problem. From the empirical study the

researcher then formulated guidelines for therapists handling and treating aggression in therapy.

As a result of these objectives concerning this study, the nature of the research was exploratory and progressed towards descriptive research. Babbie and Mouton (2001:80) refer to exploratory research as a way to satisfy the researcher's curiosity and desire for better understanding, to explain the central concepts and constructs of a study and to determine priorities for further research. By interviewing Gestalt play therapists, the researcher intended to gain a better understanding of how the Gestalt play therapist handles and treats aggression in therapy.

Descriptive research presents a picture of the specific details of a situation, social setting or relationship, and focuses on "how" and "why" questions (Fouché & De Vos, 2005:106). The researcher's goal was to describe the experiences of the Gestalt play therapist when faced with the aggressive child in therapy and to further describe how the Gestalt play therapist handles and treats aggression in a therapeutic setting. By completing this study the researcher aimed to formulate guidelines for therapists handling and treating aggression in therapy.

- **RESEARCH STRATEGY**

In order to conduct research a research strategy needs to be put in place. As previously stated a qualitative research approach was executed during this study. Qualitative methods collect information in the form of words, which give one an in-depth understanding of the nature of what people experience (Louw & Edwards, 1997:35). The research strategy for this study was the collective case study.

Fouché (2005:272) states that the case being studied may refer to a process, activity, event, programme or individual or multiple individuals. The collective

case study furthers the understanding of the researcher about a social issue or population being studied. The interest in the individual case is secondary to the researcher's interest in a group of cases. The exploration and description of the case takes place through detailed, in-depth data collection methods, involving multiple sources of information that are rich in context. These can include interviews, documents, observations and archival records. The product of this research is an in-depth description of a case or cases. For the purpose of this study, the researcher made use of unstructured interviews to examine how Gestalt play therapists handle and treat aggression in therapy. The proposed methodology for this study will be discussed in the following section.

1.4. RESEARCH PROCEDURE AND WORK METHOD

Research methodology refers to methods, techniques and procedures that are employed in the process of implementing the research design or research plan, as well as the underlying principles and assumptions that underlie their use (Babbie & Mouton, 2001:647). As mentioned previously, the researcher has selected a research topic and addressed the aim and objectives of this study. Furthermore the researcher chose the research approach and developed a research strategy. In the following section the research procedure and work method relevant to this study will be discussed.

- **CONCEPTUAL FRAMEWORK**

A conceptual framework was compiled investigating relevant literature regarding this study. A conceptual framework is built from concepts or constructs, often of a variable nature, and is utilized in the formulation of basic statements. These statements may be definitions, propositions or hypotheses that are woven together with a view to classifying, describing and in particular, explaining a human phenomenon (De Vos, 2005*a*:43). For the purpose of this study the

researcher investigated existing literature on aggression that was relevant to both the context of this study and Gestalt play therapy. Various forms of aggression displayed by children in the middle-childhood years and the development of this aggression were addressed. The researcher also distinguished between children displaying aggressive behaviour in a therapeutic setting and the concept of aggressive energy. The researcher examined various Gestalt concepts and the therapeutic relationship between the Gestalt play therapist and the child.

- **SAMPLING TECHNIQUE**

During the process of selecting or sampling the aim is to get a sample that is as representative as possible of the target population (Mouton, 1996:132). In qualitative research however, sampling can be described as being relatively limited, based on saturation, not representative, the size not statistically determined and involving low cost and less time (Strydom & Delport, 2005:328). In order to select the best sampling approach, the universe and population of the research need to be identified.

The term universe refers to all potential subjects who possess the attributes in which the researcher is interested, whereas the population refers to individuals in the universe who possess specific characteristics or to a set of entities that represent all the measurements of interest to the practitioner or researcher (Strydom, 2005:203-204). In this study the universe referred to all Gestalt play therapists working with children in South Africa and the population referred to the Gestalt play therapists working with children in the Western Cape. When the universe and population have been identified the sampling technique needs to be developed.

For the purpose of this study the researcher used non-probability, purposive sampling. Non-probability sampling refers to sampling procedures that are not based on random selection, while purposive sampling then allows the researcher

to select a sample on the basis of the researcher's knowledge of the population, its elements and the nature of the research aims and objectives (compare Babbie & Mouton, 2001:166). In the case of purposive sampling researchers purposely seek typical and divergent data (Strydom & Delport, 2005:329). A sample was selected from this population based on the aim of the research. Seven Gestalt play therapists were selected and research continued until saturation point was achieved. The sample was drawn from the population on the grounds of specific criteria. These criteria included:

⇒ The Gestalt play therapist must have been practicing in the Western Cape.

⇒ The Gestalt play therapist must have had experience in dealing with aggression in children of middle-childhood age in a therapeutic setting.

⇒ The Gestalt play therapist must have been willing to participate in this study.

- **DATA COLLECTION**

Once the researcher selected the sample, the data was collected. All the decisions with regard to obtaining the research material are now implemented (Fouché & Delport, 2005:84). As the researcher aimed to explore how Gestalt play therapists handle and treat aggression in a therapeutic setting, unstructured interviews were used to gain this information. At the root of unstructured interviewing is an interest in understanding the experience of other people and the meaning they make of that experience. It is focused and discursive and allows the researcher and participant to explore an issue. It is used to determine individuals' perceptions, opinions, facts and forecasts, their reactions to initial findings and potential solutions (compare Greef, 2005:293). When using unstructured interviews the researcher prepared a handful of main questions with which to begin and guide the conversation. These questions included the following, "How do you as a therapist find the experience of working with a child of middle-childhood age who displays aggressive behaviour in therapy?" and "Tell me about your process as a therapist working with aggression in therapy."

These predetermined questions aimed to explore how the Gestalt play therapist being interviewed handles and treats aggression in a therapeutic setting and were followed by relevant questions aimed at gaining more detailed information regarding this topic.

For the purpose of this study the researcher interviewed Gestalt play therapists working with children in the Western Cape who have experience dealing with aggression in children of middle-childhood age in therapy. By asking relevant open-ended questions in these interviews, the researcher explored the experiences of the Gestalt play therapist treating the aggressive child in therapy, and how these therapists handle these situations. The questions inquired how the Gestalt play therapist explores aggression displayed by children in a therapeutic setting and what techniques or methods are implemented to handle and treat this aggression. These interviews were done telephonically, recorded and transcribed. Consent forms were signed by respondents informing them of the fact that all interviews were to be recorded. The reason for making use of telephonic interviews is that the researcher was living overseas at the time of this study. Possible advantages of telephonic interviews included saving of time and money as well as the fact that questions being posed to the respondents and the answers they provided were less likely to be affected by the physical presence of the interviewer (compare Babbie & Mouton, 2001:257).

- **DATA ANALYSIS AND LITERATURE CONTROL**

After the completion of all the interviews the data was analyzed. Patton (in De Vos, 2005*b*:333) states that qualitative analysis transforms data into findings. This involves reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveal. Data analysis is also the process of bringing order, structure and meaning to the mass of collected data.

In order to analyze the data collected in this study, the researcher used the following as guidelines recommended by De Vos (2005*b*:336-339).

- **Managing/organizing data:** At an early stage in the analysis process, researchers organize their data into file folders, index cards or computer files (*De Vos*, 2005*b*:336). For the purpose of this study, all interviews conducted were transcribed upon completion and filed safely. To ensure the confidentiality of the respondents, letters from the alphabet were used to identify respondents.

- **Reading and writing memos:** After the organization and conversion of data, researchers continue analysis by getting a feeling for the whole database (De Vos, 2005*b*:337). This can be achieved by the researcher reading the transcripts in their entirety several times and immersing in the details, trying to get a sense of the interview as a whole before breaking it into parts. Once all the interviews were completed, transcribed and filed the researcher read all findings several times to gain an overview of what was collected and notes were made to identify preliminary themes.

- **Generating categories, themes and patterns:** Crewel (in De Vos, 2005*b*:338) states that classifying means taking the text or qualitative information apart and looking for categories, themes or dimensions of information. After preliminary themes were identified and the researcher had read through the data collected several more times the researcher made use of colour markers to highlight data related to the different main themes.

- **Coding of data:** The researcher then applied a coding scheme to those main themes and clearly marked the passages in the data using codes. The different themes were then further coded by marking the data to distinguish a number of sub-themes within the main themes.

- **Testing emergent understandings and alternative explanations:** The last two steps before writing the report were to analyze the data for usefulness and relevance to the study. De Vos (2005*b*:339) explains that the researcher should determine how useful the data are in illuminating the questions being explored and how central they are to the story that is unfolding about the social phenomenon being studied. During this phase the researcher questioned whether the data provided could be linked to any other explanation or motivation other than the research. For this purpose a literature study was done to control or test the data that has been collected.

Lastly, the writing of the report occurred and the emerging themes were formulated into recommendations to assist Gestalt play therapists on how to handle and treat aggression in therapy.

1.5. ETHICAL ASPECTS

The fact that human beings are the objects of study in the social sciences brings unique ethical problems to the fore, which would never be relevant in the pure, clinical laboratory settings of the natural science (Strydom, 2005:56). Therefore if social scientific research is going to be applied the researcher needs to be aware of the general agreements among researchers about what is proper and improper in the conduct of scientific enquiry. In the following section the researcher addresses the ethical aspects relevant to this study.

The following ethical aspects guided the research process:

- Informed consent and avoidance of harm:
  Respondents should be thoroughly informed beforehand about the potential impact of the investigation. Such information offers the respondents the opportunity to withdraw from the investigation if they so

wish. Obtaining informed consent implies that all possible or adequate information on the goal of the investigation, the possible advantages, disadvantages and dangers to which respondents may be exposed will be made known to the respondent. (Strydom, 2005:58-59.) The participation in this study was made voluntary to all respondents that were approached and the issue of avoidance of harm was addressed. Respondents also gave their consent by signing consent forms in order to participate in this study. An example of the consent form is attached at the end of this report, see Appendix 2.

- Violation of privacy/confidentiality

  The clearest concern in the protection of the subject's interest and well being is the protection of their identity (Babbie & Mouton, 2001:523). For the purpose of this study the respondents' confidentiality was ensured. The researcher used codes to identify the different respondents. This implies that the researcher was able to identify a respondent's response but ensured that this would not be available publicly. Privacy includes the element of personal privacy, while confidentiality indicates the handling of information in a confidential manner. It is imperative that researchers be reminded of the importance of safeguarding the privacy and identity of respondents and to act with the necessary sensitivity where the privacy of subjects is relevant (Strydom, 2005:61). For the purpose of this study the respondents' privacy was protected and all data collected was kept safe.

- Deception of Respondents:

  Neuman (in Strydom, 2005:60) says that deception occurs when the researcher intentionally misleads subjects by way of written or verbal instructions, the actions of other people, or certain aspects of the setting. For the purpose of this study the researcher adequately informed all respondents regarding all the necessary information concerning the study and what was expected from the respondents. The researcher is of the

opinion that by avoiding any deception the researcher will have ensured better results from the study as the respondents will have had a better awareness of what was expected of them.

- Competency of Researcher:
  Strydom (2005:63) states that researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation. Objectivity and restraint in making value judgements are part of the equipment of a competent researcher. The researcher ensures that this study has been conducted in a well-planned and ethically correct manner and that supervision was provided by the study leader throughout the research process. All possible risks were investigated and the researcher assumes responsibility by undertaking all ethically correct actions concerning this study.

- Release or publication of the findings:
  A research report was compiled containing the findings of this study and was made available. All information regarding the findings has been included in this report as well as the researcher's conclusion and further recommendations. The researcher assures the reader that the final report is accurate and objective.

1.6. DEFINITIONS AND MAIN CONCEPTS

For the purpose of this study the following concepts will be defined to ensure a uniform understanding:

- **Aggression**

Sadock and Sadock (2003:150, 282) define aggression as the forceful, goal-directed action that may be verbal or physical and is the motor counterpart of the affect rage, anger or hostility. From this one can say that aggression implies the intent to harm or otherwise injure another person, an implication inferred from events preceding or following the act of aggression. Mash and Wolfe (2002:131) explain that aggressive behaviour of children can include fighting, destructiveness and disobedience, showing off, being defiant, threatening others and being disruptive at school. For the purpose of this study the concept aggression will refer to the aggressive behaviour displayed by the child during therapy.

- **Middle childhood**

Berk (2006:6) defines middle childhood as the period when children learn about the wider world and master new responsibilities that increasingly resemble those they will perform as adults. Roughly between the ages of six and twelve, this stage of a child's life coincides in many societies with the beginning of formal schooling and being allowed a relatively unsupervised life. According to Harris and Butterworth (2002:233), during middle childhood there is an increasing emphasis on peer relations to compliment the parent-child and other family relations in the life of the child. Huston and Ripke (2006:8) explain that middle childhood is the period when children gain the fundamental skills needed for adult life, undergo the early stages of puberty, develop self-awareness and self-regulation, and form the foundations for social relationships with age-mates. Erikson (in Sroufe, Egeland, Carlson & Collins, 2005:148) described the period in terms of "industry versus inferiority", because he believed it was so important to establish oneself as a responsible, agentic, hardworking, serious minded person at this time.

- **Gestalt play therapy**

The aim of Gestalt therapy is to awaken or mobilize people enough for them to get on better with their lives than they were managing before coming for help (Houston, 2003:3). Joyce and Sills (2001:7) describe Gestalt therapy as a humanistic / existential therapy, which believes that people are born with the resources and ability to be in rewarding contact with other human beings, and lead a satisfying, creative life. However, often during childhood and sometimes later on, something interrupts this process and the person becomes stuck in fixed patterns and beliefs about themselves that get in the way. Gestalt therapy aims to investigate and uncover how these patterns are still active and affecting a person's present life. For the purpose of this study, Gestalt play therapy will refer to the therapy practiced by the respondents, namely the Gestalt play therapists interviewed during this study.

1.7. OUTLINE OF RESEARCH REPORT

This research report consists of four chapters:

Chapter One includes a general introduction and an explanation of the study. This includes motivation for the choice of topic, a problem formulation, aim and objectives, research question, research methodology, ethical aspects and definitions of main concepts.

Chapter Two provides a conceptual framework. Information relevant to the study regarding aggression and the Gestalt play therapist are discussed here. The researcher distinguishes between aggression and aggressive energy within the developmental phase in children of middle-childhood age, while a general perspective on Gestalt play therapy and the significance of the therapeutic relationship is addressed.

Chapter Three contains the empirical study as well as the data analysis. This chapter also includes a literature control comparing existing literature with the information gathered by the empirical study.

Chapter Four is comprised of the summary, conclusion and recommendations for further research on this topic. The conclusion is based on the findings of the research and the recommendations presented are in the form of guidelines for other play therapists encountering aggressive children in the course of their work.

1.8. SUMMARY

This chapter gives an overview of what this study is about. A discussion on the choice of topic, problem formulation, aims and objectives of the research are included. The research question as well as the procedure and method are also discussed. The following chapter consists of a conceptual framework where key concepts regarding this study are explored.

CHAPTER TWO

CONCEPTUAL FRAMEWORK: AGGRESSION AND GESTALT PLAY THERAPY

2.1. INTRODUCTION

The aim of this chapter is to provide a conceptual framework, which serves as a base for the empirical study in Chapter Three. Punch (2006:151) describes a conceptual framework as a framework showing the central concepts of a piece of research and their conceptual status with respect to each other. De Vos (2005*a*:35) explains that the nature of the conceptual framework is determined by the function that the framework has to fulfil. For the purpose of this research the conceptual framework provided in this chapter serves the basic function of explanation and understanding.

The researcher is of the opinion that it is essential that the reader have a unified and basic understanding of the concepts explored in the empirical study. To achieve this, chapter two will be divided into two sections, firstly a discussion on aggression and aggressive behaviour in children and how this is approached in a therapeutic setting and secondly, exploring Gestalt Play therapy.

2.2. AGGRESSION

In efforts to understand aggressive behaviour, knowledge from many different scientific disciplines must be viewed in order to provide an overall picture of what is currently known about aggressive behaviour in children. In the following sections the researcher will address various aspects concerning aggression and aggressive behaviour in children. This will be done by exploring definitions and

subtypes, looking at the development of aggressive behaviour in children while also exploring various risk and protective factors influencing this development and distinguishing between adaptive and maladaptive aggression. The researcher will then focus on children displaying aggression in a therapeutic setting. Throughout this section the researcher will focus on literature dealing with aggressive behaviour in children, while primarily looking at children of middle-childhood age.

2.2.1. DEFINING AGGRESSION

Definitions concerning aggression greatly influence the manner in which professionals in various disciplines understand, conceptualize, research and intervene with aggressive behaviour in children. For this reason it is crucial that fundamental conceptual issues be discussed. Given that aggression is a heterogeneous condition, no single term is adequate to capture all diverse presentations of such behaviour in the youth. (Connor, 2002:2.) Since the way in which aggressive behaviour is defined is so important for how aggressive children are conceptualized, the researcher will follow with a definition of aggression as well as explore the definitions of various subtypes of aggression.

Social psychologists, Baron and Richardson (in Krahé, 2001:11) define aggression as being, "…*any form of behaviour directed toward the goal of harming or injuring another living being who is motivated to avoid such treatment*". The researcher's opinion is that aggression should not only be defined as acts directed towards other living beings but also include the environment in general. In light of this, the researcher has chosen to use a combination of the above definition and the following definition from the Dictionary of concepts in general psychology. Here aggression is defined as "…*overt behaviour, both verbal or physical, that is intended to hurt others and/or*

damage property" (Popplestone & McPherson, 1988:11). The researcher therefore proposes the following definition for this study:

> Aggression can be defined as any form of behaviour, verbal or physical, directed toward the goal of harming or injuring another living being who is motivated to avoid such treatment and/or the damage of property within the therapeutic setting.

2.2.2. SUBTYPES OF AGGRESSION

Connor (2002:24) believes there are many different ways that aggression comes out in children and for very different reasons. Specific dimensions or characteristics that are commonly observed in children displaying aggressive behaviour need to be taken into consideration when conducting interventions with these children. The following section will explore the different characteristics of child aggression by defining the different subtypes of aggressive behaviour commonly displayed.

Connor (2002:24) further explains that efforts to subtype aggression in youth may prove fruitful in facilitating a better understanding of this pervasive and problematic form of behaviour. For this reason researcher is of the opinion that being aware of different subtypes of aggression and why they occur can be very beneficial to a therapist working with an aggressive child. Therefore, for the purpose of this study, the following section will focus on the following subtypes namely, overt, reactive, proactive and relational aggression.

Overt aggression includes harmful verbal and physical acts of aggression that are directed towards others, property, or self (Bloomquist & Schnell, 2002:9). According to Loeber and Dishion (in Bloomquist & Schnell, 2002:9) overtly aggressive children are often described as "fighters". Some fight at home only,

some fight at school only and some in both settings. Those children who fight in both home and school settings have the most entrenched and severe problems in the social, academic and emotional domains.

Bloomquist (2006:13) explains that whether aggressive behaviour is spontaneous or carefully planned further defines overt aggression. One subtype is *reactive aggression*, an unplanned responsive aggressive behaviour to an evoking stimulus. The stimulus may be real or perceived. The child who displays reactive aggression can be happy one minute and fist-fighting the next when an immediate situation provokes him/her. When the stimulus is present, the individual has an expectation of a negative outcome, becomes physiologically aroused and responds aggressively.

Another subtype is *proactive aggression*, when aggressive behaviour is planned with a goal in mind. A child who uses proactive aggression is more calculated in his/her aggressive actions and will actively plan retaliation. The individual who engages in this type of aggression is typically calm, has high self-confidence and has positive expectations for the result of the aggression. (Bloomquist, 2006:13.)

According to Bloomquist and Schnell (2002:11) reactive aggression occurs more often than proactive aggression and reactively aggressive children are less well liked, have poorer social skills, have problems with inattention/impulsivity, and exhibit more emotional disregulation than proactively aggressive children. Researchers have also determined that many reactively aggressive children come from backgrounds of physical abuse. Even though the reactive and proactive forms of aggression are distinct, they are also highly correlated with overall overt aggression.

Lastly, *relational aggression* will be discussed. Relational aggression is defined as aggression aimed at damaging or interfering with another person's relationships, reputation or psychological well-being; also called covert, indirect

or psychological aggression (Papalia, Olds & Feldman, 1999:492). Crick (in Bloomquist & Schnell, 2002:11) describes relational aggression as characterized by the intentional actions of one child toward another that are designed to harm through manipulation and to damage relational status.

The relationally aggressive child frequently tries to exclude another child from the peer group and often this is related to the child wanting attention or to feel superior, both of which are legitimate needs but not carried out in a way that is ultimately helpful to the child (Bloomquist, 2006:13). Most research suggests that relational aggression is more characteristic of preschool and school-age girls than boys and that relationally aggressive children are more likely to be more socially and emotional maladjusted, rejected by peers, defiant and impulsive compared to normal peers (Bloomquist & Schnell, 2002:11).

Aggressive children think differently from non-aggressive children. Vitiello and Stoff (in Bloomquist & Schnell, 2002:10) report that different neurological/anatomical and biochemical processes are involved in the activation and maintenance of different forms of aggression. Bloomquist (2006:13) explains that reactively or relationally aggressive children are prone to think that another child may be doing something negative to them "on purpose" and therefore think they must be aggressive in response. The proactively aggressive child often thinks that aggressive solutions are the best way to handle an interpersonal dispute so it is not surprising that he/she would be aggressive in this situation.

2.3. AGGRESSIVE BEHAVIOUR IN CHILDREN

Aggression and related behaviours in children and adolescents are central issues today. From public school shootings and similar instances of children killing other children, to concern about rising rates of youth crime and delinquency in the community, to the relationship between unrecognized and untreated mental

illness and violence in youngsters, there are many worries and much debate about excessive, inappropriate aggression in young people in our society. (Connor, 2002:1.)

Connor (2002:1) further explains that aggressive behaviour among the youth is not a new concern and over the past 80 years much research has been completed examining early-onset aggressive/antisocial behaviour from multiple perspectives. The researcher is of the opinion that when addressing aggression in therapy, the therapist needs to be knowledgeable concerning child aggression and the possible influences in the development of a child's aggressive behaviour. Therefore the following section will explore some of this documented research regarding the development of aggressive behaviour in children while also exploring various risk and protective factors influencing this development as well as distinguishing between adaptive and maladaptive aggression.

2.3.1. THE DEVELOPMENT OF AGGRESSION IN CHILDREN

As previously stated in Chapter One, when addressing aggression it is critical to explore how aggression manifests among the youth. In this section the researcher will review normal child development as well as the general development of aggression in children. The concept of a developmental pathway must be addressed to serve as a foundation for this discussion. According to Bloomquist and Schnell (2002:23), a developmental pathway describes the process of adaptation for a child moving toward a developmental outcome. It has to do with the level of mastery that a child achieves with successive tasks in the social, emotional, cognitive and physiological domains of functioning.

Aggression is a normal and highly frequent behaviour in young developing children. Healthy aspects of aggression facilitate competence in social assertiveness, competition in games and success in meeting daily challenges.

(Connor, 2002:29.) Children who display normal levels of aggression proceed down an early-onset continuous adaptive developmental pathway and achieve competence. The early-onset continuous adaptive pathway is observed when a child is exposed to minimal levels of risk and displays early competence or adjustment that persists over time. These children acquire mastery of tasks at different stages of development. Children eventually go through all the stages of development to achieve competence in childhood and adolescence. (Bloomquist & Schnell, 2002:25.)

For the purpose of this study the researcher will briefly address the experience and development of aggression in children from infancy to middle childhood, focusing primarily on middle childhood. Krahé (2001:48) describes this as follows. The first experience of aggressive behaviour is the recognition of anger in adults' facial expression, which infants are capable of from as early as three months. This is followed by the expression of anger by the child in response to frustration, which starts in the second half of the first year. Behavioural patterns of aggression in conflicts with peers and adults emerge during the second and third years of life in the form of temper tantrums and the use of physical force. In the early school years gender differences in aggression become apparent with boys generally showing higher levels of physical aggression than girls. Even though aggressive behaviour tends to decrease from early to middle childhood as a function of increasing self-regulatory and social skills, this does not seem to apply to sibling aggression which both genders report to be common.

According to Harris and Butterworth (2002:290) the amount of negative behaviour that children show in their interactions does not appear to change over the school years but there are noticeable changes in the form that aggressive behaviour takes. Direct physical aggression is replaced by verbal aggression that includes insult, derogatory remarks and threats. Aggressive behaviour in six to twelve year-olds is also more directed towards individuals rather than concerned with possessing particular objects or occupying a particular territory.

Crick, Bigbee and Howes (in Papalia *et al.*, 1999: 491) agree that by school-going age overt aggression typically wanes, to give way to more subtle forms such as teasing, manipulation and bids for control. Highly aggressive children tend to be unpopular in middle childhood and if they are habitually aggressive and pick on weaker children, they are commonly called bullies. Aggression becomes bullying when it is deliberately, persistently directed against a particular target, namely a victim who is weak, vulnerable and defenceless. Moeller (2001:14) explains that as children grow older development occurs in the processes by which they begin to understand, internalize and act in accord with moral and ethical values. This set of processes, called moral development encompasses prosocial behaviours as well as antisocial behaviours such as aggression and violence.

Theoretical approaches aimed at explaining the development of aggressive behaviour in children include both biological and physical approaches. The biological models refer to evolutionary and genetic principles to explain aggression. Krahé (2001:46) explains that the sociobiological approach implies that aggression has developed as an adaptive form of social behaviour in the process of evolution. The ethological perspective explains the manifestation of overt aggression as a function of an internal aggressive energy that is released by aggression-related external cues. Evidence from the field of behaviour genetics suggests that the disposition to act aggressively is at least partly determined by genetic influences.

According to Krahé (2001:46) psychological approaches have widened the frustration-aggression link into a more general model of negative affect and highlighted the role of cognitive factors, learning experiences and decision-making processes in predicting aggressive responses. The psychological explanations of aggression share the assumption that aggressive behaviour is not inevitable, but that the likelihood of its occurrence depends on the operation

of a variety of promoting and inhibiting factors located both within the person and the environment. Some of these factors will be discussed in the following section.

2.3.2. RISK AND PROTECTIVE FACTORS IN THE DEVELOPMENT OF AGGRESSION IN CHILDREN

Connor (2002:113,162) defines risk factors as conditions or influences that predispose children to the maladaptive expression of aggressive behaviour, while protective factors are contingencies that shield youngsters from the influence of risk factors. These factors do not operate independently of one another as behavioural outcomes are mediated by a complex interplay between risk and protective factors at specific times of development. In this section the researcher will review individual, family and social or environmental risk and protective factors in the development of aggression in children. First the researcher will discuss the risk factors.

Connor (2002:158) further explains that risk factors rarely exist in isolation of one another and are generally multiple and interact in complicated transactions over the course of a child's development. Individual risk factors include temperament, the quality and pattern of an infant's attachment to a caregiver, the exposure to neurotoxins during the course of the development, academic underachievement or failure and body size or build. Family risk factors include ineffective parenting practices, poor family functioning including marital conflict, divorce or domestic violence, parental psychopathology and child abuse and neglect. Social and environmental factors may include peer factors, social deprivation, media violence and other community factors exposing a child to forms of violence. Since most psychosocial risk factors are non-specific and exert an indirect influence on risk for aggressive behaviours, the specific type of risk factor appears less important for the development of such behaviours than the total number of risk factors present.

Not every youth who experiences a risk condition will have a negative outcome and the review of protective factors has the goal of identifying those variables that exert a buffering effect on high-risk youth. Factors that exert beneficial results on children's welfare at all times, regardless of a high or low level of risk are called resource factors. Examples of these include sufficient family income, adequate family functioning and an absence of parental psychopathology. Protective factors are those factors where the effects are most salient when risk is highest and include individual child factors such as an easy temperament, high IQ, academic competence, high self-esteem, social competence and competence in activities. Good parent-child relations, external support, friendships and availability of opportunities include some of the social and environmental protective factors. The impact of protective factors changes at different periods of the child's development, but can have a great impact on the child by improving individual coping skills, adaptation and the building of competence. (Connor, 2002:160.)

2.3.3. ADAPTIVE AND MALADAPTIVE AGGRESSION

In Chapter One the researcher was of the opinion that when addressing aggression in children it is important to distinguish between healthy aggression and unhealthy aggression. Therefore for the purpose of this study the researcher will distinguish between adaptive, also known as normal, appropriate or healthy aggression and maladaptive or excessive, inappropriate, unhealthy aggression in children. According to Connor (2002:4), the distinction is important and failing to recognize adaptive aggression and incorrectly identifying it as maladaptive aggression may have serious consequences for a child.

Moeller (2001:4) explains that virtually all children are aggressive at some point in their lives, and aggression can be considered to be "normative" at certain

stages of development. Children that display normal or adaptive aggression can be viewed as healthy. Adaptive aggression can even be referred to as necessary for a child's optimal development. According to Oaklander (in Blom, 2004:119) taking action and satisfying needs requires aggressive energy. The concept refers to the energy necessary, for instance to bite into an apple or to express a strong emotion, which gives the children the self-support to enable them to take action. Children with emotional problems are often confused as a result of this energy. When children act aggressively and fight for control, they experience a lack of this energy, as they act beyond their boundaries.

For the purpose of this study the researcher will refer to maladaptive aggression as aggression displayed by children that is clearly beyond the normal range that can be expected from children of their chronological age, gender and other relevant personal characteristics. Moeller (2001:2) argues that maladaptive aggression can be described as noticeably more frequent, of greater intensity and of longer duration than that of normal aggression displayed by children. Connor (2002:6) further explains that maladaptive aggression appears to be unregulated, uninhibited aggression and when it occurs it appears to result from the inability of internal mechanisms to function as they were designed.

Carroll and Oaklander (1997:193) suggest that the suppression of frustration, anger and rage is often the cause of many difficulties in a child's disturbed or inadequate sense of self. According to Johnson and Chuck (2001:240) it is common for a child's expression of self, which requires aggression in service of the self, to be misinterpreted by adults as hostility. That confusion is introjected as a part of the child's view of self. Aggressive acting-out children depend on their self-protection mechanisms to provide them with the sense of security that they are lacking. For these children, aggression often becomes the child's most reliable defence for coping with the world. Crenshaw and Mordock (2005*a*:9) advise that when unusual aggression is observed in young children, intervention should begin immediately.

2.4. AGGRESSION IN THERAPY

In recent years, one of the most common referrals of children to mental health services is for aggressive and acting-out behaviours (Johnson & Chuck, 2001:239). Cain and Seeman (2002:205) state that in psychotherapy in general, the importance of emotions has become widely recognized. Watson and Greenberg (in Cain & Seeman, 2002:205) further explain that research has demonstrated the importance of emotions both in the resolution of conflicts and in the success of the therapy process as a whole. In this study, the researcher will focus primarily on aggression in a therapeutic setting from within a Gestalt play therapy perspective.

2.4.1. RATIONALE FOR USING GESTALT PLAY THERAPY WITH AGGRESSIVE BEHAVIOUR IN CHILDREN

Most children are taught that aggression is bad, and that the expression of one's aggressive impulses may inevitably lead to destruction or damage. However in Gestalt aggressiveness as defined in the original sense of 'reaching out' is indispensable to life, love and productive activity (Clarkson, 2004:63). According to Cain and Seeman (2002:206) anger that is accompanied by the expression of other previously entangled emotions such as grief and sadness is seen as highly therapeutic, particularly in working through trauma. Carroll and Oaklander (1997:185) state it is aggression that serves the life of the child and which allows for distinctions to be made between the child and the environment. From the Gestalt view, it is aggression that enables the self to orient, mobilize and organize its excitement or energy. Aggression, therefore, is essential for growth and learning. For this reason the researcher believes that the use of aggressive energy in a therapeutic setting can have great influences on the therapeutic process as well as the emotional needs of the child.

Unlike the typical response of teachers, parents and adults in authority positions to aggression or acting-out behaviour, the objective of play therapy is not to stop the behaviour but rather to understand the child and provide an acceptable avenue for the child to express unfulfilled feelings, wants, and needs. Research shows that parents and therapists can successfully use play to help children effectively release aggressive feelings and in the process significantly improve their attitudes and behaviour outside the playroom. (Landreth, Sweeney, Ray, Homeyer & Glover, 2005:15.)

Landreth (in Johnson & Chuck, 2001:240) describes play as a child's most natural means of self-expression and an essential component of childhood development. Through play a child is able to release pent-up feelings of anxiety, disappointment, fear, aggression, insecurity and confusion. The playroom provides a safe place for a child to release these feelings and to re-enact experiences. Bringing these feelings to the surface encourages the child to deal with them, learn to master them or abandon them. Often children are unable to verbally express what they are feeling and in play therapy toys can serve as children's words and play serves as their language. The symbolic nature of play allows children to transfer strong feelings onto toy objects instead of real people. Children are protected from their own strong actions and emotions connected to traumatic experiences because their feelings are acted out in fantasy rather than reality. For these reasons play therapy is well suited to meet the needs of aggressive children as the child can use play as a language for expressing negative feelings in a safe and secure environment.

2.4.2. AGGRESSIVE BEHAVIOUR IN THE PLAYROOM

Many play therapists find it difficult to respond appropriately to acts of aggression because such acts in the playroom are often directed towards themselves

(Landreth *et al.,* 2005:15). According to Crenshaw and Mordock (2005*b*:53) every antisocial act that the child displays needs to be explored, both in terms of its appropriateness and in terms of identifying the ideas in the child's head that led to it. It is because the therapist does not punish or scold the child for these disclosures that the child learns that disclosure is not traumatic.

Johnson and Chuck (2001:243) state that during the initial play therapy sessions the emotions of distressed children are most often diffuse and undifferentiated. As the therapeutic relationship develops, expressions of aggression become less diffuse and are more directly connected to a specific experience or person. As the child releases negative feelings, the feelings become less severe and as a result are easier for the child to manage. Throughout the therapeutic process though, the therapist should expect a range of aggressive actions to surface and needs to be prepared as to how to handle them. As the physical safety of the therapist, child and playroom must be protected, it is essential that the therapist sets appropriate limits concerning these issues. In the following section the researcher will explore limit setting that is appropriate when working with aggressive children.

2.4.3. LIMIT SETTING WITH AGGRESSIVE BEHAVIOUR IN THERAPY

When working with children displaying aggressive behaviour in therapy it is essential that limits or boundaries are set. Landreth (2002:249) describes therapeutic limit setting as based on sound principles and a well thought out formulation of general areas in which intervention through limit setting will probably be needed. Limits are based on clear and definable criteria supported by a clearly thought out rationale with the furtherance of the therapeutic relationship in mind. Limits are not set simply for the sake of limiting behaviour but applied because they are recognized as facilitating the attainment of accepted psychological principles of growth.

Permissiveness in the child-centred play therapy approach does not mean the acceptance of all behaviours. Therapy is a learning experience and limits provide children with an opportunity to learn self-control, that they have choices, what making choices feels like and how responsibility feels (Landreth, 2002:246). According to Johnson and Chuck (2001:242) limit setting is one of the most important aspects of play therapy and is also the most problematic for most therapists. Therapists should not allow the child's actions to push them beyond a level that can be tolerated, thereby inhibiting positive acceptance of the child. However, it is imperative that the therapist be able to demonstrate a certain degree of tolerance and that the therapist's personal needs do not interfere with the child's need to be messy or destructive.

Axline (in Johnson & Chuck, 2001:242) states that preventing the child from physically harming the therapist or destroying toys by setting limits helps the child to develop a sense of security and consistency in the child-therapist relationship. According to Landreth (2002:247) limits should be stated in a calm, patient matter of fact, firm way and should be minimal and enforceable. Through setting limits the therapist is able to preserve feelings of acceptance, empathy and positive regard for the child. A goal of limit setting is to promote the child's release of aggression through symbolic aggression rather than direct acting-out. When children are able to symbolically express their negative feelings they are freed from potential anxiety or guilt over actually harming something. Landreth (in Johnson & Chuck, 2001:243) communicates the importance in setting limits by following certain steps namely, acknowledging the child's feelings, wishes and wants, communicating the limit and then targeting acceptable alternatives.

2.4.4. STAGES OF PLAY THERAPY WITH CHILDREN DISPLAYING AGGRESSIVE BEHAVIOUR

Mills and Allan (in Johnson & Chuck, 2001:247) reported four stages children typically work through during the play therapy process:

Stage One - Establishment of the relationship

During the first stage of play therapy, the therapist facilitates a secure and accepting environment in which the child feels safe to explore thoughts and feelings. The therapist also sets limits to further create feelings of security in the child. The therapist recognizes and accepts that a child from a family where aggression is the norm may feel comfortable with aggressive or combative play. In this initial stage the child may react with anxiety and be unable to tolerate close proximity with the therapist.

Stage Two - Testing limits

The second phase of play therapy constitutes a major shift in the child's aggressive behaviour. Here the child attempts to test the limits of the therapist's acceptance, usually by engaging in behaviours that are less tolerated in the child's home environment. The child unconsciously tests whether or not the therapist will continue to be accepting of the child regardless of behaviour in the playroom. As the child experiences acceptance from the therapist, despite aggressive behaviour and emotions, the child's defences weaken. The child learns that it is safe to express positive as well as negative feelings.

Stage Three - Working on personal needs

This is the true working stage of therapy. Here the child will typically engage in more interaction with the therapist. The child may use art, toys and even drama to continually create distance from painful feelings. The child may also direct anger and frustration over events towards the therapist. As the child progresses

through the third phase, aggressive behaviour typically declines and the child may also exhibit increased confidence, sharing and improved interpersonal skills.

Stage Four - Consolidation and termination

During this final stage the child displays distinct progress, moving from inappropriate and aggressive behaviour to socially acceptable behaviours. The child has developed interpersonal skills and may actively verbalize issues involving the home and classroom. This is the termination and consolidation phase of therapy and it is important that the therapist utilizes a termination process that does not leave the child feeling abandoned.

In the following section the researcher will focus on Gestalt play therapy.

2.5. GESTALT PLAY THERAPY

As the purpose of this study is to explore the handling of aggressive behaviour in therapy from a Gestalt perspective, the remainder of this chapter will focus on examining Gestalt play therapy. It is of the researcher's opinion that the reader must have a basic understanding of what Gestalt play therapy entails in order to make sense of the empirical findings. Before discussing the theoretical concepts of the Gestalt theory, three concepts namely Gestalt therapy, play therapy and Gestalt play therapy must be described briefly in order to give the reader a clear understanding of what is meant by each one.

Gestalt therapy is a humanistic and process-oriented form of therapy and includes principles from various other theoretical approaches such as psychoanalysis, Gestalt psychology and humanistic theories. It can be explained that Gestalt therapy can be considered an existential, phenomenological and holistic approach, with the emphasis on awareness in the here and now and the interdependence between people and their environment. This improves

organismic self-regulation in that people become aware of choices they can make in respect of their behaviour and they can thus define the significance of their life. (Blom, 2004:17,19.)

Play therapy is a helping interaction between a trained adult and a child that seeks to relieve the child's emotional distress through the symbolic communication of play (Webb, 1999:30). According to Gouws *et al.* (in Blom, 2004:19) play therapy is defined as a psychotherapeutic technique whereby the therapist attempts to give the child the opportunity to express his/her feelings verbally or non-verbally. It is assumed that the child will play out his/her problems in a symbolic manner, will learn to know and will channel his/her own emotions more effectively, will learn to enter into a relationship of trust with another person and that devious behaviour will consequently be normalized.

Gestalt play therapy can be considered a psychotherapeutic technique that uses the principles and techniques of Gestalt therapy during play therapy with child. By developing a therapeutic relationship and contact, and according to specific process, children are given the opportunity to confirm their sense of self both verbally and non-verbally, to express their thoughts and to nurture themselves. Various forms and techniques of play are used during the different stages. (Blom, 2004:20.)

2.6. THEORETICAL CONCEPTS OF GESTALT PLAY THERAPY

Carroll and Oaklander (1997:184) argue that all the concepts and principles presented in the Gestalt therapy literature are relevant to understanding child growth and development, as well as child psychopathology and psychotherapy. In the following section the theoretical concepts from the Gestalt theory, which also apply to Gestalt play therapy, will be discussed with specific reference to the way in which they apply during Gestalt play therapy with a child.

2.6.1. FIELD THEORY

Fernbacher (2005:123) regards field theory as a crucial Gestalt concept for understanding and dealing with cross-cultural situations. This is a set of principles that emphasizes the interconnectedness of events and the settings in which those events take place. Mackewn (1997:48) explains that in Gestalt the individual-environment entity is known as the field, where the field consists of all the complex interactive phenomena of individuals and their environment. Gestalt field theory looks at the total situation, affirming and respecting wholeness and complexity, rather than reducing the situation to item by item analysis. It reminds one that every person needs to be seen in the broader context of his/her life, which includes culture.

2.6.2. HOLISM

According to Blom (2004:22) the concept of holism can be considered the most important theoretical concept of Gestalt therapy. A fundamental principle of holism is that all elements in the world, such as plants, animals, people and things, survive in a changing process of coordinated activities. Yontef and Jacobs (in Blom, 2004:22) believe that most humanistic theories of personality are holistic. This implies that human beings are in themselves self-regulating, that they are growth orientated and that people and their symptomatic behaviour cannot be understood apart from their environment.

From the point of view of Gestalt theory, children can also be considered a holistic entity, which means that the sum total of their physical, emotional and spiritual aspects, language, thought and behaviour is more than its components. These components can be distinguished, but they cannot be separated. During therapy the child should be guided to be aware of his/her experience in respect of all the components in order to survive not as a fragmented entity but rather as

an integrated entity. During Gestalt play therapy with children, the focus will thus be on their physical, emotional and spiritual aspects, as well as language, thought and behaviour in order to approach them as holistic individuals. (Blom, 2004:23.)

2.6.3. HOMEOSTASIS / ORGANISMIC SELF-REGULATION

Life is characterized by a continuous process of balance and imbalance in the organism, with homeostasis being the process whereby the organism satisfies its needs by restoring balance (Nelson-Jones, 2001:131). Blom (2004:23) explains that from the Gestalt theory point of view, all behaviour is regulated by a process called homeostasis or organismic self-regulation. Homeostasis is described as the process during which the organism maintains its balance under different circumstances. This process of self–regulation is a way in which individuals satisfy their needs. In Gestalt a person is seen as having a natural or organismic tendency to regulate the self (Clarkson, 2004:22). In order to grow and develop people strive to maintain a balance between need gratification and tension elimination. Organismic self-regulation leads to the integration of polarities, where differences are accepted and integrated. (Blom, 2004:40.)

2.6.4. AWARENESS

According to Mackewn (in Fernbacher, 2005:120) awareness is the way in which we understand ourselves and what we need and also the way in which we organize our field and make meaning of our experience. Joyce and Sills (2001:28) explain that the Gestalt approach consistently emphasizes understanding the processes of awareness. One of the most important tasks then of the Gestalt therapist is that of raising the awareness of the client, of their

relationship with other people, of their impact on their environment and its impact on them.

2.6.5. THE HERE AND NOW

Yontef and Jacobs (in Blom, 2004:57) state that in Gestalt therapy, direct experience is used as a primary tool and the focus is always on the here and now. Gestalt play therapy focuses on promoting children's awareness in the present. According to Melnick and Nevis (2005:104) a basic belief of Gestalt therapy is that the present encompasses the past and helps influence the future. The influence of events from the past and expectations of the future are not denied, but growth cannot take place by recreating the past or by predicting the future. The only reality with which the therapist can work is the here and now because the child can only experience the present. Blom (2004:57) explains that during the therapeutic process, therapists play an important role in seeing to it that they focus continuously on promoting children's awareness in the present, even if attention is paid to past emotions and unfinished business.

2.6.6. CONTACT

Contact is another central interest in Gestalt therapy. According to Blom (2004:29) contact can be defined as an integral part of all experience, therefore implying that no experience can exist without contact and that contact takes place as soon as the organism uses the environment to satisfy its needs. Therefore contact making implies that the environment is used to satisfy needs. Oaklander (in Blom, 2004:29) explains that healthy contact can be regarded as a child's ability to make contact with the environment by making use of their senses, awareness of and suitable use of their body. It is also the ability to be able to express emotions in a healthy manner and the use of their intellect in various ways such as the ability to express ideas, thoughts and needs.

Although children must always be viewed as being in contact with their environment, there must also be boundaries that distinguish them from their environment, also known as contact boundaries. Boundaries must be penetrable in order to ensure exchange between children and their field environment. Through contact-making and appropriate withdrawal, children's needs are met and they grow. Healthy functioning implies that children must be capable of distinguishing between those aspects that belong to them and those aspects that are foreign to them. Children must also be capable of relevant contact and withdrawal with the environment in order to complete the Gestalt on their foreground and to effect organismic self-regulation. (Blom, 2004:30.)

2.6.7. CONTACT BOUNDARY DISTURBANCES

Blom (2004:31) states that a contact boundary disturbance occurs when children are no longer capable of forming a sound balance between themselves and the world. As a result of life experiences, children learn often from a very early age to make use of contact boundary disturbances in order to satisfy their needs. Children with contact boundary disturbances are incapable of being aware of their needs and healthy contact with the environment. These children's integrated holistic functioning of the senses, body, emotions and intellect is fragmented by using contact boundary disturbances, which negatively affect the natural process of organismic self-regulation.

Various contact boundary disturbances have been identified and the researcher will now address some of these: namely deflection, desensitization, introjection, projection, retroflection and confluence.

2.6.7.1. DEFLECTION

Deflection means ignoring or turning away either an internal stimulus or one from the environment, in order to prevent full recognition or awareness (Joyce & Sills, 2001:116). In other words, reducing awareness with the environment by for instance avoiding eye contact during a conversation or changing the subject. Clarkson (2004:60) explains that a person who habitually deflects does not use his or her energy in an effective way in order to get feedback from self, others or the environment. According to Blom (2004:36-37), deflection can manifest itself in children in various ways, in order to protect themselves against emotional pain. Children use deflection as a handling strategy for painful experiences by having outbursts of anger or other forms of reactionary behaviour or by fantasizing and daydreaming. Children making use of deflection as a contact boundary disturbance are often vulnerable and responsive in respect of their emotions and not able to understand or control them.

2.6.7.2. DESENSITISATION

According to Clarkson (2004:60), in desensitization the neurotic avoids experiencing himself/herself or the environment and is where sensations and feelings of the self are diluted, disregarded or even neglected. Blom (2004:37-38) explains that this contact boundary disturbance can be regarded as the process whereby children exclude themselves from sensory and physical experience related to aspects such as pain and discomfort. An example of a form of desensitization is where a child who is exposed to physical abuse for a long period of time does not feel the pain of the beating any more. Desensitization implies that children do not have sensory or physical contact with themselves. They are often not capable of emotional contact making because they can not distinguish the physical experiences from the emotional. Although desensitization is sometimes necessary, it can in the long term negatively influence children's

awareness of their experience and emotions, and thus also their healthy organismic self-regulation.

2.6.7.3. INTROJECTION

Introjection is a process whereby an opinion, an attitude or an instruction is unquestioningly taken in from the environment as if it were true. An introjection is not properly analyzed, digested or assimilated and is effectively a foreign body taken in and kept. (Joyce & Sills, 2001:125.) Introjection occurs in children when they take in contents from their environment without criticism and awareness. Children therefore sacrifice their own opinion and beliefs and accept the point of view of others, without questioning it (Blom, 2004:32).

Blom (2004:32) believes that introjects can negatively influence children's self-awareness in that from a young age they get the message that certain emotions are negative and may not be experienced or expressed. Environmental influences such as the way parents discipline their children can also cause introjection. Blom further explains that introjects interfere with children's natural organismic self-regulation and lead to the development of unfinished business.

2.6.7.4. PROJECTION

Perls (in Clarkson, 2004:62) defines projection as a trait, attitude, feeling, or bit of behaviour which actually belongs to your own personality but is not experienced as such. Instead it is attributed to objects or persons in the environment and then experienced as directed toward you by them instead of the other way around. Blom (2004:33) explains that projection implies that children do not accept responsibility for their own emotions or behaviour but hold others responsible for these. An example of this could be that a child justifies his or her aggressive

behaviour by blaming his/her parents' divorce for this. By means of projection, children deny their own personal experience. The child attempts to get rid of his/her own fantasized introjects and does not take responsibility for that which is projected.

However projection can also be used in a constructive way. Hardy (in Blom, 2004:34) adds that during Gestalt therapy an attempt is made to help the client to own that which he/she projects onto others, in order to enhance his/her awareness of his/her self-identity and to promote contact with the environment in a self-nurturing manner. Projective techniques during Gestalt play therapy can contribute to children owning their own projection. This can positively influence their awareness of needs on their foreground and healthy organismic self-regulation.

2.6.7.5. RETROFLECTION

A person is said to retroflect when they hold back their impulse to take action. Their energetic flow is interrupted and can have several outcomes. The withheld impulse may die away naturally. However, if the process is repeated frequently or if the impulse contains strong energy, suppressing it can lead to the energy being turned inwards toward the self. This can lead to bodily tensions, somatic illnesses, depression or even self-harm. (Joyce & Sills, 2001:114.)

According to Clarkson (2004:63), people learn to retroflect when their feelings and thoughts are not validated in their families of origin or when they are punished for the expression of their natural impulses. Children in particular tend to retroflect when their emotions and thoughts are not considered valuable by their primary caregivers or when they are punished for expressing natural impulses. Clarkson (in Blom, 2004:36) explains that anger in particular is an emotion which is often retroflected, since the child learns from an early age

learns that expressing anger is prohibited. Retroflection can sometimes be to the advantage of children, such as when a response in a specific situation is suppressed because it can be disadvantageous to them or contradict social norms.

2.6.7.6. CONFLUENCE

Clarkson (2004:65) defines confluence as the condition where organism and environment are not differentiated from each other. An example is when two individuals merge with one another's beliefs, attitudes or feelings without recognizing the boundaries between them and the ways in which they are different. Children who make use of confluence do not have a boundary that separates the 'I' from the 'not I', in other words, the self from the environment. Oaklander (in Blom, 2004:35) is of the opinion that the child who discloses confluence has a poor sense of self. These children usually act as pleasers in that they are prepared to do anything that is expected of them. It is important that children with confluence as a contact boundary disturbance must be helped during Gestalt play therapy to show resistance. Furthermore these children should be assisted to develop a strong sense of self.

2.6.8. POLARITIES

According to the Gestalt theory, the personality consists of polarities and a large part of daily life is devoted to solving conflicts arising from these polarities. Polarities can be considered as opposites that complement or oppose each other. Various forms of polarization can occur, such as polarities in respect of emotions, traits of self or traits of others. Conflict between polarities can often manifest itself within children and maintaining the antipole with which children

identify absorbs a large amount of energy and can lead to fragmentation of the children's holistic entity. (Bolm, 2004:41.)

Thompson and Rudolph (in Blom, 2004:41) define the aim of Gestalt play therapy as integrating polarities in order to allow children to function better and to ensure that each part of the polarity finds its place in a well-integrated personality. From the Gestalt play theoretical approach, the focus should be to guide the children towards awareness of polarities within themselves and their lives so that they may integrate them by making choices regarding how to handle them and take responsibility for them.

2.6.9. RESPONSIBILITY

Gestalt philosophy proposes that individuals are active in the choosing and organizing of their lives and reality (Mackewn, 1997:124). Mature people are able to take existential responsibility for themselves, for many aspects of their life and above all, for the meaning they give to their life. This implies that every moment the individual makes a choice to act, or not to act, in certain ways, and that he/she is responsible for all these choices (Clarkson, 2004:29). Gestalt therapy emphasizes that both the client and the therapist are responsible for themselves. Children often do not come to therapy out of their own free will. Therefore one of the first tasks of the therapist is to guide children from no responsibility to self-determination (Blom, 2004:58).

2.6.10. RESISTANCE

Resistance has been seen as the client's unconscious ambivalence about the therapeutic process, about his/her own wish for change and/or the therapist (Mackewn, 1997:169). According to Blom (2004:59-61) resistance is considered

a normal and essential aspect during the Gestalt play therapeutic process. This can be regarded as the manifestation of energy and is also an indication of the contact level of the child. Although the repeated incidence of resistance during the therapeutic process should be considered normal, high levels of continuous resistance in the child will normally have a negative influence on contact making between the therapist and the child. There are various ways that resistance can manifest during the therapeutic process and should be considered an essential part of the child's growth. The therapist should be sensitive to the way in which resistance manifests in order to react to it in an appropriate way.

2.7. OBJECTIVES OF GESTALT PLAY THERAPY

Gestalt therapy is viewed as a process therapy during which attention is paid to the 'what' and 'how', rather than the 'why' of behaviour (Blom, 2004:51). Gestalt therapists believe that people potentially have all the necessary abilities to solve their problems or face their difficulties (Joyce & Sills, 2001:7). However, sometimes people get stuck and need some assistance.

According to Blom (2004:51) the aim of Gestalt play therapy with children is to make them aware of their own process. One of the central objectives of Gestalt play therapy is to enhance children's awareness in order to promote their ability to live in the here and now. Gestalt play therapy thus focuses on enhancing children's awareness of their own process, rather than on analyzing why specific behaviour manifests in children. An important goal of Gestalt play therapy is for children to become more aware of their emotions, how each emotion feels in their body, what each emotion means and how they can use and express them in direct and appropriate ways. Carroll and Oaklander (1997:193) believe a child in therapy usually has restricted his/her emotional expression, which can lead to the onset and maintenance of troubling symptoms. Helping children to feel this

energy from a solid place within them and to be comfortable with it is a prerequisite for the expression of suppressed emotions.

Blom (2004:52) states other important objectives are to teach them to be self-supporting by accepting responsibility for themselves and to facilitate the achievement of personal integration. Self-support as an objective of Gestalt play therapy implies that children are guided to take more responsibility for themselves and for satisfying their own needs, as well as making relevant choices in respect of satisfying their needs. The Gestalt play therapist will establish how children support themselves in solving problems and will facilitate problem solving by means of self-regulation and self-support. During Gestalt play therapy, children should be guided to know, understand and accept themselves and their needs in order to exercise responsible choices in respect to satisfying their needs in accordance with their age. Awareness of needs, self-knowledge and self-acceptance and the ability to exercise choices and to take responsibility for these are also regarded as important skills which children should master regarding their emotional intelligence.

Another objective of Gestalt play therapy is integration. Thompson and Rudolph (in Blom, 2004:54) explain that the aim of integration is to assist children to function more systematically and holistically in order to pay their full attention to the relevant satisfaction of their needs. Integration as an objective of Gestalt play therapy requires that children, as a holistic entity, must be helped to integrate their cognition, emotions, body and senses in order to complete unfinished business on their foreground. Integration and maturity are continuous processes that are directly related to the individual's awareness in the here and now. Integration can be regarded as the completion of an unfinished business to form a new entity. If children's functioning is integrated, their needs can be satisfied more easily. These aspects form the main objectives of Gestalt play therapy and are addressed simultaneously during the therapeutic process. (Blom, 2004:53-54.)

2.8. THE THERAPEUTIC RELATIONSHIP

Clarkson (2004:19) believes the most essential aspect of Gestalt play therapy is the therapeutic relationship. Gestalt practitioners affirm the primary values of the living existential encounter between two real human beings, both of whom are risking themselves in the dialogue of the healing process. Landreth (in Blom, 2004:54) explains that building the therapeutic relationship starts with what the child sees and observes in the therapist and depends on the therapist's sensitivity in respect of that which the child experiences at that specific moment.

According to Nelson-Jones (2001:124) all Gestalt therapists regard the therapeutic relationship as a 'working' rather than a 'talking' relationship. In this working relationship, both the therapists and clients are self-responsible. Therapists are responsible for the quality of their presence and self-awareness, their knowledge and skills in relating to the client and for maintaining an open and non-defensive stance. While clients are responsible for their commitment to working to become more in charge of their lives through developing greater self-awareness. Blom (2004:58) explains that from the Gestalt perspective, the therapeutic relationship rests on the fact that both the child and the therapist must accept responsibility for their own experiences, choices and behaviour. Deliberate attention should be paid to this when building the therapeutic relationship with children, as they often do not go for therapy out of their own choice. When children's parents take them for therapy, they can experience that others make a choice for them and this can have a negative influence on them taking responsibility for themselves.

Schoeman (2005:121-123) states that the therapeutic relationship is a horizontal one, where the therapist and the client both speak the same language and the direct experience of each is highlighted. According to the Gestalt approach, the healing process does not occur as a result of the therapist's interpretation of the client's symptoms, thereby giving the client insight into his/her symptoms, but

rather as a result of the relationship built between the therapist and the client. Dialogue and the creation of boundaries in the therapeutic relationship, amongst other things, fosters effective communication and respect, which are important for well being. Because a relationship is built, the therapist is able to become sensitive to verbal as well as non-verbal communication.

Schoeman (2005:135) believes that the therapist-client relationship develops from a process of contact, which is characterized by a dialogic attitude. This attitude involves full inclusion and confirmation of the client by the therapist, honest and authentic presence on behalf of the therapist, a lack of exploitation of the client and a commitment to allow the process to unfold without interference. Clients generally enter therapy due to an estrangement in their relationship with their world. The therapist would act as facilitator in helping the client become integrated once again through the process of therapy, wherein the client can ultimately become aware, responsible and can accept him/herself as they actually are. This can only happen if there is a safe therapeutic relationship.

2.9. SUMMARY

Chapter two consisted of a conceptual framework. The researcher focused on existing literature on aggression relevant to the context of this study and Gestalt play therapy. Various forms of aggression displayed by children of the middle-childhood years and the development of this aggression were addressed. The researcher also distinguished between children displaying aggressive behaviour in a therapeutic setting and the concept of aggressive energy. As this study focuses on results from a Gestalt perspective, various Gestalt concepts including the therapeutic relationship between Gestalt play therapist and the child were examined.

The following chapter will focus on the results of the empirical study. In this chapter the research process is addressed. It also looks at how the data was collected and analyzed as well as including a literature control based on the findings of this research.

CHAPTER THREE

RESEARCH FINDINGS AND LITERATURE CONTROL

3.1. INTRODUCTION

In Chapter Two the researcher provided a conceptual framework where basic concepts relevant to this study were explored. The purpose of this conceptual framework was to provide the reader with a basic understanding of some of the concepts relevant to the research findings. Now that the reader has a basic understanding of the key concepts relevant to this study, the focus will shift to the empirical research that was undertaken during this study.

Patton (in De Vos, 2005*b*:334) points out that analysts have an obligation to monitor and report their procedures. This means that they must observe their own processes, and analyze and report on the analytical process. Chapter Three will focus on the research process, addressing how the data was collected and analyzed in this study. The focus will then turn to a literature control based on the findings of this study.

3.2. AIM AND OBJECTIVES OF RESEARCH

The aim of this study was to explore how Gestalt play therapists handle and treat aggression in therapy. In order to achieve this aim certain objectives needed to be addressed. For the purpose of this chapter the following objectives were applied:

⇒ To analyze the data received from the empirical study and then conduct a literature control where existing literature was compared to the data obtained in this study.

3.3. RESEARCH PROCESS

In the following section an overview of the research process that was followed will be described.

3.3.1. RESEARCH AND WORK PROCEDURE

The identification and selection of a researchable topic was completed prior to the commencement of the empirical research. Motivation and rationale for this topic were discussed in Chapter One of this report. For the purpose of this study the researcher also developed the following research question: How do Gestalt play therapists handle and treat aggression in therapy?

The research followed a qualitative approach of an exploratory and descriptive nature. This study aimed to explore and describe the experiences of respondents, namely Gestalt play therapists focusing on how they handle and treat aggression in therapy. A conceptual framework was conducted to gain information and explore central concepts to this study namely, aggression and Gestalt Play therapy. This information was documented in Chapter Two of this report. The conceptual framework provided serves the basic function of explanation and understanding of the concepts explored in the empirical study.

3.3.2. DESCRIPTION OF UNIVERSE, SAMPLE AND SAMPLING TECHNIQUE

For the purpose of this study the universe referred to all Gestalt play therapists working with children in South Africa and the population referred to the Gestalt play therapists working with children in the Western Cape. Once the universe and population were identified the sampling technique needed to be developed.

The researcher identified a definite purpose for this study prior to commencing with the investigation. Therefore the researcher used non-probability, purposive sampling. A sample was selected from this population based on the aim of the research. In other words, the sample was drawn from the population on the grounds of specific criteria. These criteria included:

⇒ The Gestalt play therapist must have been practicing in the Western Cape.
⇒ The Gestalt play therapist must have had experience in dealing with aggression in children of middle-childhood age in a therapeutic setting.
⇒ The Gestalt play therapist must have been willing to participate in this study.

Seven Gestalt therapists were approached and interviewed during this study. The researcher interviewed until saturation point was reached. All respondents who participated in this study were female.

3.3.3. METHOD OF DATA COLLECTION

As previously stated, the qualitative approach was found to be the most suitable for this type of research. As the researcher aimed to explore how Gestalt play therapists handle and treat aggression in a therapeutic setting, unstructured interviews were used to gain this information. When using unstructured interviews the researcher prepared two or three main questions with which to begin and guide the conversation. These predetermined questions aimed to

explore how the Gestalt play therapist being interviewed handles and treats aggression in a therapeutic setting.

For the purpose of this study the researcher interviewed seven Gestalt play therapists working with children in the Western Cape who have experience treating aggression in children of middle-childhood age in a therapeutic setting. By asking relevant open-ended questions in these interviews, the researcher explored how these therapists handle and treat aggression in a therapeutic setting. The questions inquired how the Gestalt play therapist handles aggression displayed by children in a therapeutic setting and what techniques or methods are implemented to work through and treat this aggression.

The time spent on each interview varied between thirty to forty-five minutes per respondent. These interviews were done telephonically, recorded and transcribed. For the purpose of transcribing the interviews, a voice recorder was used. All respondents were made aware of this and consent forms were signed. The respondents were also informed via e-mail of the aim of the research and what was required of them in order for the respondents to be able to make an informed decision as to whether or not they were willing to participate. Copies of the letter and the consent form have been attached as part of the research report in the form of Appendix 1 and 2 respectively.

3.3.4. INTERVIEWING SCHEDULE

Unstructured interviews were conducted with the respondents over a period of three weeks. One telephonic interview was conducted with each respondent with the interviews taking approximately thirty to forty five minutes. The researcher arranged an appointment with the respondent for when it would be most convenient for the Gestalt therapist to be interviewed. The researcher found this beneficial as the respondent could choose the best setting and time to be

interviewed in order to ensure privacy and limit distractions. All interview schedules and contact details were arranged via e-mail as the researcher was living overseas when this study was undertaken.

The questions used by the researcher during these interviews served mainly as a guide. Where necessary the researcher would use clarifying questions relating to the response given by the respondent.

3.3.5. METHOD OF DATA ANALYSIS

Once the interviews had been conducted they were transcribed and analyzed. This involved reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data revealed (De Vos, 2005*b*:333). The data was then divided into themes, categories and patterns and from these findings a comparison was made with existing literature. This in-depth study will aim to support research findings with existing literature and to further explore these themes.

The results of the empirical study as well as the literature control will be provided in the following section.

3.4. EMPIRICAL DATA

The research report is structured so that all the main themes are listed and if relevant, followed by sub-themes. The main themes were identified by analyzing and coding the data. The main themes were based on information provided by the respondents that related to the aim of the study. In saying this, main themes included relevant data collected that addressed how to handle and treat

aggression in therapy from a Gestalt perspective. The data that was found relevant to these themes were then provided in transcribed form. The themes were then explored and compared to existing literature.

The main themes regarding how Gestalt play therapists handle and treat aggression in therapy are listed as follows:

- Setting boundaries/limits in the playroom.
- Promoting the child's emotional awareness.
- Establishing a good therapeutic relationship with the child.
- Staying with the child's process during therapy.
- Encouraging the child to take responsibility for his/her emotions and behaviour.
- Exploring appropriate alternatives with the child.
- Involving the parents as part of the child's therapy.

All themes will be discussed in the following section. The themes are not discussed in order of priority or importance. The verbal responses from the respondents regarding the themes will be provided first and will then be compared to existing literature.

3.4.1. Main theme One: Setting boundaries/limits in the playroom

Following are the verbal responses of the therapists with regard to setting boundaries and limits in the playroom when handling aggression in therapy.

- **Respondent A**

"I have got boundaries when it comes to working with aggression. I have got boundaries when working with any child. Children feel safer when there are boundaries and they know what is expected of them."

- **Respondent B**

"And obviously in the playroom there are boundaries and there are rules. I think without being rude you just need to show the children that good behaviour will be rewarded and bad behaviour will have consequences."

- **Respondent C**

"In the playroom I have boundaries. We are a multidisciplinary team working with these children so when the children start displaying difficult behaviour we will all get together and set boundaries together and then everyone needs to keep the same boundaries."

- **Respondent D**

"I basically tell them that they are free to express themselves but they must be aware of the limits like not to hurt me, themselves or break anything in the playroom. It is very important to have boundaries when working with children, especially with aggressive children."

- **Respondent E**

"I do have boundaries but I don't set boundaries or limits in the beginning of therapy. I don't do that. I feel many children are so anxious already that I first try to build up a relationship with them and if we do get to the point where they start to cross the boundaries I will just mention it to them that they are allowed to play rough with the toys but they are not allowed to break them. If the moment allows for it then I will bring in the rules. My boundaries in terms of aggressive behaviour are that they are not allowed to hurt the therapist, hurt themselves or break things in the playroom. It is very seldom necessary to tell them the rules. I find they might be aggressive in the playground or at home but they are not normally like that when they are with me."

- **Respondent F**

"My only limit or boundary is that we don't hurt each other. If I see a child is getting too rough with a toy then I will also tell them that there is a rule in the playroom that we don't break things. But I only bring these boundaries up if I feel it is necessary."

- **Respondent G**

"Before we start I will always tell the child that I have three rules. You are not allowed to hurt yourself, you not allowed to hurt me and you are not allowed to break something that is of value. I also tell the child that those don't only apply to my office but apply to outside the office like at home or school. Those are universal rules that I want them to understand. Otherwise they will do well in the playroom but the moment they step out of the playroom they will behave inappropriately, like hitting their brother or sister or kicking the cat or breaking the rosebushes in the garden. So that is why those rules need to apply to my playroom as well as outside."

From the responses it was evident that all Gestalt play therapists felt that limits or boundaries were necessary at some point during the therapeutic process. Some therapists felt stronger than others about the importance of and appropriate time concerning the implementation of these limits and boundaries but all agreed that they were none the less important to the therapeutic process especially when handling aggression.

James (1977:44) states that most child therapists seem to agree that reasonable and consistent limits are necessary in play therapy, however there are differences in opinion about the specific limits required in therapy. For example, Dorfman (in James, 1977:45) is quite conservative in the setting of limits emphasizing that the therapist should set no limits on the child's verbal expression of feelings and suggests that the setting of limits involve directing the child's physical expression of feelings into acceptable channels. Dorfman further

differentiates between playroom limits and those outside the playroom in suggesting that the playroom limits are fewer and that there is an acceptance of the child's need to break these limits.

James (1977:44-46) explains that therapists such as Bixler and Ginott stress that limits are an integral part of the process, while Axline and Moustakas insist that the setting of limits allows the process to occur and adds unique dimensions to the play therapy relationship. Although Dorfman believes in setting very few limits when working with children, Dorfman agrees limits are beneficial to the therapeutic process because they lend structure to the situation and reduce its anxiety-inducing potential. By setting limits they increase predictability of the situation and add to the security of the client and therapist. (James, 1977:44-46.)

According to McNeil *et al.* (2006:177) it is best to establish clear, strict boundaries early on otherwise if the child is allowed to engage in any minor problematic behaviours during the first sessions, these behaviours will continue throughout the sessions and become larger issues. McNeil *et al.* also believe that rules should typically be reviewed at the beginning of each session as a reminder to the child and that by establishing rules this clearly indicates to the child what is acceptable versus unacceptable behaviour.

According to O'Connor and Braverman (1997:24) limits are not set until they are needed. Providing a long list of prohibited activities at the beginning of the first session would certainly not encourage or facilitate exploration and expression by the child. At the point that children are emotionally involved there is a greater opportunity for significant learning.

O'Connor and Braverman (1997:24) advise that when limits are needed the therapist should be firm and matter-of-fact so the child will not feel punished. The limits should be minimal, specific and total rather than conditional and enforceable. When limit setting becomes necessary, the child's desire to break

the limit is always the primary focus of attention because the child-centred play therapist is dealing with intrinsic variables related to motivation, perception of self, independence, need for acceptance, and the working out of a relationship with a significant person.

3.4.1.1. Sub theme One: Boundaries/limits promote a therapeutic relationship and safety within the playroom

Moustakas (in James, 1977:45) contends that one of the most important aspects of the therapeutic relationship is the setting of boundaries. The limits for a child define his/her boundaries within the relationship and tie the relationship to reality. They remind a child of his/her responsibility to him/herself, to the therapist, and to the playroom. This offers the child security and at the same time permits him/her to move freely and safely within the playroom. Blom (2004:62) agrees by stating that boundaries provide a structure for the development of the therapeutic relationship, which contributes to the experience of physical and emotional security in the child. This positively promotes the child's sense of self.

Bixler (in James, 1977:48) suggests that the most effective rules to use in the establishment of limits are those which feel comfortable to the individual therapist. He indicates that most therapists use limits and that these limits are essential. A few therapists limit some verbal behaviour in children but almost all limit the range of nonverbal activity. They allow the therapist to maintain his/her accepting attitude toward the child. The provision of limits also helps to differentiate this relationship from others which the child has known and so allows the relationship to develop on a level of integrity.

According to O'Connor and Braverman (1997:24) the purpose for setting limits can be summarized as follows: (1) Limits define the boundaries of the therapeutic relationship; (2) limits provide security and safety for the child, both physically and emotionally; (3) limits demonstrate the therapist's intent to provide safety for

the child; (4) limits anchor the session to reality; (5) limits allow the therapist to maintain a positive and accepting attitude toward the child; (6) limits allow the child to express negative feelings without causing harm, and the subsequent fear of retaliation; (7) limits offer stability and consistency; (8) limits promote and enhance the child's sense of self-responsibility and self-control; (9) limits protect the play therapy room; and (10) limits provide for the maintenance of legal, ethical and professional standards.

3.4.1.2. Sub theme Two: Boundaries/limits should be flexible according to the child's needs

According to Johnson and Chuck (in Landreth, 2001:242) limit setting is an area of particular concern when working with aggressive acting-out children. The physical safety of the child, therapist and the playroom must be protected through appropriate limit setting and through limit setting the therapist is able to preserve feelings of acceptance, empathy and positive regard for the aggressive acting–out child.

However, Landreth (in Landreth, 2001:242) explains it is imperative that the therapist be able to demonstrate a certain degree of tolerance and that the therapist's personal needs do not interfere with the child's needs to be messy or destructive. A goal of limit setting is to promote the child's release of aggression through symbolic expression rather than direct acting-out and when children are able to symbolically express their negative feelings they are freed from potential anxiety or guilt over actually harming someone or something. James (1977:45) agrees by stating that limits are important to the child in that they furnish him/her with a feeling of reality and allow him/her to function freely without taking chances on the stimulation of anxiety and guilt.

Bixler (in Landreth, 2001:242) maintained that the foundation for working with aggressive children lies in a strict adherence to limits on behaviour in conjunction

with an acceptance of the child's feelings that motivate the behaviour. It is important to note that while the therapist limits the child's undesirable behaviour, the therapist allows the child to express feelings through verbal and play outlets. In this way limits help strengthen the child's self-control as the child learns to differentiate between desires and actions.

James (1977:50) explains that many of the writers who have included sections on the use and value of limits in regard to the play therapy process have also discussed counsellor action in the event that the child refuses to accept the limit. Axline stresses the need to remain accepting of the child even when the limit is broken. Ginott suggests that when a child breaks a limit, the therapist must maintain a calm authority and must not be argumentative or verbose. There should be no opportunity for argument or manipulation to occur and the therapist must behave in a consistent manner to allow the child to feel secure in the ability of the therapist. Schoeman (2005:135) believes that when limits are broken the therapists should suggest an alternative action.

3.4.2. Main theme Two: Promote the child's emotional awareness

The second main theme addresses the importance of promoting the child's emotional awareness as part of the therapeutic process. The verbal responses of the therapists in relation to promoting emotional awareness during therapy are as follows:

- **Respondent A**

"…is very important for the therapist to help the child to be aware of what and why he is angry. In the second or third session I will do emotional awareness with the child."

- **Respondent C**

"I always make them aware of their situation by making the child aware of his emotions. I also encourage them to explore these emotions with me to make sure the child has a good understanding of what these different emotions mean."

- **Respondent D**

" …to help them acknowledge and make a connection with their aggression. I think just to do what you would do with any other child and that is to go through the process of helping the child become aware of what they are feeling and then to help them get in contact with those feelings. To explore the child's feelings."

- **Respondent E**

"When I start out working with a child, and I do it with all the children I see, it is quite important that I start out with emotional awareness activities. So if I am with a child and they start to express aggression then we will first acknowledge the anger and explore it…"

- **Respondent G**

"Underlying things will often make the child react in certain ways and this is usually because the child is frustrated or angry and these feelings need to be acknowledged and dealt with. It is important to understand that most children are not aware of why they react a certain way and that is why it is the therapist's job to make the child aware of his feelings by bringing him to the here and now. So to acknowledge the child's anger and to tell him it is okay for him to feel angry and aggressive. One should rather accept the child's aggression and say to the child I acknowledge what you are feeling and to rather explore those feelings more than to tell the child that what he is feeling is wrong."

From the following responses it is clear that all the therapists saw the exploration of emotions and the promotion of emotional awareness as a big part of helping the child to deal with his/her emotions. Respondents felt that this was especially

valuable when working with aggression in a therapeutic setting. Most therapists clearly stated that it was the first activity to do with the child in order to get a better understanding of where the child is emotionally and of his/her emotional intelligence before doing any other techniques in play therapy.

According to Blom (2004:53) promoting children's awareness as an objective of Gestalt play therapy implies that children are placed in full contact with themselves on cognitive, sensory and affective levels, but also with other people and their environment, that they know and accept themselves and that they take responsibility for their choices. O'Connor and Schaefer (1983:77) explain that awareness encompasses many aspects of life and of the individual and along with becoming aware of one's process, awareness of sensation, feelings, wants, needs, thought processes and actions strengthens one's sense of self and self-determination.

Schoeman (2005:123) further explains that the goal of Gestalt therapy, reached by means of the therapeutic relationship, is awareness and the ability to be self-regulating. The clients focus of this awareness is not the presenting problem but rather their awareness of themselves and their environment. This results in integration and wholeness. According to Clarkson (1989:79) one of the most important skills that a Gestalt client can acquire is to follow his/her own 'awareness continuum'. The awareness continuum in this context is meant to refer to the ever-changing consciousness of moment-by-moment changes within oneself and the environment.

3.4.2.1. Sub theme One: Encourage the experience and exploration of emotions through verbal communication with the child

O'Connor and Schaefer (1983:77) explain that experience is the key to awareness, especially when working with children. Providing varied experiences for children is an essential component of the therapeutic process. According to

Joyce and Sills (2001:29) as therapists, by reflecting back to the client what one is hearing, asking how he/she is feeling, by exploring his/her belief system with him/her, we invite him to listen to him/herself and also to bring his full awareness to bear on his/her experience and the way he makes sense of the world.

When working with aggressive children, respondents in this study placed emphasis on encouraging the child to become aware of not only his/her process, environment, thoughts and senses but also most importantly his/her emotions. Oaklander (1988:122) points out that it is important for children to talk about their emotions.

Schoeman (1996:171) believes the child who owns his/her anger can feel his/her emotions and is more in contact with him/herself than the child who continually tries to suppress the anger and assumes that no negative feelings exist. According to Fontana and Slack (in Blom, 2004:23) the more children are allowed to acknowledge and experience their emotions, and to gain insight into the fact that emotions are a natural part of human nature, the easier they will be able to learn skills to express their emotions in a healthy and socially acceptable manner.

Oaklander (1988:122) believes that when encouraging emotional awareness, talking about feelings is an important first step when working with children. Reading a book about feelings such as *Feelings inside You* and *Outloud Too* or *Grownups Cry Too* is a good way to begin talking about what people feel. There are games and exercises too that can be used to help children contact their own feelings. They need to know what kind of feelings there are, that everyone has feelings, that feelings can be expressed, shared and talked about. Children also need familiarity with the many variations of feelings to help them get in touch with what they are feeling.

Schoeman (1996:175-176) proposes getting the child to talk about the anger. If the negative energy level is very high it will be necessary to support the child to act the anger out and make him/her aware of what he/she is feeling and thinking, smelling and hearing. Schoeman states that it will sometimes be necessary to do some exercises and creative dramatics with the child. This can help the child to be more aware of his/her body. The purpose of sensory work is for the child to feel more in touch with the self.

Blom (2004:148) advises different techniques and activities to guide children to talk about emotions, before projective techniques are used to own and express their emotions and obtain handling strategies for these. Examples include making a collage of people in magazines that experience different emotions, making feelings masks or depicting different emotions by means of clay. Emotions can also be linked to colours in order to convey them more concretely to the child.

3.4.3. Main theme Three: Establish a good therapeutic relationship with the child

The verbal responses of the therapists with regard to establishing a good therapeutic relationship with the child are as follows:

- **Respondent A**

"The first few sessions I also just focus on building a strong therapeutic relationship with the child. The child needs to feel safe in therapy and then he will be more willing to open up and grow in the therapy. The child needs to trust me."

- **Respondent C**

"I think it is firstly very important for the therapist to have a good relationship with the child. Get the child to trust you. It is also important to explain to the child the reason for the therapy and what the child can expect in the sessions. To build a

good therapeutic relationship with the child before you start working with the child's emotions or problems."

- **Respondent D**

"When I can see the child trusts me and is more relaxed in the playroom then I know we can start working with deeper problems but there must be a good therapeutic relationship first."

- **Respondent E**

"It is very important for there to be a good therapeutic relationship before you start to work with the aggression in the child. I have made the mistake before of trying to work with the child's aggression before the child was ready and it was a big mistake. To this day I still feel guilty about it because I know I moved the child too fast. Our therapeutic relationship was not ready for it and after that he gave me so much resistance. He did not trust me enough yet and our relationship was not ready to move forward. Often in private practice there is a lot of pressure when parents can only afford a certain amount of sessions and feel you need to get everything done in a shorter period of time when the child is not ready for it."

- **Respondent F**

"In the beginning I just play with the child and build a good therapeutic relationship with the child. If this is not done then the therapy will not be a success."

- **Respondent G**

"So focus on building a good therapeutic relationship with the child until the child is ready to move on. Resistance or aggression can also be a part of a good therapeutic relationship because it is a part of the therapeutic process. It does not mean that you do not have a good relationship with the child. It is not about you but about what the child experiences in therapy. So it is normal for a child who has a good relationship with the therapist to still experience resistance or

aggression during therapy. But the child should feel safe to feel this with you because he knows you will not push him over the boundaries."

From the responses of the therapists it is evident that building a good therapeutic relationship is essential to the success of the therapy. It can also be noted that part of having a good therapeutic relationship is to ensure that the child trusts the therapist and that there is a good working relationship before exploring different emotions or projections with the child. Respondent E even provides an example of what can happen if the therapist moves too quickly and a good therapeutic relationship has not been established yet.

The researcher is of the opinion that from these responses one can say it will be more beneficial in the long run if the therapist first takes the time to establish a good therapeutic relationship with the child before addressing the aggression. It is only once the child has shown the therapist that there is trust and safety in the relationship that the therapist can begin to move on with what is on the child's foreground.

According to O'Connor and Braverman (1997:192) the most essential aspect of Gestalt play therapy is the therapeutic relationship. Blom (2004:54) maintains that the focus of the first few sessions during Gestalt therapy is mainly to build a therapeutic relationship. The therapeutic relationship is considered the most fundamental aspect of the therapeutic process and therapy without it is worthless.

O'Connor and Schaefer (1983:34) explain that in work with children, the relationship takes on great proportions, for it is the foundation of the therapeutic process. According to Landreth (in Blom, 2004:54) building the therapeutic relationship starts with what the child sees and observes in the therapist and depends on the therapist's sensitivity in respect of that which the child experiences at a specific moment.

Oaklander (in Blom, 2005:54-55) believes the development of the relationship and the child's ability for contact are prerequisites for further therapy. Blom (2004:54) explains that contact occurs during the therapeutic process between the child and the therapist by means of building an I-thou relationship. The I-thou relationship means a relationship where both the therapist and the client are equals, irrespective of aspects such as their age or education. This contributes to the child feeling comfortable in the presence of the therapist, despite the fact that the therapist is an adult. Schoeman (2005:124) maintains it is where two people interact with one another and are completely present, real and aware of each other in their interactions that an I-Thou relationship will flourish and change will take place.

Schoeman (2005:122-123) explains that because of the reciprocal nature of the therapeutic relationship, the client builds a relationship of trust with the therapist and feels safe to be vulnerable. This provides support for the client during the therapeutic process and fosters wholeness. Dialogue and the creation of boundaries in the therapeutic relationship, amongst other things foster effective communication and respect, which are important for well-being. Because a relationship is built, the therapist is able to become sensitive to verbal as well as non-verbal communication.

3.4.3.1. Sub theme One: The therapeutic relationship should provide security, acceptance and empowerment

Schoeman (2005:122) believes the client's feeling of safety within the therapeutic context is an essential element of a successful therapeutic encounter. According to Korb *et al.* (1989:80) some clients need a great deal of time to develop the sense of safety and the necessary trust in the therapist before being willing to risk attending to anything new. They may need more time to develop the necessary contact with the therapist and even more time to tolerate the

necessary contact with and trust in themselves. With these clients, the Gestalt therapist is present as an authentic self, responding with the support, validation, and love essential for the client's maturation.

Norton and Norton (1997:5) explain that by providing a secure relationship for the child, the therapist lays the foundation upon which the child may build his/her therapeutic issues, test them, watch them crumble, then rebuild them in such a way that he/she can understand, tolerate and accept them. In other words, as the therapist provides the relationship, the child begins to add content to his/her play. As the child does this, the therapist provides acceptance, warmth, comfort and empowerment through the relationship, and the two of them travel together on a journey through the child's travails toward resolution.

According to Joyce and Sills (2001:42) the working alliance starts with an offer from the therapist to help, support and communicate. Norton and Norton (1997:6) explain that given the support, protection, and freedom to direct their own play, the child will move directly toward the pain. Because the relationship with the therapist is providing acceptance and safety, children will play out the traumatic event and the healing process will begin. Schoeman (2005:122) agrees by stating that it is only once the clients can feel they are within a safe environment and with someone who has a genuine concern for them that they will feel secure enough to open up and allow true selves and true feelings to be revealed. When this occurs, positive growth can be experienced.

3.4.4. Main theme Four: Staying with the child's process during therapy

The verbal responses of the therapists with regard to staying with the child's process during therapy are as follows:

- **Respondent A**

"It is essential to stay with the child's process when choosing techniques or mediums. It all depends on the child and the child's process. Sometimes you get children that don't want to draw and other children love drawing. Sometimes I find that these children, they just want to talk. Then it is more through dialogue and I don't need to use mediums."

- **Respondent B**

"You really have to adapt as a therapist to the child's process and their developmental level when looking at techniques and mediums to use. The child needs to direct the therapy."

- **Respondent E**

"I think what I would say to other therapists is that it is important for the therapist to go with the child's process. That would be my best advice. Don't push the child and always be accepting towards their process. The playroom needs to be a safe place where the child can feel free to explore their emotions without getting into trouble or being told what to do all the time. The fact that you are giving the child an opportunity to really express themselves is very valuable so that would be my best advice."

"It is important to stay with the child's process and only explore aggression when they come up with the emotion themselves. Obviously you can't work with aggression or do the activities if the child is not angry at that moment. I have made the mistake before of trying to work with the child's aggression before the child was ready and it was a big mistake."

- **Respondent F**

"It is important for the therapist to be aware of the child's process when trying different mediums and techniques. For example, some children love to play where they can make a mess and other children are uncomfortable with that."

- **Respondent G**

"Working with Gestalt it is important that you keep with the child's process so should aggression come up you need to stay with the child's process and not let the child feel like he is doing wrong."

"Usually I stick with the child's process if he shows resistance. What I mean by that is that if a child shows resistance sometimes I will give them a ball with a bell in it that they can keep in their hand. And if they feel uncomfortable with something that I do or say, they can ring the bell. So then I know that the child is not comfortable with what I am doing now. Then I will stop what I am doing there and I will go back to a previous stage where I know it is not threatening for the child. So we will then play or do something so that the child can feel comfortable again. So the next time the child comes to therapy he knows that I will not go further than what he feels comfortable with doing. That builds trust in the therapeutic relationship and the child also knows that it is okay to say no and that I won't push him further. So that is a very effective technique. It is also important that the therapist does not feel bad if the child shows resistance because it shows that you have hit a nerve and that you are on the right track. It is just that maybe the child is not ready or does not have enough inner strength to face what ever he feels resistant about. It is important to not push the child towards what you want him to reveal and to stay with the child's process. Even if it takes a few sessions."

From the responses it is evident that the therapists feel strongly about staying with the child's process while working with aggression during therapy. In this way it is important that the therapist does not push the child to experience emotions or do activities that the child does not feel comfortable with. Most respondents also referred to staying with the child's process when looking at techniques and mediums to use with the child. Allow the child to choose activities that go with the child's way of doing things and mediums that he/she is comfortable with.

Schoeman (2005:155) believes in order to understand the child, it is essential to understand his/her process. As is universally understood each individual – and therefore each child – is unique and will consequently manifest his process in a unique manner. According to Blom (2004:83) a person’s process refers to the way they present themselves to the world and satisfy their needs.

Schoeman (2005:118-119) maintains that besides the developmental phase, expectation from school, parents and peers, each and every child has his/her own unique way of organizing the world. This unique way must be taken into consideration when working with the child. Blom (2004:145) explains that the way in which children express their emotions is related to their process and is often expressed in their behaviour rather than in their verbalization.

Schoeman (2005:156,162) maintains that different therapists have their own unique way of assessing the client’s process as a basis of therapy. To be able to explore the child’s process, the therapist must create an obstacle to be able to evaluate his/her modus operandi. The therapist must always discuss his/her own evaluation with the child to make sure the child accepts this part of his/her functioning.

3.4.4.1. Sub theme One: Allow the child to direct the flow of the therapy

According to Norton and Norton (1997:11,14) the astute therapist who understands the language of children will be receptive to the message that the child is communicating, have faith in the child’s knowledge of his/her own emotional needs, and allow the child to direct his/her own therapy. When a child is allowed to be the director of his/her own play, he/she will create an environment in such a way as to let the therapist know what it feels like to be this child and live in his/her world.

Axline (in Schoeman, 2005:134) further states that the therapist should not attempt to direct the child's actions or conversations in any manner. The child leads the way and the therapist follows. The therapist, therefore, would never hurry the therapeutic process but would accept that it is a gradual process. Rogers (in Schoeman, 2005:134) explains that in this way the Gestalt therapist respects the child's psychological readiness to disclose significant material.

3.4.4.2. Sub theme Two: The therapist must remain flexible within the therapeutic process

In order for the therapist to stay with the child's process, the therapist needs to be flexible within the therapeutic process. Korb *et al.* (1989:106) believes flexibility is the key element in the choice of strategy for any therapeutic situation. When a therapist depends on techniques as working tools, the coherence of the Gestalt approach will be missed. The therapist who is bound by a set of techniques has little choice in the therapeutic situation, the design of the technique controls the encounter instead of awareness of the client's experience as the operative factor.

Korb *et al*. (1989:106) explains that a therapist who follows a set of techniques is functioning in a closed system (ideas and thoughts) as opposed to an open system (organismic responses). The therapist who functions in an open system knows the formulas and is willing to abandon any structures in favour of observations of the moment-to-moment signals the client is giving about the on-going experience and in this way stays with the client's process.

When working with an aggressive child the therapist needs to allow the child to express his/her emotions according to his/her process and only when the child feels safe enough within the therapeutic relationship to explore these emotions and behaviour. O'Connor and Schaefer (1983:74) believe that the Gestalt therapist's purpose in focusing on those inappropriate behaviours in this stage of

the child's therapy is to provide the child with the opportunity to fully experience the self within his/her process.

3.4.5. Main theme Five: Encourage the child to take responsibility for his/her emotions and behaviour

The verbal responses of the therapists related to encouraging the child to take responsibility for his/her emotions and behaviour are as follows:

- **Respondent B**

"The child needs to take responsibility for their aggressive behaviour. Also the child needs to understand that as the child he will also have to take responsibility in this whole process because it is not only the therapist or parents that play an important role but the child too."

- **Respondent D**

"Basically the child also needs to take responsibility for the ways he reacts and expresses his emotions. They can decide how they want to react when angry but then they must take responsibility for how they act."

- **Respondent E**

"By cleaning up after themselves it also teaches them about responsibility. Teaching them to take responsibility for their actions and behaviour is important."
"The child needs to take responsibility for his part in the therapeutic process and to see he is also responsible for the outcome. This gives the child some control and empowers the child."

- **Respondent F**

"I think that it is an important part of the therapist's role to help the child practice self-control and to take responsibility for his actions."

- **Respondent G**

"The therapist needs to guide the child to take responsibility for his emotions and his behaviour so that he feels more in control of his life and actions. This encourages self-control."

The preceding responses clearly show that most of the respondents feel strongly about the child's need to take responsibility for his/her emotions and behaviour not only in the playroom but also in the other areas of the child's life. The therapists also state that the child needs to be aware of his/her responsibility in the therapeutic process and within the therapeutic relationship.

According to Clarkson (2004:29) the Gestalt approach is profoundly based on the notion that each person is responsible for the experience of his/her own life. Clarkson (1989:79) further explains that Gestalt is based on a fundamental assumption that people are responsible for their own feelings and behaviour as well as a philosophical commitment to the existential position which stresses the person's inalienable self-direction. According to Korb *et al.* (in Blom, 2004:53), taking responsibility for the self means being capable of reacting to expectations, wishes, fantasies and actions in the self and others.

Blom (2004:58) emphasizes that responsibility is considered an important component of the Gestalt therapy relationship. Children often do not come into therapy out of their own free will therefore one of the first tasks of therapists is to guide children from no responsibility to self-determination. Schoeman (2005:126) maintains it is important for clients to discover that they are responsible for themselves in the therapeutic relationship. According to Frankl (in Clarkson, 2004:29), even when we are not personally responsible for the circumstances in which we find ourselves (like a child in therapy), we are still responsible for the meaning we give to our lives as we choose our attitudes towards and our behaviour in such situations. Korb *et.al* (1989:150) agrees stating that part of the

work of the therapist is to help clients to be clear regarding the aspects of their experiences for which they are willing to take responsibility and to be aware of where the limits of personal responsibility are set.

Blom (2004:52) maintains that a therapeutic goal of Gestalt therapy is to teach children to accept more responsibility for themselves and to expect less support from the environment, in order to develop into adult persons. They therefore learn to accept increasingly more responsibility for their own existence and are capable of more realistic choices regarding their behaviour. Clarkson (1989:81) explains in Gestalt, clients are encouraged to experiment with constructing their experience verbally in ways that demonstrate that they are taking responsibility for it. To invite clients to change their language is to invite them into taking responsibility for themselves, not into following another set of instructions which are prescribed from the outside.

According to Korb *et al.* (1989:50) an implication of taking responsibility for one's own behaviour and feelings is that each person is also free to choose responses in any circumstance. Gestalt therapy emphasizes this freedom of the individual and therapists may seek ways of demonstrating to the client the personal freedom that always exists. Without a belief in such personal freedom, the individual typically becomes convinced that there is no way to change. With the awareness that each individual sets limits upon private and public behaviour, chooses what is done, describes whose influence is important and whose opinions are valid comes the awareness of the ways in which each individual sets limits and relinquishes personal freedom.

3.4.5.1. Sub theme One: Responsibility enhances self-control and empowers the child

Many of the respondents stated that by encouraging the child to take responsibility for his/her emotions and behaviour, the therapist also encourages

the child to have more self-control and even empowers the child. Landreth (2002:137) believes the development of self-control grows out of the interaction between the child's responsibility to make decisions, to choose without adult interference or guidance, and his/her redirection of unacceptable behaviours into controlled, acceptable avenues.

In this way the therapist needs to encourage the child to take responsibility for his/her actions and behaviour, even in the playroom in order to give them a sense of control and empowerment. According to Landreth (2002:24) there are many experiences in childhood in which children feel they have little or no control. Play is children's way of working out balance and control in their lives for as children play they are in control of the happenings in play, although it may not be possible to actually be in control of the life experience represented in the play. It is the sense or feeling of control rather than the actual control that is essential to children's emotional development and positive mental health.

Self-control empowers a child and Schoeman (1996:173) explains that in reality, power means that a child is allowed to take responsibility for his/her own life, to make decisions concerning his/her own functioning, without harming him/herself or any one els. Power also means that a child is allowed to negotiate about his/her situation and to take action after properly thinking things through. In this way self-control enables an angry child to take responsibility for his/her emotions and empowers the child to make an educated decision concerning what to do or how to react to these emotions. Schoeman (1996:180-181) maintains that empowerment can only occur when the relationship between the therapist and the child is so supportive that the child can take responsibility for him/herself. Through empowerment a child must get a feeling of power, he/she must get the feeling that he/she is in control of his/her anger.

According to Blom (2004:62) boundaries and limitations during the play therapy session can contribute to giving the child the opportunity to make choices and

take responsibility for these choices. This aspect, together with the fact that boundaries promote self-control, can indirectly contribute to the child's skills for emotional control.

3.4.6. Main theme Six: Exploring appropriate alternatives with the child

The verbal responses with regard to exploring appropriate alternatives with the child during therapy are as follows:

- **Respondent A**

" It is important that after you have acknowledged the anger and the child has had a chance to explore the emotion and get rid of some of the anger and frustration that the therapist looks at appropriate alternatives with the child."

- **Respondent B**

"When getting ready to look at alternatives the first thing I do is explain that everyone does get angry. That is normal but how you express that anger makes it right or wrong. And then we will look at certain things like alternatives to the inappropriate behaviour that they are allowed to do when they do get angry. Like if I have got balloons in the playroom, depending on the age of the child, I will say ok blow that anger into the balloon and then you externalize their anger and then you can tell the child to play with it now that it is out of you and then burst it. I could also use paper and I will hold a piece of paper and they can hit the paper and then we can throw the paper and all the anger away. These are ways that the child can get rid of his anger without getting into trouble."

"Another good technique that the child can use as a safe alternative is the traffic light. I will explain to them that when you get angry you should think of a traffic light, the red tells you to stop, the orange tells you to think about your options. What are my options? I can kick this boy now or I can just walk away or I can go and tell my mom that he has just hit me and what will the consequences be of

every behaviour? If I kick him I will get into trouble and probably get a hiding from my parents. If I walk away I will still feel angry and how do I get rid of this anger? What are my options? I can go kick a wall or I can talk to someone and I won't get into trouble. And the green light is when you choose a reaction and do it. So the red light is stop and the yellow light is your options and the green light is when you choose. You are also trying to teach the child not to react immediately to anger but first to think of the options and the consequences and then to choose the best one. You will try and help the child look for appropriate ways to deal with his anger."

- **Respondent C**

"When looking at alternatives with the child I will often teach them and let them practice relaxation exercises."

"When exploring alternatives I often do role-play with the children and we discuss different types of behaviour. Looking at the correct behaviour to use in different situations through role-play where the child gets to exercise these behaviours during role-play in therapy. I also videotape the child sometimes so they can see themselves and how they react. When the child sees the inappropriate reaction they are usually motivated to try new appropriate behaviours."

"I usually encourage the child to step away from the problem and first think about the best reaction before just reacting immediately. I try to also teach the child to empower themselves in order to make the right decisions and think of better alternatives when becoming aggressive."

- **Respondent D**

"It is important to help the child find alternatives to his inappropriate behaviour. I try giving the child specific tasks and safe ways to express this anger. For example, using clay or hitting and tearing up newspaper. Basically giving them permission to express their anger in a safe and suitable environment as well as helping them to acknowledge and make a connection with their aggression and express it in suitable ways."

"Another technique I use when exploring alternatives with aggressive children is, um, I use a story sometimes where there are aggressive animals in the story and then I ask the child if he can relate to the animals and how he thinks the animals may feel or what they should do when they feel angry. This helps the therapist to explore different alternatives with the child."

- **Respondent E**

"When finding alternatives for the child to use, the therapist needs to make suggestions and do activities that the child can do or use at home as well. For example, what I will do with newspaper is to let the child draw big circles on the newspaper. The child then uses his whole arm in this activity. The scribbling will also make them quite tired and get the same effect. Another activity is to take egg boxes and cut them in half and then the child can hit the egg boxes with a toy hammer."

"So once we have clarified then we will look at techniques and alternatives. Then basically this is when I feel it is best to look at alternatives. Handling aggression and your feelings is part of the alternatives and once you can get the anger out of the way we can move on."

"I allow them to come up with the alternatives themselves because it must be an alternative that will work for them. It must be an alternative that they will want to use and be able to use in their environment. I always ask them what they think they should do which is hard for most children. The older children who are 9, 10 and older come up with amazing solutions but the younger children struggle sometimes. I will try to help them a bit by making suggestions, but I will not give them the solutions. I will make suggestions and then usually they will come up with their own solutions. It is important to make sure that they come up with a few alternatives so they have an idea of various alternatives to use in different situations."

- **Respondent F**

"The child needs to stop and think of alternatives before just acting-out or becoming aggressive in a situation that he has the skills to control. When children get too worked up I ask them to stop and calm down for a second and think about what he is feeling and how to control his feelings. This works better with older children, like 10 and up."

- **Respondent G**

"Then I will say lets think of things you can do when you are at home that you can do when you feel like you felt today. To look at safe alternatives for the child to do at home when he feels angry and aggressive."

From the responses of the therapists it is evident that therapy would not be effective if the child is not given the opportunity to explore appropriate alternatives as a way of correcting aggressive, inappropriate behaviour. Finding suitable alternatives is the key to the child realizing that he/she can have control over how he/she reacts to feelings of anger or frustration.

Oaklander (1988: 122) believes children need to learn that they can make choices about ways of expressing feelings. These choices can be seen as alternatives or solutions to inappropriate behaviour and an important phase of the child's therapy. Schoeman (2005:177) states that according to the child's process the therapist and child should discuss alternatives as solutions.

Schoeman (1996:178) maintains that children can be helped to express their feelings and verbalize what they need to say to the person with whom they are angry. Enactment is a valuable technique to motivate the child to put his/her feelings or thoughts into action. There are many ways of helping the child to express his/her feelings. He can do it through creative play, namely sandwork, clay work or drawings.

3.4.6.1. Sub theme One: The therapist should guide the child into finding his or her own alternatives

Schoeman (2005:177) believes it is not the therapist's role to give the child advice but to guide the child into finding his/her own alternatives and solutions to the problem. At this stage the child can make choices and decisions with regard to his/her future. The therapist is only a guide and a facilitator in this process. Responsibility needs to be taken by the child and it is often necessary for the child to own his/her emotions once again.

According to Schoeman (2005:177), by working in confluence with the child, the pace is determined by the child. By intimating obstacles into the alternatives or by using polarities, the child is able to think of sound alternatives to his/her problem. Therefore, the therapist needs to make it possible for the child to realize that polarities exist and that they are acceptable. By acknowledging this aspect, the child can learn to assimilate polarities into alternatives.

Schoeman (2005:177-178) explains that the therapist can also look at the past, present and future while working with alternatives. The child can look at how he/she used to deal with this, how he/she deals with it now and how he/she could deal with it in the future. Once all the alternatives have been discussed the child needs to choose for which alternatives he/she will take responsibility. If the child is not able to choose yet, the therapist must go through all the alternatives again and for each one ask the child whether or not he/she thinks that it is possible for one of these to be the alternative. In this way the therapist helps the child to make the decision but he/she still does it on his own.

According to Schoeman (2005:178) once the alternative is chosen, it may be necessary for the child to experience this before actually doing it. The therapist could allow a role-play or use the empty chair technique to get the child to

experience the alternative in reality, therefore making it easier for him/her to take responsibility for the alternative.

3.4.7. Main theme Seven: Involve the parents as part of the child's therapy

The verbal responses of the therapists with regard to involving the parents as a part of the child's therapy are as follows:

- **Respondent A**

"And then also to get the parents involved. The parents need to be involved because if the child gets angry at home the parents need to work on it in the home environment. They actually need to work with you. In my work most of the child's problems and aggressive behaviour can be helped if the parents are willing to work on it but they are not. If they are not willing to give their cooperation and really make the changes, then it is really difficult to see long-term success if the parents are not willing to give their cooperation."

"I normally tell the parents to discuss feelings with their children first of all. The happy, the sad, the frustrated and so on on a daily basis. Discuss it with their children so they can get the opportunity to discuss feelings with their parents. And also if they know that their parents also feel angry and sad sometimes and that it is alright to express it. And then I tell the parents to do active things with the children. Play swing-ball or kick a pillow or shout into pillows or I sometimes have these pool-noodles that I cut in half and I almost let them have fights with these pool-noodles with their parents. Um, just so as soon as the parent realizes that the child is getting angry to acknowledge that anger and then to help the child express it in a positive way rather than the child hitting his brother or sister or kicking the dog or whatever."

- **Respondent B**

"If there are problems with aggression then I will get the parents involved and give them some techniques they can use at home."

"I will also recommend that parents do things at home and I explain to them that there are different ways that the child can express their anger. They can either exercise or we can identify certain people they can talk to when they feel angry. I have also got boxing gloves in my playroom and parents can also buy them and have them at home because they are only about R20. And also obviously if they express their anger in inappropriate ways at home, there needs to be consequences like with any other behaviour like time out, so that they learn. And also if the parents see that they are expressing their anger in appropriate ways they should be rewarded for it. It is very important that the parents should also parent their child in the appropriate way. I think it is very important that not only the child should be responsible but also the parents in expressing their anger. Because I think the parents are the role models and if the parents do express it in inappropriate ways then I think the child might also do that."

- **Respondent C**

"I try to get the parents involved as much as possible. I think a thorough assessment of the parents will also help with your therapy with the child"

"We encourage them to do a lot of physical things with the children. We usually explain to the parents what we do with the children and explain how they can do these things at home with the children."

- **Respondent D**

"It is then the therapist's role to help the parents understand their child's behaviour and if the behaviour is inappropriate to explain to the parents ways they can teach their children to express emotions appropriately."

"…helping the parents to acknowledge and accept their child's emotions and also for the parents to acknowledge their own emotions."

“Yes, I do give the parents guidelines to help their children to express their emotions safely. Giving them practical ways and setting up a plan to help the children to express their emotions in appropriate and practical ways at home and at school.”

- **Respondent E**

“As soon as you get the parents involved and the parents start helping the child understand their emotions better you will already see an improvement in the child’s reactions.“

“Often after I have done the emotional awareness activities with the children I will discuss it with the parents. I will talk to the parents about using more emotional language with their children because often it is difficult for the child to understand why they are feeling a certain way.”

“I also recommend to the parents certain techniques the children can use at home like shouting into a pillow or punching their pillows at home. Also by having their parents reinforce what the child is feeling by acknowledging the child’s emotions it can help the child understand what they are feeling. A good way for the parents to do this is to watch children’s videos with their child. There is always someone getting angry or being happy or sad in these shows. By watching it with their children the parents can identify with their children the different emotions the characters portray. By asking your child questions about why they think the character is sad, happy or angry and asking your child what the character can do when they feel like that, you are also exploring alternatives with the child. Encourage the parents to start having discussions about different emotions with their children. It is very important. It is also so important that the parent acknowledges the child’s different emotions. Children need that acknowledgement instead of only being told that they should not feel that way or not act that way. So getting the parents to acknowledge their child’s emotions is important. As a therapist I will also encourage the parents to read books on different emotions and activities to do with their children.”

- **Respondent F**

"And to involve the parents as much as possible. I think it is very important to include the parents in the child's therapy."

"I also encourage the parents to help their child take responsibility for their emotions and the actions that they take because of those emotions. Parents should also talk about their own emotions with their children so that the child can know that it is normal to feel different emotions. For me I think the most important thing is that the parents support their children and try to be understanding about what the child is going through. I always tell the parents to read the book "*How to talk so your kids will listen and listen so your kids will talk"* written by Adele Faber and Elaine Mazlish."

- **Respondent G**

"The parents should be seen as co-therapists and that is why it is important to work well with the parents and keep in contact with them. You only see the child for about half an hour every week and the rest of the time they are with their parents so it is very important that they get involved in the therapy."

"Before I see a child I first have a session with the parents just to get their idea of what the problem is. That usually takes an hour or two just to get a thorough idea of their experience of the child and what they think the problem is. Then I will give the parents information on what therapy is all about so that they can tell the child about it and explain to the child why they are coming to me. They can also explain to the child some of the things they can expect in the playroom and talk about the kinds of things we will do. After every session I usually have a five to ten minute feedback time with the parents."

"After every fourth session I will have an hour feedback session with the parents giving them information on what I have picked up and what is my plan. Also giving the parents tasks to do at home with the child so that when they come back after every session I will ask them if they tried things and what worked and what did not work. Especially with the aggressive child you will sometimes have that the children will hit the parents or break things in the house and the parents

need to keep disciplining the child. A lot of parents feel sorry for the child so they won't discipline them, but discipline is very important with these children. Discipline and structure are very important when working with aggressive children."

"Discipline and routine at home are very important. You will find that not many households have a constant routine and it is very important for the child to feel safe in a routine that he knows. Making parents aware of how different parenting skills can affect a child. I also try to get the parents to implement a reward system at home where the child is rewarded for positive behaviour. I also try to get the parents to focus on how to make the child feel good about themselves. It is very important because many parents work fulltime and don't have a lot of time to spend with their children and many children feel unloved or misunderstood and that will come out as frustration or as aggressive behaviour. It is very important for parents to make special time for the child, like before the child goes to bed to read him stories or talk to him about his day. Spend some time with their children. I also recommend that they have family meetings where they can all talk about what everyone thinks or feels about how things happen around the house. Parents need to encourage communication with their children. Usually when you speak to parents in the first session you can already identify certain aspects about the child's lifestyle at home and what are the hassles or troubles at home concerning the family dynamics or the child."

It is clear from these responses that the therapists felt strongly about including the parents as a part of the child's therapy. According to the respondents, parents should be seen as the co-therapists and should be encouraged to explore certain techniques in the home environment. Positive behaviour needs to be reinforced outside of the playroom and a safe environment needs to be created in order for the child to be able to reflect and test what he/she has learnt. The child's parents play an important role in this part of the child's therapy.

Most of the major theorists in the area of child therapy have included their views on the importance of working with parents as they work with the children. Hambridge (in James, 1977:104-105) stresses the importance of involving the parents so that they will be able to assist in the treatment process. Carroll and Oaklander (1997:194) explain that a fundamental tenet of Gestalt therapy is that behaviour is a function of the field of which it is a part. In order to understand a child's behaviour or symptoms, the therapist must begin with the situation as a whole and not exclude any part of it including the child's parents.

Anna Freud emphasized the value of involving the parents of the children whom she saw from the very beginning. She obtained an intensive, detailed case history of the child from the parents. Solomon recommends working with parents whenever possible, especially as it is reflected in the handling of the child. According to Axline, the therapy may even move faster if the parents were involved in counselling or therapy themselves. (James, 1977:104-105.)

One of the strongest findings to emerge from the study of childhood aggression is the significant role that parents play in the development of aggressive behaviour (Cavell, 2000:13). Several parenting variables have been examined including parent's effectiveness as disciplinarians, their tendency to be overly punitive or emotionally rejecting of children, their level of warmth and positive involvement, their ability to monitor children's whereabouts, and the level of stability and organization they create in their home. From these findings it is evident that the therapeutic process would benefit from not only working with the child but also involving the parents and encouraging certain changes in the home environment in order to see optimal results.

McNeil *et al.* (2006:169) believe that parents are the key to accomplishing goals in a short time because they can support the therapist's efforts outside the therapy hour. Parents can also speed up the therapeutic process by providing the therapist with essential knowledge concerning the child. James (1977:104)

maintains parents can be sources of valuable information in that they can give the therapist another view of the activities of the home.

3.4.7.1. Sub theme One: Ways to get the parents involved in the child's therapy

According to McNeil *et al.* (2006:169), parents can be incorporated into the child's therapy in three ways. Firstly by structuring time so that the therapist can check in and out with the parents in each session, secondly by giving the parents weekly homework assignments to support the therapy goals, thirdly and by coaching the parents to use play therapy skills at home to accomplish such goals as enhancing the parent-child relationship and improving the child's self esteem.

Throughout the course of therapy, increasing involvement from the parents should be encouraged. McNeil *et al.* (2006:179) believe parents should be taught to be "cotherapists" by teaching parents valuable skills in order to improve their relationship with the child, empower them to become more independent of the therapist, and enhance generalizations of treatment gains. Essentially there should be a transfer of dependence and responsibility from the therapist-child relationship to the longer-term and more primary parent-child relationship.

There are many ways that therapists can encourage parents to be involved in their child's therapy. According to McNeil *et al.* (2006:176) one effective method is to give the parents homework assignments specific to the child's session with the therapist. If the therapy session involved helping the child express anger through acceptable channels, the homework assignment for the parent might be for the parent to prompt and reinforce appropriate ways of expressing anger, such as scribbling on a piece of paper really hard or writing an angry letter and tearing it up. Similarly, if the child's therapy involved prompting the child to recognize accomplishments, the homework assigned to the parents might include having the child keep a chart of things he/she did well each day.

Another method of involving the parents could be to suggest that they implement a special playtime with their child. McNeil *et al.* (20006:180) maintain that special playtime goals should be established and individualized for the family. These goals may include increasing the child's self-esteem, decreasing anger, improving social skills, developing constructive play skills, strengthening family relationships and using words to communicate feelings. When conducting special playtime, parents can be asked to avoid using commands, criticisms and questions. Instead, they are encouraged to use skills such as praise, reflection, imitation, description and enthusiasm.

Parents can be taught that a key component for managing behaviour and making special playtime a high-quality, positive time is the use of attention. Parents should provide a lot of positive attention to the child when he or she is engaging in appropriate behaviours and to ignore the child when he or she is engaging in inappropriate behaviour during playtime. Parents should also be instructed on how to handle misbehaviour during play. (McNeil *et al.*, 2006:181.)

3.5. SUMMARY

Chapter Three focused on the research process, addressing how the data was collected and analyzed in this study. The experience, knowledge and insight of the Gestalt play therapists interviewed during this study served as a valuable means of data collection. The data collected was explored further and a literature control was done.

Chapter Four will include the conclusions based on the findings and will provide guidelines for therapists on how to handle aggression in therapy from a Gestalt perspective.

CHAPTER FOUR

CONCLUSION, SUMMARY AND RECOMMENDATIONS

4.1. INTRODUCTION

Chapter Three focused on the research process, addressing how the data was collected and analyzed in this study. Seven main themes concerning how respondents handle and treat aggression displayed by children in a therapeutic setting were identified and explored by comparing the results to existing literature.

The aim of the final chapter is to determine whether the research question has been answered and to make conclusions and recommendations in the form of guidelines. In the following section the research question will be repeated as well as the aim and objectives of this study. To ensure that the study achieved the aim, the researcher will re-examine the aim and objectives in order to evaluate whether these were met during this study. A summary of each chapter will then be provided followed by the conclusions drawn from the study. Lastly recommendations or guidelines that the researcher has formulated will be provided, which will equip therapists with the knowledge on how to handle and treat aggression in therapy from a Gestalt perspective.

4.2. RESEARCH QUESTION

The identification and selection of a researchable topic was completed prior to commencing with the empirical research. For the purpose of this study the researcher developed the following research question: How do Gestalt play

therapists handle and treat aggression in therapy? As a result the research followed a qualitative approach of an exploratory and descriptive nature.

4.3. EVALUATION OF MEETING THE AIM AND OBJECTIVES

The aim of this study was described in Chapter One. To ensure that the study achieved this aim, it is necessary to re-examine the aim and the objectives of this study.

4.3.1. AIM

The aim of this study was to explore how Gestalt play therapists handle and treat aggression in therapy.

This aim was achieved by conducting unstructured, telephonic interviews with seven Gestalt play therapists that have experience treating aggression in a therapeutic setting. These unstructured interviews took place over a period of three weeks and specifically focused on ways to handle and treat aggression in therapy from a Gestalt perspective. The experience, knowledge and insight of the Gestalt play therapists interviewed during this study served as a valuable means of data collection. The data collected was further explored and a literature control was conducted comparing the data to existing literature.

4.3.2. OBJECTIVES

To be able to achieve the aim of this study certain objectives had to be reached. In the following section the researcher will list the objectives of the study and describe how each objective was met.

4.3.2.1. Objective 1

- To provide a conceptual framework describing aggression within the context of this study and discussing Gestalt play therapy and the significance of the therapeutic relationship.

Chapter Two consisted of a conceptual framework, which satisfied the meeting of this objective. The researcher focused on existing literature on aggression and Gestalt play therapy relevant to the context of this study. The researcher focused on various forms of aggression displayed by children of the middle-childhood years as well as the development of this aggression. The researcher also focused on children displaying aggressive behaviour in a therapeutic setting. As this study focused on results from a Gestalt perspective, various Gestalt concepts including the therapeutic relationship between the Gestalt play therapist and the child were examined. Chapter Two met the first objective of this study and served the function of providing the reader with a basic understanding of some of the concepts relevant to the research findings and in this way formed a basis for the following objective, namely to conduct an empirical study.

4.3.2.2. Objective 2

- To conduct an empirical study by means of unstructured, telephonic interviews to explore how Gestalt play therapists handle and treat aggression in therapy.

The empirical study, of which Chapter Three was comprised, was successfully concluded and the second objective of this study was reached. Unstructured interviews were conducted with seven Gestalt play therapists working with children in the Western Cape who have experience treating aggression in children of middle-childhood age in a therapeutic setting. By asking relevant open-ended questions in these interviews, the researcher explored how the

Gestalt play therapist handles aggression displayed by children in a therapeutic setting and what techniques or methods are implemented to work through and treat this aggression. The time spent on each interview varied between thirty to forty-five minutes per respondent and these interviews were done telephonically, recorded and transcribed.

4.3.2.3. Objective 3

- To analyze the data received by the empirical study and then conduct a literature control where existing literature was compared to the data obtained in this study.

After the completion of all the interviews the data was analyzed. This involved reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data revealed. Through analyzing the data obtained from the interviews exploring how Gestalt play therapists handle and treat aggression in therapy, seven main themes were identified and were as follows:

⇒ Setting boundaries/limits in the playroom.
⇒ Promoting the child's emotional awareness.
⇒ Establishing a good therapeutic relationship with the child.
⇒ Staying with the child's process during therapy.
⇒ Encouraging the child to take responsibility for his/her emotions and behaviour.
⇒ Exploring appropriate alternatives with the child.
⇒ Involving the parents as part of the child's therapy.

In some cases sub-themes were identified and discussed as a part of Chapter Three. By conducting the interviews, transcribing and analyzing the data obtained from the interviews and identifying these main themes from the data

concerning how Gestalt play therapists handle and treat aggression in therapy, the third objective of this study was achieved.

4.3.2.4. Objective 4

- To provide a summary and conclusion based on the research findings and formulate recommendations on how Gestalt play therapists can handle and treat aggression in therapy.

The last objective will be achieved in this chapter when the conclusion and recommendations in the form of guidelines for therapists on how to handle and treat aggression in therapy from a Gestalt perspective are made. It can therefore be validated that the aim and objectives of this study were reached.

4.4. SUMMARY OF THE CHAPTERS OF THIS REPORT

In the following section a summary of the chapters presented in this research report will be provided.

4.4.1. Chapter One: Introduction to research

Chapter One gives an overview of what this study is about. A discussion of the choice of topic, problem formulation, aims and objectives of the research were included. The research question as well as the procedure and method were also discussed in this chapter.

4.4.2. Chapter Two: Conceptual framework

In Chapter Two the researcher provided a conceptual framework where basic concepts relevant to this study were explored. The purpose of this conceptual

framework was to provide the reader with a basic understanding of some of the concepts relevant to the research findings.

The researcher focused on existing literature on aggression relevant to the context of this study and Gestalt play therapy. Various forms of aggression displayed by children of the middle-childhood years and the development of this aggression were addressed. The researcher also distinguished between children displaying aggressive behaviour in a therapeutic setting and the concept, aggressive energy. As this study focuses on results from a Gestalt perspective, various Gestalt concepts including the therapeutic relationship between the Gestalt play therapist and the child were examined.

4.4.3. Chapter Three: Research findings and literature control

Chapter Three focused on the research process, addressing how the data was collected and analyzed in this study. Seven main themes were identified during the analysis of this data. The data collected was then further explored by conducting a literature control where research findings were compared to existing literature.

In the following section the researcher will discuss these themes collected in Chapter Three. These become the conclusions to this empirical study and then form guidelines with the aim of providing therapists with recommendations on how to handle aggression in therapy from a Gestalt perspective.

4.5. CONCLUSIONS

The following conclusions were made regarding how to handle and treat aggression in therapy from a Gestalt perspective, based on the findings following

the empirical research. These results can therefore not be generalized to all play therapists working from a Gestalt perspective.

- Make use of limits and boundaries as a way of handling and treating aggression in therapy. Some therapists felt stronger than others about the importance of and appropriate time concerning the implementation of these limits and boundaries but all agreed that they were none the less important to the therapeutic process when working with aggression in therapy.

- Limits and boundaries promote the therapeutic relationship and safety within the playroom. By setting specific limits/boundaries within the playroom it will promote the therapeutic relationship as well as provide the child with a sense of security and safety within the therapeutic environment.

- The limits and boundaries should be flexible in accordance the child's needs. When working with an aggressive child it is important that the therapist remains flexible when setting limits or boundaries according to the specific child's needs and the therapist's goals regarding the handling and treating of aggression in therapy.

- The exploration of emotions and the promotion of emotional awareness are seen as a big part of helping the child to deal with his/her emotions. Most therapists clearly stated that it was the first activity to do with the child in order to get a better understanding of where the child is emotionally and of his/her emotional intelligence before doing any other techniques in play therapy.

- Encourage the experience and exploration of emotions through verbal communication with the child. The benefits of encouraging the child to explore and express his/her anger verbally while being in a secure and supportive environment were emphasized.

- Building a good therapeutic relationship is essential to the success of the therapy. It can also be noted that part of the rationale for having a good therapeutic relationship is to ensure that the child trusts the therapist and that there is a good working relationship before exploring different emotions or projections with the child.

- The therapeutic relationship should provide security, acceptance and empowerment. The importance of establishing a good relationship with the child and ensuring that the relationship provides the child with security, acceptance and a feeling of empowerment before testing the therapeutic relationship in any way were emphasized. This also ensures that the therapist is putting the child's needs and process first.

- Staying with the child's process during therapy. It is important that the therapist does not push the child to experience emotions or engage in activities that the child does not feel comfortable with. It is also essential to stay with the child's process when looking at techniques and mediums to use with the child during therapy. Allow the child to choose activities that are in keeping with the child's way of doing things and mediums that he/she is comfortable with. No particular technique or medium is noted as being the most effective when working with aggression in therapy, as it is mainly the specific child and the child's process that will determine which technique or medium is most effective. This again proves how important it is for the therapist to remain with the child's process during therapy.

- In stating this, emphasis is placed on allowing the child to direct the flow of the therapy and the therapist to remain flexible within the therapeutic process. It is important that the child is able to express aggression and explore this emotion as he/she feels comfortable.

- Encourage the child to take responsibility for his/her emotions and behaviour. The child needs to take responsibility for his/her emotions and behaviour not only in the playroom but also in the other areas of the child's life. The child needs to be made aware of his/her responsibility in the therapeutic process as well as within the therapeutic relationship.

- By encouraging the child to take responsibility for his/her emotions and behaviour, the therapist also encourages the child to have more self-control and even empowers the child.

- Exploring appropriate alternatives with the child was noted as an essential part of the therapeutic process. Therapy would not be effective if the child is not given the opportunity to explore appropriate alternatives as a way of correcting aggressive, inappropriate behaviour. Finding suitable alternatives is the key to the child realizing that he can have control over how he/she reacts to feelings of anger or frustration.

- It is essential that the therapist merely guides the child to find his/her own alternatives so that the child is encouraged to come up with alternatives that will work for him/her. This also enhances the child's feelings of self-control and empowers the child to take appropriate action regarding his/her frustrations and aggression.

- Include the parents as a part of the child's therapy. Parents should be seen as the co-therapists and should be encouraged to explore certain techniques in the home environment. Positive behaviour needs to be reinforced outside of the playroom and a safe environment needs to be created in order for the child to be able to reflect and test what he/she has learnt. The child's parents play an important role in this part of the child's therapy.

4.6. GUIDELINES FOR THERAPISTS

In the next section the researcher wishes to make recommendations in the form of guidelines for therapists on how to handle and treat aggression in therapy from a Gestalt perspective. These guidelines have been based on recommendations made by the Gestalt play therapists who participated in this research as well as existing literature that was consulted during this study. The guidelines are as follows:

- Therapists should make use of limits and boundaries when working with aggression in therapy. It should be up to the therapist as to when to implement these limits/boundaries and how to do it in accordance with the therapist's style or therapeutic process, but setting these limits/boundaries should be seen as an important part of the therapeutic process when working with aggression in therapy.

- Implement limits and boundaries as a way to promote the therapeutic relationship and safety within the playroom. The therapist should be firm when implementing these limits and boundaries and ensure that the child has a good understanding of what they mean. This will allow the child the opportunity to express his/her aggression in a safe and accepting environment.

- When implementing these limits/boundaries allow them to be flexible in accordance with the child's needs. In other words the therapist should be aware of the child's needs and in this way be flexible when introducing the limits and boundaries. Be aware that every child is different and will adjust differently to specific limits/boundaries so it is important to be flexible in this regard.

- Promote the child's emotional awareness as part of the initial evaluation regarding the child's emotional intelligence and well being. A child can not explore and deal with his/her emotions unless he/she is aware of what he/she is feeling so it is up to the therapist to encourage emotional awareness and to explore these emotions with the child. This can be achieved through various Gestalt techniques and mediums.

- Encourage the experience and exploration of emotions through verbal communication with the child. By encouraging the child to explore and express his/her anger verbally while being in a secure and supportive environment, the therapist allows the child to become more aware of emotions and to experience his/her anger in a therapeutic environment. This will allow better insight into the child's emotions and process.

- Establish a good therapeutic relationship with the child. This includes allowing the child to test boundaries and become familiar with the therapeutic environment. The child needs to understand that he/she can trust the therapist and feel safe within the therapeutic setting. It is essential to ensure a good therapeutic relationship before working on projections or problems that the child may experience. A good therapeutic relationship can be achieved through various activities including activities that promote the child's emotional and sensory awareness, self-esteem and self-control.

- Before addressing aggression in therapy, establish a good therapeutic relationship that provides the child with security, acceptance and a feeling of empowerment. It is essential that the therapist does not test the relationship or guide the therapy in any direction before the goals for the therapeutic relationship have been attained.

- In order to ensure a good therapeutic relationship is maintained the therapist should stay with the child's process during therapy. This implies that the child

will guide the therapy and not be pushed to do or explore emotions he/she is not ready to deal with. A child will show resistance if he/she feels he/she is being pushed to do things he/she is not comfortable with and will begin to doubt one's intentions as a therapist.

- When the child is ready to deal with what is on his/her foreground, the child will let it surface as a part of the therapy hour. The therapist should therefore stay with the child's process and allow the child to direct the therapy and chose the pace. If the therapist senses that the child is uncomfortable with a certain activity or technique, allow the child to choose a new activity or give the child the space and time to feel comfortable with the activity before moving on.

- By staying with the child's process it is important to be flexible within the therapeutic process. Ensure that the child is comfortable and sets the therapeutic pace. This may require of the therapist to be patient and set aside his/her own process in order to stay with the child's foreground.

- Encourage the child to take responsibility for his/her aggressive emotions and behaviour. It is important through the exploration of boundaries and activities that the child is encouraged to take responsibility and have a sense of what the consequences are when not being responsible or taking responsibility for these emotions.

- As part of the therapy it is important to promote the child's self-esteem and self-control and by encouraging responsibility these goals will be achieved. This can be encouraged by asking the child to clean up at the end of a therapy session or simply by exploring responsible alternatives with the child concerning aggressive behaviour.

- Explore appropriate alternatives with the child. It is essential as part of the child's therapy that the therapist explore appropriate alternatives to the child's aggression together with the child and to practice these alternatives in the therapeutic session to ensure the child can do them and understands these alternatives.

- Ensure that the alternatives are realistic for the child and an alternative that the child is willing to try. The child should be encouraged to be the one to come up with the alternatives and should be praised when doing this. This will encourage a strong sense of control and empower the child while also giving the child the encouragement to be able to make these changes in his/her behaviour.

- Involve the parents as part of the child's therapy. As previously stated in this report, the parents should be seen as the co-therapists. Parents should be encouraged to be a part of the child's therapy and to initiate change in the home environment in order to support what is established in the therapy session. The therapist is encouraged to maintain a relationship with the parents and ensure that the parents are involved in the implementation and support of the therapeutic process.

4.7. LIMITATIONS OF THE STUDY

A limitation of this study was that no children were approached or interviewed concerning this topic. The researcher is of the opinion that their input regarding what they felt was effective and ineffective in therapy could be extremely valuable to this study. Other limitations include the loss of non-verbal data when using telephonic interviews and not having a broader sample of Gestalt Play therapists outside of the Western Cape.

4.8. RECOMMENDATIONS FOR FURTHER RESEARCH

The researcher recommends that further research be done concerning aggression in therapy and how or what the best ways to handle and treat aggression in therapy are. Related studies could possibly focus on children in other developmental stages dealing with aggression or compare other psychological interventions in handling aggression in therapy with the Gestalt guidelines recommended in this study. The researcher is also of the opinion that therapists would benefit from further studies regarding how parents handle aggression at home.

4.9. SUMMARY

Whether a child has been referred to a therapist for aggressive behaviour in the home or school environment or aggressive behaviour simply surfaces during therapy, certain guidelines and techniques can be used from the Gestalt perspective to ensure the therapist is able to handle and treat this aggression. Although research has been conducted exploring aggression in children how it develops and types of aggression displayed by children the researcher felt there was a lack of information on how to handle and treat this aggression in a therapeutic setting.

The research indicated that there are many techniques and ways established from the Gestalt perspective that can serve as a guide when working with aggression in therapy and these have formed the guidelines of this chapter. The aim of this research was to formulate guidelines and suggest various child friendly techniques and mediums that may help the therapist in handling aggression in therapy.

REFERENCE LIST

Babbie, E. & Mouton, J. 2001. The practice of social research. Cape Town, Oxford University Press.

Baron, R.A. & Byrne, D. 2000. Social Psychology. 9th ed. USA: Allyn and Bacon.

Berk, L.E. 2006. Child development. 7th ed. USA: Pearson Education, Inc.

Bestbier, A.M. 2005. The effect of music on the aggressive primary school child from a Gestalt play therapy perspective. Unpublished M.A. dissertation. University of South Africa.

Blom, R. 2004. Handbook of Gestalt therapy. Practical guidelines for child therapists. Bloemfontein: R Blom

Bloomquist, M.L. 2006. Skills training for children with behavior problems: revised edition: a parent and practitioner guidebook. New York: The Guilford Press.

Bloomquist, M.L. & Schnell, S. V. 2002. Helping children with aggression and conduct problems. New York: The Guilford Press.

Borsten, G.F. 1978. Aggression and levels of moral development. Unpublished M.A. dissertation. Rand Afrikaans University.

Carroll, F. & Oaklander, V. 1997. In O'Connor, K.J. & Braverman, L.M. 1997. Play therapy. Theory and practice: a comparative presentation. New York: John Wiley and sons Inc.

Cain, D.J. & Seeman, J. 2002. Humanistic Psychotherapies: Handbook of research and practice. Washington, DC: American Psychological Association.

Cavell, T.A. 2000. Working with parents of aggressive children: A practitioner's guide. The American psychological association, Washington DC.

Clarkson, P. 1989. Gestalt counseling in action. London: SAGE Publications Ltd.

Clarkson, P. 2004. Gestalt counseling in action. 3rd ed. London: SAGE Publications Ltd.

Connor, D.F. 2002. Aggression and antisocial behavior in children and adolescents: Research and treatment. New York: The Guilford Press.

Crenshaw, D.A. & Mordock, J.B. 2005*a*. A handbook of play therapy with aggressive children. USA: Jason Aronson.

Crenshaw, D.A. & Mordock, J.B. 2005*b*. Understanding and treating the aggression of children. USA: Jason Aronson.

De Vos, A.S. 2005*a*. Scientific theory and professional research. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2005. Research at Grass Roots. For the Social Sciences and Human Service Professions. Pretoria: Van Schaik.

De Vos, A.S. 2005*b*. Qualitative data analysis and interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2005. Research at Grass Roots. For the Social Sciences and Human Service Professions. Pretoria: Van Schaik.

De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2005. Research at Grass Roots. For the Social Sciences and Human Service Professions. Pretoria: Van Schaik.

Du Plooy, A.S. 1985. Aggression as symptom of a child's learning problems. Unpublished M.A. dissertation. University of Potchefstroom.

Fernbacher, S. 2005. Cultural influences and considerations in gestalt therapy. In Woldt, A.L. & Toman, S.M. 2005. Gestalt therapy: history, theory and practice. London: SAGE Publications, Inc.

Fouché, C.B. 2005. Qualitative research designs. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2005. Research at Grass Roots. For the Social Sciences and Human Service Professions. Pretoria: Van Schaik.

Fouché, C.B. & Delport, C.S.L. 2005. Introduction to the research process. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2005. Research at Grass Roots. For the Social Sciences and Human Service Professions. Pretoria: Van Schaik.

Fouché, C.B. & De Vos, A.S. 2005. Problem formulation. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2005. Research at Grass Roots. For the Social Sciences and Human Service Professions. Pretoria: Van Schaik.

Graziano, A.M. & Raulin, M.L. 2004. Research methods: a process of inquiry, 5th ed. Boston: Allyn & Bacon.

Greef, M. 2005. Information collection: Interviewing. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2005. Research at Grass Roots. For the Social Sciences and Human Service Professions. Pretoria: Van Schaik.

Harris, M. & Butterworth, G. 2002. Developmental psychology: a student's handbook. Psychology Press Ltd.

Houston, G. 2003. Brief Gestalt therapy. London: SAGE Publications.

Huston, A.C. & Ripke, M.N. 2006. Developmental contexts in Middle childhood: Bridges to adolescence and adulthood. New York: Cambridge University Press.

James, D.O. 1977. Play Therapy: An overview. DABOR Science Publications: New York.

Johnson, S.P. & Chuck, P. 2001. Play therapy with aggressive acting-out children. In Landreth, G.L. 2001. Innovations in play therapy: Issues, process and special populations. USA: Taylor & Francis: Brunner-Routledge.

Joyce, P & Sills, C. 2001. Skills in Gestalt counselling and psychotherapy. London: SAGE Publications.

Korb, M.P., Gorrell, J. & Van de Riet, V. 1989. Gestalt therapy: Practice and theory. 2nd Ed. USA. Pergamon Press, Inc.

Krahé, B. 2001. The social psychology of aggression. USA: Psychology Press Ltd.

Krug, E., Dahlberg, L., Mercy, J.A., Zwi, A.B., & Lozano, R. 2002. World report on violence and health. Geneva: WHO.

Landreth, G.L. 2001. Innovations in play therapy: Issues, process and special populations. USA: Taylor & Francis: Brunner-Routledge.

Landreth, G.L. 2002. Play therapy: The art of the relationship. 2nd ed. USA: Taylor & Francis: Brunner-Routledge.

Landreth, G.L., Sweeney, D.S., Ray, D.C., Homeyer, L.E. & Glover, G.J. 2005. Play therapy interventions with children's problems: Case studies with DSM-IV-TR diagnosis. 2nd ed. USA: Rowman & Littlefield Publishers, Inc.

Louw, D.A. & Edwards, D.J.A. 1997. Psychology: An introduction for students in Southern Africa, 2nd ed. Heinemann Higher and Further Education Ltd.

Mackewn, J. 1997. Developing Gestalt counselling. London: SAGE Publications.

Mash, E.J. & Wolfe, D.A. 2002. Abnormal child Psychology. 2nd ed. Wadsworth Group.

McNeil, C.B., Bahl, A.B. & Herschell, A.D. 2006. Involving and empowering parents in short-term therapy for disruptive children. In Kaduson, H.G. & Schaefer, C.E. 2006. Short-term Play therapy for children. 2nd Ed. The Guilford Press: New York.

Melnick, J. & Nevis, S.M. 2005. Gestalt therapy methodology. In Woldt, A.L. & Toman, S.M. 2005. Gestalt therapy: history, theory and practice. London: SAGE Publications, Inc.

Moeller, T.G. 2001. Youth aggression Violence: A psychological approach. London: SAGE Publications, Inc.

Mouton, J. 1996. Understanding social research. Pretoria: Van Schaik.

Nelson-Jones, R. 2001. Theory and practice of counselling and therapy. 3rd ed. New York: Continuum.

Norton, C.C. & Norton, B.E. 1997. Reaching children through play therapy: An experiential approach. The publishing Cooperative: Denver.

Oaklander, V. 1988. Windows to our children. New York: Gestalt Journal.

O'Connor, K.J. & Braverman, L.M. 1997. Play therapy. Theory and practice: a comparative presentation. New York: John Wiley and sons Inc.

O'Connor, K.J. & Schaefer, C.E. 1983. Handbook of play therapy. Volume Two: Advances and Innovations. New York: John Wiley and sons Inc.

Papalia, D.E., Olds, S.W. & Feldman, R.D. 1999. A child's world: Infancy through adolescence. USA: The McGraw-Hill Companies, Inc.

Phangela, B.A. 1993. An investigation into social perspective-taking of aggressive children. Unpublished M.A. dissertation. University of Natal.

Popplestone, J.A. & McPherson, M.W. 1988. Dictionary of concepts in general psychology. USA: Greenwood Press.

Punch, K.F. 2006. Developing effective research proposals. 2nd ed. London: SAGE Publications Ltd.

Reid, J. 2003. A narrative deconstruction of aggression in children. Unpublished M.A. dissertation. Potchefstroom University for CHE.

Sadock, B.J. & Sadock, V.A. 2003. Synopsis of psychiatry: Behavioral sciences/clinical psychiatry. 9th ed. USA: Lippincott Williams & Wilkins.

Schoeman, J.P. 1996. Handling aggression in children. In Schoeman, J.P. & Van der Merwe, M. 1996. Entering the child's world: A play therapy approach. Pretoria: Kagiso Publishers.

Schoeman, J.P. & Van der Merwe, M. 1996. Entering the child's world: A play therapy approach. Pretoria: Kagiso Publishers.

Schoeman, J.P. 2005. Centre for play therapy and training: Advanced course in Play therapy, notes and reading work. Unpublished manual for training in Play therapy. Gansbaai: South Africa.

Sroufe, L.A., Egeland, B., Carlson, E.A. & Collins, W.A. 2005. The development of the person. New York: The Guilford Press.

Storm, W. 2001. The relationship between aggression and social skills. Unpublished M.A. dissertation. University of Stellenbosch.

Strydom, H. 2005. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2005. Research at Grass Roots. For the Social Sciences and Human Service Professions. Pretoria: Van Schaik.

Strydom, H. & Delport, C.L.S. 2005. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. 2005. Research at Grass Roots. For the Social Sciences and Human Service Professions. Pretoria: Van Schaik.

Van der Lith, H.C. 1998. Dealing with aggression in the mid-childhood boarding school child by using play therapeutic group work. Unpublished M.A. dissertation. Pretoria. University of Pretoria.

APPENDIX 1: RESPONDENT LETTER

HUGENOTE KOLLEGE HUGUENOT COLLEGE

11 June 2007

Dear Play Therapist,

My name is Nicola Richardson and I am currently a student at the University of South Africa (UNISA), completing my M Diac in Play Therapy. For the purpose of my studies I am currently doing research and would be honored if you would consider being a respondent in this study. Following is a brief description of the research at hand including what is required to participate. I would greatly appreciate it if you could take a moment and consent to being a part of this research. It will not take long and aims to benefit our field.

TITLE OF RESEARCH

THE HANDLING OF AGGRESSION IN THERAPY FROM A GESTALT PERSPECTIVE

AIM OF RESEARCH

Gestalt play therapists working with children in a therapeutic setting are commonly being faced with aggressive behavior posing many therapeutic obstacles including resistance and physical or verbal harm. How this aggression is experienced by therapists and can be overcome will be researched in this study and it is of the researcher's opinion that through this research other therapists faced with aggression in a therapeutic setting can then greatly benefit

from these findings. Therefore this research aims to explore how Gestalt play therapists handle aggression displayed by children in therapy and from this study provide the reader with basic recommendations in treating aggression in therapy.

RESEARCH PROCEDURES

The researcher intends to interview Gestalt play therapists. The therapists approached are selected on the grounds of potentially meeting specific criteria. These criteria include:

- The Gestalt play therapist must be practicing in the Western Cape.
- The Gestalt play therapist must have experience in dealing with aggressive behavior in children of middle-childhood age in a therapeutic setting.
- The Gestalt play therapist must be willing to participate in this study.

The researcher will conduct an individual interview with each participant in the study. The ***questions will focus on*** your experience of working with aggression in therapy and how you as a Gestalt Play therapist handled this. The duration of the interview will last no longer than 30 minutes and will be conducted telephonically as the researcher is currently living overseas. The information gathered by this interview will be recorded and kept confidential and the respondent will remain anonymous. There are no risks to the participation in this research and the respondent may withdraw at any time from this study.

Please reply via e-mail to Nicci Richardson at richardson_nicci@yahoo.com as to whether you will be willing or not to participate. If the respondent feels that he/she meets the criteria and is willing to participate in this study, please include in the e-mail when would be the most appropriate time for the interview, including contact numbers. Below is a possible schedule sheet and it will be greatly appreciated if the respondent could select an appropriate time to be interviewed. The schedule sheet is merely a guide as the researcher is flexible and willing to

accommodate the respondent in any way possible concerning the time and date of the interview. **Please note that the researcher will be able to fit in with your schedule – should the dates not suit you, please just arrange another time and date**. A consent form is attached to this e-mail / fax and is required to be signed and faxed to the following number (021) 864 1480.

As previously stated, the interview will take no longer than 30 minutes and the researcher would greatly appreciate your professional experience and input in this study. If there are any further questions please do not hesitate to contact the researcher. Look forward to hearing from you!

Yours sincerely,

NICOLA RICHARDSON

INTERVIEW SCHEDULE:

11th June (Monday)	**12th June (Tuesday)**	**13th June (Wednesday)**
08:00 – 08:30	**08:00 – 08:30**	**08:00 – 08:30**
08:30 – 09:00	**08:30 – 09:00**	**08:30 – 09:00**
09:00 – 09:30	**09:00 – 09:30**	**09:00 – 09:30**
09:30 – 10:00	**09:30 – 10:00**	**09:30 – 10:00**
Other Time:	**Other time:**	**Other time:**

APPENDIX 2: CONSENT FORM

CONSENT FORM

To whom it may concern,

I ________________________________ am aware that Nicola Richardson is doing research for the University of South Africa (UNISA) for the purpose of exploring the handling of aggression in therapy from a Gestalt Perspective. I hereby give permission to Nicola Richardson to be interviewed telephonically regarding my experiences with aggressive children of middle-childhood age in a therapeutic setting. I acknowledge that the information gathered by this interview will be recorded and kept confidential and that I will remain anonymous. I am also aware that at anytime I may withdraw from this study.

Signed: ______________________

Date: ___________________