

Utilising the bridging technique during therapy to overcome contact-making barriers in adolescents

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“The human heart yearns for contact – above all it yearns for genuine dialogue.... Each of us secretly and desperately yearns to be “met” – to be recognized in our uniqueness, our fullness and our vulnerability” (Hycner and Jacobs, 1995:9)

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FOREWORD

This dissertation is presented in article format in accordance with the guidelines set out in the **Manual for Postgraduates Studies, 2008 of the North-West University**. The technical editing was done according to the guidelines and requirements set out in Chapter Two of the Manual.

The article will be submitted to the journal *Social Work/Maatskaplike Werk*. The guidelines for the submission to the journal are attached in Addendum 8: Journal submission guidelines. For the purposes of the examination process, the article is longer than the prescribed word length of 10 000. The article length will be reduced for submission to the above journal.

DECLARATION

I, Christina, J. Louw, declare herewith that the dissertation entitled:

Utilising the bridging technique during therapy to overcome contact-making barriers in adolescents, which I herewith submit to the North-West University Potchefstroom Campus, is my own work and that all references used or quoted were indicated and acknowledge.

Signature: _____

Mrs. C.J. Louw

Date: _____

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6 November 2011

TO WHOM IT MAY CONCERN

I confirm that I have edited the language in the Master's dissertation **Utilising the bridging technique during therapy to overcome contact-making barriers in adolescents** at the request of Christene J. Louw, for the purposes of submission of her dissertation.

The editing was done electronically, using Track Changes, to enable the author to accept or reject the suggested changes, thus retaining her authorial discretion and right to assert authorship. The editing included checking the referencing and general formatting in line with the guidelines set out in Quoting Sources by Engela J. van der Walt (2006) and in consultation with the client.

I assert that I am qualified to do such editing, as I have an MA in English, have lectured English since 1985, and have been a freelance editor since 1990. I have also offered courses in editing at the undergraduate and graduate levels for more than 10 years.

Yours faithfully

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SUMMARY

KEY TERMS: Contact, contact-making barriers, adolescence, bridging technique, organismic self-regulation, creative adjustment, therapeutic intervention.

This study focuses on the use of a bridging technique to overcome contact-making barriers in adolescents. Contact is regarded as an integral part of all human experiences, but barriers (also called contact boundary disturbances) often hinder effective contact-making with the environment. To overcome contact boundary disturbances, several model bridges were constructed prior to the study and these were used as a metaphor during the intervention phase with adolescents. The goal of the research was to determine whether a technique called “bridging” could overcome contact boundary disturbances in adolescents in therapy. The research was conducted from an existential-phenomenological Gestalt approach. Combined quantitative and qualitative approaches were followed and a single system experimental design, A-B-A-A, was applied.

A total of 14 adolescent participants between the ages of 11 and 14 were purposefully selected from three different schools in the Gauteng Province, South Africa, as well as their parents and teachers. Quantitative data were collected from the pre-intervention assessment, the post-intervention assessment and a follow-up assessment where questionnaires were completed by the researcher for each of the adolescent participants. The follow-up assessment was done four weeks after the post-assessment in order to determine the consistency of the intervention. These questionnaires were analysed according to the semantic differential scale, and raw scores were plotted on line and bar graphs in order to assess the contact skills and contact boundary disturbances in the participating adolescents.

Qualitative data were collected through semi-structured interviews with parents and teachers and through therapeutic interventions with adolescents. The data were analysed using the Creswell spiral and the *a priori* and inductive coding approaches. Three main themes were identified which were contact boundary disturbances, personal emotional factors and behavioural factors. Quantitative and qualitative data

results and findings were discussed in context, to the relevant literature. The findings of the data indicated that the bridging technique can be useful in working with adolescents in therapy to overcome contact-making barriers.

OPSOMMING

SLEUTELTERME: Kontak, kontakgrensversteurings, adolessensie, oorbruggings-tegniek adolessensie, organismiese self-regulering, kreatiewe aanpassing, terapeutiese intervensie

Hierdie studie fokus op die toepassing van 'n oorbruggingstegniek om kontakgrensversteurings in adolessente in terapie te oorkom. Kontak word gesien as 'n integrale deel van alle menslike ervarings, maar blokkasies (ook genoem kontakgrensversteurings), verhinder soms effektiewe kontakmaking met die omgewing. Om blokkasies te oorkom, is verskeie model brûe vooraf gekonstrueer en dit is as metafoor gebruik, tydens die intervensiefase met adolessente. Die doel van die navorsing was om te bepaal of 'n oorbruggingstegniek wat "bridging" genoem word, kontakgrensversteurings in adolessente tydens terapie kan oorbrug. Die navorsing is vanuit 'n eksistensiële fenomenologiese en 'n Gestaltbenadering uitgevoer. 'n Gekombineerde kwantitatiewe en kwalitatiewe navorsingsmetode, met 'n enkel eksperimentele ontwerp, A-B-A-A, is toegepas.

'n Totaal van 14 adolessente tussen die ouderdomme van 11 en 14 jaar is uit drie verskillende skole in die Gauteng Provinsie, Suid-Afrika, selektief gekeur, asook hul ouers en onderwysers. Kwantitatiewe data is ingesamel deur gebruik te maak van assesseringsvraelyste, wat deur die navorser vir elke adolessente deelnemer voltooi is. Die data-insameling het plaasgevind voor die intervensie fase, genoem die pre-assessering, na die intervensie, die post-assessering en 'n opvolg-assessering. Die opvolg-assessering het plaasgevind vier weke na die post-assessering, om die konsekwentheid van die intervensie te bepaal. Data wat verkry is uit die vraelyste is volgens 'n semantiese differensiële skaal ontleed, en die resultate is in die vorm van lyn en staafgrafieke weergegee, om die kontakvaardighede en blokkasies in die deelnemende adolessente te bepaal.

Kwalitatiewe data is ingesamel deur middel van semi-gestruktureerde onderhouds met ouers en onderwysers, asook terapeutiese intervensie met adolessente. Die data is ontleed met behulp van die Creswell spiraal en die *a priori* en induktiewe

koderingsbenaderings. Drie hoofteemas is geïdentifiseer naamlik, kontakgrens versteurings, persoonlike emosionele faktore en gedragsfaktore. Die kwantitatiewe en kwalitatiewe data resultate en bevinding is in konteks met die relevante literatuur bespreek. Die navorsingsresultate dui daarop dat die oorbruggingstegniek nuttig kan wees in terapie met adolessente om kontakgrensversteurings te oorbrug.

SECTION A: ORIENTATION TO THE RESEARCH

1. CONTEXTUALISATION AND PROBLEM STATEMENT

The essence of human life is contact – a meeting with various kinds of others (Hycner, 1993:67,137; Joyce & Sills, 2010:3). According to Perls, Hefferline and Goodman (1951:230), all organisms are capable of effective and fulfilling contact with others in their environment and pursue ways of making and maintaining contact with others, so that these organisms can survive and grow to maturity. These authors consider all contact a form of creative adjustment by the organism to and in its environment. Yontef and Jacobs (2000:305) refer to contact as “being in touch with what is emerging here and now, moment to moment”. Contact is seen as an integral part of all experiences: therefore, no experience can exist without contact (Yontef & Jacobs, 2000:313).

For effective contact-making to occur in a therapeutic environment, therapists and adolescents must be able to understand both verbal and non-verbal messages and to send and receive such messages accurately (Ibrahim, 1985:625; Sue & Sue, 1990:420, 2003:169). Most theories on therapy place a high premium on verbal, emotional and behavioural expressiveness and the attainment of insight. In line with this view, Gestalt therapy regards healthy contact as the ability to make contact with the environment through the senses, such as seeing, smelling, touching, tasting, the awareness of and suitable use of the body and the ability to express ideas, thoughts and needs (Perls *et al.*, 1951:73,105,118; Oaklander, 1999). Breakdowns and misunderstandings in therapy, which are also called barriers or blocks (Hahn, 2005), often hinder effective contact-making with the self and with others. In a therapeutic environment, these barriers may also hinder effective intervention, such as the formation of a client-therapist relationship and the building of trust and rapport (Sue & Sue, 2003; Clarkson, 2004:28; Drewes, 2006:72).

Hanks (1991:59) and Treffry (1999:449) define barriers as “[a]nything that prevents progress” or “anything that separates or hinders union” and can be seen as an obstacle or impediment. From a Gestalt perspective, contact takes place at the boundary (also called the meeting) created by differences, the “me” and the “not me”

(Latner, 1992; Yontef, 1993:126). Interruptions or contact boundary disturbances block contact-making and the disturbances becomes fixed and prevents the natural and healthy process of organismic self-regulation (Oaklander, 1994:144; Yontef & Jacobs, 2000:315; Corey, 2005:197). Several researchers have identified disturbances such as introjection, projection, confluence, retroflection, deflection, desensitization and egotism as potential barriers to contact-making. Adolescents may use some or several of these contact disturbances or barriers to satisfy their needs and to adjust (Perls *et al.*, 1951:406; 1977:183; Clarkson & Mackewn, 1994; Yontef & Jacobs, 2000; Woldt & Tolman 2005: foreword x; Mortola, 2006).

The contact-making barriers mentioned above are not the only barriers identified by various researchers that may affect therapy. Other potential barriers include non-verbal communication in the form of the maintenance or non-maintenance of personal space, eye contact and social conventions: how one speaks, greets people and makes body contact (Karaban, 1990:22; Saldanha, 2001:95; Sue & Sue, 2003; Lee, 2003:12).

The focus of this study was on early adolescents who experience barriers in making contact with therapists. According to Erikson (1963), early adolescence is seen as the phase which focuses on identity versus identity confusion. Adolescents asks questions such as “Who am I?” and “What is my place in society?” Unsuccessful attempts to answer these questions may contribute to adolescents struggling to express their emotions and hindering the contact-making process. These barriers could arise from several factors, such as the adolescents’ developmental level, not being able to express themselves in their mother tongue, limited linguistic skills and/or insufficient insight into or awareness of inner feelings. In addition, adolescents might suppress feelings and thoughts, and/or disassociate themselves from trauma and painful experiences (cf. Gusman *et al.* 1996:439-457; Boik & Goodwin, 2000; UNICEF, 2007). These barriers restrict optimal communication and the contact-making of adolescents, not only externally, but also internally, with the self. This may cause a state of *impasse* where adolescents start to look for external support in order to solve their problems (Yontef, 1993:58,144).

Several theorists' views were taken into account to enhance understanding of the developmental phases of adolescence. Piaget (1971) regards the adolescent phase as formal operational, where the adolescent is capable of more complex, abstract reasoning. During this phase, adolescents are able to make contact at a cognitive level, expressing their needs. Bronfenbrenner's ecological systems theory (Bronfenbrenner & Evans, 2000:115-125; Bronfenbrenner, 2010) focuses on four levels of development, namely the micro-, meso-, exo- and the macro-system. This theory can be compared with the Gestalt Field Theory, where the organism must be seen as part of the environment, influencing each other all the time (Perls *et al.*, 1951; McConville & Wheeler, 2002:49).

The goal in this study was to overcome contact-making barriers in adolescents during therapy, by utilising the bridging technique. Redgrave (2000:65,158,162) and Van der Merwe (2010) sees bridging as a process whereby a bridge as a metaphor becomes the object which the adolescent needs to cross in order to overcome the barrier. The actual crossing of a physical bridge or the building of a bridge in order to cross it becomes a reinforcer, leading to homeostasis and satisfaction. According to Schoeman and Van der Merwe (1996:86) and Blom (2006:169-170), a metaphor is a way of communicating symbolically. It serves as a basis for comparison, can be adapted to suit each adolescent's unique needs, accommodates various temperaments, offers an opportunity to portray numerous non-verbalised images and is a medium to express the hitherto unspoken verbally.

The researcher constructed different types of bridges prior to the start of the study, offering adolescents different options for constructing a bridge or several bridges of their choice, whilst facilitating contact and overcoming contact-making barriers or interruptions (see Addendum 2A: Bridges).

The researcher was interested in "how" adolescents make contact and "what" contact-making barriers might hinder contact between therapists and adolescents. The research question was formulated through observations of adolescents in therapy, a literature review, as well as questions that related to the study's goals, objectives and hypotheses, as recommended by Rubin and Babbie (2005:109) and Fouché and

Delport (2011:70). Primary and secondary research questions were formulated in line with this focus.

The primary research question was the following: How can the bridging technique be used in therapy to overcome contact-making barriers in adolescents?

The secondary research questions were the following:

- What contact-making barriers might hinder contact between therapists and adolescents?
- What contact-making boundaries might prevent adolescents from making contact with the self?

The hypothesis according to De Vos and Strydom (2011:35) is a statement that postulates a certain relationship between two or more variables. The dependent variable in this study was how adolescents make contact and what contact-barriers were present during therapy. The independent variable was the intervention strategy, which was the utilisation of the bridging technique to overcome contact-barriers in adolescents during therapy. The hypothesis is that the bridging technique will overcome contact-barriers between therapist and adolescents as well as contact-barriers within the self. This implied that the independent variable, the utilisation of the bridging technique during therapy had a positive impact on the dependent variable, namely the contact-making barriers in adolescents.

2. AIM AND OBJECTIVES OF THE STUDY

According to Fouché and De Vos (2011:94), there is a difference between goals and objectives. Goals imply “the end towards which effort is directed”, whereas objectives are the concrete measurable steps that need to be taken in order to reach the goals (Babbie, 2001:91-94; Mouton, 2001:53). The goal of this study was to explore how the bridging technique could be used to overcome contact-making barriers in adolescents.

This resulted in the following objectives:

- To explore how contact-making barriers might hinder contact between therapists and adolescents;
- To explore the contact-making boundaries that might prevent adolescents from making contact with the self.

3. THE META-THEORETICAL FRAMEWORK OF THE STUDY

The research was conducted using an existential-phenomenological Gestalt approach, as it focused on the perceptions of adolescents' reality and on the process of becoming and evolving (Clarkson & Mackewn, 1994; Daniels, 2004:1-7; Corey, 2005:192; Anderson, 2008:2). Two principles, Holism and Field Theory, formed the basis of this research, as adolescents were seen as "unified" and "coherent whole(s)" in their environment, "the field", consisting of both external and internal worlds (Corey, 2005:193). The goal was to establish and facilitate adolescents' contact-making processes (Yontef, 1993:294).

The researcher's contact style was derived from the stance of an I-Thou relationship (cf. Buber 1970:51; Joyce & Sills, 2010:42) that is fully present and committed to process and dialogue (Mackewn, 1997:104; Polster & Polster, 1999:105; Melnick & Nevis, 2005:109; Oaklander, 2007:21). Gestalt principles and concepts formed the theoretical basis for this research, as it provide a perspective on and structure for describing and explaining "how" adolescents function within their fields. These principles and Gestalt concepts are briefly described in the next section.

4. DESCRIPTION OF GESTALT PRINCIPLES AND CONCEPTS

4.1 Gestalt therapy is relational

Gestalt therapy can be seen as systematically relational in its underlying theory and methodology. According to Yontef (2002:15-35) and Jacobs (1992:25-60), a relational perspective is so central to the theory of Gestalt therapy that without it, there is no coherent core to Gestalt-based therapy, Gestalt Theory or practice. The relation between the different elements in a Gestalt approach, such as the principles, methods and interconnectedness between these elements, forms the theoretical basis of this approach. Being theoretically anchored and thus able to conceptualise the therapeutic change process is a prerequisite for contributing to the effectiveness of any therapeutic encounter and therefore for growth (Latner, 1986, 2000; Kirchner, 2000). It was from this perspective that the therapeutic encounters with adolescents were perceived.

4.2 Existential phenomenology

The researcher facilitated the intervention phase of this study by applying the phenomenological method of enquiry. Phenomenology derives from the Greek word *phainomenon* meaning “appearance”, as explicated by Edmund Husserl (1931; cf. Marshall & Rossman, 2011:403). Phenomenology is seen as a theory of consciousness – how the world appears to us, or how we experience the world and reality in the moment (Yontef, 1993:239; Patton, 2002:107). The focus in this study immediate experiences of adolescents in contact-making with the researcher, whilst simultaneously bracketing off the researcher’s own ideas, judgements and beliefs by not interpreting, explaining or prescribing meanings for events (LeVasseur, 2003:408; Clarkson, 2004:15; Spinelli, 2005; Brownell, 2009:339; Joyce & Sills, 2010:16-17).

4.3 Holism

Yontef and Jacobs (2000:305) and Latner (2000:19) consider the concept of holism to be the most important theoretical concept underpinning Gestalt therapy. In this study, adolescents were therefore considered holistic entities, implying that the sum total of their physical, emotional and spiritual aspects, language, thoughts and behaviour were more than their components, and cannot be separated (cf. Blom, 2006:22). Yontef (1993:84), Kirchner (2000) and Corey (2005: 194) support this view that people and thus adolescents, are “*unified*” and “*coherent wholes*” that cannot survive without the environment, as they need the environment to satisfy their needs.

4.4 Field theory

The field is a metaphor to describe a web of mutually influencing forces. According to Yontef (1993:322), the most basic premise of Field Theory is that everything is of the field and that everything in the field affects everything else. All objects, events and dynamics are interrelated and connected in a web of relationships. The field, according to Yontef (1993:323), is a framework for studying any event, experience, object, organism or system. This research focused on how adolescents make contact with their internal and external fields. Field Theory is grounded in the principle that an

organism must be looked at in its environment or in its context (Corey, 2005:194; Brownell, 2010).

As organisms, adolescents move in their environment and experience the field as self and other. Five important principles of field theory, as described by Schulz (2004) were relevant in the study, namely the **principle of changing process** – everything in the field is in a process of becoming, evolving and changing. For adolescents, it is a process of becoming, discovering and coming into awareness of physical, emotional and social changes within themselves and their fields.

The **principle of singularity** implies that every situation that adolescents encounter is seen as a new co-creation of interactions between organisms and the environment, even though the situation could be experienced as a repeat or as a continuation.

The **principle of contemporaneity** refers to the “here and now” concept in Gestalt Theory. The researcher and adolescent can only experience the present in their meeting with each other. Events in adolescents’ past or future are not seen as part of the current field and cannot influence the adolescent’s current experience. However, past events are important in two ways: first, how the adolescent holds the memory of a past event that has shaped the current experience and, second, how the past event has influenced the adolescent in organising his/her perceptions in the field in the present.

The **principle of possible relevance** implies that each aspect of contact-making may be relevant as the researcher needs to be cautious and aware of premature “figure formation”, in other words, the possibility that a hypothesis can be formed too quickly, leading to an over-emphasis of some aspects over others. Figure formation is a dynamic process, in which whatever emerges in the foreground is the figure and contrasts with the background. Taken together, the foreground and the background comprise a “Gestalt”.

The **perspective on reality** refers to a person’s perspective and position within the field (Yontef, 1993:322; Schulz, 2004). According to Parlett (2005:48) and Brownell (2010), realities are co-created when individuals make contact with one another. In the

case of the study, when contact between therapist and adolescents occurred during the intervention phase of the study, relationships were configured, and co-created realities were formed.

4.5 Dialogical relationship

“Dialogue” is a term commonly used for spoken communication between people, either in everyday life or in psychotherapy between clients and therapists. In Gestalt Theory, dialogue implies being in contact with another being, whether verbally or non-verbally (Sapriel & Palumbo, 2001; Levine Bar-Yoseph, 2005:17). In Gestalt Theory, both verbal and non-verbal communication are seen as important components of contact. Communication, contact and dialogue are often seen as synonymous, and as a continuous process by which meaning is assigned and conveyed in an attempt to create shared understanding (Daniels, 2004). Dialogue takes place within a relationship, which is seen as the core of Gestalt therapy, as it focuses on vibrant contact and on the healing connection of an authentic meeting between two human beings (Jacobs, 1992:25-60; Joyce & Sills, 2010:43). Spagnuolo Lobb (2005:37) sees the formation of a relationship as the place where the “I” and the “you” arrive at a new truth, a momentary configuration of harmony that immediately gives way to other figures and the ability to stay in the ceaseless equilibrium of the moment.

Many Gestalt authors and theorists describe the relationship between the therapist and the client as “an active partnership” (Joyce & Sills, 2010:41), or as a “between person and person meeting” (Hycner, 1993:67; Schulz, 2004) or as a betweenness (Clarkson, 2004:29). The researcher supports the views of Spagnuolo Lobb (2005:37), who sees the relationship as an experiential space between the “I” and the “you” and of Buber (1970:73), who refers to an “I” and “Thou”. It is a “dance we co-create” as therapist with our clients (Martin, 2009:2).

4.6 Awareness

Yontef (1993:139) argues that awareness takes place in the here and now, in the present moment, and can be defined as being in touch with one’s own existence, with what is. Yontef (1993:179) sees full awareness as “a process of being in vigilant

contact with the most important event in the individual's environment/field with full sensori-motor, emotional, cognitive, and energetic support". Awareness is always intentional and occurs in an organism's environment/field. Characterised by contact, sensing, excitement and Gestalt formation, is a subjective experience; it is being in touch with one's own existence, inclusive of all senses at a given moment (Crocker, 1999; Kirchner, 2000).

The aim in Gestalt therapy is increased awareness, contact and integration (Perls *et al.*, 1951). Joyce and Sills (2010:30-32) see awareness holistically, as consisting of an inner, middle and an outer level, refer to as the "zones of awareness". For the purposes of the research, the inner zone refers to the internal world of the adolescent, which includes subjective phenomena such as bodily sensations and feelings. The outer zone is awareness of contact with the outside world and how contact functions (such as seeing, hearing, speaking, tasting, touching, smelling and moving) are used. The middle zone consists of thinking, memories, fantasies and anticipations. It acts as a mediator between the inner and outer zones. Its main function is to organise our experiences and help us make sense of external and internal stimuli. Its function is to organise the experiences so that there is emotional and cognitive understanding (Joyce & Sills, 2010:30-33).

Healthy functioning is the ability to move between these zones, whereas being stuck or fixated in one area of awareness is considered dysfunctional, blocking contact with the self and others (Joyce & Sills, 2010:30-32). These zones and the ecological systems theory of child development are seen in context of the field theory, which focuses on how adolescents make contact with the self and its environment. Creating awareness requires a phenomenological method of description, a dialogical relationship and a process of interaction between therapists and adolescents (Mackewn, 1997:116). The researcher's goal was to facilitate adolescents' contact-making with themselves (in the inner zone) and with others (in the outer zone). From a Gestalt perspective, it can be compared with the field or seen in context with the different levels of adolescent's development, such as the micro-, meso-, exo- and macro-systems (Bronfenbrenner & Evans, 2000:115-125; McConville & Wheeler, 2002:49). For the purposes of this study, contact was facilitated through dialogue and the use of a bridging technique in order to create awareness.

4.7 Contact and contact boundary disturbances

Healthy contact can be seen as the human capacity for good contact with the self and others, as supported by Clarkson (2004:41). Healthy functioning depends on contact functions being fully available to the organism to meet changing requirements. Healthy contact involves the use of senses (seeing, listening, touching, smelling), awareness and appropriate use of all aspects of body, the ability to express emotions, the use of the intellect in various forms such as learning, expressing, ideas, thought, curiosity, wants, needs and dislikes (Latner, 1992; Oaklander, 2001:48).

Contact takes place at the boundary which is created by the meeting of differences, also called the contact boundary (Latner, 2000:22). The contact boundary can be seen as the point where an adolescent experiences the “I” in relation to that which is “not I” (Yontef, 1993:126,203). This boundary has two functions: on the one hand, it connects people with one another, but on the other hand, it also maintains a form of separation between people (Yontef, 1993; Blom, 2006:30). According to Perls *et al.* (1951:230), contact “is the awareness of, and behaviour towards, the assimilable novelty; and the rejection of the unassimilable novelty”. According to Polster and Polster (1973), “contact is the lifeblood of growth”. Zinker (1978) sees the prerequisites of good contact as clear awareness, full energy and the ability to express oneself. For adolescents to make good contact during the intervention phase, they need to be aware of internal and external processes and to be able to express themselves.

The stages or processes in making contact are also referred to as the awareness cycle, homeostasis cycle, the contact-withdrawal cycle, the Gestalt formation cycle, the cycle of experience or the cycle of self-regulation, depending on the author or theorist (Joyce & Sills, 2009:34; Clarkson, 2004:34). For the purposes of this study, the researcher refers to **The Gestalt Cycle of Experience** as discussed by Reynolds (2005:159-162) as a continuum of phases, and together these phases and the movement between them constitute the process of experience (Perls *et al.* 1951). These phases are the pre-contact, contact, final contact, post-contact and closure/withdrawal phases. **The Gestalt Cycle of Experience** refers to the primary contact-making and interrupting/resisting processes that a person uses in creatively adjusting and balancing personalized contact with his/her environment.

Resistance in contact is seen as contact boundary interruptions (Perls *et al.* 1951:151,463; Woldt, 2009) or interruptions in self-regulation (Polster & Polster, 1973), contact-styles or contact modifications (Wheeler, 1991:123; Joyce & Sills, 2010) or blocks (Oaklander, 1994:144). The boundary between the self and the environment thus becomes unclear, and gets lost and this disrupts both contact and awareness (Yontef, 1993:137; Blom 2006:31). According to Yontef and Jacobs (2000:315), a contact boundary disturbance may lead to isolation, as it is fixed, non-responsive to a whole range of needs and fails to allow close contact to emerge. The researcher addressed this fixedness and non-responsiveness of adolescents by using the bridging technique. The focus in this study was contact, contact-making barriers or contact modifications (Joyce & Sills, 2011:110), as briefly described below.

- **Desensitization (vs sensation/perception):** This refers to a process of coping, by altering perception, minimising experience of self by shutting down the inner zone and bodily needs (Joyce & Sills, 2010:118). Sensory experiences and the emotions associated with them are blocked and kept from becoming a figure (Clarkson & Mackewn, 1994:46, 77).
- **Introjection (vs awareness):** This refers to a tendency to accept uncritically others' beliefs, ideas, attitudes or behaviour without discriminating, assimilating them to make them congruent with who we are (Yontef, 1993:137; Corey, 2005:197). An individual experiences something as him-/herself, when in fact it belongs to the environment. It becomes a false identification (Kirchner, 2000), not clear of the individual's own wants, needs (Polster & Polster, 1973), and ruled by internalised "shoulds" (Joyce & Sills, 2010:125).
- **Projection (vs excitement/mobilisation):** This refers to a confusion of the self and other that results from attributing to the outside something that is truly part of the self (Yontef, 1993:138), in other words, disowning certain aspects of the self (Corey, 2005:198).
- **Retroflection (vs encounter/action):** This occurs when a person does to him-/herself what was originally intended for the other person or object (Perls *et al.*, 1951). It is resisting aspects of the self by the self (Yontef 1993:137; Woldt, 2009),

where an individual holds back a response intended for the environment and substitutes it with a response for him-/herself (Kirchner, 2000).

- **Deflection (vs full contact):** This refers to a process of distraction, so that it is difficult to maintain a sustained sense of contact (Corey, 2005:198). There is some form of avoidance, misdirecting and turning aside from contact or awareness. This is an active way of ignoring internal stimuli, feelings and impulses (Yontef, 1993:138; Joyce & Sills, 2010:117). In some situations, a person will be talking about rather than to (Polster & Polster, 1973).
- **Egotism (vs assimilation/integration):** In this situation, the individual is stepping outside him-/herself and becomes a spectator in his/her relationship with the environment (Joyce & Sills, 2010:122). The adolescent has an objective and rational awareness of his/her experience, but not a subjective or emotional awareness. There is a lack of spontaneity and excessive preoccupation with one's own thoughts, feelings, behaviour and its effect on others (Clarkson & Mackewn, 1994; Blom, 2006:39).
- **Confluence (vs differentiation/withdrawal):** It occurs when there are no boundaries between adolescents and their environment. This lack of boundaries may keep adolescents from making positive contact with others. Instead of an "I" and a "You", there is a "We" or a vague, unclear experience of the self (Blom, 2006:34). The boundary between the self and other becomes so impermeable that the connectedness is lost (Yontef 1993:136; Woldt, 2009). Oaklander (2007:5) sees this experience of no difference, no contact, and no meeting, as a boundaryless dimension due to a poor sense of self.

5. DESCRIPTION OF THEORETICAL CONCEPTS

5.1 Adolescence

The word adolescence is Latin in origin, and derived from the verb *adolescere*, which means "to grow into adulthood" (Louw, Van Ede & Louw, 1998:388). Adolescence is a time of moving from the immaturity of childhood into the maturity of adulthood (Berk,

2006:6). Berryman *et al.* (2002:313) see adolescence as a stage in development which begins with puberty and ends when physiological or psychological maturity is reached. However, there is no single event or boundary line that denotes the end of childhood or the beginning of adolescence. Instead, experts think of the passage from childhood into and through adolescence as composed of a set of transitions that unfold gradually and affect many aspects of an individual's behaviour, development and relationship(s). These transitions are biological, cognitive, social and emotional (Berryman *et al.*, 2002:313; Berk, 2006:6-7; Steinberg, 2007:68,133).

Adolescence is divided into three stages: early adolescence (between the ages of 11 and 14), middle adolescence (between the ages of 14 and 18) and late adolescence, (between the ages of 18 and 21) (Berk, 2006). The focus in this study was on early adolescence, as this is seen as a stage where major developmental changes occur which may affect the emotional well-being of adolescents (Heubner, 2000; Thorn, Louw, Van Ede & Ferns 2001, 388-392).

The researcher supports the views of McConville and Wheeler (2001:54-71), who understand adolescence from a Gestalt perspective as a “progressive unfolding of the comprehensive field, an unfolding that includes structuring of childhood unity, expansion and differentiation of life space and transformation of the boundary processes that organize and integrate the field”. In terms of Gestalt Theory and therapy, the developing child in his/her adolescence is seen as a product of the organismic environmental and inter-subjective fields (McConville, 1995:7). McConville (1995:5) explains that contact functions emerge and evolve throughout the adolescent developmental process. The emergence of these functions involves a deepening and more defined awareness of intra-psychic and interpersonal processes, the interrelatedness of the interior and outer worlds, which are figural to the emergent self throughout adolescent development.

5.2 Metaphor

Metaphors enrich the language of individuals in ways that literal statements cannot match and are thus extremely useful as a therapeutic medium to express feelings and thoughts (Schoeman & Van der Merwe, 1996:86; Blom, 2006:168). In Gestalt Theory, metaphors are considered a form of metaphorical, figurative expression, based on a

comparison and similarity, meaning that a picture is put in place of the actual representations (Sternberg, 2003:337; Blom, 2006:170). It is also considered a technique that can be used to convey messages more effectively. Schoeman and Van der Merwe (1996) suggest the following guidelines for choosing metaphors. Metaphors must provide a metaphorical crisis in the context of an unavoidable solution, whereby the main character can solve the crises:

- they have to provide a parallel learning situation within which the main character succeeds; the learning situation can start at the onset of the metaphorical crisis;
- they must lead to the development of a new sense of identification in the main character, as a result of own victory;
- the child and, in this case, the adolescent, must identify with the metaphor and must contain elements of spontaneous learning;
- the child's individuality must be respected when choosing a metaphor;
- the main character must be prominent and must be in contact with the primary world; and
- the secondary world created by the fantasy must contain order, structure, and be convincing and credible.

5.3 Bridge

A bridge is a structure spanning a gap or barrier to provide a passage over the gap or barrier, such as a river, ravine, roadway or other obstacle. It provides a connection between two points (Oxford English Dictionary, 2008). A model bridge can be seen metaphorically as spanning the barrier/problem that needs to be overcome or as a solution. Building or constructing a bridge facilitates contact between therapist and adolescent. It creates opportunities for adolescents to make contact with themselves, their figurative needs, as well as with their broader external field. For the purposes of this study, a bridge has therefore been chosen as a metaphor to establish contact and to overcome contact-making barriers in adolescents.

Barnard (2010), a model builder at Inventive Studio, constructed several bridges, such as beam, truss, suspension and arch bridges prior to the study and were utilised during contact-making with adolescents. These model bridges could be

(re)constructed on a set base, which was called a veld in this research,¹ consisting of a river, ravine, rocks and trees. Several features of the different bridges were emphasised, such as the pillars/piers, cement, steel and weight – indicating strengths or weaknesses, the foundation of bridge, indicating values and norms; rails and safety features across the bridge – symbolising safety and security, boundaries and support systems. Water, rivers, weather conditions, wind, etc. represented external factors which could be seen as barriers/blocks or the “what” in adolescents’ lives. However, these features did not represent specific pre-assigned characteristics, but were chosen by the adolescent(s) who gave their own meaning to the features. Internal barriers within adolescents were seen as the contact-making disturbances, the “how” preventing the adolescent(s) from making contact with therapists (see Addendum 2A: Bridges).

5.4 Bridging technique

“Bridging” is a term used by many psychotherapists to describe a method to narrow the gap between objects or standpoints. Several examples, such as comparing and bridging methods in a sand tray and play therapy, applying experiential exercises to bridge the practical aspect of theory, bridging the gap between science and practice, or bridging intra-psychic psychodynamic methods to Gestalt therapy can be mentioned (Simonyi-Elmer, 2008; O’Connor & Braverman, 2009; Levy & Ablon, 2010; Van der Merwe, 2010; Schaefer, 2011:61).

In this study, bridging as technique was used – the researcher formulated questions to make adolescents aware of contact-making barriers, both internal and external. During the first two therapeutic sessions, the focus was on creating a safe and trusting environment, as described in Erikson’s social developmental theory (Berk, 2006:18). The model bridge(s) was introduced to adolescents during the third, fourth and fifth sessions (see Addendum 2B: Utilising the bridge(s)). During the therapeutic intervention, the following questions were asked:

- Have you seen a bridge before?
- Do you want to play in this veld?

¹This term was chosen to distinguish this physical space from the concept of the “field” as used in Gestalt Theory. The spelling of “veld” was preferred to “veldt” in order to distinguish between the construct used in the study and the broader meaning of the South African “veldt”.

- Can we have a picnic in this veld?
- Can we play hide and seek?
- What can one do in a ravine, under the trees or behind the rocks?
- Do you want to add some objects to the veld?
- Where do these two roads on the bridge lead?
- How can we bridge the gap between the roads?
- Where does this road take you?
- What kind of bridge would you like to build?
- What features of the bridge are appealing to you?
- What in this veld represents something in your life?
- Do you want to share this with the researcher?
- Would you like to tell your own story?

The researcher focused on three levels of intervention. Firstly, the emotional awareness and contact abilities of adolescents, such as verbal and non-verbal clues, tone of voice, body language and eye contact, were observed. Secondly, emotional expressions, pleasant or unpleasant, were addressed by asking non-threatening questions in the third person. Thirdly, an awareness of inter- and intra-personal feelings were facilitated through dialogue. The goal was to determine the metaphorical value of the bridging technique by asking questions such as the following:

- Did the adolescents make contact with the therapist and with themselves?
- How did adolescents make contact: at a verbal level (language, articulation) or at a non-verbal level (body and expressions)?
- What contact-making barriers were present?
- Did adolescents gain sensory, emotional and social awareness?
- To what extent did the bridging technique assist in the above?

6. RESEARCH METHODOLOGY

6.1 Research approach

Delpont and Fouché (2011:434-435) describe a combined-method or “mixed” method of study as using multiple methods of data collection and analysis. For the purposes of this study, a quantitative and a qualitative approach were chosen in order to determine

the effectiveness of the therapeutic intervention (Babbie, 2007:113). In a combined approach, the validity and congruence of findings can be increased by means of data and methodological triangulation (Menon & Cowger, 2010:612). Applied research was conducted to explore, describe and evaluate the research data (Terre Blanche & Durrheim, 1999:41; Neuman, 2000:23; Ivankova, Creswell & Clark, 2010:263; Fouché & De Vos, 2011:97-98).

6.2 Research design

In this study, a single system experimental design, A-B-A-A, with different phases, namely a baseline phase (A), an intervention phase (B), a return to the baseline phase (A) and a follow-up phase (A), was applied. According to Strydom (2011a:162), a single systems design is the ideal way to evaluate the effectiveness and impact of treatment interventions and to establish the existence of a cause-and-effect relationship between variables. The dependent and independent variables were identified for this study. Strydom (2011a:165) defines dependent variables in operational terms as the specific measurable indicators that allow a researcher to evaluate the outcomes that are produced in a study, in other words, the problem that must be worked on. In this study, the dependent variable (A) to be determined was how adolescents make contact and what contact-barriers were present. Strydom (2011a:165) describes the independent variable (B) as the intervention strategy, procedures and techniques that the researcher applies. The independent variable in this study was the utilisation of the bridging technique to overcome contact-making barriers in adolescents during contact-making in a therapeutic situation.

The qualitative part of this study was an instrumental case study (Babbie, 2008:94-97; Creswell, 2008:199; Fouché & Schurink, 2011:322). It included the therapeutic intervention with adolescents, over a period of eight weeks, where the bridging technique was introduced and semi-structured interviews were conducted with parents and teachers. The quantitative part of this study involved the completion of assessment questionnaires by the researcher for each adolescent participant, before the intervention phase (the pre-intervention assessment), after the intervention phase (the post-intervention assessment) and a follow-up assessment, which took place four

weeks after the post-intervention assessment to determine the effectiveness and consistency of the intervention.

6.3 Research sampling

The universe, using Strydom's (2011b:223) definition in the study consisted of all adolescents who experienced barriers to contact-making and living in Gauteng, their parents and teachers. The population (Strydom, 2011b:223) was confined to all adolescents between the ages of 11 and 14 years who experienced contact-making barriers, their parents and teachers living in the Ekurhuleni Metropolitan district, Northern Region, Gauteng. Non-probability sampling was applied, with purposeful selection, as recommended by Babbie (2008:52), Maree and Pietersen (2010:176) (cf. also Strydom, 2011b:231). The sample consisted of 14 adolescents who lived in and attended school in Kempton Park, in the Ekurhuleni Metropolitan district, as well as their parents and teachers. Teachers from three different schools identified the adolescent participants who then, with the informed consent of their parents, agreed to participate voluntarily in this study.

The adolescent population and their parents were divided into three sub-populations. Population A consisted of four participants – two boys and two girls, who attended a school that focuses on learners with intellectual and mental disabilities. Population B included four participants – two girls and two boys, who attended a school for learners with special needs, also called a full service school. Population C consisted of six participants – two girls and four boys, who attended a mainstream high-functioning school.

6.4 Data collection methods

The researcher employed different methods to collect the data, such as interviews, therapeutic intervention, observation and assessments. The quantitative data collection method included assessment questionnaires that were completed by the researcher for each adolescent participant, before the intervention phase (pre-intervention assessment), after the intervention (post-intervention assessment) and a follow-up, to measure the consistency of the intervention after four weeks. The focus

in the assessment questionnaire was the therapeutic relationship, contact-making, resistance, emotional expression, cognitive aspects, the participants' sense of self, the process and the temperaments of the participating adolescents. The Directive Interactive Supportive and Corrective (DISC) temperament analysis developed by Boyd (1994:51-84) and Rohm (1998:29-32) was used as part of the assessment (see Addendum 1: Assessment Questionnaire).

The qualitative data collection method included semi-structured interviews with parents and teachers and through therapeutic interventions with adolescents. The data were collected before the therapeutic intervention (pre-intervention assessment) after the therapeutic intervention (post-intervention assessment) and during a follow-up assessment. An ecomap or genogram was completed for each of the adolescent participants during the first session with adolescents, which enabled the researcher to obtain a visual presentation of the adolescent's Gestalt field, which included his/her family environment, relationship bounds, resources and connections to a larger social system, as advocated by Goldenberg and Goldenberg (2004:89,507). This data did not form part of the empirical analysis.

During the therapeutic intervention with the adolescents, the bridging technique was applied and sessions were video-recorded. Themes and categories were identified using an *a priori* coding approach and an inductive coding approach, as described by Braun and Clarke (2006:93) and Nieuwenhuis (2010:107).

6.5 Data-analysis

The quantitative data were analysed according to the semantic differential scale or scores, and were then transformed statistically to help describe the data more succinctly. According to Maree and Pietersen (2010:167), scales "are intended to help researchers discover strength of feelings or attitude. The response options are set up in such a way that the variables measured can be expressed as numerical scores that are of either an ordinal, interval or ratio type". The main aspects and components in the assessment questionnaire were given numerical scores from one to four to assess the participants' contact-making skills, resistance and the effectiveness of the intervention at an interval level (Terre Blanche & Durrheim, 1999:98-99; Maree & Pietersen, 2010:168). The scores were designed in such a manner as to show an

increase in the scores as a positive influence and a decrease in the scores as a negative influence.

The raw scores were plotted on line graphs and the percentage change that occurred for each aspect and sub-component was plotted on a bar graphs. These two kinds of graphs are both, different graphical indicators to show the effect of the intervention: the use of the bridging technique. The movement of the lines on the line graph upwards indicated a positive effect. The bar graph indicated the percentage change, and was a representation of how much the line moved up or down on the line graph. The percentage change between pre-intervention assessment and the post-intervention assessment indicated the immediate effect of the technique, whereas the percentage change between the post-intervention assessment and the follow-up assessment was an indication of the longevity/sustainability of the intervention. The higher the percentage change, the more positive the effect of the intervention. If the percentage change between the post-intervention assessment and the follow-up assessment stayed relatively constant or increased, it could be inferred that the effect of the intervention was lasting.

The qualitative data were analysed and interpreted using a Creswell spiral, as described by Marshall and Rossman (2011:402-403) and Creswell (2007). The researcher focused on several aspects in the spiral to analyse the findings, circling around and “upwards” towards the completion of the process:

- planned video recordings took place at the relevant schools and at the researcher’s private practice;
- data were collected and preliminary interpretations of the data were done, guided by the initial concepts;
- data were organised (labelled according to date, place and interview) and back-up copies were made of video recordings;
- notes/memos were read and written;
- themes, patterns and categories were identified according to an *a priori* coding approach, where themes were selected from the research topic, namely contact-making boundaries, and from an inductive coding approach, where themes, categories and patterns emerged from semi-structured interviews with parents, the

therapist and teachers, and during the intervention phase with adolescents (Braun & Clarke, 2006:83; Nieuwenhuis, 2010:107);

- data were coded according to key words and coloured highlighting;
- data were evaluated in terms of their usefulness, centrality and the search for alternative explanations and meanings; and
- data were presented by compiling the dissertation in an article format, as recommended by Heppner and Heppner (2004).

Combined quantitative and qualitative methodologies were used to ensure the validity and congruence of the research findings (Menon & Cowger, 2010:612; Delport & Fouché, 2011:434-436). Data from multiple sources, such as the semi-structured interviews, participant observations and field notes were cross-checked for regularities (this is also called triangulation), in order to give a more detailed and balanced picture of the research findings (O'Donoghue & Punch 2003:78; Creswell, 2008).

The researcher used existing assessment guidelines and analysis compiled by therapists and authors in the field of Gestalt play therapy as part of the quantitative data collection method, which added reliability to the research. These analyses were the Directive Interactive Supportive and Corrective (DISC) temperament analysis developed by Boyd (1994:51-84) and Rohm (1998:29-32) and of Oaklander (1999) and Blom (2006:69) for assessing children during Gestalt play therapy. The research can be duplicated, as raw scores are available and have been validated externally. Interval measurements were done during the pre-intervention, post-intervention and follow-up assessment which added transferability (also called external validity) to the research findings. The empirical research was integrated with a literature control which added trustworthiness to the study, as recommended by Terre Blanche and Durrheim (1999: 61,87,431) and Schurink, Fouché and De Vos (2011:419-421)

7. ETHICAL ASPECTS

Ethical principles and guidelines as described by Terre Blanche and Durrheim (1999: 66), Babbie, (2008:63-67) and Strydom (2011c:114) were integrated into the research study. The following ethical measures were applied:

- The **autonomy and confidentiality** of all participants were respected. Informed and voluntary consent were obtained, and participants were assured of their freedom to withdraw from the research at any time. Strydom (2001c:119) regards privacy as synonymous with the right to self-determination and confidentiality. Confidentiality and honesty were central to the formation of a client-therapist relationship. Therefore, all participants were fully informed regarding the research topic, the intervention phase that was video-recorded, interviews, as well as the assessment questionnaires. All participants were given time to ask questions before signing the consent form to participate. Copies of the signed consent form were issued to the parents of the adolescent participants.
- The principle of **non-maleficence** was adhered to by the researcher, who considered all potential risks that might inflict physical, emotional, social or any other forms of harm on participants. This principle, according to Terre Blanche and Durrheim (1999:66; Corey, 2005:40) places a responsibility on the researcher, to ensure that participants are not emotionally harmed or deceived. This principle was honoured by informing participants beforehand of the goals and the objectives of the study and by being honest and transparent during the research process (Babbie, 2007:63, 67). Support was available to all the participants after the study.
- **The research findings benefitted** participants, because data given to the relevant parents, teachers and other therapists on how to make contact and address behavioural symptoms led to ongoing therapy. Recommendations on the bridging technique might benefit other researchers and therapists in making contact with adolescents during therapy (Terre Blanche & Durrheim, 1999:66).
- The researcher's own code of ethics is in line with the Ethical Code of the South African Council for Social Service Professions (SACSSP, 1989), as well as the professional Gestalt code of ethics prescribed by the European Association for Gestalt Therapy (EAGT, 2001). Both ethical codes state that every human being has a unique value and potential, irrespective of the person's origin, ethnicity, sex, age, beliefs, socio-economic and legal status. From a Gestalt perspective, the importance of autonomy and self-regulation of the individual in the context of interpersonal relationships is also stressed.

8. RESEARCH LIMITATIONS

The research had a number of limitations:

- The use of the bridging technique was a new concept, as well as a learning process during the intervention phase of the research. From a reflective perspective, it would have been more helpful to conduct a small pilot study to smooth and address problem areas beforehand.
- The time allocated to using the bridging technique with Population C was too short, and at times the sessions were interrupted by intercom announcements, school activities and alterations in examination rosters. This population's participants had to be picked up from school and sessions had to be conducted at the researcher's practice. However, it had a positive result in that adolescents had made contact more openly and freely than at the school, where interaction was restricted.
- The size of the bridge model was large, to accommodate the scale of the different types of bridges, the veld and accessories. This was effective when sessions took place at the practice, however, for sessions conducted at various schools, a smaller model consisting of several modules would have been better.

9. REPORT LAYOUT

The report is laid out as follows:

Section A: Orientation to the Research

This section is a general introduction to the research study. The meta-theoretical paradigm and concepts that are discussed indicate the stance of the researcher and the research problem. The methodological approach, data collection and analysis are discussed in this section.

Section B: Journal Article

The article, entitled “Using the bridging technique during therapy to overcome contact-making barriers in adolescents”, is set out in this section.

The journal selected for the submission of the article is *Social Work/Maatskaplike Werk: A professional Journal for the Social Worker*. This journal publishes articles, short communications, book reviews and commentary on articles already published from any field of social work (see Addendum 7: Journal submission guidelines).

Section C: Summary, Evaluations, Conclusions and Recommendations

This section of the study comprises the research findings, conclusions and recommendations that the researcher reached.

Section D: Addenda

All the relevant addenda used in this study, such as assessment questionnaires, photographs, and examples of quantitative and qualitative data analysis are attached.

Section E: Consolidated list of references used in the study

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SECTION B: ARTICLE

UTILISING THE BRIDGING TECHNIQUE DURING THERAPY TO OVERCOME CONTACT-MAKING BARRIERS IN ADOLESCENTS

ABSTRACT

This article focuses on the utilisation of a bridging technique to overcome contact-making barriers in adolescents. A combination of quantitative and qualitative approaches were followed and a single system experimental design, A-B-A-A, was applied. Fourteen adolescent participants were selected from three schools, with their parents and teachers. Quantitative data were collected from pre-intervention assessment, post-intervention assessment and follow-up assessment questionnaires. Qualitative data were collected by means of semi-structured interviews with parents and teachers, and therapeutic intervention with adolescents. The findings indicated that the bridging technique shows potential in working with adolescents to overcome contact-making barriers.

KEY TERMS

Contact, contact-making barriers, adolescence, bridging technique, organismic self-regulation, creative adjustment, therapeutic intervention.

1. INTRODUCTION

The essence of human life is contact - a meeting with various kinds of others (Hycner, 1993:67,137; Joyce & Sills, 2010:3). According to Perls, Hefferline and Goodman (1951:230), all organisms are capable of effective and fulfilling contact with others in their environment and pursue ways of making and maintaining contact with others, so that these organisms can survive and grow to maturity. These authors consider all contact as a form of creative adjustment by the organism to and in its environment. Yontef and Jacobs (2000:305) refer to contact as "being in touch with what is emerging here and now, moment to moment". Contact is seen as an integral part of all experiences: therefore, no experience can exist without contact (Yontef & Jacobs, 2000:313).

For effective contact-making to occur in a therapeutic environment, therapists and adolescents must be able to understand both verbal and non-verbal messages and to send and receive such messages accurately (Ibrahim, 1985:625; Sue & Sue, 1990:420, 2003:169). Most theories on therapy place a high premium on verbal, emotional and behavioural expressiveness and the attainment of insight. In line with this view, Gestalt therapy regards healthy contact as the ability to make contact with the environment through the senses such as seeing, smelling, touching, tasting, the awareness of and suitable use of the body and the ability to express ideas, thoughts and needs (Perls *et al.*, 1951:73,105,118; Oaklander, 1999). Breakdowns and misunderstandings in therapy, which are also called barriers or blocks (Hahn, 2005), often hinder effective contact-making with the self and with others. In a therapeutic environment, these barriers may also hinder effective intervention, such as the formation of a client-therapist relationship and the building of trust and rapport (Sue & Sue, 2003; Clarkson, 2004:28; Drewes, 2006:72).

Hanks (1991:59) and Treffry (1999:449) define barriers as “[a]nything that prevents progress” or “anything that separates or hinders union” and can be seen as an obstacle or impediment. From a Gestalt perspective, contact takes place at the boundary (also called the meeting) created by differences, the “me” and the “not me” (Latner, 1992; Yontef, 1993:126). Interruptions or contact boundary disturbances block contact making, as it becomes fixed and prevents the natural and healthy process of organismic self-regulation (Oaklander, 1994:144; Yontef & Jacobs, 2000:315; Corey, 2005:197). Several researchers have identified disturbances such as introjection, projection, confluence, retroflexion, deflection, desensitization and egotism as potential barriers to contact-making. Adolescents may use some or several of these contact disturbances or barriers to satisfy their needs and to adjust (Perls *et al.*, 1951: 406, 1977:183; Clarkson & Mackewn, 1994; Yontef & Jacobs, 2000; Woldt & Tolman, 2005; Mortola, 2006).

The contact-making barriers mentioned above are not the only barriers identified by various researchers that may affect contact-making in adolescents. Other potential barriers include non-verbal communication in the form of the maintenance or non-maintenance of personal space, eye contact and social conventions: how one speaks,

greet people and makes body contact (Karaban, 1990:22; Saldanha, 2001:95; Sue & Sue, 2003; Lee, 2003:12).

The focus of the study was on early adolescents who experience barriers in making contact with therapists. According to Erikson (1963), early adolescence is a phase which focuses on identity versus identity confusion. Adolescents ask questions such as “Who am I?” and “What is my place in society?” Unsuccessful attempts to answer these questions may contribute to adolescents struggling to express their emotions. This hinders the contact-making process. These barriers could arise from several factors, such as the adolescents’ developmental level, their ability or inability to express themselves in their mother tongue, limited linguistic skills and/or insufficient insight into or awareness of inner feelings. In addition, adolescents might suppress feelings and thoughts, and/or disassociate themselves from trauma and painful experiences (cf. Gusman *et al.*, 1996:439-457; Boik & Goodwin, 2000; UNICEF, 2007). These barriers restrict optimal communication and the contact-making of adolescents, not only externally, but also internally, with the self. This may cause a state of *impasse*, where adolescents start to look for external support in order to solve their problems (Yontef, 1993:58, 144).

Several theorists’ views were taken into account to enhance understanding of the developmental phases of adolescence. Piaget (1971) regards the adolescent phase as formal operational, where the adolescent is capable of more complex, abstract reasoning. During this phase, adolescents are able to make contact at a cognitive level, expressing their needs. Bronfenbrenner’s ecological systems theory (Bronfenbrenner & Evans, 2000:115-125; Bronfenbrenner, 2010) focuses on four levels of development, namely the micro-, meso-, exo- and the macro-system. This theory can be compared with the Gestalt Field Theory, where the organism must be seen as part of the environment, and the organism and the environment are seen as influencing each other all the time (Perls *et al.*, 1951; McConville & Wheeler, 2002:49).

The goal in this study was to overcome contact-making barriers in adolescents in therapy, by using the bridging technique. Redgrave (2000:65,158,162; 2010) and Van der Merwe (2010) sees bridging as a process whereby a bridge as a metaphor becomes the object which the adolescent needs to cross in order to overcome the

barrier. The actual crossing of a physical bridge or the building of a bridge in order to cross it becomes a reinforcer, leading to homeostasis and satisfaction. Metaphors are metaphorical, figurative expressions, based on comparison and similarity, meaning that a picture is put in the place of the actual representations (Sternberg, 2003:337; Blom, 2006:170; 2010). The researcher wanted to determine in what way the bridging technique as a metaphor could be adapted and used in order to suit each adolescent's unique needs, accommodate various temperaments, offer the opportunity to portray numerous non-verbalised images and be used as a medium to express verbally (Schoeman & Van der Merwe, 1996:86; Blom, 2006:169-170). The researcher constructed different types of bridges prior to the start of the study (Barnard, 2010), offering adolescents different options for constructing a bridge or several bridges of their choice, whilst facilitating contact and overcoming contact-making barriers or interruptions (see Addendum 2A: Bridges).

Based on the problem formulation, the following research question was asked:

How can the bridging technique be utilised in therapy to overcome contact-making barriers in adolescents?

Secondary questions were asked to support the primary question, namely:

- What contact-making barriers might hinder contact between therapists and adolescents?
- What contact-making barriers might prevent adolescents from making contact with the self?

The hypothesis according to De Vos and Strydom (2011:35) is a statement that postulates a certain relationship between two or more variables. The dependent variable in this study was how adolescents make contact and what contact-barriers were present during therapy. The independent variable was the intervention strategy, which was the utilisation of the bridging technique to overcome contact-barriers in adolescents during therapy. The hypothesis is that the bridging technique will overcome contact-barriers between therapist and adolescents as well as contact-barriers within the self. This implied that the independent variable, the utilisation of the bridging technique during therapy had a positive impact on the dependent variable, namely the contact-making barriers in adolescents.

2. THE META-THEORETICAL FRAMEWORK OF THE STUDY

The research was conducted using an existential-phenomenological Gestalt approach, as it focused on the perceptions of adolescents' reality and on the process of becoming and evolving (Clarkson & Mackewn, 1994; Daniels, 2004:1-7; Corey, 2005:192; Anderson, 2008:2). Two principles, Holism and Field Theory, formed the basis of the research, as adolescents were seen as "unified" and "coherent whole(s)" in their environment, "the field", consisting of both external and internal worlds (Corey, 2005:193). The goal was to establish and facilitate adolescents' contact-making processes (Yontef, 1993:294).

The researcher's contact style was derived from the stance of an I-Thou relationship (cf. Buber, 1970:51; Joyce & Sills, 2010:42) and being fully present and committed to process and dialogue (Mackewn, 1997:104; Polster & Polster, 1999:105; Melnick & Nevis, 2005:109; Oaklander, 2007:21). Gestalt principles and concepts formed the theoretical basis for this research, as it provide a perspective and structure to describe and explain "how" adolescents function within their fields.

3. AIM AND OBJECTIVES OF THE STUDY

The goal of this study was to explore how the bridging technique could be utilised in therapy to overcome contact-making barriers between the therapist and adolescents and within the adolescents themselves. The researcher was interested in **how** adolescents make contact and **what** contact-making barriers might hinder contact with the therapist and in adolescents.

In order to reach this goal, a number of objectives were identified, which, according to Babbie (2001:91-94) and Mouton (2001:53) are measurable steps that need to be taken in order to reach the goal. These objectives included a literature study, an empirical study in the form of a single systems design, the analysis of data and conclusions and recommendations.

4. RESEARCH METHODOLOGY

4.1 Research approach

A combined or “mixed” approach (Delpont & Fouché, 2011:357) was used, which implies that the researcher used multiple methods of data collection and analysis in order to determine the effectiveness of the intervention, as recommended by Babbie (2008:113) and Delpont (2010). By following a combined approach, the validity and congruence of findings were both increased as a result of data and methodological triangulation (Menon & Cowger, 2010:612). Applied research was conducted to explore, describe and evaluate the research data (Terre Blanche & Durrheim, 1999:41; Neuman, 2000:23; Ivankova, Creswell & Clark, 2010:263; Fouché & De Vos, 2011:97-98).

4.2 Research design

In this study, a single system experimental design, A-B-A-A, with different phases, namely the baseline phase (A), an intervention phase (B), a return to the baseline phase (A) and a follow-up phase (A), was applied. According to Strydom (2011a:162), a single systems design is the ideal way to evaluate the effectiveness of treatment interventions. Dependent and independent variables were identified for this study. Strydom (2011a:165) defines dependent variables in operational terms as the specific measurable indicators that allow the researcher to evaluate the outcomes that are produced in a study, in other words, the problem that must be worked on. In this study, the dependent variable (A) was how adolescents make contact and what contact-barriers were present. Independent variables (B), according to Strydom (2011a:165), are the intervention strategy, procedures and techniques that a researcher applies. The independent variable in this study was the utilisation of the bridging technique to overcome contact-making barriers in adolescents during contact-making in a therapeutic situation.

The qualitative part of this study was an instrumental case study (Creswell, 2008:199; Babbie, 2008:94-97; Fouché & Schurink, 2011:322). It included the therapeutic intervention with adolescents, over a period of eight weeks, where the bridging

technique was introduced and semi-structured interviews were conducted with parents and teachers. The quantitative part of this study involved the completion of assessment questionnaires by the researcher for each adolescent participant during an intervention phase (the pre-intervention assessment), after the intervention phase (the post-intervention assessment) and during the follow-up, which took place four weeks after the post-intervention assessment to determine the effectiveness and consistency of the intervention.

4.3 Research sampling

The universe, using Strydom's (2011b:223) definition in the study consisted of all adolescents who experienced barriers to contact-making, their parents and teachers, and living in Gauteng. The population (Strydom, 2011b:223) was confined to all adolescents between the ages of 11 and 14 who experienced contact-making barriers, their parents and teachers, and living in the Ekurhuleni Metropolitan district, Northern Region, Gauteng. Non-probability sampling was applied, with purposeful selection, as recommended by Babbie (2008:52), Maree and Pietersen (2010:176) and Strydom (2011b:231). The sample consisted of 14 adolescents who lived in and attended school in Kempton Park, in the Ekurhuleni Metropolitan district, as well as their parents and teachers. Teachers from three different schools identified the adolescent participants, who then, with the permission of their parents, agreed to participate voluntarily in this study.

The adolescent population, their parents and teachers were divided into three sub-populations. Population A consisted of four participants – two boys and two girls, who attended a school that focuses on learners with intellectual and mental disabilities. In Population B, there were four participants – two girls and two boys, who attended a school for learners with special needs, also called a full service school. Population C consisted of six participants – two girls and four boys, who attended a mainstream high-functioning school.

4.4 Data collection methods

The researcher employed different methods to collect the data, such as interviews, observation and assessments. The quantitative data included an assessment questionnaire developed by Oaklander (1999) and adjusted by Blom (2006:68; 2010). The questionnaire was completed for each adolescent participant before the intervention phase (pre-intervention assessment), after the intervention (post-intervention assessment) and a follow-up, to measure the consistency of the intervention after four weeks. The Directive Interactive Supportive and Corrective (DISC) temperament analysis developed by Boyd (1994:51-84) and Rohm (1998:29-32) was used as part of the assessment (see Addendum 1: Assessment Questionnaire).

The qualitative data collection method included semi-structured interviews with parents and teachers and through therapeutic interventions with adolescents. The data were collected before the therapeutic intervention (pre-intervention assessment) after the therapeutic intervention (post-intervention assessment) and during a follow-up assessment. An ecomap or genogram was completed for each of the adolescent participants. This enabled the researcher to obtain a visual presentation of each adolescent's Gestalt field, which included his/her family environment, relationship bounds, resources and connections to a larger social system, as advocated by Goldenberg and Goldenberg (2004:89,507). This data did not form part of the empirical analysis.

During the therapeutic intervention with the adolescents, the bridging technique was applied and sessions were video-recorded. Themes and categories were identified using an *a priori* coding approach as an inductive coding approach, as described by Braun and Clarke (2006:93) and Nieuwenhuis (2010:107).

4.5 Data-analysis

The quantitative data were analysed according to the semantic differential scale or scores, and were transformed statistically to help describe the data more succinctly. According to Maree and Pietersen (2010:167), scales "are intended to help

researchers discover strength of feelings or attitude. The response options are set up in such a way that the variables measured can be expressed as numerical scores that are of either an ordinal, interval or ratio type". The main aspects and components in the assessment questionnaire were given numerical scores from one to four to assess the participants' contact-making skills, resistance and the effectiveness of the intervention at an interval level (Terre Blanche & Durrheim, 1999:98,99; Maree & Pietersen, 2010:168). The scores were designed in such a manner as to show an increase in the scores as a positive influence, and a decrease in the scores as a negative influence.

The raw scores were plotted on line graphs and the percentage change that occurred for each aspect and sub-component was plotted on bar graphs. These two kinds of graphs are both different graphic indicators to show the effect of the intervention: the use of the bridging technique. The movement of the lines on the line graph upwards indicated a positive effect. The bar graph indicated the percentage change, and was a representation of how much the line moved up or down on the line graph. The percentage change between pre-intervention assessment and the post-intervention assessment indicated the immediate effect of the technique, whereas the percentage change between the post-intervention assessment and the follow-up assessment was an indication of the longevity/sustainability of the intervention. The higher the percentage change, the more positive the effect of the intervention. If the percentage change between the post-intervention assessment and the follow-up assessment stayed relatively constant or increased, it could be inferred that the effect of the intervention was lasting.

The qualitative data were analysed and interpreted using a Creswell spiral, as described by Marshall and Rossman (2011:402-403) and Creswell (2007). The researcher focused on several aspects in the spiral to analyse the findings, circling around and "upwards" towards the completion of the process:

- planned video recordings took place at the relevant schools and at the researcher's private practice;
- data were collected and preliminary interpretations of the data were done, guided by the initial concepts;

- data were organised (labelled according to date, place and interview) and back-up copies were made of video recordings;
- notes/memos were read and written;
- themes, patterns and categories were identified according to an *a priori* coding approach, where themes were selected from the research topic, namely contact-making boundaries and from an inductive coding approach, where themes, categories and patterns emerged from semi-structured interviews with parents, the therapist and teachers, and during the intervention phase with adolescents (Braun & Clarke, 2006:83; Niewenhuis, 2010:107);
- data were coded according to key words and coloured highlighting;
- data were evaluated in terms of their usefulness, centrality and the search for alternative explanations and meanings; and
- data were represented by compiling the dissertation in an article format, as recommended by Heppner and Heppner (2004).

Combined quantitative and qualitative methodologies were used to ensure the validity and congruence of the research findings (Denzin, 2006; Menon & Cowger, 2010:612; Delport & Fouché, 2011:434-436). Data from multiple sources were cross-checked for regularities (this is also called triangulation), in order to give a more detailed and balanced picture of the research intervention, as suggested by O'Donoghue and Punch (2003:78) and Creswell (2008).

The researcher used existing assessment guidelines and analysis compiled by therapists and authors in the field of Gestalt play therapy as part of the quantitative data collection method, which added reliability to the research. These analyses were the Directive Interactive Supportive and Corrective (DISC) temperament analysis developed by Boyd (1994:51-84) and Rohm (1998:29-32) and of Oaklander (1999) and Blom (2006:69) for assessing children during Gestalt play therapy (See Addendum 1: Assessment guidelines). The research can be duplicated, as raw scores are available and have been validated externally. Interval measurements were done during the pre-intervention post-intervention and follow-up assessment, which added transferability (also called external validity) to the research findings. The empirical research was integrated with a literature control which added trustworthiness to the

study, as advocated by Terre Blanche and Durrheim (1999:431,87,61) and Schurink, Fouché and De Vos (2011:419-421).

5. ETHICAL ASPECTS

The researcher followed and integrated a number of ethical principles and guidelines in the research study:

- The **autonomy and confidentiality** of all participants were respected. Informed and voluntary consent were obtained, and participants were assured of their freedom to withdraw from the research at any time. Confidentiality and honesty were central to the formation of a client-therapist relationship. Therefore, all participants were fully informed regarding the research topic, the intervention phase that was video-recorded, interviews, as well as the assessment questionnaires. All participants were given time to ask questions before signing the consent form to participate. Copies of the signed consent form were issued to the parents of the adolescent participants.
- The principle of **non-maleficence** was adhered to by the researcher, who considered all potential risks, that might inflict physical, emotional, social or any other forms of harm on participants. The researcher was transparent during the research process and support was offered to all participants after the completion of the study.
- **The research-benefitted** participants, as findings and recommendations were given to the relevant parents, teachers and other therapists. This allowed ongoing therapy to be given by school therapists to some of the participants, and provided insight to parents on how to address the adolescents' behavioural symptoms.
- **The researcher's own code of ethics** is in line with the Ethical Code of the South African Council for Social Service Professions (SACSSP, 1989), as well as the professional Gestalt code of ethics as prescribed by the European Association for Gestalt Therapy (EAGT, 2001). Both ethical codes state that every human being has a unique value and potential, irrespective of the person's origin, ethnicity, sex, age, beliefs, socio-economic and legal status. From a Gestalt perspective, the importance of autonomy and self-regulation of the individual in the context of interpersonal relationships is also stressed.

6. RESEARCH FINDINGS

6.1 Quantitative data results

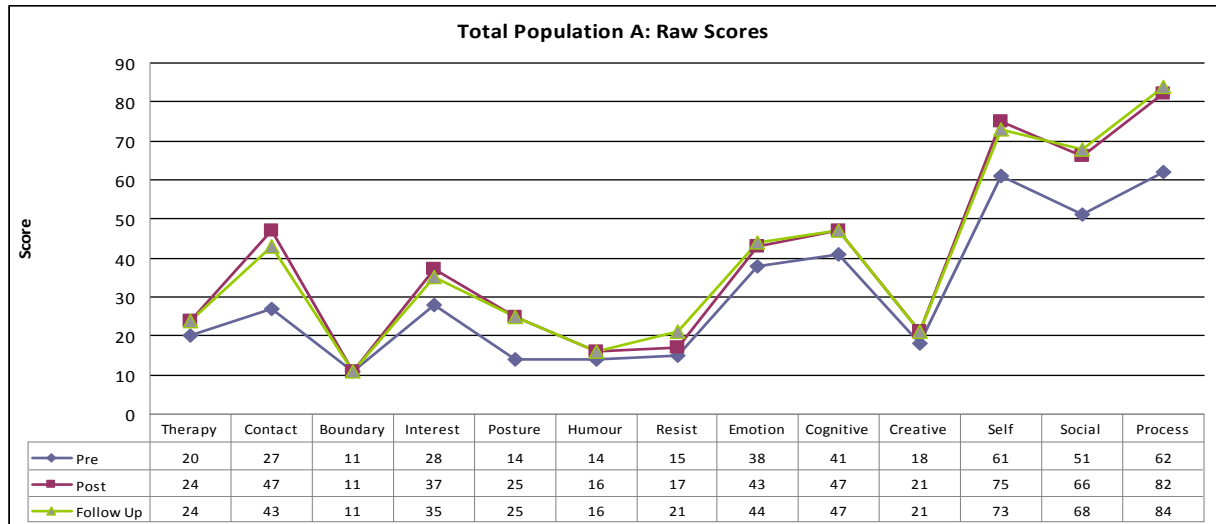
The quantitative data results are presented in the form of line and bar and line graphs. The raw scores of each population group were obtained from the questionnaires completed by the researcher on the participating adolescents' contact-making skills before the intervention (pre-intervention assessment), after the intervention (post-intervention assessment) and in a follow-up assessment (see Addendum 3: Example of quantitative data analysis).

The percentages illustrated in the bar graphs, Graphs 2A, 2B and 2C, were calculated on the basis of the results of the pre-intervention assessment and those of the post-intervention assessment – taking the difference between the scores of the pre-intervention assessment and those of the post-intervention assessment and dividing it by the pre-intervention assessment score. The post-intervention to follow-up change percentages were calculated by taking the difference between the scores of the post-intervention assessment and those of the follow-up assessment and dividing it by the post-intervention assessment score. The total population's raw scores were combined and calculated in order to give an overall picture of the findings obtained during the intervention and follow-up assessments for all the participants to indicate the consistency of the findings (see Graphs 1P and 2P). For the purposes of the study, the focus of the data analysis was on the contact, contact boundary and resistance components. However, noticeable changes in other components that had an effect on the above components have also been commented on.

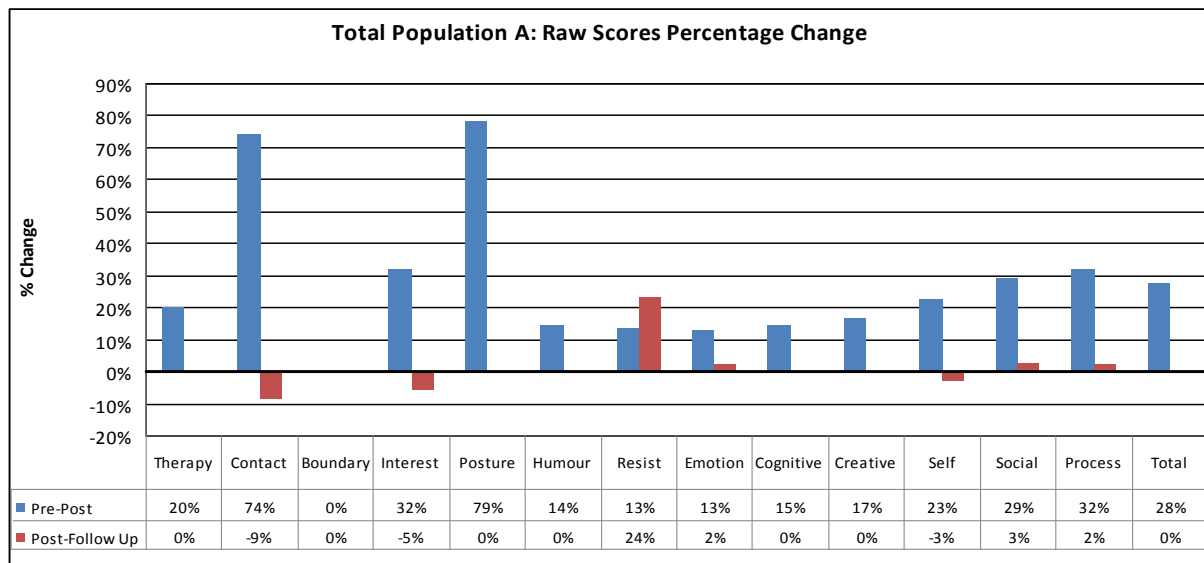
6.1.1 Results for Population A

The results for Population A are presented below.

Graph 1A: Total Population A: Raw Scores



Graph 2A: Total Population A: Raw Scores Percentage Change



Graphs 1A and 2A represent Population A, which consisted of four participants with intellectual and mental disabilities. The following findings were obtained:

- The bridging technique was used in twelve sessions for this specific population – three sessions were spent with each participant. The lines in Graph 1A show a general positive upward movement. Graph 2A shows a general improvement (28%) across all components from the pre-intervention assessment to the post-

intervention assessment, and consistency in the findings from the post-intervention assessment to the follow-up assessment.

- In Graph 2A, the contact and contact skills of participants showed an improvement of 74% from the pre-intervention assessment to the post-intervention assessment. There was a slight drop of 9% in the improvement from the post-intervention assessment to the follow-up assessment. This can be attributed to the fact that one participant felt sick during the follow-up session, but still wanted to participate. This also affected the scores on the component labelled interest, which showed an improvement from 32% from the pre-intervention assessment to the post-intervention assessment but a decrease of 5% from the post-intervention assessment to the follow-up assessment.
- Resistance showed a general improvement of 24% from the post-intervention assessment to the follow-up assessment, which suggests that resistance arising from barriers was reduced after the contact-making process with the therapist/researcher. This implies that the higher the percentage change, the less resistance was present.
- The participants' sense of self showed an improvement of 23% from the pre-intervention assessment to the post-intervention assessment, but with the follow-up assessment, a slight decrease of 3% was noted.
- A noticeable change in body posture from the pre-intervention assessment to the post-intervention assessment (79%) was noted, and constant findings were recorded from the post-intervention assessment to the follow-up assessment.

6.1.2 Discussion for Population A

The use of the bridging technique facilitated a form of contact between the therapist/researcher and the participants that was playful and non-threatening. Participants were able to use the base/veld² the bridge by constructing different bridges, by adding objects such as animals, camping gear, and/or figurines which facilitated contact-making. Discussion between the researcher and the participants focused on physical abuse, bullying, a loss of significant others (a parent, doll and dog) and trauma (housebreaking and theft).

²This term was chosen to distinguish this physical space from the concept of the "field" as used in Gestalt Theory. The spelling of "veld" was preferred to "veldt" in order to distinguish between the construct used in the study and the broader meaning of the South African "veldt".

Given the intellectual and mental disabilities of these participants, they were unable to use the bridge metaphorically; however, the different bridges they built and their exploration of the veld helped to establishing contact and sensory awareness that were sustained during a second follow-up. The responses of this population tended to be on a fairly concrete level, rather than on the level of abstract thinking and feeling. Heubner (2000) points out that limited linguistic skills or mental capabilities might hinder the process of contact-making with the self and the environment. This was evident during the contact-making with adolescents where participants tried to comprehend their world by fitting it into a cognitive scheme.

The participants showed less resistance from the post-intervention assessment to the follow-up assessment than in the pre-intervention assessment, which can be attributed to the formation of trusting relationships between the therapist/researcher and the participants, as well as the use of the bridging technique. A general improvement in most components from the pre-intervention assessment to the post-intervention assessment was noted, and consistent findings from the post-intervention assessment to the follow-up assessment were recorded. The literature describes the importance of the therapeutic relationship and offers empirical support (Callaghan, Naugle & Folette, 1996:381) for a link between a positive client-therapist relationship and outcome(s), as is also pointed out with regard to two components in this population, namely contact and resistance. According to Clarkson (2004:183), “everything is relationship-connectivity”. Similarly, according to Oaklander (2007:20), contact is the first reality, but the relationship comes first (Hycner & Jacobs, 1995).

The “self” in Gestalt is seen as a system of present contacts that occur at the boundary (Perls *et al.*, 1951:372). Contact requires a sense of being connected to the surrounding field, as well as a sense of being defined and bounded in the process of discovering the connection (Oaklander, 1988; Yontef, 1993:372). A poor sense of self implies that the person is not in contact, or in awareness, and that contact boundary interruptions might be present. Population A displayed an improvement in their sense of self, indicating an awareness of their surroundings and with their “selves”. A slight decrease in this component can be attributed to the fact that one participant was

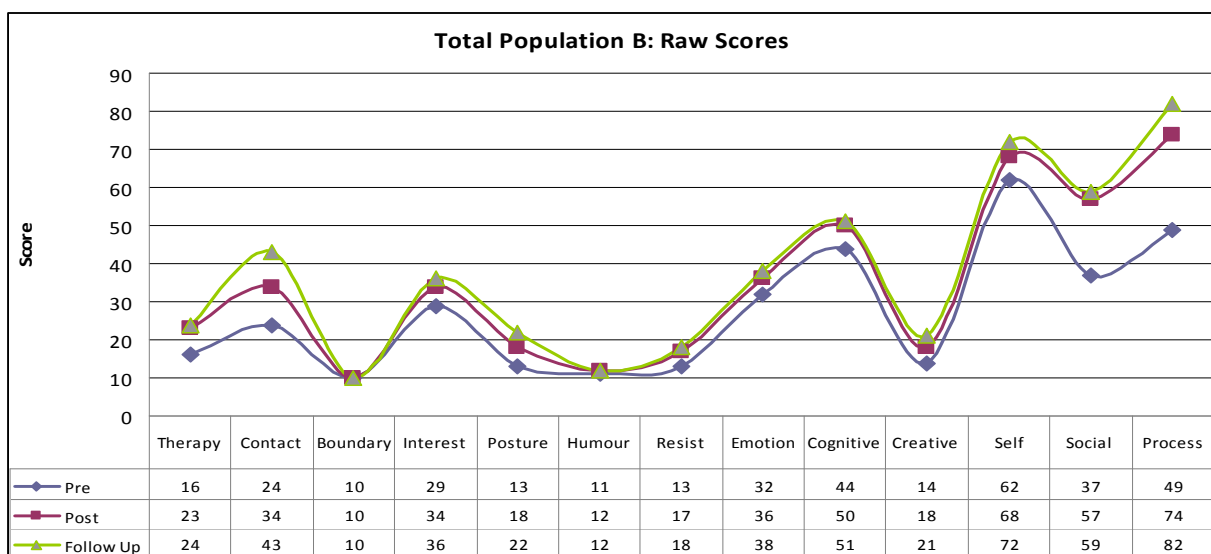
placed in safety with extended family members after the disclosure of physical abuse in the sessions.

This population responded well to body movement (playfulness with bean bags and throwing balls) during the use of the bridging technique. The literature provides supporting evidence of the positive effect of movement as a way of communicating with the elderly, adolescents and young children, where the spoken word is not a primary means of communicating. Meekums (2002:14-21) and Payne (2006:14-21) are of the opinion that movement creates awareness and body-mind integration. Sakata, Shiba, Maiya and Tadenuma (2004:428) point out that non-verbal information is reflected in a person's tone of voice, manner of breathing, facial expression and posture, which are conveyed through the human body, also called “ body language” or “ creative acting” by Payne (2006:3-7).

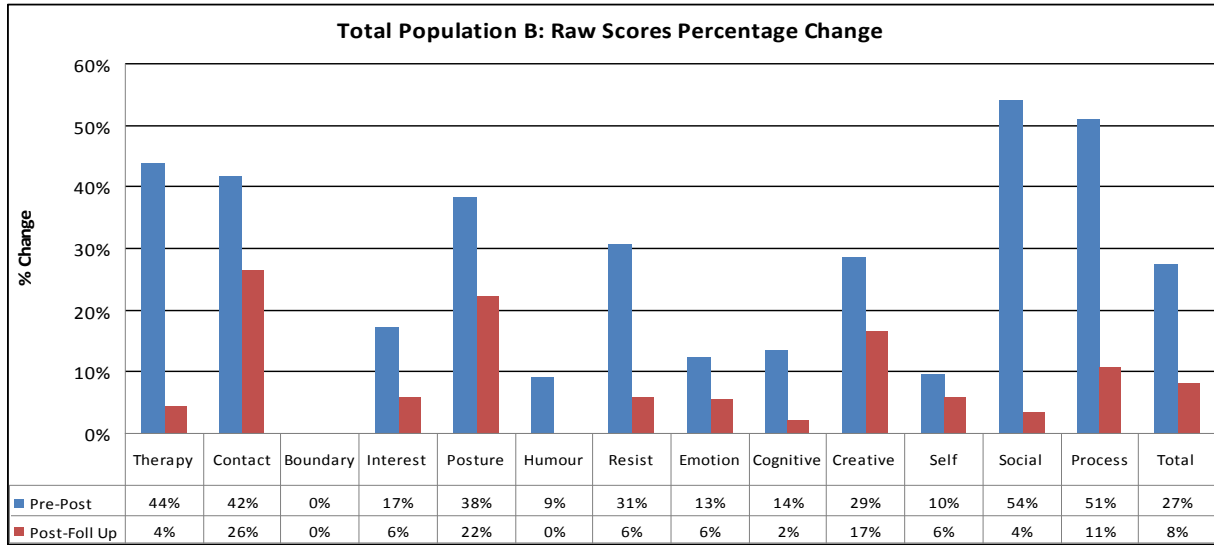
6.1.3 Results for Population B

The results for Population B are presented below.

Graph 1B: Total Population B: Raw Scores



Graph 2B: Total Population B: Raw Scores Percentage Change



Graphs 1B and 2B represent Population B, which consisted of four participants. They attended a full service school for learners with learning disabilities. The following findings were obtained:

- The bridging technique was used during eight sessions for this specific population, with two sessions spent with each participant. The lines in Graph 1B show a general positive upward movement. Graph 2B shows a general improvement (27%) across all components from the pre-intervention assessment to the post-intervention assessment and an additional 8% from the post-intervention assessment to the follow-up assessment.
- The contact and contact skills of these participants improved by 42% between the pre-intervention assessment and the post-intervention assessment and by an additional 26% from the post-intervention assessment to the follow-up assessment.
- The therapeutic relationship between the therapist/researcher and participants improved 44%, from the pre-intervention assessment to the post-intervention assessment, and by an additional 4% from the post-intervention assessment to the follow-up assessment. This had a direct effect on the component resistance, which showed an improvement of 31% from the pre-intervention assessment to the post-intervention assessment and a further improvement of 6% from the post-intervention assessment to the follow-up.
- The social skills component, which focused on the participants' relationship with significant others and the satisfying of needs, registered an improvement of 54% from the pre-intervention assessment to the post-intervention assessment and an

additional improvement of 4% from the post-intervention assessment to the follow-up assessment, suggesting that social skills stayed relatively consistent.

- Posture showed an improvement of 38% from the pre-intervention assessment to the post-intervention assessment and an additional improvement of 22% from the post-intervention assessment to the follow-up assessment.
- Process displayed an improvement of 51% from the pre-intervention assessment to the post-intervention assessment and an additional improvement of 11% from the post-intervention assessment to the follow-up assessment.

6.1.4 Discussion for Population B

The use of the bridge facilitated contact between the therapist/researcher and the participants that was non-threatening to the participants. Participants constructed different bridges, adding objects to their veld, which facilitated contact and dialogue. Two of the participants were able to relate metaphorically to the bridge, addressing unfinished business within their field, such as divorce, relationship difficulties and inappropriate sexual behaviour.

The therapeutic relationship between the therapist/researcher and adolescents contributed to positive outcomes in the components called contact and resistance. It is within a relationship that dialogue between two people takes place. According to Mackewn (1997:82), dialogue involves turning your being to their being and addressing them with real respect, being genuinely interested, confirming, understanding and authentic. Yontef (1993:40) describes this dialogical relationship as “[b]ecoming yourself. “I” happens by entering into relationship. By presenting yourself as you are, other people can treat you as Thou. By treating another person as a Thou, you become more fully yourself”.

Improvement in the component labelled social skills can be attributed to the bridging technique, which facilitated dialogue between the therapist/researcher and the given participant, as well as between participants, their teachers and parents. The full support from teachers and other therapists for the research study (reminding participants to attend sessions, permitting sessions during school hours without any interruptions) contributed to positive results. Three of the participants were selected to

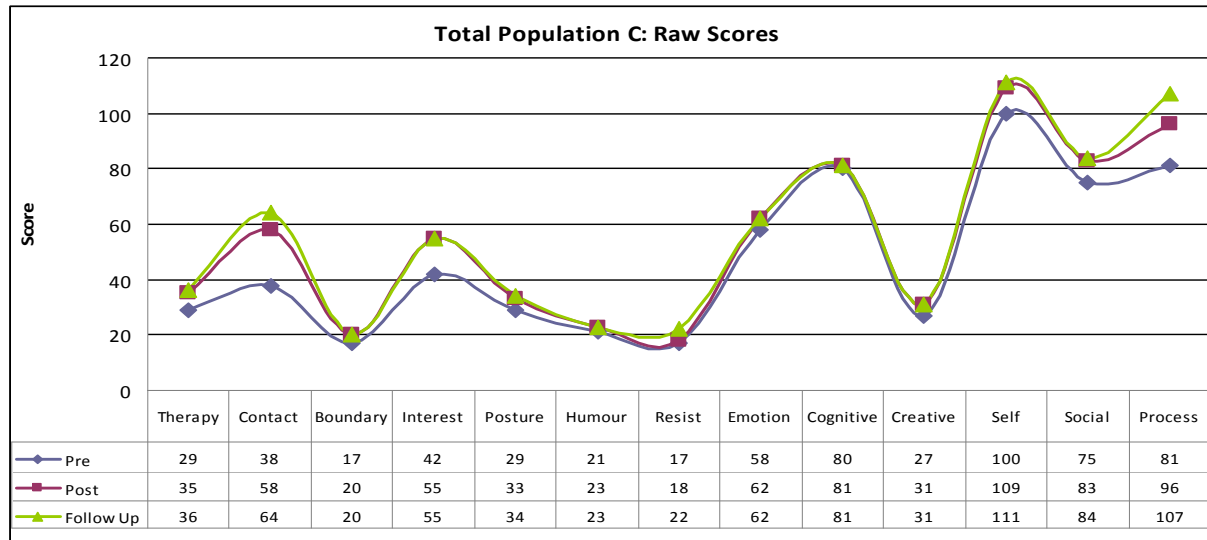
attend leadership courses and were selected thereafter. The Attitudes and perceptions of parents changed as they adopted an authoritative parenting style (Baumrind, 1971) versus an authoritarian style, which created more support and less criticism (Berk, 2006:564-559). The literature shows that support from family and friends is necessary to build a strong sense of self (McConville, 1995:35). Some older views in the literature on family relationships during adolescence mention conflict and disengagement, whereas newer views emphasise interdependent relationships and connectedness within the family field (McConville, 1995:35; Louw, Van Ede & Louw, 1998:449; Blom, 2006:102-103).

The component called process refers to the unique temperament of adolescents. According to Papalia, Olds and Feldman (1998:237) it is “a person’s characteristic way of approaching and reacting to people and situations”. It can be described as the how of behaviour, rather than the what. In this study, the Directive Interactive Supportive and Corrective (DISC) temperament analysis was used in the assessment questionnaire to determine adolescents’ processes. Yontef (1993:270) and Perls *et al.* (1951:375) regard the “self” as a process of continuously becoming and evolving. Improvement in this component can be attributed to adolescents’ becoming aware of their own intra-psychoic and interpersonal processes, such as their thoughts, feelings and inappropriate and destructive behaviour.

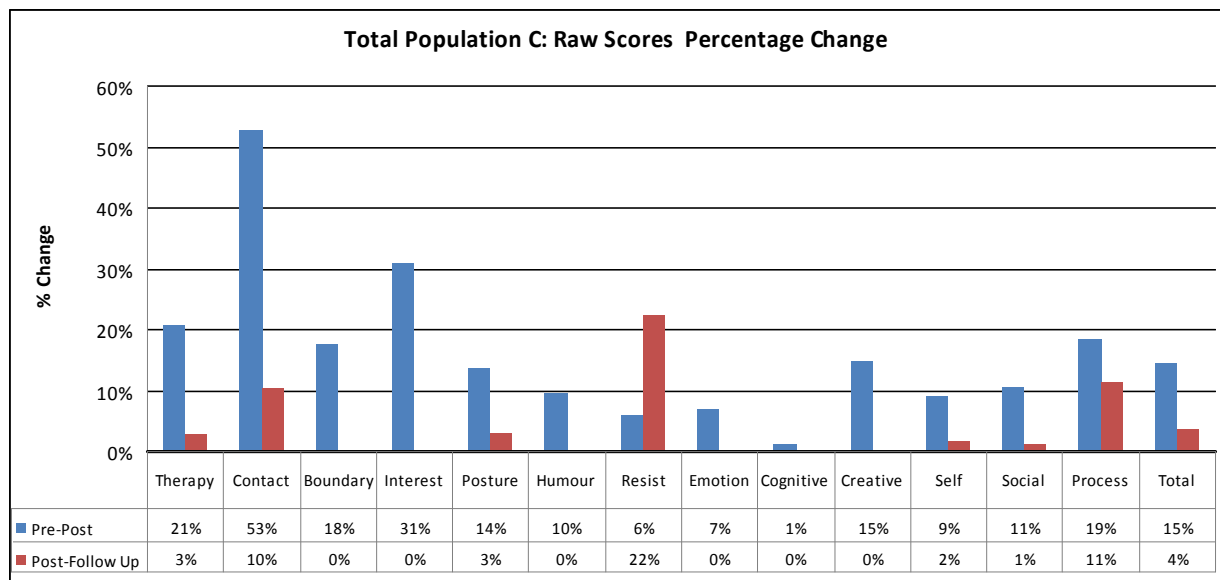
6.1.5 Results for Population C

The results for Population C are presented below.

Graph 1C: Total Population C: Raw Scores



Graph 2C: Total Population C: Raw Scores Percentage Change



Graphs 1C and 2C represent Population C, which consisted of six participants attending a high-functioning, mainstream school. The following findings were obtained:

- The bridging technique was utilized during eight sessions for this specific population, with two sessions each with two participants and one session each with four participants. In Graph, 2C contact and contact skills of participants registered

an improvement of 53% from pre to post and an additional improvement of 10% from post to follow up.

- Boundary showed an improvement of 18% from the pre-intervention assessment to the post-intervention assessment and a consistent reading from the post-intervention assessment to the follow-up assessment. This indicates that there was neither a deterioration in the effect of the intervention, nor any further improvement.
- Resistance showed an improvement of 6% from the pre-intervention assessment to the post-intervention assessment and an additional improvement of 22% from the post-intervention assessment to the follow-up assessment. This population group displayed a higher percentage change from the post-intervention assessment to the follow-up assessment than from the pre-intervention assessment to the post-intervention assessment than Populations A and B.

6.1.6 Discussion for Population C

This population represented participants with higher cognitive developmental abilities than those of Population A. Four of the six participants were able to use the bridge metaphorically. The bridge facilitated playfulness, contact and dialogue, which related to war games, picnics and camping. This population group did not participate as much as the other two groups during the use of the bridging technique. This can be attributed to two factors – first, their ability to respond at a cognitive level (to comprehend and articulate well) and second, owning their projections during the utilisation of the bridging technique and thereafter only referring to the bridge (as a mental representation) when discussing identified barriers in their lives.

Findings in the boundaries component indicated an improvement from the pre-intervention assessment to the post-intervention assessment, which implied that participants made better contact with the therapist/researcher and with themselves than members of the other two populations, with fewer contact-making interruptions during the post-intervention assessment to the follow-up assessment. Contact-making boundaries or interruptions are discussed in the analysis of the qualitative data (see Section 6.2).

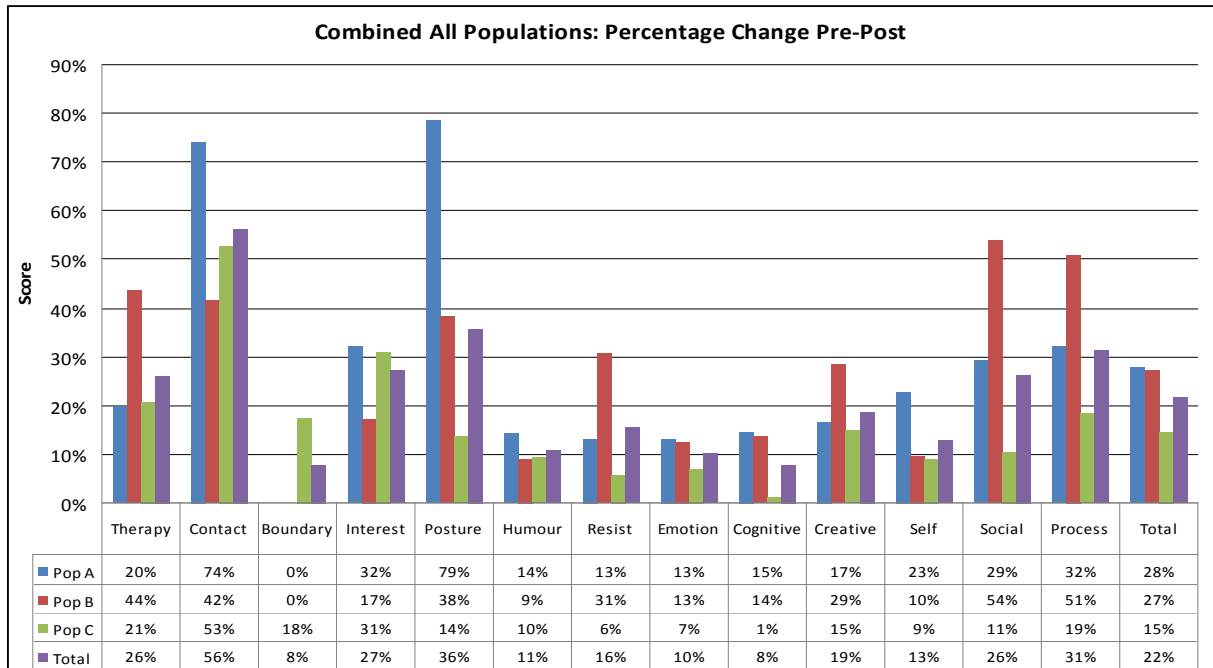
Resistance is considered a normal and essential part of the therapeutic process. It can be seen as a manifestation of energy, and as an indication of the contact level of the adolescent (Blom, 2006:59-61; Oaklander, 2007:23). Resistance manifested in different ways in this group, namely in a passive manner during the contact-making with the therapist/researcher: in ignoring her when they were spoken too, in answers such as “I don’t know” or excuses to end sessions. Polster and Polster (1973) regard resistance as something which prevents a person from experiencing the present in full. However, Latner (1992) replaces the term “resistance” with “creative adjustment”, implying a natural process of organismic self-regulation. Resistance is also considered a healthy response, showing a strong sense of self and clearly defined boundaries.

The research findings in this group were affected by the resistance by one participant who refused to participate in the use of the bridging technique. He refused to allow sessions to be video-recorded despite the fact that permission had been obtained prior to the sessions. He was kept in the study because he was able to voice his feelings via other media and his process was respected. The findings relating to this participant are valid for the study, because the researcher and other therapists are likely to encounter other children and adolescents in private practice who choose not to use the bridge. For ethical reasons, the counselling process with this participant and his parent was completed.

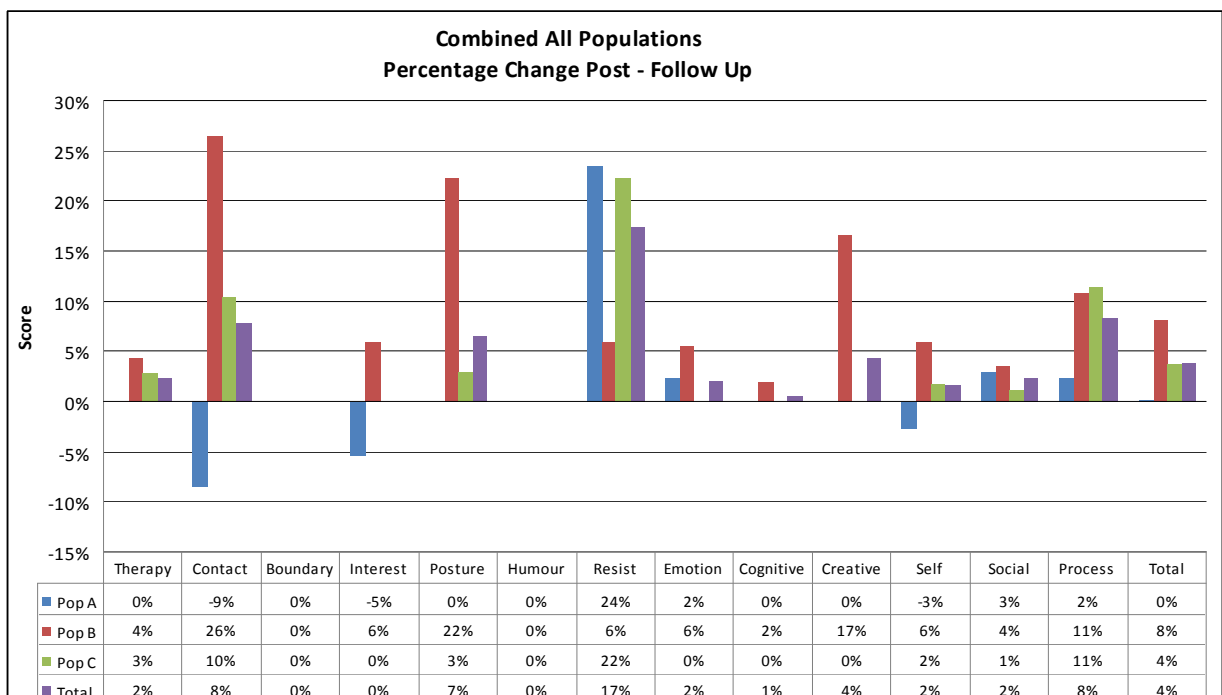
6.1.7 Combined results for All Populations

The results for All three populations were combined, and are presented below.

Graph 1P: Combined Results for All Populations: Percentage Change from the Pre-intervention Assessment to the Post-intervention Assessment



Graph 2 P: Combined Results for All Populations: Percentage Change from the Post-intervention Assessment to the Follow-up Assessment



Graphs 1P and 2P represents the combined scores and percentage change for all populations from the pre-intervention assessment to the post-intervention assessment and the post-intervention assessment to the follow-up assessment:

- The bridging technique was used during a total of 28 sessions with 14 participants. The overall picture showed an improvement (22%) in all components from the pre-intervention assessment to the post-intervention assessment for the whole population and an additional improvement of 4% from the post-intervention assessment to the follow-up assessment.
- The most noteworthy result was recorded for the contact-making skills component, which improved by 56% from the pre-intervention assessment to the post-intervention assessment and displayed an additional improvement of 8% between the post-intervention assessment and the follow-up assessment.
- The therapeutic relationship improved by 26% from the pre-intervention assessment to the post-intervention assessment and there was an additional improvement of 2% from the post-intervention assessment to the follow-up assessment.
- There was a reduction in resistance (thus an improvement) towards the therapeutic process. Even though this component improved only by 16% between the pre-intervention assessment and the post-intervention assessment, this component improved the most (17%) between the post-intervention assessment and the follow-up assessment for the whole population.
- The process component showed a noticeable improvement of 31% between the pre-intervention assessment and the post-intervention assessment and an additional improvement of 8% between the post-intervention assessment and the follow-up assessment.
- The social component reflected an overall improvement score for the whole population of 26% between the pre-intervention assessment and the post-intervention assessment and an additional 2% between the post-intervention assessment and the follow-up.
- Posture showed a remarkable improvement of 79% for Population A, 38% for Population B and 14% for Population C, with 36% in total between the pre-intervention assessment and the post-intervention assessment. An additional improvement (7%) from the post-intervention assessment to the follow-up was noted for the whole population.

6.1.8 Discussion for Combined Results All Populations

Both Graphs 1P and 2P register consistency of the intervention for each of the population groups. The components boundary, humour and interest showed a zero percentage change from the post-intervention assessment to the follow-up assessment, which suggests that, although there was no deterioration in the effect of the intervention, there was no further improvement. The graphs illustrate that contact, resistance and process were the components that improved further for all populations from the post-intervention assessment to the follow-up assessment. However, for Population A, there was a slight deterioration (as discussed in Section 6.1.2, under Graph 1A and 2A). Contact and posture were the two components that were most influenced by the intervention, followed by the social and process components.

6.2 Qualitative data results

The qualitative results were obtained by using the Creswell spiral. They are presented in table format. Themes were selected from the research topic (*a priori* coding) and data was gathered in semi-structured interviews (inductive coding) with parents, teachers and adolescents during the intervention phase. The responses of the participants are referred to in table format below, using the labels P (Population A, B or C) and the number of the participant, to correlate with the qualitative data analysis themes. The responses of the teachers are labelled using T, and those of primary caregivers, including parents, as C. The words of the participants are cited *verbatim* where appropriate, and are then printed in italics. Where participants' words are cited in Afrikaans, a translation is provided in square brackets. Explanatory additions to the participants' words are also presented in square brackets. Three main themes (see Addendum 4: Qualitative data analysis – themes) were identified, namely:

- contact boundary disturbances and sub-themes, which are discussed in the context of healthy functioning;
- personal emotional factors, which focus on how adolescents experienced events and their effects; and
- behavioural factors that were identified by parents and teachers during the semi-structured interviews, which focused on the “what” that might have caused symptomatic behaviour by the adolescents.

6.2.1 Main Theme 1: Contact boundary disturbances

Table 1: Sub-theme – desensitisation vs sensation and perception

<p>Responses and behaviour of adolescents during the intervention phase</p>	<p>Four of the participants blocked contact, as they were unable to respond or show emotions. They appeared blunt, avoided eye contact, stared and used limited verbal expressions (“<i>I don’t know</i>”, “<i>yes</i>” and “<i>no</i>”) or resorted to long periods of silence. They pulled up their shoulders, adopted a body posture - turned away from the therapist/researcher and ignored the therapist/researcher. One participant was unaware of wetting his pants and smelled strongly of urine. These participants were victims to domestic violence, physical and emotional abuse, and or trauma-armed robbery.</p>
<p>Reference to the literature</p>	<p>The literature shows that adolescents who were exposed to domestic violence, physical, emotional and sexual abuse for long periods do not feel the pain of beating, shouting and screaming, as they cut themselves off from sensory and physical experiences (Blom, 2006:37). Clarkson and Mackewn (1994:7) describe this unawareness as a state where individuals numb themselves to the sensation of their bodies by a process called desensitisation. The existence of pain or discomfort is kept outside their awareness. It involves blinding and anaesthetizing oneself by limiting stimulation, dullness, avoiding feelings, blocking sensory information and becoming “senseless” (Woldt, 2009).</p> <p>By contrast, healthy functioning allows individuals’ sensory processes (called “<i>Id functions</i>”) to make contact with their field and try to satisfy their needs</p>

	(called a process of organismic self-regulation) (Perls <i>et al.</i> , 1951:381; Latner, 2000:28).
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Table 2: Sub-theme – introjection vs awareness

<p>Responses and behaviour of adolescents during the intervention phase</p>	<p>Nine of the 14 participants blocked contact by accepting passively the points of view (thoughts and actions) of significant others such as their parents, grandparents and friends, through compliance. Typical responses were:</p> <ul style="list-style-type: none"> • <i>“My stepmother told me I am a liar – everything coming from my mouth is a lie.... Nobody believes me, she hits me, pulled my hair – ‘cause I am a liar. The children in school told me I am lying to my teacher” (PA1).</i> <p>This participant was removed from the stepmother and biological father and placed in a place of safety after the disclosure and an investigation of severe physical abuse.</p> <ul style="list-style-type: none"> • <i>“Toe my pa dood is, sê my ma ek is nou die man van die huis. Ek moet na hulle kyk – my boetie en my ma. Sy sê seuns huil nie...my pa het ook nooit gehuil nie, nou wil sy hê ek moet met jou praat oor my ‘feelings’...ek verstaan nie”. (PC6).</i> <p>[When my father died, my mother told me that I was the man of the house. I have to take care of her and my brother. She told me boys do not cry.... my father never cried. Now she wants me to talk to you about my ‘feelings’, I don’t understand.]</p>
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- *“I can’t be the best. My mother wants me to be the best.... I do not have friends because I am not the best” (PC3).*
- *“My grandmother told me that my mother did not love me. She [my mother] has done bad things to me...she pushed my pram down the stairs. She left my dad and me. It is my fault” (PA2).*
- *“Ek het gehoor my ma praat met Tannie H en vertel haar dat my pa goed is vir niks...hy is ‘n ‘womaniser’. Sy sê ek lyk net soos my pa...dan is ek mos ook goed vir niks” (PB4).*

[I heard my mother talking to Auntie H and telling her that my father is a good-for-nothing ... he is a ‘womaniser’. She says I look just like my dad ... so then I’m also no good.]

This participant stopped speaking after he heard his mother’s conversation and was diagnosed by an educational psychologist as presenting with selective mutism. During the first few sessions, the participant only nodded or smiled.

- *“My ma is ‘n prostituut. Ek het haar gevang met mans. Dit was nie baie lekker nie. Sy slaap saam met swart mans. Sy lyk vuil en siek. Sy het Aids. Nou sê my ouma, ek is net soos my ma. Sy het my gevang iets doen in die badkamer... Ek is seker soos my ma... dit maak my bang” (PB1).*

[My mother is a prostitute. I caught her with men. It was not very pleasant. She is sleeping with black men. She looks dirty and sick. She has Aids. My grandmother told me that I am just like my mother. She caught me doing something in the bathroom

	<p>(inappropriate sexual behaviour)...I'm probably like my mom ... it scares me.]</p>
<p>Reference to the literature</p>	<p>Yontef (1993: 137) and Kirchner (2000) argue that an acceptance of others' beliefs of who and what one is constitutes a false identification, which people such as these participants have assimilated indiscriminately to make them congruent with who they really are.</p> <p>To make healthier contact with the environment and with the self is to deconstruct that which is useful and to discard that which is not, which is called a process of assimilation (Blom, 2006:32). Introjections interfere with these participants' natural self-regulation and leads to the development of unfinished business, as illustrated in the comments of the adolescents (Clarkson & Mackewn, 1994:73).</p> <p>Selective mutism or the avoidance of talking, according to Barlow and Durand (2005:497), is a communication disorder where an adolescent does not speak in some social situations, although he/she is able to talk normally at other times. The most common place for children to exhibit mute behaviour is in the classroom, so that teachers often first notice the disorder. According to statistics, boys are almost five times more likely than girls to be affected (Barlow & Durand, 2005:497).</p> <p>From a Gestalt perspective, this can be viewed partly as deficient Gestalt processing (not taking in all of the details as a whole scene) and partly as an inability to read emotional expressions (Woldt, 2009). Awareness typically involves aspects of our total self – emotional,</p>

	<p>physical, cognitive (talking and language) and sometimes spiritual processes (Woldt, 2009).</p> <p>Joseph (1999:308) attributes selective mutism to family dynamics that included an overprotective mother and an abnormally strict or very distant father (cf. Dow, 1995:836). This was evident in the adolescent PB4's background history and contact-making with the environment, as he stopped talking in the presence of his mother and girls. He appeared almost paralyzed and ignored his father to avoid verbal communication with him.</p> <p>Healthy functioning involves experiencing and moving towards a goal or contact and an outcome by experiencing the result of the contact (Woldt, 2009).</p>
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Table 3: Sub-theme – projection vs motivation and excitement

<p>Responses and behaviour of adolescents during the intervention phase.</p>	<p>Three of the participants blocked contact with the environment and with the self by projecting emotions and feelings onto others. Typical responses were:</p> <ul style="list-style-type: none"> • <i>“Dit is nie my skuld nie. Ek het nie die porno-foto’s na my eie selfoon gestuur nie. Ek het nie gelieg nie. Ek word nou daarvoor gestraf. Hulle het my leierskap-balkie gevat” (PC1).</i> [It is not my fault. I did not send the porno pictures to my own cell phone. I did not lie. I am now being punished for that. They took my leadership badge from me]. • <i>“Hulle [onderwysers en kinders] blameer my as ek so aggressief optree. Hulle soek daarna... as jy my familie vloek dan gaan ek vir jou uithaal. My pa sê</i>
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	<p><i>ek mag so optree Dit is hulle skuld... hulle tart my” (PC5). [They [the teachers and children] blame me when I act so aggressively. They are looking for it... if you swear at my family, I will take you out. My father says that I am allowed to act like that.... It is their fault ... they taunt me.]</i></p>
Reference to the literature	<p>By denying their own personal experiences, adolescents project their emotions and feelings onto others. According to Blom (2006:33) and Oaklander (1994), this response is due to weak ego strength, blaming or confronting the environment, as they are not strong enough to take responsibility for their own actions. The participants behaved like victims of the circumstances, attributing to the outside that which they feel within themselves (Corey, 2005:198, Yontef, 1993:138, 442).</p> <p>Not accepting one’s own emotions, personality traits, likes and dislikes, and projecting them onto others, might hinder the contact-making process in adolescents and lead to identity confusion (Erikson, 1981; Louw <i>et al.</i>, 1998:433).</p> <p>Healthy functioning allows contact to take place, generating sufficient energy to explore possibilities and be aware of potential contact internal and external (Woldt, 2009).</p>

Table 4: Sub-theme – deflection vs full contact

Responses and behaviour of adolescents during the intervention phase	Eight of the participants used deflection to avoid the impact of stimuli from the environment. Two of the participants changed the subject whilst talking to the therapist/researcher:
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- Therapist/Researcher: Wil jy vir my vertel hoe dit vir jou was om by jou ma te bly?
“Ek het, ’n boek gelees, dit was n liefdesroman”
 (PB1).
- [Do you want to tell me how it was for you to stay with you mother? “I read a book, it was a romance”].
- Therapist/Researcher: Hoe het dit vanoggend met jou dissiplinêre verhoor gegaan?
“Kan ek met klei speel vandag, jy het belowe ek kan?” (PC4).
 [How did it go this morning with your disciplinary hearing? “Can, I play with clay today, you promised that I could.”]

Four of the participants blocked contact by looking away, turning their bodies aside, and avoiding eye contact, making excuses that the sessions were over, or started to talk about placing more objects on the bridge.

Two of the participants talked non-stop. They told elaborate and exaggerated stories of snakes, lizards and computer war games.

Reference to the literature	<p>According to Joyce and Sills (2010:116), people will deflect from their feelings or impulses by talking endlessly, not looking at a person, laugh at themselves instead of taking themselves seriously, being vague, understating their feelings and experiences and focusing on the needs of others.</p> <p>Blom (2006:37) mentions that deflection could also manifest in a sudden outburst of anger, or fantasizing and daydreaming. By asking questions, participants would keep themselves safe, hidden and unknown – trying to trick the researcher (Corey, 2005:201).</p>
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Table 5: Sub-theme – retroreflection vs action and interaction

Responses and behaviour of adolescents during the intervention phase	<p>Three of the participants presented retroflective behaviour by substituting the environment with the self. One participant is taking anti-depressants and self-mutilates, whilst two participants presented voluntary encopresis, as well as psychosomatic symptoms, such as headaches and stomach pains. These were some of the responses:</p> <ul style="list-style-type: none"> • <i>“I hate myself.”</i> • <i>“I am angry with myself.”</i> • <i>“I hate my mother for not being there for me”.</i> <p>Feelings of guilt towards the self for expressing feelings of hate and anger toward mother by punishing self by self-mutilation were evident: <i>“When I cut myself, I feel better, at least I feel something”</i> (PC2).</p> <p>The two participants with voluntary encopresis had control over when and where bowel movements occur and chose inappropriate places such as at the school</p>
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	<p>and visiting one of the parents during school holidays. The participants came from divorced families; one of the participants had a history of physical and possibly sexual abuse.</p>
Reference to the literature	<p>Yontef (1993:137) sees retroreflection as a split within the self, a resisting of aspects of the self by the self. Some of the adolescents substituted the self for the environment (doing to the self what they wanted to do to someone else, or doing for the self for what they wanted someone else to do for the self).</p> <p>Foreschle and Moyer (2004:13-20) are of the opinion that self-mutilation releases stress, depression, rejection, hyperactivity and numbness. Roubal (2007:4-10) perceives the symptomatic behaviour of self-mutilation and depression as a fixed Gestalt (cf. Perls <i>et al.</i>, 1951:176). Adolescents may also turn to self-cutting as a way to deal with peer pressure, conflict at school, the loss of a parent, sexual abuse, or having observed family violence (Mondadori, 2000:45-68; Lukomski & Folmer, 2004:91-93).</p> <p>Adolescents described self-mutilation as an out-of-body experience in which they bypass the body's defences and desire pain along with the need to regain control by injuring the body (Foreschle & Moyer, 2004:13-20), which in Gestalt is seen as creative adjustment (Zinker, 1978). Clarkson (2004:77) regards it as a desperate attempt by adolescents to re-establish organismic sensation function.</p>

	<p>Some theorists comment that voluntary encopresis may result from a power struggle between adolescent and adult, sexual abuse, oppositional defiant disorder or high levels of psychological stressors (Kuhn, Bethany, Pitner & Pitner, 1999:8-18).</p> <p>From a Gestalt point of view, this could be seen as turning impulses back on the self as the participants try to undo mistakes, such as expressed feelings of hate towards parent, or not standing up for the mother when the father is saying bad things about her, or blaming the self for physical and sexual abuse. These participants were more concerned about the self through actions such as self-blame and self-destruction (Woldt, 2009).</p>
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Table 6: Sub-theme – egotism vs assimilation and integration

Responses and behaviour of adolescents during the intervention phase	<p>Two participants blocked contact by acting out, and by dramatised and self-centred behaviour. Their responses were:</p> <ul style="list-style-type: none"> • <i>“Ek is so goed, in hierdie battleship game, niemand kan my beat nie.... Almal sal my maat wil wees.... Die meisies...hulle almal hou van my.... Die skoolhoof het my geglo en die ander ou geskors”</i> (PC5). [I am so good, in this battleship game, nobody can beat me...Everyone wants to be my friend.... The girls... they all like me.... The principal believed me, and suspended the other guy.] • <i>“Stanley took me to the pet shop. He bought me a snake and a lizard. I kept them at home.</i>
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	<p><i>Sometimes I put them around my neck. They [the snake and the lizard] only obey me. I also feed them rats that I caught. I am the only one that is not scared. If they with me, everyone is afraid of me” (PA2).</i></p> <p>This participant was a victim of bullying at school, his uncle validated exaggerated stories, and the participant is playing the hero in his stories.</p>
Reference to the literature	<p>Acting-out behaviour is characterised by an excessive preoccupation with one’s own thoughts, feelings, behaviour and effect on others. This preoccupation can be positive, self-congratulatory and admiring or negative, critical and undermining (Joyce & Sills, 2010:122).</p> <p>According to Blom (2006:39), participants who are victims of long-term physical abuse will be able to voice their experiences at a rational and cognitive level but not at an emotional level. This was evident in one of the participants, who had been physically abused, whilst the other participant was rejected by his parents.</p> <p>Egotism became a contact boundary disturbance when these participants continuously tried to control every interaction, eliminated contact and the intent on their own contributions. Such individuals fear assimilation, integration and full contact (cf. Latner, 1992). By contrast, healthy egotism is the capacity for self-reflection and an objective look at one’s situation and oneself, leading to assimilation and integration (Joyce & Sills, 2010:122).</p> <p>This was evident in the contact-making sessions with four of the participants, where they were able to reflect</p>

	<p>on their destructive behaviour, and gained insight into what steps they needed to take to address symptomatic behaviour such as swearing, aggression, self-mutilation and inappropriate sexual behaviour.</p>
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Table 7: Sub-theme – confluences vs differentiation and withdrawal

<p>Responses and behaviour of adolescents during the intervention phase</p>	<p>Two of the participants presented confluence during the intervention sessions. They were not able to say no, make decisions on their own and/or suggest what they would like to do during sessions. They agreed on everything that the researcher suggested, as in the following interaction.</p> <p>Therapist/Researcher: “Ek het alles uitgepak wat ek saam gebring het vir ons sessie. Jy kan besluit wat ons vandag saam gaan doen”. [I have unpacked everything that I brought today for our session. You can decide what we can do together today.] No response.</p> <p>Therapist/Researcher: “Wil jy vandag met klei speel of met die brug?” [Do you want to play with clay today, or with the bridge?]. No response.</p> <p>Therapist/Researcher: “Kan ons met die brug speel?” [Can we play with the bridge?] “Ja.” [Yes.]</p> <p>Therapist/Researcher: “Wil jy enige items by die brug voeg?” [Do you want to add any of the items to your bridge?]. No response.</p> <p>Therapist/Researcher: “Kyk in die mandjies, daar is baie items waarvan jy kan kies.” [Look in the baskets, there are many items that you can choose from.] No response.</p> <p>Therapist/Researcher: “Kan ek van hierdie diere vir</p>
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	jou hier uitpak?” [May I unpack some of the animals for you?] “Ja.” [Yes.]
Reference to the literature	<p>Clarkson (2004:65) describes confluence as a condition where the organism and the environment are not differentiated from one another; the boundaries are blurred, as illustrated in the example above. Blom sees this vague unclear experience of the adolescent as a “we” instead of an “I”-therapist/researcher and “You”-participant (Blom, 2006:34).</p> <p>A merging with “the other”, be it a person or situation “leads to loss of self, to lack of satisfactory contact and ultimately to disintegration” (Clarkson, 2004:65). According to Yontef (1993:136), this is when the boundary between the self and other becomes so impermeable that the connectedness is lost (cf. Woldt, 2009).</p> <p>This almost “pleasing” behaviour of adolescents could be seen as a sign of a poor sense of self (cf. Oaklander, 2007:5). By contrast, a healthy person can move easily along the continuum between attachment and withdrawal (Joyce & Sills, 2010:120).</p>

6.2.2 Main Theme 2: Personal emotional factors

Table 8 Sub-theme – loss, trauma and stress

<p>Responses from participants during the intervention phase.</p> <p>Focus on how adolescents felt – internal factors.</p>	<p>Nine of the 14 participants referred to the divorce of their parents and the loss they experienced in not having regular contact with an absent parent. Five participants had been abandoned after their parents’ divorce. Four participants verbalised feeling stressed. Two participants lost a parent through a traumatic event (one in a motorcar</p>
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	<p>accident, and one by giving birth to the participant.)</p> <p>Adolescents with mental disability expressed loss at a concrete level, referring to a doll taken away by an abusive stepmother or a dog shot during an armed robbery. All 14 participants referred to their relationships with a particular family member or object and the desire to have better relations. Adolescents described the lack of connectedness as <i>“losing something of themselves”</i>.</p>
Reference to the literature	<p>Adolescents who experienced stress displayed an inability to handle the physical and/or emotional demands of the specific situation. They reacted differently to a stressor such as temper tantrums, aggressiveness or avoidance. Parents, teachers and therapists confirmed these behavioural patterns in the adolescents, as the participants appeared withdrawn or depressed and had mood swings.</p> <p>Adolescent participants who experienced loss and trauma had regular outbursts of anger. Two of the participants were bed-wetting. According to Blom (2006:185), this kind of behaviour is a “normal” reaction to “abnormal” situations. Emotional problems, according to the literature, tend to manifest in various behaviour patterns, such as blaming the self, a loss of self, feelings of betrayal, anger, shame and depression (Oaklander, 2006). These responses were evident during the contact-making with the adolescent participants.</p> <p>Wheeler (1997:234) suggests that the shame that adolescents experience can be seen as pulling away, a “disconnect in the field”, which involves an absence of support from, or loss of connection with others, or the</p>

	<p>worst acts of hurtful rejection, sarcasm or public exposure. This “disconnection” can be described as a break in the cohesion of the self – preventing contact with self and the environment. It is important to regard the environment not only as something outside the self, but also as part of the inner world and as an essential and integral part of the self (Wheeler, 1997:234).</p>
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Table 9: Sub-theme – rejection and exclusion

<p>Responses from participants during the intervention phase. Focus on how adolescents felt – internal factors.</p>	<p>Seven participants verbalised feelings of rejection either by their peers or significant others, and the negative impact thereof on their self-perception. Typical responses were:</p> <ul style="list-style-type: none"> • <i>“They do not want me to be part of their group... I am not invited to parties. I feel bad ... not good enough”</i> (PC2, PC3). These were feelings of exclusion that led to introjection. • <i>“Hulle [kinders by die skool] misbruik my net. Hulle wil net my brood, lekkergoed en games [rekenaarspeletjies] hê. As ek nie wil deel nie, dan is ek nie in hulle groep nie ... Ek word dan kwaad en vloek hulle’</i> (PC5). [The children at school just use me. They just want my sandwiches, sweets and computer games. If I do not want to share with them, I cannot be part of their group. Then I get cross and swear at them.] Feelings of rejection led to anger and aggressive behaviour.
<p>Reference to the literature</p>	<p>Marcia (1966:551-558), and Erikson (1968) referred to adolescence as a time of continual crisis, and as one of the most difficult transitions in life.</p>

	<p>Feelings of inferiority arise when an adolescent is rejected by a peer adolescent group. Self-worth depends on peer acceptance, and adolescents' self-images need to be validated by others, as it often shapes their identity in terms of how they are perceived by others.</p> <p>Hycner and Jacobs (1995) argue that the human heart yearns for contact, yearns to be met, and to be recognised in all its uniqueness, fullness and vulnerability (Joyce & Sills, 2001:43). Adolescent participants expressed this "yearning" for acceptance when they reported being excluded from functions, groups and affection from significant others. Yontef (1993:218) believes that showing acceptance means to honour the phenomenological field of the adolescent.</p>
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Table 10: Sub-theme – bullying and abuse

<p>Responses from participants during the intervention phase.</p> <p>Focus on how adolescents felt – internal factors.</p>	<p>Three participants had a history of being subjected to physical abuse, and one participant disclosed physical abuse during the research study, after which the participant was removed from her home and placed in safety. Five of the adolescent participants were subjected to emotional abuse from a relative or nearby family member. Five adolescents indicated that their peers bullied them. Parents and teachers confirmed the bullying. Two schoolteachers had subjected three participants to verbal abuse. These participants experienced anxiety and avoidance with regard to attending school. Typical responses were the following:</p> <ul style="list-style-type: none"> • <i>“They pulled my hair ... everybody was laughing and I started to cry. They held me to the ground while they made a ponytail on top of my head. They say I look</i>
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	<p><i>like a girl. The bus driver, Aunty R, was making them do it to me, she was laughing too” (PA2).</i></p> <ul style="list-style-type: none"> • <i>“The bus driver told me that I look like somebody living in a squatter camp. Everybody was laughing at me. I just keep quiet... I wanted to cry” (PA1).</i> • <i>“Teacher told everybody in class that I have problems, that why I have to come and see you. She called me names” (PC1). A parent validated this comment.</i> • <i>“Hulle het my nie eers gevra hoe dit met my gaan nie. Ek was vir ‘n paar dae siek. Al wat hulle sê, is hoekom het jy nie maar by die huis gebly nie – dit was lekkerder sonder jou – almal lag, Juffrou ook” (PC5).</i> [They did not even ask me how I feel. I was sick for a few days. All that they said was why did I not stay at home – it was nicer without me – everybody laughed, Teacher too.] • <i>“Hulle maak grappe oor die kleur van my hare. Ek haat my kleur hare. Ek en my ouma het dit gekleur. Nou het ek straf gekry by die skool” (PC2).</i> [They joke about the colour of my hair. I hate the colour of my hair. My grandmother and I dyed my hair. I was punished at school.] <p>The participant introjected negative feedback from peers and schoolteachers. She had a history of family depression and the participant herself has been diagnosed with depression and self-mutilation.</p>
Reference to the literature	<p>Colorosa (2008:42) points out that victims of bullying are singled out and targeted because they are different in some way, like the victim with the red hair. Victims are anxious, insecure, have low self-esteem, are reluctant to defend themselves and lack age-appropriate social skills.</p>

They withdraw from school activities, sport and social situations and become severely depressed and even suicidal (Carpenter, 2009:59).

Oster and Caro (1990:3-29) have reported a correlation between depression, guilt, internal anger and the dynamics within the family. Often adolescents mirror depressive behaviour in fear of separating from the parent. This was evident in the adolescent who engaged in self-mutilation and was depressed – she feared that her mother would not return after the participant's mother had been admitted to hospital several times.

According to Blom (2006:103), negative feedback and comments made to adolescents are introjected false messages about themselves from the field. This will lead to behaving in dysfunctional ways to satisfy their needs, in the best way they can, called creative adjustment.

Being bullied at school, named and shamed was accompanied by a deeply held sense of not being worthy. Shame is marked by rage, disgust and self-hate. With shame comes the desire to hide and, according to Yontef (1993:503-504), it is part of retroflection, whereby a shame-prone person will avoid exposure and the sense of shame that comes with social contact, which in this case means being humiliated by bullies and a misuse of adult power.

Adolescents' responses, as pointed out by Mackewn (1997:24-25), include anger, confluence or a need to be looked after and supported by others as a way of deflecting real emotion and underlying needs. From a Gestalt perspective, any symptomatic behavioural pattern

	<p>is usually defined as dysfunctional and, according to Spagnuolo Lobb (2005:33), could be seen as a creative adjustment of adolescents in a difficult situation. Their loss in ego function (the inability to make contact) is seen as a creative choice to avoid contact with the environment. This triggers previous anxiety and/or experiences of fear in past contacts.</p>
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6.2.3 Main Theme 3: Behavioural factors

Table 11: Sub-theme – aggression, inappropriate sexual behaviour, self-mutilation, encopresis and enuresis

<p>Responses from parents, teachers during the semi-structured interviews.</p> <p>Focus on what adolescents were doing – external factors.</p>	<p>The above sub-themes mentioned were grouped together as symptomatic responses or behavioural patterns presented by adolescent participants (see Addendum 4: Qualitative data analysis: themes). Two participants presented inappropriate sexual behaviour. Three participants presented overt aggression. One participant self-mutilated and had depressive episodes. Two participants displayed encopresis and two participants had enuresis. Typical comments were:</p> <ul style="list-style-type: none"> • Teacher: <i>“Hy is altyd aggressief... slaan met sy vuiste, skop almal op die stoepe. Hy is al verskeie kere gewaarsku. Die ander ouers kla en hy is al dissiplinêr verhoor, niks help nie”</i> (T1). [He is always aggressive... hits with his fists, kicks everybody in the corridors. He has been warned several times. The other parents are complaining and he had had a disciplinary hearing... nothing helps.] • Parent: <i>“Ek sal nie staan vir hierdie gedrag nie [aggressie]. Ek het hom goed gemoker. Ek het maar self ‘n ‘anger management’ probleem”</i> (C1). [I will not
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stand for this kind of behaviour. I beat him thoroughly. I have an anger management problem myself.]

- Teacher: *“Ek is geskok, sy [adolescent] het met ‘n passer haar naam op die sykant van haar been uitgegrafeer. Sy is ook depressief”* (T2). [I was shocked. She used a compass to gouge her name into the side of her leg. She is also depressed.]

The self-mutilating act was confirmed by other class pupils and participating adolescents.

- Grandmother: *“Ek is so ontsteld, ek het haar [adolescent] in die badkamer gekry ... masturbeer met ‘n gevaarlike objek. Sy is nou net soos haar ma. Ek moes haar pa daarvan vertel”* (C2). [I am so upset, I found her in the bathroom... masturbating with a dangerous object. She is just like her mother. I had to tell her father.]

Negative feedback from significant others has an impact on the formation of an adolescent’s self-concept as well as false introjection.

- Parent: *“Die skool het pornografie op sy sel gekry. Ek weet nie waar kom dit vandaan nie. Sy leierskapbalkie is ook van hom weggevat. Hy word nou verplig om ‘n gedragsmodifikasieprogram by die kliniek te volg. Ek dink nie dit help nie. Hy’s nukkerig een oomblik en die volgende huilerig. Die onderwyseres het hom in die klas verneder, sy noem hom ‘n pervert. Hy het nie meer maats nie en wil nie meer skool toe gaan nie. Hy het aanmekaar maagpyn”* (C3).

[The school found pornography on his cell. I do not know where it came from. His leadership badge was taken away from him. He is now forced to attend a

behaviour modification programme at the clinic. I don't think it is working. He is moody one minute and weepy the next. The teacher humiliated him in class. She called him a pervert. He does not have friends any more and does not want to go to school. He has constant tummy ache.]

- Parent: *“Hy maak sy bed nat en praat nie daaroor. Ek het hom nie beskerm teen sy pa se aanranding nie. Hy vra nooit oor sy pa nie. Ek dink hy is bly hy het ons verlaat”* (C4). [He is wetting his bed and does not talk about it. I did not protect him from his father's physical abuse. He never asks about his father. I think he is happy that his father deserted us.]
- Teacher: *“Hy kon net gevra het om die klas te verlaat, maar hy bly stil en maak homself nat. Ek dink nie hy kom dit agter nie”* (T3). [He could just have asked to leave the classroom, but he kept quiet and wet his pants. I think he is not even aware of it.]
- Teacher: *“Hy maak sy broek vuil. Die kinders kla dat hy ruik. Ons het al met sy ma hieroor gepraat. Sy praat met hom soos ‘n babatjie”* (T4). [He soiled his pants. The children complain that he smells. We have spoken to his mother about this. She talks to him as if he is a baby.]
- Parent: *“Sy speel met haar faeces (ontlasting) en rol klein bolletjies of smeer dit teen die badkamer muur. Sy doen dit net wanneer sy by my kuier... haar ma kla nie daaroor nie”* (C5) [She plays with her faeces and rolls small globules or smears it on the bathroom wall. She does that only when she visits me...her mother doesn't complain about it.]

Reference to the literature	<p>Roubal (2007:4) perceives behavioural or symptomatic responses from adolescents as “fixed gestalts” and the actions of creative selves. Parents and teachers tended to focus on what participants were doing “wrong”, whether in class, on the playground or at home. Thus, such behaviour, according to Mash and Wolfe (2002:133), is seen as negative and abnormal if it deviates from the values and norms of society. The participating adolescents were labelled, blamed and shamed by significant others, where the focus was on punishment rather than acceptance, understanding and/or any therapeutic intervention.</p> <p>Adolescent participants expressed their anger in destructive ways such as verbal and physical attacks to satisfy their needs (a process called organismic self-regulation) in order to gain homeostasis (Blom, 2006:210). Adolescents tend to act out in aggression to survive, or, as Oaklander (2007:73) puts it, as an attempt to make contact with the environment to meet their needs. These unacceptable behaviours can become protective mechanisms to provide a sense of security. According to Blom (2006:220), such behaviour will disappear once a deeper sense of self-developed and healthier ways are found to satisfy needs.</p> <p>However, Yontef (1993:183) and Berk (2006:465-569) have commented on the importance of positive feedback and good parenting, to ensure positive outcomes. An authoritative rearing style will grant autonomy to an adolescent, as the parent is warm, responsive, and attentive to the adolescent’s needs. Such positive feedback from parents, according to Berk (2006:566) and Beyers, Bates, Pettit and Dodge (2003:35-53), creates</p>
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	high self-esteem, autonomy, social and moral maturity and promotes academic achievement (cf. Slicker & Thornberry, 2002:9-10; Berk, 2006:569).
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6.2.4 Discussion for Qualitative data results

During the therapeutic intervention with adolescents, it became evident that *contact boundary disturbances, personal emotional and behaviour* factors could be addressed during the use of the bridging technique (see Addendum 2B: Utilising the bridge(s)). The following data were obtained, which therapists can apply in working with adolescents in bridging contact-making barriers:

- It was noted that all participants responded positively to the veld of the bridge as it addressed the *outer zone functions* of adolescents, such as the sensory modalities: seeing, hearing, tasting, touching, smelling and moving. Non-threatening fun and fantasy elements, such as picnics in the veld, swimming in the river, climbing rocks, touching the trees and the surface of the veld were addressed through the elements of the bridge. Different objects such as camping gear, boats, figurines, ropes, food and drinks enhanced their experiences. The therapist/researcher facilitated this by asking questions relevant to each adolescent's process and story telling. Sensation/perception, awareness, as well as excitement and mobilisation were enhanced. Adolescents with contact boundary disturbance such as numbness, desensitisation became more aware of the senses, which facilitate contact with the environment and with the self.
- The structures of the bridge were used in focusing on the *middle zone* – the thinking and memory processes of adolescents. High-functioning adolescents were able to express and project their present circumstances and situations within their fields onto the structures of the bridge, or recall memories of seeing or travelling over a bridge. The mentally disabled adolescents responded more positively to the veld and were able to relate relevant stories. The rails of the beam bridge facilitated discussion on boundaries, rules and safeness, whereas the suspension bridge facilitated discussions on flexibility, compromising efforts in meeting one another, whether parents and/or friends. The truss bridge was effective in focusing on family unity, as the individual trusses combined to create strength and support. One participant was able to use four different bridges metaphorically by projecting

family members' traits and the participant's relationship with each of these family members onto a particular bridge.

- The arch bridge facilitated discussion on internal strength and the acquisition of skills in dealing with problems, which related to the way in which an arch bridge is built. It starts from both sides, and scaffolding has to support the structure until it is completed in the middle. This type of bridge was effective in explaining that parents, teachers and adolescents had to work together in addressing behavioural problems. It is recommended that the arch bridge be used to facilitate joint discussion between an adolescent, parents and teachers by making them aware of the impact of negative feedback and comments to adolescents that contribute to introjection, retroflective and symptomatic behaviour.
- Behavioural problems were discussed by referring to road and safety signs on bridges and the consequences of disobeying them. This facilitated interaction on choices and responsibilities and created a platform for learning and gaining insight into cause and effect.
- The road on the bridge that runs through the veld was used to address solutions, choice and future goals. Adolescents with higher cognitive abilities were able to discuss and express where they want to be and what needs to be put in place in order to obtain positive results. Some adolescents were able to see their "old life" on the one side of the veld/road and their "new life" at the other side of the bridge and at the other end of the road. One participant had placed her problems on the one side of the veld, Point A, and she saw the bridge as the solution (which the participant considered the therapy to be), and Point B as her future, free from pressure, shame and self-mutilation.
- Adolescents with mental disabilities responded on a concrete level to the road as it facilitated fantasies or memories as to where the road led. Typical responses were "*leading to the sea*", their "*home*" or "*school*". Objects which were added by adolescents to the veld, such as animals and homes, facilitated contact and created opportunities to discuss unfinished business, such as bullying, rejection and abuse of adult powers. Adolescent participants were able to integrate healthier ways of making contact with the self and the environment, through awareness, acknowledging and adopting more appropriate ways of behaving, such as voicing feelings of hurt, anger and rejection.

- The personal emotional factors, which focused on internal processes of adolescents or the inner zone, were facilitated by elements such as hiding under the bridge(s), behind the rocks, or keeping the gap between the two ends. This was noted specifically in cases where abuse and bullying were evident. One of the participants chose not to build a bridge over the ravine, as the gap between Point A and Point B (representing the ravine and rocks in between) kept him safe as “*nobody can get to him*”. High-functioning adolescents were able to voice personal feelings after the introduction of the bridging technique and the establishing of a trusting relationship. It is recommended that additional bridges could be added to the bridging technique, such as tunnel bridges, which one adolescent suggested will keep the person safe from the ravine, or a transporter bridge, that will give the person power and control as to who is chosen/allowed to cross the bridge. This projection enabled the researcher to determine a participant’s ego-strengths, as well as threatening situations, which were addressed during the therapeutic intervention, as well as within the field, such as physical abuse.
- The bridging technique also facilitated contact between parents and participants. One parent commented on the value of the therapeutic sessions and in particular the use of the bridge as the parent gained insight into how the participant had perceived the intervention. This particular participant has a speech and hearing disability.
- The bridge facilitated interaction between class members, as teachers reported that participants from Population A commented on their session with the bridge and their experiences to their classmates. This opens up the possibility of using the bridging technique with groups, as group work, according to Feder (2006:25), allows therapists to gain a better understanding of the intra- and interpersonal levels of functioning.
- During the therapeutic intervention, the researcher noticed that boys selected the truss and beam bridge more, whereas girls selected the suspension and arch bridges by more often. This could be attributed to the heavier, more solid structure that the beam and truss bridges projected to the boys, and to the girls the appearances of the bridges affected their choices.
- Participants in Population A played more on the bridge and this could be attributed to the participants’ levels of concrete cognitive thinking. They responded positively to sensory stimuli such as visual objects, including the bridge, tasting, touching,

and smelling, whereas the four participants in Population C, with higher cognitive ability, were able to refer to mental pictures of the bridge whilst addressing foreground needs.

- During the eight-week intervention, adolescents discussed and possibly relived painful and disturbing events such as long-term physical abuse, the death of a parent, or placement in a children's home. The psychological effects on both the participants and the therapist/researcher can be described by the concepts transference and counter-transference which therapists must be aware of in therapy. Transference is the redirection of feelings and desires, especially those which are unconsciously retained from childhood, toward a new object (Gill, 1982; Bisbey, 1993). Participants expressed the lack of being nurtured and taken care of. Comments such as "*I wish you were my mother*" or "*please adopt me*" were voiced as maternal transferences. Counter-transference refers to the unconscious processes that affect a researcher (Giarni, 2001; Martin, 2010). These feelings came to awareness and could be attributed to the caring and nurturing nature of the therapist/researcher. This could be viewed as inappropriate or negative, but with awareness, this contributed valuable information regarding the research question, on how adolescents make contact with environment and with the therapist.

The focus in this study was on how adolescents make contact with the environment and what might prevent them from making healthy contacts. When focusing on the how and what, the researcher asked questions based on Gestalt principles (Parlett, 1993:11-24) and use the model of inquiry of Barber (2006:39), asking questions such as the following:

- "What is happening in the adolescent's life?" (*Figure*);
- "What were the constant structures in adolescents' lives/fields?" (*Ground*);
- "How did adolescents seek to make contact or separate themselves from others that they meet?" (*Differentiation*);
- "In what ways did adolescents seek to merge with others they meet?" (*Confluences*); and
- "How resistant or willing/able were adolescents to make contact?" (*Resilience and reconfiguration*).

This enabled the researcher to identify themes and to try to understand each adolescent's unique process in making contact. The focus was not on behavioural symptoms or causes as such, but on the meaning of these behavioural symptoms to the individual adolescent. The focus was on adolescents who adopted, demonstrated and/or modified various ways of blocking themselves from healthy functioning, effective Gestalt formation and completion and an awareness of self.

Despite behavioural problems that were identified by teachers and parents, positive feedback was also given regarding changes noticed in adolescents during the intervention phase and follow-up sessions. Adolescents were more communicative, less abrupt and aggressive and, in one participant, self-mutilation stopped. These changes could be explained by referring to Beisser's (2001) paradoxical theory of change. Beisser (2001:78-92) argues that change is a natural state of humankind; it is movement towards wholeness where there is constant change, based on the dynamic transactions between the self and the environment. The more adolescents become aware of who they are, and of their environment, the more their behaviour changes – leading to integration and holism: "Change occurs when one becomes what he is, not when he tries to become what he is not" (Beisser, 2001:77).

The bridging technique is not a set of rules to be followed to the letter, but was guided by the unique processes of adolescent participants, the here and now moment and the creativity of the therapist to use the bridge as a metaphor to overcome contact barriers.

7. CONCLUSIONS

This study has focused on contact-making barriers in adolescents during contact with the environment, which included the internal and external worlds of adolescents. The bridging technique was introduced during therapy, using several model bridges as a metaphor to address and overcome these barriers. Different bridges such as an arch, a suspension, a beam and a truss bridge were selected and constructed on a set base, which represented a veld. The same bridges and set base were introduced to all participants, which enhanced the empirical research from which the consistency of the intervention was measured.

The quantitative data were obtained from questionnaires that were completed by the researcher for each participant, before the intervention (a pre-intervention assessment), after the intervention (a post-intervention assessment) and a follow-up assessment four weeks after the post-intervention assessment to determine the consistency of the therapeutic intervention. The results were plotted on line and bar graphs to illustrate noteworthy changes and the consistency of the intervention. These results showed clearly that there was a marked improvement in the contact-making of adolescents, a reduction in resistance, an overall improvement in posture and process, which took place within a therapeutic relationship.

The results of the qualitative data were obtained through a process of contacts with adolescents during the intervention phase and semi-structured interviews with parents and teachers. The adolescents' fields, which include internal and external factors, contributed to the barriers in preventing contact-making. Some of the adolescent participants' external factors, such as the divorce of their parents, the death of a loved one, bullying and rejection by peers, as well as physical and emotional abuse, played an important role in how they presented themselves to others. Three main themes were identified which were contact boundary disturbances, personal emotional factors and behavioural factors. The themes were discussed in the context of healthy functioning and references to literature. It can be concluded that the research results were positive, which indicated the value of the bridging technique to overcome contact-making barriers in adolescents.

8. LIMITATIONS AND RECOMMENDATIONS

During the research process, the following points were noted from the feedback from the participating adolescents, parents and teachers:

- **Parents and teachers** were more focused on the symptomatic or behavioural aspects of the adolescents' lives than on the personal emotional effects on adolescents. Despite positive feedback regarding the research and the bridging technique, the researcher noticed that parents showed limited insight into the important and vital roles that they played in the functioning of adolescents. A lack in consistent parenting/rearing skills and ineffective communication skills were

evident. The researcher could have addressed this by arranging group sessions with parents for each population group to discuss parenting styles and the outcomes thereof. This would ensure a more sustainable impact on the contact-making of these adolescents. In retrospect, a comprehensive and easy measuring scale could also been handed to parents and teachers to help them to measure changes that they noticed in the adolescents. This would have supported the findings in the quantitative research data, as well as enhanced involvement in the research project.

- **Relevant teachers** who were involved in the research project gave regular feedback to the researcher; however, some teachers were unaware of the nature of the research and responded negatively when participants did not attend their register classes. Two participants showed resistance to attending sessions and voiced the negativity of teachers to the researcher. This could have been addressed through a general information session to all teachers of that specific grade before the commencement of the research. In order to accommodate these participants, arrangements were made for them to attend sessions at the practice of the researcher/therapist.
- **Adolescents** responded positively to the invitation to participate in the research. Two of the adolescents indicated that they were named and shamed for attending sessions, and comments were made about their home circumstances and behavioural problems. Adolescents were selected to fulfil the requirements of the research topic and not behavioural problems and/or home circumstances. This was addressed with the relevant persons; however, it had an impact on the emotional well-being of the adolescents, who needed counselling to undo some of the damage. This problem could have been prevented if all teachers in this specific population group and grade had been included in the information session regarding the research.
- Some **adolescents** suggested joint sessions with their parents during the intervention and utilisation of the bridging technique. This was not part of the scope in this research study; however, this may be included in future research.
- After the completion of the research, some of the adolescents that needed ongoing support were referred to relevant therapists.
- The **research participants** were representative of the Ekurhuleni Metropolitan district, as well as representative of the present educational programmes offered to

pupils. However, it is recommended that future research on this topic consider the inclusion of a larger sample of diverse groups to determine the effectiveness of the bridging technique.

- It is recommended that a smaller **modular bridge** be constructed and used when therapy and assessment take place at different venues, other than private practices, which will ensure that the technique can be introduced in places such as clinics, hospitals and schools.
- It is recommended that the **bridging technique** be further researched to determine the value of applying the technique with traumatised children, as well as in assessing children from different cultural groups. During the use of the bridging technique, it became evident that it could also be valuable in group therapy. These aspect could be explored further.

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SECTION C:

SUMMARY, EVALUATION, CONCLUSION AND RECOMMENDATIONS

1. INTRODUCTION

This section aims to provide a summative overview of the study. The aims and objectives and findings are evaluated and conclusions are drawn regarding the value and effectiveness of the bridging technique to overcome contact-making barriers in adolescents. Lastly, recommendations are made regarding the bridging technique and future research.

2. SUMMARY OF THE RESEARCH

This research focused on the utilisation of a bridging technique to overcome contact-making barriers in adolescents. The essence of human life is contact, a meeting with various kinds of others (Buber, 1970; Joyce & Sills, 2010:3). Contact is seen as an integral part of all human experiences. Thus breakdowns and misunderstandings in therapy (also called barriers or interruptions) often hinder effective contact-making with others (Yontef & Jacobs, 2000:313). To overcome such barriers, several model bridges were constructed beforehand, such as a suspension, arch, truss and beam bridges, and these were used as a metaphor during therapy with adolescents (Barnard, 2010).

The research was conducted from an existential-phenomenological Gestalt approach. Combined quantitative and qualitative approaches were followed, and a single system experimental design, A-B-A-A, was applied, as recommended by Delport and Fouché (2011:357). A total of 14 adolescent participants were purposefully selected from three different schools, and their parents and teachers were also involved as appropriate. Quantitative data were collected using pre-intervention, post-intervention and follow-up assessment questionnaires, which were completed by the researcher for each of the adolescent participants. These questionnaires were analysed according to the semantic differential scale, and raw scores were plotted on line and bar graphs (Maree & Pietersen, 2010:168). The different population scores were discussed and the overall improvements in contact-making noted. Qualitative data were collected through

semi-structured interviews with parents and teachers, as well as during intervention with adolescents. The data were analysed according to the Creswell spiral and the *a priori* and inductive coding approaches. Quantitative and qualitative results were integrated and the findings were discussed in context with reference to the literature. The findings of the data indicated that the bridging technique could be useful in working with adolescents in therapy to overcome contact-making barriers. Recommendations were made regarding the bridging technique when working with children and adolescents.

3. EVALUATION OF THE RESEARCH

3.1 Aim and objectives of the study

The purpose of this study was to explore how the bridging technique can be used in therapy to overcome contact-making barriers in adolescents. In order to reach the goal, a number of objectives were identified. These objectives were addressed as follows:

- A literature study was done which focused on contact, contact boundary disturbances, developmental phases, metaphors, as well as conceptualising relevant concepts, such as holism, Field Theory and dialogue within a Gestalt therapy framework.
- An empirical study was done in the form of a single systems design, which took place over a 12-week period. It was an intense process, as it took place during two school terms, when participants were involved in sport activities and the writing of national examination papers, as well as cycle tests. During the first eight weeks, intervention with participants took place to assess the participant's contact-making abilities and to introduce the bridge and the bridging technique. The bridge(s) was/were introduced during the third, fourth and in some cases during the fifth sessions, after which participants were assessed (the post-intervention assessment). Follow-up assessments took place four weeks after the post-intervention assessment to measure the consistency of the interventions. Semi-structured interviews with parents and teachers were conducted before the intervention (the pre-intervention assessment), after the intervention (the post-intervention assessment) and in a follow-up to validate findings that were obtained

through the assessments of the participants. The findings were compiled in the form of an article.

- The analysis of quantitative took place after data had been collected in the form of the pre-intervention assessment, post-intervention assessment and follow-up assessment scores obtained from the questionnaires on the adolescents, who were divided into three populations, based on the schools they came from: a school for the mentally disabled, a high-functioning stream school and a full service school. The quantitative data were analysed, and raw scores and percentages changes were plotted to show the effect of the intervention to determine whether the bridging technique would be effective in overcoming contact boundary disturbances. Three main themes were identified through *a priori* and inductive coding approaches, namely contact boundary disturbances, personal emotional factors (which included the sub-themes of loss, trauma, stress, rejection, exclusion, bullying and abuse), and behavioural factors (which included the sub-themes of aggression, inappropriate sexual behaviour, self-mutilation, encopresis and enuresis). The themes were discussed in table format with reference to the responses of adolescents and parents, as well as the relevant literature.
- Conclusions and recommendations were made on the basis of both the qualitative research findings and the quantitative research findings. These have been integrated in order to give valuable recommendations regarding the effectiveness of the bridging technique.

3.2 Research findings

Research findings in this study indicated that participants responded to different aspects of the bridge and the bridging technique. The bridging technique was used during 28 sessions with 14 participants. The overall findings showed an improvement (22%) in all components from the pre-intervention assessment to the post-intervention assessment for the whole population and an additional improvement of 4% from the post-intervention assessment to the follow-up assessment:

- The bridge facilitated playful contact at a non-threatening level, which enhanced the contact-making process between the therapist/researcher and the participants. Contact showed an improvement of 56% from the pre-intervention assessment to the post-intervention assessment and an additional 8% improvement from the

post-intervention assessment to the follow-up assessment, indicating more awareness in contact among the participating adolescents. This was substantiated by the reduction in resistance (16%) from the pre-intervention assessment to the post-intervention assessment and an additional 17% from the post-intervention assessment to the follow-up assessment, which indicated the consistency of the intervention.

- High-functioning adolescents (six participants) responded metaphorically to the bridge, whereas adolescents (four participants) with limited cognitive abilities responded at a more concrete level.
- The positive results in the improved contact could be attributed to participants being able to address the foreground needs during the bridging technique in a safe and trusting relationship. Relationship, according to Hycner and Jacobs (1995), is the most important aspect of therapy, followed by contact. The component relationship showed an overall improvement of 26% from the pre-intervention assessment to the post-intervention assessment and an additional improvement of 2% from the post-intervention assessment to the follow-up assessment.
- The researcher gave feedback and guidance to four parents regarding their communication and parenting styles, which they altered during the research period. This contributed to some changes noted in the social component, with an overall improvement of 26% from the pre-intervention assessment to the post-intervention assessment, and an additional 2% from the post-intervention assessment to the follow-up assessment.
- The posture of adolescents showed a remarkable improvement of 79% for Population A, 38% for Population B and 14% for Population C, with 36% in total between the pre-intervention assessment to the post-intervention assessment. An additional improvement (7%) from the post-intervention assessment to the follow-up assessment was noted for the whole population.
- The main themes, namely contact boundary disturbances, personal emotional and behavioural factors, were addressed through the use of the bridging technique.

4. CONCLUSIONS

This study provided valuable insight into the utilisation of a bridge as a metaphor and the bridging technique to overcome contact-making barriers in adolescents. This technique has shown potential as it can be used in working with adolescents who experience different barriers, not only those defined as contact-making disturbances or interruptions, but also as a result of trauma.

In a therapeutic environment, bridging refers to the willingness of the therapist to meet others through their separateness, and to be able to listen and to be trusted. It also implies the willingness to be changed and affected by others. The researcher saw the bridge and bridging technique as a medium, a vehicle through which this contact with adolescents could take place.

The researcher is of the opinion that the primary objective of the study, which was to determine whether contact-making barriers in adolescents could be overcome in therapy, has been accomplished, although the issue and some aspects raised by the findings deserve to be explored further.

5. RECOMMENDATIONS

The following overall recommendations were made:

- The sample of the study was small (14 participants), and therefore the findings cannot be generalised to all populations of adolescents. However, the finding in this research cannot be overlooked in terms of the value of the bridging technique in working with adolescents who experienced contact-making barriers.
- It is recommended that a modular size bridge be constructed and used when therapy and assessment take place at different venues, other than private practices, for example, in schools, hospitals and clinics.
- It is recommended that the bridging technique be researched further to determine the value of applying the bridging technique with traumatised children, as well as assessing children from different cultural and language groups.

- During the utilisation of the bridging technique, it became evident that the technique could also be valuable in group therapy, which could be explored in future research.

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SECTION D: ADDENDA

Addendum 1: Assessment guidelines

Addendum 2A: Bridges

Addendum 2B: Utilising the bridge(s)

Addendum 3: Example of quantitative data analysis

Addendum 4: Qualitative data analysis: themes

Addendum 5: Reflective Notes on Research study

Addendum 6: Ethics

Addendum 7: Consent to participate in research study

Addendum 8: Journal Submission Guidelines

ADDENDUM 1: ASSESSMENT QUESTIONNAIRE

The assessment guideline, was adjusted by Blom (2006:68) from the one originally developed by Oaklander (1999a) for assessing children during Gestalt play therapy. The researcher utilised this assessment guideline to conduct the research. The assessment guideline was applied before the intervention phase (pre), after the intervention (post) and follow-up, to measure the consistency of the intervention.

Main Aspect	Subcomponents		Score	Pre-Test	Post - Test	Follow Up
1. Therapeutic Relationship	1.1 What is the adolescent's level of trust?	None	1			
		Good	2			
	1.2 Is the relationship taking shape?	Yes	2			
		No	1			
	1.3 Does the adolescent manifest Relevant resistance or does He/she appears confused?	Resistance	2			
		Confused	1			
	Total					
2. Contact and Contact skills	2.1 Does the adolescent make good contact with the therapist?	Yes	2			
		No	1			
	2.2 Can the adolescent maintain contact during therapy?	Yes	2			
		No	1			
	2.3 Withdraw relevantly at times?	Yes	2			
		No	1			
	2.4 How does the adolescent use his/her contact skills?	Sensory	1			
		Bodily	2			
Speech		3				
	Total					
3. Contact boundary Disturbances	3.1 Does the adolescent make use of any contact boundary disturbances to satisfy needs?	Yes	1			
		No	2			
	3.2 Influence of introjects?	Yes	2			
		No	1			
	Total					

4. Interest	4.1 Does the adolescent show involvement, interest and excitement?	Yes	2			
		No	1			
	4.2 Is his/her voice expressive or weak?	Expressive	2			
		Weak	1			
	4.3 How does the adolescent use his/her breathing	Fast	2			
		Slow	1			
	4.4 What is the adolescent's energy level?	High	3			
		Low	1			
		Moderate	2			
	4.5 When does the adolescent have more or less energy?	During Activities	2			
Talking		1				
		Total				
5. Body Posture	5.1 How does the adolescent walk, sit and stand?	Fast pace	2			
		Slow	1			
	5.2 Is his/her body impaired, loose and flexible?	Impaired	1			
		Lose	2			
		Flexible	3			
	5.3 How is his/her posture?	Straight	2			
		Bent	1			
		Total				
6. Humour	6.1 Does the adolescent respond relevantly to humour?	Yes	2			
		No	1			
	6.2 Does the child have a sense of humour?	Yes	2			
		No	1			
			Total			

7. Resistance	7.1 What is the adolescent's level of resistance?	High	1			
		Low	3			
		Moderate	2			
	7.2 How does the resistance manifest in the adolescent?	Doesn't talk	1			
		Don't know	0			
		Uninvolved	2			
		Change the subject	3			
Inattentive		4				
Total						
8. Emotional Expression	8.1 Does the adolescent know what emotions are?	Yes	2			
		No	1			
	8.2 Can the adolescent express basic emotion: anger, sadness, fear and happiness?	Yes	2			
		No	1			
	8.3 Is the adolescent's emotional expression relevant?	Yes	2			
		No	1			
	8.4 How does the adolescent Handle emotion towards therapist, friends, family?	Verbally	2			
		Reserved	1			
	8.5 How does the adolescent handle emotions/anger?	Outburst/Aggression	1			
		Restraint	2			
	8.6 Does the child have old or unexpressed and unfinished emotions of grief or anger?	Yes	1			
		No	2			
	Total					

9. Cognitive Aspects	9.1 Can the adolescent express his/her feelings/thoughts?	Yes	2			
		No	1			
	9.2 How are the adolescent's language skills?	Good	2			
		Limited	1			
	9.3 Can the adolescent follow directions, make choices, solve problems and organise?	Yes	2			
		No	1			
	9.4 Does what the adolescent says make sense?	Yes	2			
		No	1			
	9.5 Does the adolescent has his/her own opinions?	Yes	2			
		No	1			
	9.6 Does the adolescent use age appropriate abstractions and symbols?	Yes	2			
		No	1			
	9.7 Does the adolescent have a sense of right and wrong?	Yes	2			
		No	1			
		Total				
10. Creativity	10.1 Is the adolescent capable of taking part openly/freely in creative techniques?	Yes	2			
		No	1			
	10.2 Can the adolescent test new things?	Yes	2			
		No	1			
	10.3 Is the adolescent withdrawn/restricted or defensive?	Yes	1			
		No	2			
		Total				

11. Sense of self	11.1 Does the adolescent have a degree of self-awareness and introspection?	Yes	2			
		No	1			
	11.2 Can the adolescent own his/her projection from various projection techniques?	Yes	2			
		No	1			
	11.3 Does the adolescent run himself/ herself down?	Yes	1			
		No	2			
	11.4 Is the adolescent self-critical/uncertain and seeking acceptance?	Yes	1			
		No	2			
	11.5 Can the adolescent make statements about him/ herself?	Yes	2			
		No	1			
	11.6 Can the adolescent make choices?	Yes	2			
		No	1			
	11.7 Is the adolescent self-assertive or inhibited?	Assertive	2			
		Inhibited	1			
	11.8 Is the adolescent capable of separating from parents?	Yes	2			
		No	1			
	11.9 Does the child reveal confluent behaviour?	Yes	1			
		No	2			
	11.10 Does the adolescent fight for power?	Yes	1			
		No	2			
	11.11 Does the adolescent have an age-related sense of mastery?	Yes	2			
		No	1			
		Total				

12. Social Skills	12.1 How is the adolescent's relationship with others in his/her life?	Good	3			
		Moderate	2			
		Bad	1			
	12.2 Does the adolescent have friends?	Yes	2			
		No	1			
	12.3 Does the adolescent have independent thoughts and actions?	Yes	2			
		No	1			
	12.4 Does the adolescent have environmental support for his/her needs?	Yes	2			
		No	1			
	12.5 How does the adolescent satisfied his/her needs?	Friends	1			
		School	2			
		Activities	3			
		Family	4			
		Withdrawn	0			
	12.6 Does the adolescent have age-related egocentricity?	Yes	2			
		No	1			
		Total				

13. Process	13.1 How does the adolescent behave towards parents, siblings, teacher, therapist ?	Quiet	3			
		Noisy	4			
		Aggressive	2			
		Passive	1			
		Good	6			
		Follower	5			
		Leader	7			
	13.2 Is the adolescent fast-paced or slow paced?	Slow paced	1			
		Fast paced	2			
	13.3 Is the adolescent introvert, or extrovert?	Introvert	1			
		Extrovert	2			
	13.4 What is the adolescent's temperament according to DISC analysis? * See footnote DISC Analysis	Directive	2			
		Interactive	4			
		Supportive	3			
		Corrective	1			
	13.5 Does the child reveal any inappropriate behaviour?	Yes	1			
		No	2			
	13.6 Do the events in therapy and events outside correspond?	Yes	2			
		No	1			
			Total			
Grand Total						

Footnote: The DISC temperament analysis of Boyd (1994:51-84; Rohm, 1998: 29-32) has been utilised to facilitate the assessment, however must not be used to label adolescents. A brief explanation of the DISC temperament analysis is given below:

- Children may be either fast-paced or slow-paced and task-orientated or people orientated.
- Fast-pace children are always on the go and are extroverts: they focus their actions on their outside environment.
- Slow-pace children are introverts and tend to be more quit, shy reserved and self-contained.
- Task-orientated children focus on doing things: plan activities and base decision on facts rather than opinions and feelings.
- People-orientated children focus on being with people and are warmer personal and caring.

- Fast-paced and task-orientated children fall into the **D** (*directive/determine*) behavioural style.
- Fast-paced and people-orientated children fit into the **I** (*interactive/influencing*) category.
- Slow-paced and people-orientated children fit in the **S** (*supportive/soft-hearted*) category.
- Slow-paced and task-orientated children can be described as **C** (*corrective/conscientious*).

Directive Children (D)	Interactive Children (I)	Supportive Children (S)	Corrective Children (C)
High self confidence	People orientated	Steadfast	Maintains high standards
Courageous	Emotional	Team player	Attention details
Result-orientated	Talkative	Prefer familiarity	Self-disciplined
Demanding	Fun-loving	Helpful	Cautious
Competitive	Optimistic	Committed	Analytical
Change-agent	Spontaneous	Pragmatic	Highly intuitive
Direct	Seek social acceptance	Humble	Perfectionists

ADDENDUM 2A: BRIDGES



Base or foundation which is a solid/fixed feature facilitating the construction of different bridges. (See photograph: IMG_2185.jpg)



Arch bridge is the oldest type of bridge. It has natural strength. Unstable until the two spans meet in the middle. Scaffolding or centring (vertical) needs to be put below the spans for support until the bridge is stable and secure. (See photograph: IMG_2206.jpg).

ADDENDUM 2A: BRIDGES (CONTINUED)



Beam Bridge is a rigid horizontal structure that rests on two piers, one located at each end of the bridge. The beam itself must be strong so that it doesn't bend under its own weight. (See photograph: IMG_2207.jpg).



Truss is a type of Beam Bridge. It is a series of connected triangles that distribute the weight to each member of the truss. It consists of a top and bottom chord and web members. It is very strong, due to the open triangles along its sides. (See photograph: IMG_2199.jpg).

ADDENDUM 2A: BRIDGES (CONTINUED)



Suspension bridge is composed of a deck that is attached to or suspended from cables. The cables are attached to two tall towers and are secured at each end by anchors. (See photograph: img_2210.jpg).

Model builder Paul Barnard from:



ADDENDUM 2B: UTILISING THE BRIDGE(S)



ADDENDUM 2B: UTILISING THE BRIDGE(S) (CONTINUED)



ADDENDUM 3: EXAMPLE QUANTITATIVE DATA-ANALYSIS

Participant B1

	Pre	Post	Follow Up
Therapy	4	6	6
Contact	8	11	12
Boundary	3	3	2
Interest	11	12	12
Posture	4	6	7
Humour	4	4	4
Resist	4	5	6
Emotion	8	11	11
Cognitive	12	14	14
Creative	5	6	6
Self	17	18	19
Social	8	15	12
Process	11	19	23
Total	99	130	134
	100%	131%	135%

Participant B2

	Pre	Post	Follow Up
Therapy	4	6	6
Contact	5	7	12
Boundary	2	2	3
Interest	6	9	11
Posture	3	5	6
Humour	2	3	3
Resist	2	3	3
Emotion	8	9	10
Cognitive	11	13	13
Creative	3	4	6
Self	18	21	21
Social	8	13	18
Process	10	16	19
Total	82	111	131
	100%	135%	160%

Participant B3

	Pre	Post	Follow Up
Therapy	4	5	6
Contact	5	6	8
Boundary	2	2	2
Interest	6	6	6
Posture	3	3	3
Humour	2	2	2
Resist	5	7	6
Emotion	8	8	8
Cognitive	11	12	12
Creative	3	4	4
Self	12	12	15
Social	7	10	10
Process	17	24	24
Total	85	101	106
	100%	119%	125%

Participant B4

	Pre	Post	Follow Up
Therapy	4	6	6
Contact	6	10	11
Boundary	3	3	3
Interest	6	7	7
Posture	3	4	6
Humour	3	3	3
Resist	2	2	3
Emotion	8	8	9
Cognitive	10	11	12
Creative	3	4	5
Self	15	17	17
Social	14	19	19
Process	11	15	16
Total	88	109	117
	100%	124%	133%

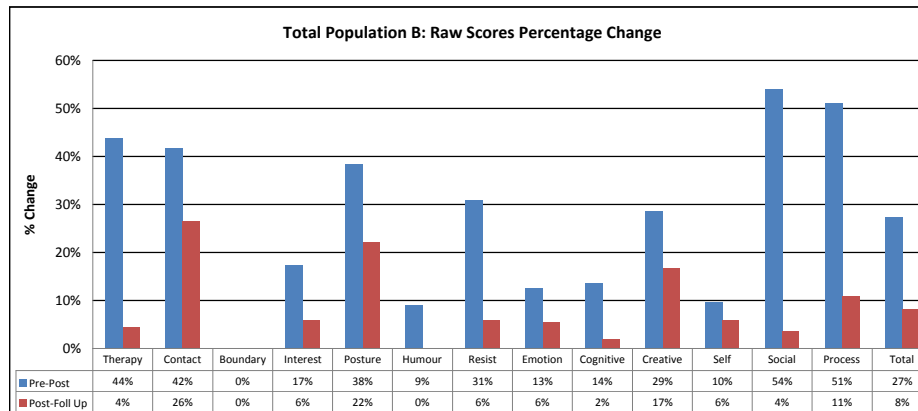
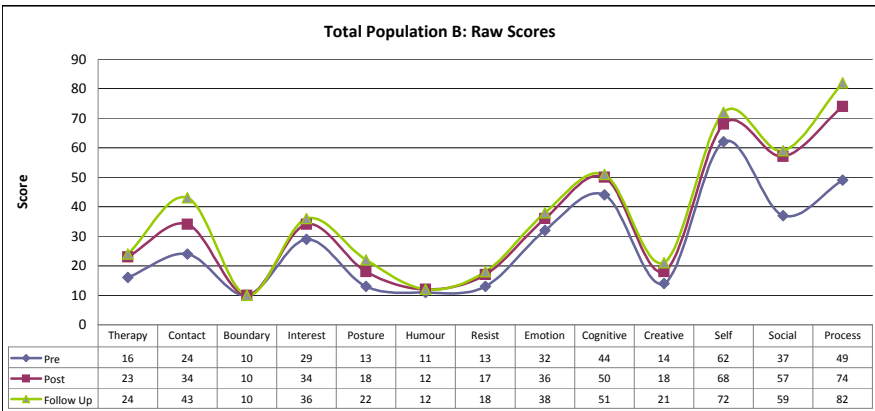
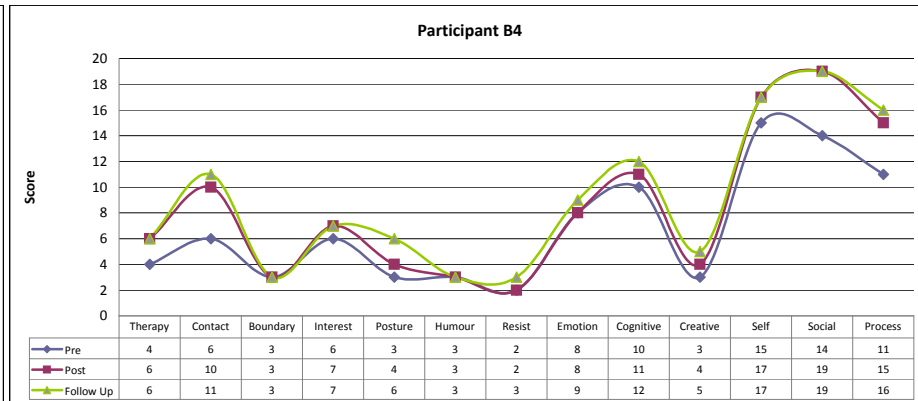
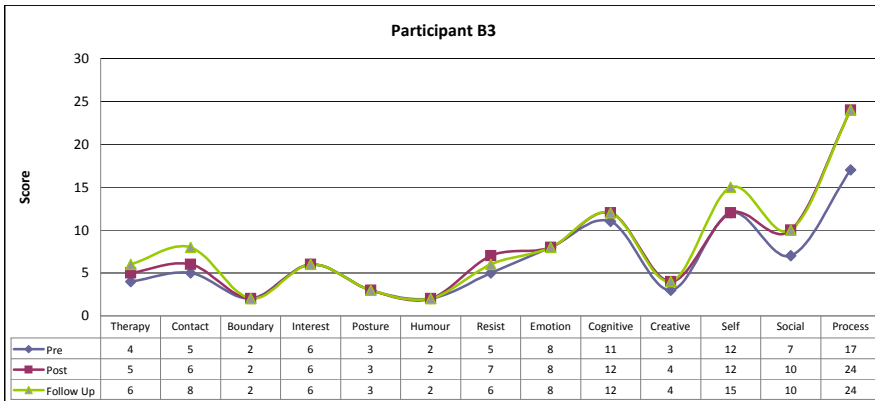
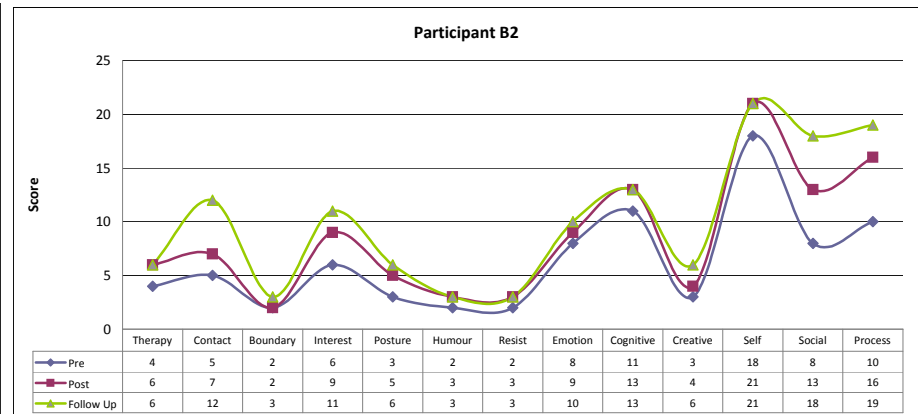
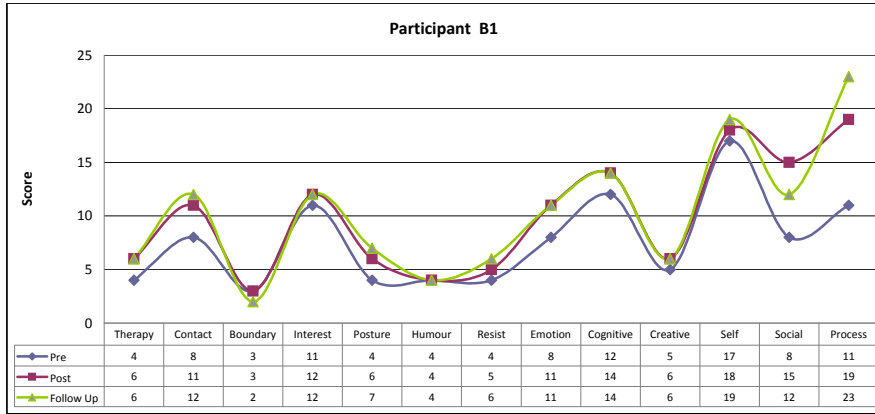
Percentage Change Population B

	Part B1		Part B2		Part B3		Part B4		Total Pop	
	Pre-Post	Post-Foll U	Pre-Post	Post-Foll U	Pre-Post	Post-Foll U	Pre-Post	Post-Foll U	Pre-Post	Post-Foll U
Therapy	50%	0%	50%	0%	25%	20%	50%	0%	44%	4%
Contact	38%	9%	40%	71%	20%	33%	67%	10%	42%	26%
Boundary	0%	-33%	0%	50%	0%	0%	0%	0%	0%	0%
Interest	9%	0%	50%	22%	0%	0%	17%	0%	17%	6%
Posture	50%	17%	67%	20%	0%	0%	33%	50%	38%	22%
Humour	0%	0%	50%	0%	0%	0%	0%	0%	9%	0%
Resist	25%	20%	50%	0%	40%	-14%	0%	50%	31%	6%
Emotion	38%	0%	13%	11%	0%	0%	0%	13%	13%	6%
Cognitive	17%	0%	18%	0%	9%	0%	10%	9%	14%	2%
Creative	20%	0%	33%	50%	33%	0%	33%	25%	29%	17%
Self	6%	6%	17%	0%	0%	25%	13%	0%	10%	6%
Social	88%	-20%	63%	38%	43%	0%	36%	0%	54%	4%
Process	73%	21%	60%	19%	41%	0%	36%	7%	51%	11%
Total	31%	3%	35%	18%	19%	5%	24%	7%	27%	8%

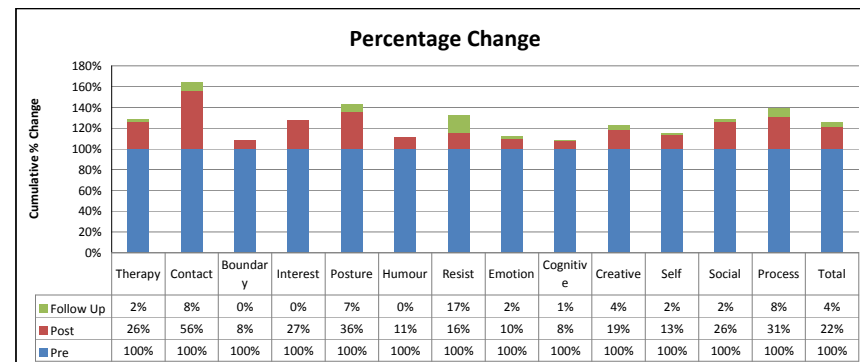
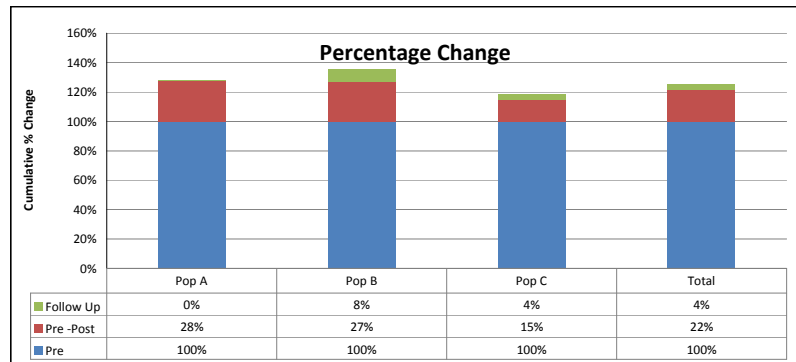
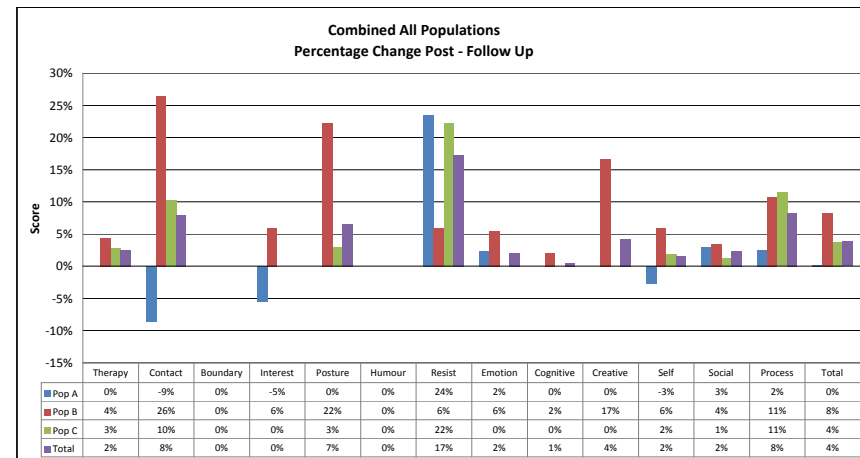
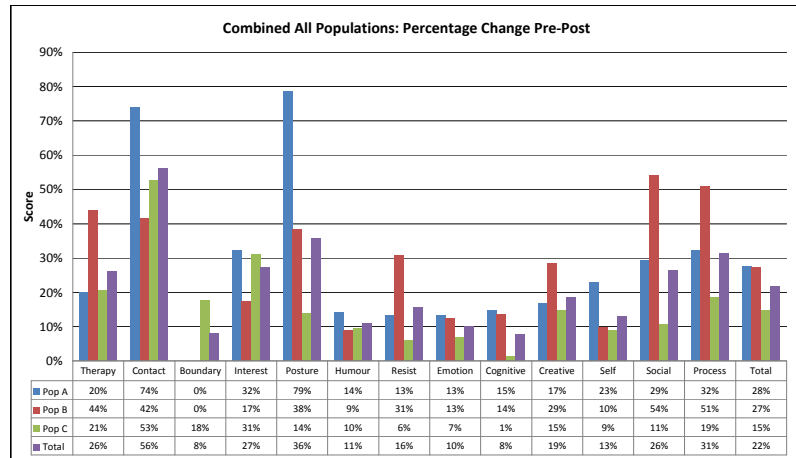
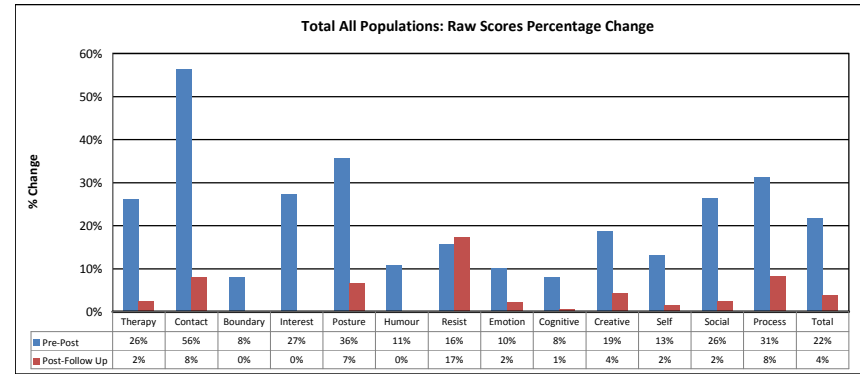
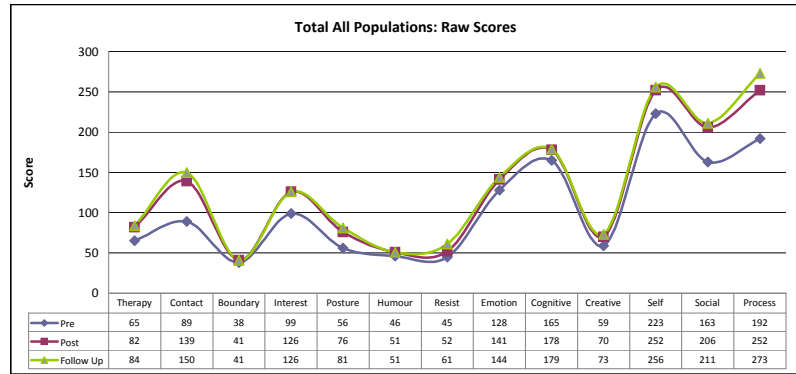
Total Population B

	Pre	Post	Follow Up
Therapy	16	23	24
Contact	24	34	43
Boundary	10	10	10
Interest	29	34	36
Posture	13	18	22
Humour	11	12	12
Resist	13	17	18
Emotion	32	36	38
Cognitive	44	50	51
Creative	14	18	21
Self	62	68	72
Social	37	57	59
Process	49	74	82
Total	354	451	488
	100%	127%	138%

ADDENDUM 3: EXAMPLE QUANTITATIVE DATA-ANALYSIS (CONTINUED)



ADDENDUM 3: EXAMPLE QUANTITATIVE DATA-ANALYSIS (CONTINUED)



ADDENDUM 4: QUALITATIVE DATA-ANALYSIS: THEMES

No	Participants	Parents	Teachers	Selection session	Pre-assessment session 1	Session 2	Session 3	Session 4	Session 5	Post assessment Session 6	Follow up Session 7
1	A1	Mom died Loss Child behaviour problems: ran away, lies, temper tantrums & withdrawn, do not answer when spoken to. In Collin house children's home of safety.	Withdrawn, sad, isolate self from friends - rejection. In place of safety - Colin house. Rejected by friends. Negative relations re stepmother. Father absent.	Mentally disabled Reserved. Limited contact, anxious, suspicious, bite nails, limited communication	INTROJECTION: My stepmother - I am a liar, I am bad. Friends at school I am a liar. Teacher Lenie believes me. Ran away from home. Placed in Collin house. Verbal and physical abuse. Being bullied	Clay work, cards, face. Fights with friends: telling lies (call girl fat) mother tell Collin home friends to stop calling - isolate. I am a liar - my mother told me. I am bad. INTROJECTION	UTILIZED BRIDGE: facilitates com. Animals: giraffe & dog (me) look/watch over me - projection. Lacks security, desire acceptance. Physical abuse: hit me with stick. Sister - I am crazy. Treat me -dog 'voertsek"	UTILIZED BRIDGE good. Camping with Lawrence. Fish/camping. Truss bridge. Friends blames me. Sister says I am crazy and liar. Father does nothing. Loss of doll Danella. "I like the bridge"	UTILIZED BRIDGE Session with Lawrence - picnic on bridge. Busdriver talks about me - lives in squatter camp. Feels helpless/keep quite. Discuss solutions - give friend advice	Has make a new friend. Stepbrother is kind to her. Father is helping with homework. Relationship with sister strain[scapegoat] Parents are fighting. Domestic violence and abuse. Report to school authorities.	Good contact. Talk no stop. Spoke about domestic violence. Dad left. ?alcohol abuse/ stepmom abusive. Little bit sad re last session. Will write letters/has a new friend. Me and my sister with uncle and aunt.
2	A2	Raised by Uncle Stanley. Mother absent Loss / living with another man & child. No contact. Grandmother look after him. Telling stories? Exaggerated. Times withdrawn. Not talking. Resistance	Taken care by Uncle. Mother passed away. Unsure about father's involvement. Shy and withdrawn at times versus exaggerated stories.	Mentally disabled Withdrawn & shy. Limited speech and eye contact. Answers I don't know, appears to be in own world	Eco map: lives with uncle. Father with granny. No mention of mom. Play cards with granny, has two brothers. Verbalizes Losses father and rejection from mother. I am bad - my mother left me- done bad things to me	Sleep over at gran. Saw my father for my Birthday, Do not have a mom. " She is bad, Has done bad things to me. Lives in the park. Pushed my pram of stairs. She left cause of me - don't love me. INTROJECTION	UTILIZED BRIDGE. Play hide and seek. Snakes & Lizards/crocodile. DEFLECTION Exaggerated stories- tattoo and cousin's snake. Not afraid, put around neck. Not true according to Stanley	UTILIZED BRIDGE reoccurred play - snakes/lizard. Crocodile mom, pregnant, kind TO babies. Projection. In the house lived his friend K and therapist. Exaggerated stories of dad in fights with men. EGOTISM	UTILIZED BRIDGE. Combined session with Kabashnee. Snakes/ Lizards/ not scared. Spoke about abuse of power by bus driver Rita. Pulled his hair, make ponytail. Bullied. Children held him. He cried, feels helpless. Solutions discussed together.	Played cards/dominos, and ball games. Spoke about week-end. His hair cut. Loves school. Got star on head. No deflection/ exaggerated stories. Good contact	Lawrence appears sick, coughing and fever. Not feeling well. Throw ball. Asked if I can come again. He has lost weights. Phone Stanley. Confirms illness.
3	A3	Parents divorced. Low-self esteem. Two hearing aids, limited speech. Experienced trauma breaking & theft. Both parents involved.	Shy and withdrawn. Spoke about trauma-breaking and theft. Feel angry. Low self-esteem	Mentally disabled Slow paced. Do not answer/ignores/ Run away from therapist. Pull shoulders up/ or Do not know. Yes or No	Reserved. Ball games. Spoke about the trauma, Withdrawn. Stikato answers. Little eye contact.	Eye contact. Ball games + energy, Clay work - power and control, verbalizes and recognizes feelings/emotions. Played music - sensory.	UTILISED BRIDGE facilitates picnic, 2 homes/ hide and seek, swim. Place farm animals on bridge/houmor. CONFLUENCE. Pleasing. Walk with therapist - compliant	UTLIZED BRIDGE. Energy ballgame. een beentjie jumps Excited, Mastered skill, confidence. Speech more clearly. Animals and two homes /bridge. Parents, Plays in boat with army clothes. Dolphin and shark in water. Humor- put pig in boat - laughter	UTILISED BRIDGE - in group. In discussion. More self confidence to speak up, got new suitcase, possessive re Therapist No trauma discussion, On bridge - went to Zoo	Walk with therapist, Visit dad week-end. Busy integrating two homes/divorce. More talkative. Play with clay, Mother positive feedback Bridge facilitates discussion at home.	Happy to see Therapist. Eye-contact, smile through games. Take lead with cards, snakes and ladders/ dad on roof. Makes choices, speech more clear. Stronger sense of self.
4	A4	Parents divorced. Father emotional games. Grandfather-dying. Crying spells. Hides under bed. Stop talking. Temper tantrums. Encopresis when with dad. Bite nails +++ Retroflection feels guilty re taking re mom.	Shy and withdrawn last few weeks. Crying spells, stop talking when spoken to. Mother new boyfriend. New school in 2011. Father in Zambia playes games	Mentally disabled. Eye-contact, more stares. Limited speech yes/no answers. Anxious - bite nails. Reserved. Personality/behaviour change.	Genogram - faces and emotional chart. Anxious. Only um, yes/no answers.info re field - friends/parents RETROFLECTION ENCOPRESIS	Creative play: biscuits draw picture of dog red /face of biscuits. bubbles, bean bags. Role-play through soft toys about parents. Relationship starts.	UTILISED BRIDGE explore field - wild animals. 2 bridge on board. Facilitates communication - swim in river/drown to doc. Talk about grandparents.	UTILISED BRIDGE playful - all dogs and camping with boyfriend and parents In car - my mother is bad because she has a new boyfriend INTROJECTION- my father told me	UTILISED BRIDGE - through drawings - place old school on one side/ new on other. How to get their. Prepare for visit to new school. Imagination. Concrete level re love association with table. Small little big table lots of love.	Went on holiday with stepdad/met new family at Sun City. Goodbyes to friends and teacher. Exited about new school. Like the school. More confidence	Interview dad. Loves new school and home. Been on holiday with dad. Farewell party at office. Phone 2x since. Laughter/ able to terminate.

No	Participants	Parents	Teachers	Selection session	Pre-assessment session 1	Session 2	Session 3	Session 4	Session 5	Post assessment Session 6	Follow up Session 7
5	B1	Parents divorce. Both in SAPD. Temper tantrums, aggressive behaviour/physically attacks grandma. In Epworth children's home. Stealing and lying.	withdrawn, sad and weepy spells. Complains about grandmother refusing to read books. Academic performances - drop. Feel rejected by mom	High stream primary - children with special needs High pitch voice. Shy and withdrawn. No eye contact but wants to be part of research. Answers only Yes/no or I dont know.	Genogram - faces. Spoke about field: parents divorced. Grandma not understanding her need to read. Talk not stop re books. DEFLECTION. Reading her way of cope/avoid stress	UTILISED BRIDGE. Appears confused/unorganized. identify problems on bridge associate with different bridge. Projection of problems on objects.	UTILISED BRIDGE Mother bad "whore" focus - divorce, mother's bad behaviour HIV/ uncertainty re mother and acceptance INTROJECTION - my mother is bad - a prostitute	Off camera: spoke about menstrual circle. Tampons/ showed sister. Been sexually fondled by Children's Home inmates. Will she also become like mom. Inappropriate sexual behaviour. RETROFECTION	Creative Play: Biscuits & icing, Discussion boyfriend. Sister's birthday, Valentines day and helped grandmother. Less conflicts and fights.	Feedback teachers: improvement - bubbly outspoken Selected as media leader/class leader. Projection re snakes and ladders help she got. Seek acceptance and reassurance re mother	Good contact, openness. Laughter. Spoke about non-threatening subjects. Eat vetkoekies together, New spectacles. Wants to carry on with therapy. Has cell nr. Had phone 2x
6	B2	Living in poor conditions. Shy and withdrawn/ stubborn Constant conflicts with sister. Scared to go to school. Negative attitude.	Appears frightened. To scared to walk in class/wait outside. No communication. Stares at teacher. Yes/no and attitude/ Blocks	High stream primary - children with special needs. Limited eye contact and communication. Appears bored. Do not want to be in therapy. Blocks. Avoiding DESENSITAZATION	Uninvolved and uninterested. Limited contact and communication. Little eye contact. Only threw ball, and wants to go back to class. No hand contact	Claywork. Sensory awareness. Create faces - emotional chart. Scared of ghosts, brothers and sisters tell on her. DEFLECTION She is always in trouble. No owning of work.	UTILISED BRIDGE. Better contact, still reserved. Camp on bridge with boyfriend. I don't know answers. Utilized horses & dolls.	UTILISED BRIDGE facilitates more communication. School camping with brother on leaders camp. Sing song. Played hide and seek. Selected as prefect. Mother did not say anything Seek approval and love from mom.	Creative Play. Clay and cards. Utilized biscuits & icing. Create flowers. Foreground: loss of grandfather(close relation)Spoke about public swimming pool & valentines day	Played snakes and ladders. Correct therapist, eye contact, Loss about jack Russell dog, spoke about choices. Like playing on bridge. Hesitant to go back to class.	Spoke about birthday party. Smiling and communicate- friends wants to be her. Self confidence. Talkative. Paintwork - owning projection, Humor in naming. Not shy anymore.
7	B3	Severe physical and emotional abuse. Lacks coincidence. Low self-esteem. Parents divorce/deserted. Neglected in nurturing/bonding. Mother feels guilty not protected.	Withdrawn. No communication when speaking to. Limited eye contact. Live in upliftment centre. Destitute. He is Ashamed of living conditions.	High stream primary- children with special needs. No emotion on face. Limited contact - eye and communication. Very shy. DESENSITAZATIONS Meek/mild attitude= CONFLUENCE	Genogram. Emotional faces. Limited speech. Yes/no or I don't know. Pull shoulders up/ I cant' do it.	UTILISED BRIDGE. Facilitates com. Hang bridge- photos of uncle. Very strong feel safe. Dad is a mechanic, help him, cars. SPCA - to fetch the dogs no food	UTILISED BRIDGE - Wild animals. Tiger. And Zebra Catch fish with friends. Picnic & valentine's day Do not connect bridge. Smell urine. Pants wet. DESENSITAZATION	Creative Play. Biscuits & icing. Confluent behaviour slow pace. Motivate & push to partake. Mastering- proud	Sick and next session moved to new home. Upliftment centre closed Feedback Teachers - walk strait, more eye contact. Smiling	Snakes and ladders. Smiling. Eating sandwiches together. Very good in Match. Spoke about other subject and upcoming holiday.	Spoke about mother's new friend. Move in with him. Not sure if he likes him. Step out. Camera off unsure how/ communicate freely about not being shy. Played clay - empowerment.
8	B4	Divorce. Withdrawn and shy. Tested by Psychologist - selective mutism. Lacks confidence. Apply to transfer to special school. Ignores you	Quiet and withdrawn. Mother a teacher - does everything for him. Has friends. Low self esteem and no confidence.	High stream primary - children with special needs. Only knods head, pull up shoulders. Eye contact - but almost a stare, Limited verbal interaction but non-verbal. Wants to be in therapy.	Genogram - faces and emotional chart. Answers yes/no or I don't know. Block discussion. Play in silence ball and cards. Ignores. DEFLECTION	UTILISED BRIDGE acknowledge field/river and catch fish. Put friends [2dogs and 2 horse down] Separates him from them no bridge. Facilitates talk re friends	UTILISED BRIDGE Spoke about types of bridges. Put beambridge on with any other objects. Mother is arch - strong helps him Father beam rails helps him studies. Makes him safe.	Claywork - emotion faces. Passive. swordfight [sponge] aggression. Girl at school - aggravates Doesn't like her. Talk about solutions. PROJECTION	Painting - confluence - stop dont like. Cards - go fish. Family talk about dad -adultery. Mother - He is just like dad - Am I bad? A Womaniser INTROJECTION	Played battleship 6 sessions - limited talk. Wants to come back.He wants parents to talk to each other. They ignore - spoke about dad girlfriend	More relax Wants to play battle field Mastering won, feels good. Snakes and ladders. Dad broke up relationship. Hope for reconciliation. Smiling

No	Participants	Parents	Teachers	Selection session	Pre-assessment session 1	Session 2	Session 3	Session 4	Session 5	Post assessment Session 6	Follow up Session 7
9	C1	Withdrawn since Oct 2010. Prefect badge was taken away re porno on cell. Refer to Kidz Clinic. Labile/being rejected by friends/ picked on by teachers.	Appears disrespectful; ignores when spoken to. Absent quite often. Absent father figure. Stange mannerisms	High Stream school. High pitch voice. Shy and withdrawn. No eye contact but wants to be part of research. Answers only Yes/no or I dont know.	Genogram and emotional chart. Became emotional - crying. Swith camera off. Teacher pickson him [Margariet] Teacher Kay - his a liar and not really sick	UTILISED BRIDGE Very emotional - crying. No eye contact. Played army/rambo and sniper on brige. Facilitate communication. Help with containment.	UTILISED BRIDGE Jurassic Park. Associated teachers - Dinosaurs. Left bridge off/ Focus on solutions. Teachers stop picking no ignores. Spoke about prefect badge. Wants it back	Claywork: sensory faces. Built house with on window. Enterance only door 3 persons - me I am ok. Mudmonster-predator. Allow hand game.	Establish telephone contact. Off sick. Spoke about exams/ Feeling better. His one friend Frans helps him with homework. Mother supportive. Never talks about his father.	Focus on Kidz Clinic program - boaring. Did not helped. Cell phones and how to protect self. Friends rejected him. He has been made feeling bad INTROJECTION	Very relax - layed back, eye contact. Sister ran away - angry with her. Feel little silly about the bridge/clayplay. I am now ok. Laughter and hand touch game.
10	C2	Parents Divorce Mother 22 operations Grandparents involve. Juane been in trauma-hijack. Depression. Lacks selfconfidence	Depression/withdrawn avoids eye contact. Shy. Disrespectfull - ignores.not follow rules. Suspects self-mutilation reported by school peers.	High functioning-high stream school Very shy and withdrawn. Limited eye and verbal contact. Seek acceptance through compliance. Appears sad, hang shoulders	Genogram - faces and emotional chart. Spoke about father. DEFLECTION - board and yawns. family violence/alcohol abuse	UTILISED BRIDGE. Picnic and friends/hangbrige. Roads led to hospital and grandparents. Loss of mother in hospital and dog ran away. Selfcutting behaviour	Switch camera off. Crying. Mother admit to hospital. Express feelings of unsafeness & rejection from dad. Anger - not normal girl nobody understands RETROFECTION-SELF CUTTING	Claywork: mother out of hospital. Scared mother will die. Not part of a group. teachers/children. Make cakes/laughter handplay. Do not want to go.	Homevisit to grandparents. Joint meetingWriting exams during school, Spoke: parenting, rules extra classes. Support	Session at practice. Draws picture - cross. Not accepting self. Trauma re armed robbery. Parents and positive aspect of life: Danie [mother'sboy] and grandparents.	Good contact. Snakes and ladders. Projection of good and bad in live. Address learning difficulties. Uncle out of prison, eye-contact and communication good.
11	C3	Withdrawn & tearful. Poor homecircumstance. No friends & rejection. Poor academic progress. Kept behind in Gr 4 must be in 6	Difficult homecircumst. Deprived social stimulation. Food parcels. Shy and withdrawn. Rejected by friends/isolation	High functioning-high stream school. Appears shy & withdrawn Extreme petit slow pace and cautious. Scared she has done something wrong. I am not good enough for a friend? INTROJECTION	Genogram faces and emotional chart. Likes and dislikes. Take care of brothers&sisters. Reserverd. Limited communication.	Claywork. Sensory awareness. Foreground: rejection by friends. Create self - Able to acknow I. " Ek kan nie die beste wees nie" PROJECTION Desire relationship with mom/excepttance	UTILISED BRIDGE. Appears upset/address problem lost key and solutions. Played camping, hide and seek and fishing on bridge. Facilitate communication	Snakes and ladders loves the game. Joy and laughter. Sing songs. Played camping again with dolls& horse. Therapist her friend/trust Own projection. Seek acceptance.	Been to school/Exams. Lizette off sick with diaree. Has no cellphone. Only dad. No contact	Crying and labile. Sleepover with friend. Shock to see other live. Compare life with friend's Realises deprived/lack in food. Togetherness. Focus on what good in own house/parents	Snakes and Ladders. Seen day before Test again/ Integrate previous session learning. Positiveness in own life - better in academics/friends/ parents loves her/hugged her/
12	C4	Parents divorced Motor-car accident 2009/10. Withdrawn isolate himself due to enkopresis. Good relation with stepd/not with brother - physichally	Struggles in Social setting/school. No friends. Been rejected. Seek acceptance. ENCOPRESIS Becomes withdrawn Mother over protective	High Stream school. Appears vulnerable/shy. Makes eye-contact not verbale com. friends & rejection . DEFLECTION -changing subject.	Genogram- faces. Emotional chart. Block about family. Talked about holiday- Betty's baai. Mother's work and been bullied by brother. Likes/dislikes	Claywork: got new friend. Brought anger out - clay. Creative bescuits&icing. Touch/tasts/musical-Wants to terminate session/	UTILISED BRIDGE disciplinary hearing/negatives. Truss bridge. Played out married life military fishing and bungyjumping. DEFLECTION	12:50m Loves claywork- Monster Glu. Own projection. His father in their live 46 years/ comes out at night/deflects re how they are affected.	Continuous contact. Telephone. Wrote exams and played rugby. Spoke about rugby. Birthday present, Mother - improvement.	Sessions at practice. Spoke about accident. Teased by school peers. Lost memory and basic functions. LOSS friends/position in rugby. In contact with feelings/self	Battleship and clay. Eye contact and communication. Spoke about safing child out of swimmig pool? Intergaton and effects-changing subject.

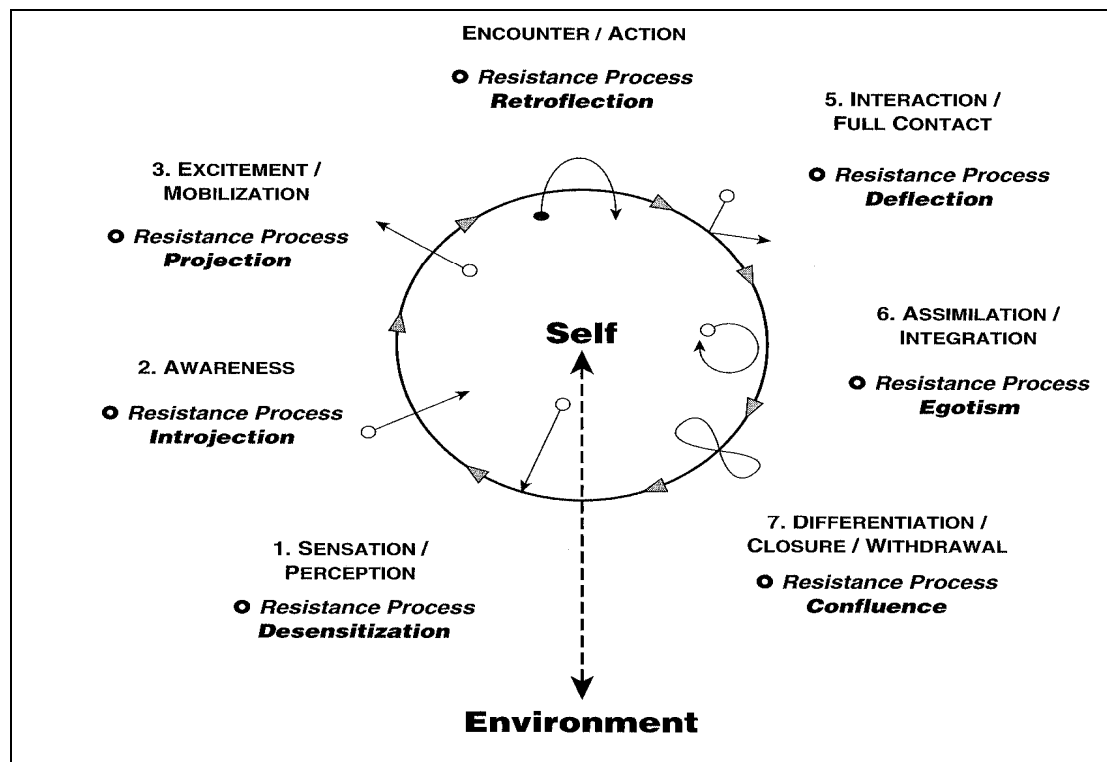
No	Participants	Parents	Teachers	Selection session	Pre-assessment session 1	Session 2	Session 3	Session 4	Session 5	Post assessment Session 6	Follow up Session 7
13	C5	Divorced Aggressive behaviour. Physical and emotional abuse by mother. Temper tantrums. Manipulates. Father admits he himself has anger/temper issues	Aggressive- physical and verbale Swear words. Abruptness. No respect. Tells stories and lying. Bullied	High stream school. Makes eye contact/ Acting clown like . No in contact with emotions/feelings. DEFLECTION - exagorate stories/boost. " ek is so goed, almal hou van my" EGOTISM	Genogram - faces/drawings. Emotional chart. Admits to negative/aggressive behaviour. Highly intelligent. Exaggerate stories. DEFLECTION	Focus on behaviour as discussed in first session. He protects himself. Determine triggers - rejections/ unsafeness. Verbalises feelings of vulnerability. Transference	UTILISED BRIDGE projection of feelings. Played out past, present and furture/desires. Expresses- feelings of been part of and acceptance.	Focus on unfinished aspects. School peers. Replace swearwords with alternative words/ Awareness of safety net/bubble to protect and red alert sign to prevent inappropriate behaviour.	Continuous contact. Cellphone. Writing exams. Got negative for pushing girl. Father did not hit him. Spoke nicely to him. Kids less pestering.	Sessions in practice. Communicate freely. Battleship - won. Stop hitting peers. Over exaggeratio deflects out of contact with self. Transferences "mamma'	Snakes and ladders. Eyecontact. Sad last session. Uncomfortable about new friend speaking of sex/ got hiding for work not done/negative . Played handgame.
14	C6	Father died in motorbike accident. Kirsten saw accident. Seen by several Therapist. Defying behaviour. No respect for mom. Temper tantrums. Push bound	Quite and withdrawn. Ignores when spoken to. Appears spoiled brat. Mother overcompensate. Gets everything he asks. Calls mom a stripper [clothes and new boyfriend]	High stream school. Quite - almost stare. Power and control in not answering. Appear to have a attitude /spoiled and disrespectful. Lies to mom/teachers. Push boundaries.	Genogram- faces and emotional chart. Focus on likes and dislikes. Dont'answer. Difficult to make choices re games/faces/ Reserved+++	Claywork and creative play. Focus on sensory awarness. Loves clay - show how to create rose.Spoke about soccer/rugby father's motorbike.	UTILISED BRIDGE Reserved. Place lion/tree/2 men and crooks/home. Watch everyone/no bridge/ Men in boat under beambridge is him. Blocks.	Requested camera to be switched off. Mother wants him to have therapy. He doesn't wants to talk about dad. Had 4 different therapist. Loss of home and friends in area	Played snakes and ladders. Talked about soccer practice and decision to play rugby. He singing in choir. Eet sweets together. Most in silence.	Exams. No session. Agree to decide whether he wants to have 2nd follow-up session.Give parental guidance to mom and feedback.	Kirsten Choose to see therapist. Played battleship - won. Smiling, more talkative re holiday to Drakensberg. Eye contact and integration. Did not like bridge but liked clay.

ADDENDUM: 5 REFLECTIVE NOTES ON RESEARCH STUDY

Introduction

As a therapist, I was interested in **how** clients and for the purpose of this study, how adolescents tried to make contact with their environment, with themselves and with me as a therapist and **what** prevented adolescents from making contact. During my studies in Gestalt Therapy, two of my assignments namely **contact** and the **client–therapist relationship** played an important role in the selection of my research topic. What was contact and how and where do we make contact? If contact cannot be establish, how can I as a therapist overcome or bridge that which prevented me from making contact with my clients. The Gestalt Circle of Experience (see figure 1) had an impact on my perception and understanding of contact and what prevented contact making with self and with other.

Figure: 1 Gestalt Cycle of Experience



During my first year of studies focussing on Gestalt theor, Dr Hannie Schoeman (lecturer) discussed notes on the Gestalt Personal homeostasis cycle: A guide to understanding the boundary and contact functions, which

was given to her by Ansel L. Woldt, (Emeritus Professor at Kent State University) during her meeting with the author. This has made contact and the resistance processes more clearly to me as a therapist as it describes the inner and outer circle of making contact and resistance. I have put this in context with the ecological systems theory of Bronfenbrenner and with the Gestalt field theory, which had formed the basis of this research study.

In an article by Latner (1992) on contact and contact-boundary, published by the Association for the Advancement of Gestalt Therapy these concepts were illustrated as follows:

The **contact-boundary** always has duality – one it acknowledge differences, without which there could be no contact and two it acknowledge what unifies them, without which there could be no **gestalt**, no whole of experience.

The contact-boundary is illustrated by the following example using sea and sand: There is nothing between the sea and sand, no physical entity as the sand and the sea is. There is a shoreline at the point where the sea and sand meets. When the ocean's water is lapping the beach, the sand taking in the waters, there are meeting. [Illustrating **process**: ebb and flow] This meeting consist of the touching of two things, which are different: sand and sea. *In Gestalt therapy, the meeting of differences is called contact.* Therefore, this meeting of sand and sea is contact. The event that is created by this meeting of differences is called the contact-boundary. The shoreline is the contact- boundary, which does not belong to one side or to the other – it belongs to itself, to the meeting.

As a therapist/researcher, I experienced this meeting with each of the contacts I made with lecturers, authors, my supervisor, adolescents, parents and teachers during the research study.

Research Proposal

With the submission of my research proposal, **Dr Mariette van der Merwe** suggested to look in to therapy done by **Ken Redgrave** a psychotherapist, college lecturer and author of *Care – Therapy for children - direct work in counselling*, regarding the bridging technique that he applied with children in children's homes. These children were place into foster care, or reunited with

their families. He made use of a bridge as a metaphor to address problems as experienced by parents, foster parents and children, but from a cognitive behavioural framework.

Therapist/Researcher made telephonic contact with the author, **Ken Redgrave** and through many e-mails and discussions, my concept of bridging barriers/contact-interruptions with a physical bridge(s) as metaphor took shape. The goal was to establish contact – concretely through the building of different bridges, in order to facilitate projection of feelings as well as the forming of a client-therapist relationship. I believe that contact and the client-therapist relationship between a therapist and client are the foundation of a therapeutic process.

Contacts with the following lectures, authors and therapists in private practice had played an important role in the completion of this research study:

- **Prof Rina Delport** input re the research design, in order to measure the effectiveness of treatment interventions over time. The treatment intervention in this study was the utilisation of a bridging technique. It was suggested to use the same assessment instrument in all three the measures (pre, post and follow-up) and to identify the dependent and independent variables.
- **Dr Rinda Blom** re her applied Gestalt assessment guidelines, which were used in the pre- post- and follow-up assessments in this research study.
- **Dr Herman Grobler's** input and practical guidance during the research study re the utilisation of the bridge and the bridging technique.
- **Paul Barnard**, designer of the model bridges who was able to create my vision of what I wanted to accomplished through my contact sessions with adolescents.
- Therapist became aware during the research process of the willingness of lecturers, authors to share their knowledge as well as guidance and support given to the research study.

Research study

The research took place over twelve weeks, which was exciting yet very tiresome and intense. Three different schools were visited, four days per week where 14 participants were seen, for six to eight sessions each, as well as two to three sessions with teachers and two to three sessions with parents of the adolescent participants. Most of the research participants (teachers and parents) were supportive, however it was noted that there were a lack in knowledge regarding the research process, confidentiality and the importance of ethical standards.

Researcher was surprised at aspects that became known during the therapeutic sessions with adolescents such the influence of divorce, extended family members, loss of significant others, abuse and trauma and the important role it played in **what** prevented or impacted contact making of adolescents.

The naming, blaming and shaming of adolescent participants as well as the abuse of power were noted, which made therapist aware of how easy it is to generalise and assume – contributed towards maintaining the problem, namely how adolescents made contact or prevented them from making contact in order to protect the “self”. A lack in parenting was noted, which contributed together with the above in **how** adolescent presented themselves to the outside world.

Researcher noted the value of the bridging technique, how it contributed to adolescents gaining awareness of inner feelings, of their “destructive” behaviour as well as the positive changes noted by themselves, parents and teachers.

Conclusion

During the research study, I gained insight into my own processes: how I make contact with adolescents, with myself and significant others in my field. I learned, to trust my inner feelings, my capabilities and to trust the **process**.

The paradox of the human spirit is that I am not fully myself until I am recognised in my uniqueness by another – and that other person needs my recognition in order to become the unique person he or she is – We are inextricably intertwined.

ADDENDUM 6: ETHICS

DISSERTATION TITLE: Utilising the Bridging technique during therapy to overcome contact-making barriers in adolescents.

APPLICATION TO INSTITUTE: The Institute for Child, Youth and Family Studies at Huguenot College (UNISA) for clearance of new Projects.

SUBMITTED DOCUMENTS: Ethics Committee Application form and consent to Participate.

DATE OF SUBMISSION: 19/07/2010 **DATE OF APPROVAL:** 30/09/2010

The Institute for Child, Youth and Family Studies at Huguenot College (UNISA) original approved the clearance of new project. During the beginning of 2011, the Huguenot College could no longer accommodate the study due to foreclosure. The study was transferred to North-West University, Potchefstroom campus. The research was approved and clearance given to complete the study.

NEW REGISTRATION: North-West University Potchefstroom Campus

DATE: 24/03/2011

STUDENT: C.J. Louw

SUPERVISOR: Dr. H.B. Grobler

North-West University

Potchefstroom Campus (Wellington)

0027 21 864 3593 (tel)

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ADDENDUM 6: ETHICS (CONTINUED)
ETHICS COMMITTEE APPLICATION FORM
SUBCOMMITTEE A
2010

**Application to Institute for Child, Youth and Family Studies at the
Huguenot College for clearance of new research projects**

This application must be typed or written in capitals

Name: Prof/Dr/Mr./Ms: CHRISTENE LOUW

Position/Professional Status: MA STUDENT

Affiliation:

Institution: HUGUENOTE COLLEGE WELLINGTON

Telephone and extension no.

(011) 976 2288 AND CELL: 084 8722 768

Fax: (011) 976 2288

Email address: Christene@iburst.co.za

Title of research project: (*Do not use abbreviations*)

UTILISING THE BRIDGING TECHNIQUE DURING THERAPY TO OVERCOME CONTACT-
MAKING BARRIERS IN ADOLESCENTS.

Where will the research be carried out?

AT THE PRIVATE PRACTICE OF THE RESEARCHER AS, WELL AS AT RELEVANT SCHOOLS IN
EKURHULENI METROPOLITAN, NORTHERN REGION GAUTENG.

All the following sections must be completed (Please tick all relevant boxes where applicable)

1. FUNDING OF THE RESEARCH: How will the research be funded?

THE RESEARCHER WILL FUND THE COST OF THE RESEARCH STUDY.

2. PURPOSE OF THE RESEARCH:

THE PURPOSE OF THIS STUDY IS TO EXPLORE HOW THE BRIDGING TECHNIQUE CAN BE
UTILISED DURING THERAPY TO OVERCOME CONTACT-MAKING BARRIERS IN
ADOLESCENTS.

3. AIMS AND OBJECTIVES OF THE RESEARCH: (*Please list objectives*)

- THE GOAL OF THIS STUDY IS TO EXPLORE HOW THE BRIDGING TECHNIQUE CAN BE
UTILISED DURING THERAPY TO OVERCOME CONTACT-MAKING BARRIERS IN
ADOLESCENTS. THE FOLLOWING OBJECTIVES WILL BE FOLLOWED:

- A LITERATURE STUDY WILL BE CONDUCTED TO CONCEPTUALISING RELEVANT CONCEPTS IN GESTALT THERAPY THEORY AND CONCEPTS SUCH AS CONTACT-MAKING BARRIERS, METAPHOR, ADOLESCENT, AND DEVELOPMENTAL PHASES.
- AN EMPIRICAL STUDY WILL BE CONDUCTED BY APPLYING A COMBINED QUALITATIVE AND QUANTITATIVE APPROACH IN THE FORM OF A SINGLE SYSTEMS DESIGN
- QUALITATIVE DATA WILL BE ANALYSED ACCORDING TO THE INDUCTIVE AND PRIOR APPROACHES AND THE CRESWELL'S SPIRAL;
- QUANTITATIVE DATA WILL BE ANALYSED ACCORDING TO THE SEMANTIC DIFFERENTIAL SCALE AND TRANSFORMED STATISTICALLY TO DESCRIBED THE DATA.
- TO MAKE RECOMMENDATIONS TO THERAPISTS.

4. SUMMARY OF THE RESEARCH (give a brief outline of the research plan – not more than 200 words)

THE **FOCUS OF THIS STUDY** WILL BE ON ADOLESCENTS WHO EXPERIENCE BARRIERS IN MAKING CONTACT DURING THERAPY. THESE BARRIERS COULD BE DUE TO SEVERAL FACTORS SUCH AS THEIR DEVELOPMENTAL LEVEL, NOT ABLE TO EXPRESS THEMSELVES IN THEIR MOTHER TONGUE, LIMITED LINGUISTIC SKILLS, INSUFFICIENT INSIGHT INTO AN AWARENESS OF INNER FEELINGS. THESE BARRIERS NOT ONLY RESTRICT OPTIMAL COMMUNICATION AND CONTACT-MAKING OF ADOLESCENTS EXTERNALLY BUT ALSO INTERNALLY WITH THE SELF.

THE GOAL OF THIS STUDY IS TO OVERCOME CONTACT-MAKING BARRIERS IN ADOLESCENTS BY UTILISING A BRIDGING TECHNIQUE DURING THERAPY SESSIONS. THE RESEARCHER WILL UTILISE A BRIDGE AS METAPHOR TO OVER-COME CONTACT- MAKING BARRIERS IN ADOLESCENTS DURING THE THERAPEUTIC INTERVENTION.

WRITTEN PERMISSION WILL BE OBTAINED FROM PARENTS AND RELEVANT SCHOOL AUTHORITIES BEFORE COMMENCING RESEARCH (SEE CONSENT FORM TO PARTICIPATE).

SEMI-STRUCTURED INTERVIEWS WILL BE CONDUCTED WITH PARENTS AND TEACHERS IN ORDER TO OBTAINED RICH INFORMATION REGARDING THE FIELD OF ADOLESCENTS. **AN ASSESSMENT QUESTIONNAIRE** WILL BE COMPLETED FOR EACH ADOLESCENT BEFORE THE INTERVENTION PHASE (PRE) AFTER THE INTERVENTION PHASE (POST) AND A FOLLOW UP FOUR WEEKS AFTER THE POST ASSESMENT TO DETERMINE THE CONSISTENCY OF THE INTERVENTION. [184 WORDS]

5. NATURE AND REQUIREMENTS OF THE RESEARCH

5.1 How should the research be characterized (Please tick ALL appropriate boxes)

5.1.1 Personal and social information collected directly from participants/subjects	X
5.1.2 Participants/subjects to undergo physical examination	

5.1.3 Participants/subjects to undergo psychometric testing
5.1.4 Identifiable information to be collected about people from available records
5.1.5 Anonymous information to be collected from available records
5.1.6 Literature, documents or archival material to be collected on individuals/groups

5.2 Participant/Subject Information Sheet attached? (For written and verbal consent)

YES	
NO	X

5.3 Informed Consent form attached? (for written consent)

YES	X
NO	

5.3.1 If informed consent is not necessary, please state why:

NB: If a questionnaire, interview schedule or observation schedule/framework for ethnographic study will be used in the research, it must be attached. The application cannot be considered if these documents are not included.

5.4 Will you be using any of the above mentioned measurement instruments in the research?

YES	X
NO	

PLEASE SEE ATTACHED ADDENDUMS 1: ASSESSMENT QUESTIONNAIRE

6 PARTICIPANTS/SUBJECTS IN THE STUDY

6.1 If humans are being studied, state where they are selected:

ADOLESCENTS WHO ARE REFERRED TO THE PRIVATE PRACTICE OF THE RESEARCHER AS WELL AS FROM RELEVANT SCHOOL IN GAUTENG PROVINCE WILL FORM PART OF THE STUDY

6.2 Please mark the appropriate boxes:

Participants/subjects will:	YES	NO
be asked to volunteer	X	
be selected	X	

6.2.1 State how the participants/subjects will be selected, and/or who will be asked to volunteer:

ADOLESCENTS WILL BE ASSESSED BY THE RESEARCHER RE THEIR CONTACT-MAKING SKILLS AND THOSE PARTICIPANTS WHO EXPERIENCE CONTACT-MAKING BARRIERS WILL FORM PART OF THE STUDY WITH THE PERMISSION OF THEIR PARENTS/GAURDIAN.

6.3 Are the participants/subjects subordinate to the person doing the recruiting?

YES	x
NO	

6.3.1 If yes, justify the selection of subordinate subjects:

THE SELECTION IS PURPOSEFULLY WITH THE PERMISSION OF THEIR PARENTS AND WILL THE HELP OF SCHOOL AUTHORITIES.

6.4 Will control participants/subjects be used?

YES	
NO	X

6.4.1 If yes, explain how they will be selected:

What records, if any, will be used, and how will they be selected? N/A.

6.5 What is the age range of the participants/subjects in the study?

ADOLESCENTS BETWEEN THE AGE OF ELEVEN AND FOURTEEN WILL FORM PART OF THE STUDY.

6.5.1 Was assent for guardians/consent for participants/subjects obtained?

YES	X
NO	

If YES, please attach the appropriate forms.

SEE ATTACHED CONSENT TO PARTICIPATE.

6.5.2 If NO, please state why:

6.7 Will participation or non-participation disadvantage the participants/subjects in any way?

YES	
NO	X

6.7.1 If yes, explain in what way:

6.8 Will the research benefit the participants/subjects in any direct way?

YES	X
NO	

6.8.1 If yes, please explain in what way:

ADOLESCENTS MIGHT BENEFIT FROM THE THERAPEUTIC INTERVENTION TO OVERCOME CONTACT-MAKING BARRIERS AND ONGOING SUPPORT AND REFERRAL TO THERAPISTS.

7. PROCEDURES

7.1 Mark research procedure(s) that will be used:

Literature	X
Documentary	
Personal records	
Interviews	X
Survey	
Participant observation	X
Other (please specify) ASSESSMENT QUESTIONNAIRE	X

7.2 How will the data be stored?

DATA WILL BE TRANSFER TO COMPUTER FOLDERS AND BACKUP COPIES WILL BE STORED. A PASSWORD HAS BEEN INSTALLED ON COMPUTER AND THE FILES AND BACK UP COPIES WILL BE LOCKED IN THE RESEARCHER'S OFFICE CABINET.

7.3 If an interview form/schedule; questionnaire or observation schedule/framework will be used, is it attached?

YES	X
NO	

7.4 Risks of the procedure(s): Participants/subjects will/may suffer:

No risk	
Discomfort: POSSIBLE DURING THE INTERVENTION PHASE	X
Pain	
Possible complications	
Persecution	
Stigmatization	
Negative labeling	
Other (please specify)	

7.4.1 If you have checked any of the above except "no risk", please provide details:

8. RESEARCH PERIOD

When will the research commence: **OCTOBER/NOVEMBER 2010**

(a) Over what approximate time period will the research be conducted:

THE SELECTION OF PARTICIPANTS, AND ASSESSMENT WILL BE CONDUCTED OVER TWO WEEKS AND THE INTERVENTION OVER EIGHT WEEKS. A POST TEST WILL BE CONDUCTED AFTER THE INTERVENTION PHASE AND A FOLLOW UP ASSESSMENT FOUR WEEKS AFTER POST ASSESSMENT.

9. GENERAL

9.1 Has permission of relevant authority (ies) been obtained?

YES	X
NO	

9.1.1 If yes, state name/s of authority (ies):

RELEVANT SCHOOL AUTHORITIES

9.2 Confidentiality: How will confidentiality be maintained to ensure that participants/subjects/patients/controls are not identifiable to persons not involved in the research?

INFORMATION OBTAINED IN THIS STUDY WILL REMAIN CONFIDENTIAL AND DISCLOSURE CAN ONLY TAKE PLACE WITH THE WRITTEN PERMISSION OF PARENTS. CONFIDENTIALITY WILL BE MAINTAINED BY MEANS OF A CODING PROCEDURE, TO PROTECT IDENTITIES. ALL TRANSCRIPTS, VIDEO RECORDINGS WILL BE SAFEGUARDED AND LOCK IN A CABINET IN THE STUDY OF THE RESEARCHER. KEYS ARE KEPT IN SMALL SAFE. THE RESEARCHER IS THE ONLY PERSON WHO HAS ACCESS TO THE CABINET, SAFE AND A PASSWORD HAS BEEN PLACED ON COMPUTER TO PROTECT THE DATA AND IDENTITIES.

9.3 Results: To whom will results be made available, and how will the findings be reported to the research participants.

THE FINDINGS WILL BE DISCUSSED WITH THE RELEVANT PARENTS, WITH THE GOAL TO ENSURE ON-GOING SUPPORT.

9.4 There will be financial costs to:

participant/subject	No
institution	No
Other (please specify) _____	

9.4.1 Explain any box marked YES:

9.5 Research proposal/protocol attached:

YES	X
NO	

9.6 Any other information which may be of value to the Committee should be provided here:

Date: 30 September 2010

Applicant's signature:

Who will supervise the project?

Name: DR. HERMAN GROBLER

Centre for Child, Youth and Family Studies

Faculty of Health Sciences

North-West University

Potchefstroom Campus (Wellington)

0027 21 864 3593 (tel)

0027 21 864 2654 (fax)

Programme/Institution/Department: **Institute for Child, Youth and Family Studies
at Huguenot College**

Date: _____

Signature: _____

**Director/Head/Research Coordinator of Department/Institute in which study is
conducted:**

Name: Institute for Child, Youth and Family Studies at Huguenot College

Date:

Signature: _____

ADDENDUM 7: CONSENT TO PARTICIPATE IN RESEARCH STUDY

TITLE OF STUDY: UTILISING THE BRIDGING TECHNIQUE DURING THERAPY TO OVERCOME CONTACT- MAKING BARRIERS IN ADOLESCENTS.

You are asked to participate in a research study conducted by Christene Louw, a student at the Institute for Child, Youth and Family Studies at Huguenot College. The research will be compiled in a dissertation format and submitted as part of fulfillment of the requirements for a degree in Masters of Diaconiology, direction: Play Therapy. Play Therapy is a psycho-therapeutic technique whereby trained Play therapists attempts to give children and for the purpose of this study, adolescents the opportunity to express feelings verbally and non-verbally through play, which serves as symbolic language.

1. PURPOSE OF THE STUDY

The study is to explore how the bridging technique can be utilized during therapy to overcome contact-making barriers in adolescents.

2. PROCEDURES:

A literature study will be conducted regarding contact making and contact barriers, developmental phases of adolescents, metaphors as well as conceptualising relevant concepts within the Gestalt therapy theory.

An empirical study will be conducted by applying a combined qualitative and quantitative approach in the form of a single systems design. An instrumental case study in the form of semi-structured interviews with parents and teachers will form part of the qualitative research together with the bridging technique, which will be applied during the intervention phase with adolescents during therapy sessions. An assessment questionnaire (pre- post- and follow-up) will be completed by the researcher as part of the quantitative approach (See Addendum 1: Assessment Questionnaire).

Conclusions will be drawn and recommendations will be made to parents and therapists regarding the utilisation of the bridging technique, possible changes to the technique to accommodate adolescents in facilitating contact-making.

If you volunteer to participate in this study, you will be asked to partake as follows:

Parents and teachers: will be involved in semi-structured interviews with the researcher to obtain information regarding how the adolescent makes contact with you the parent/ teacher and with his/her environment. Feedback will be given to parents and teachers during and after the therapeutic intervention to determine the effectiveness of the therapy. This is to validate and triangulate research findings.

Adolescents: will be asked to participate in the research, as their permission is valued. They will attend more or less eight sessions of one hour each, where the bridging technique will be utilized during the intervention phase. The sessions will be video recorded with the parent's consent. These recordings and reports will be kept lock at all times to protect the identities of adolescents. Only professionals and specifically the researcher's Supervisor, Dr H. Grobler will have access to these videos to assist and direct the research if necessary.

POTENTIAL RISKS AND DISCOMFORTS

There are no known risks or discomfort associated with this project, however if participants feel any discomfort during participation, support and counseling will be rendered by researcher and/or arranged counselor(s). Participants can withdraw from the research at any given time and the researcher will act in the best interest of adolescents.

4. POTENTIAL BENEFITS TO SUBJECTS AND/OR TO SOCIETY

Participants selected for the research might benefit in bridging contact-making barriers, which might prevent them from functioning optimal. Ongoing support can be arranged for adolescents by referring adolescents to therapists.

5. PAYMENT FOR PARTICIPATION

The participants will receive no payments and participation is voluntary to adhere to strict ethical codes and principals.

6. CONFIDENTIALITY

Any information obtained in this research study will remain **confidential and disclosure can only take place with your written permission as stipulated by law**. Confidentiality will be maintained by means of a coding procedure, protecting your identity. All transcripts, video recordings will be safeguarded and lock in a cabinet in the study of the researcher. Keys are kept in small safe. The researcher is the only person who has access to the cabinet, safe and a password has been placed on computer to protect the data and identities. The identities are protected by pseudonyms, for example adolescent P4 (Participant four).

7. PARTICIPATION AND WITHDRAWAL

You can choose whether to be in this study or not. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also refuse to answer any questions you don't want to answer and still remain in the study. The investigator may withdraw you from this research if circumstances arise which warrant doing so.

8. IDENTIFICATION OF SUPERVISOR AND RESEARCHER

Location of intervention will take place at relevant schools, with the permission of School Principals, as well as at the private practice of the researcher. If you have any questions or concerns about the research, please contact:

CONTACT DETAILS OF SUPERVISOR

Dr Herman Grobler
Centre for Child, Youth and Family Studies
Faculty of Health Sciences
North-West University

Potchefstroom Campus (Wellington)

0027 21 864 3593 (tel)

0027 21 864 2654 (fax)

CONTACT DETAILS OF THE RESEARCHER

Mrs. Christene Louw

Private Practice [Practice number: 0218294 and SACSSP: 10-09880]

Physical Address: 17 Oribi avenue Van Riebeeck Park, Kempton Park.

Cell: 084 872 2768 and +27(0)11 976 2288

9. RIGHTS OF RESEARCH PARTICIPANT

You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study. If you have questions regarding your rights as a research Participant, you may contact the Institute for Child, Youth and Family Studies at Huguenot College.

**SIGNATURE OF RESEARCH PARTICIPANT OR LEGAL
REPRESENTATIVE**

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

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

Name of Participant

Signature of Participant or
Legal Representative

Date: _____

SIGNATURE OF RESEARCHER

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

Mrs. C. J. Louw

Signature of Researcher

Date

ADDENDUM 8: JOURNAL SUBMISSION GUIDELINES

EDITORIAL POLICY/REDAKSIONELE BELEID

The Journal publishes articles, book reviews and commentary on articles already published from any field of social work. Contributions may be written in English or Afrikaans. All articles should include an abstract in English of not more than 100 words. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee. All refereeing is strictly confidential. Manuscripts may be returned to the authors if extensive revision is required or if the style or presentation does not conform to the Journal practice. Articles of less than 2,000 words or more than 10,000 words are normally not considered for publication. Submit the manuscript as a Microsoft Word document, in 12 pt Times New Roman, double line spacing. Use font Arial in charts and diagrams. The manuscript should be sent electronically to hsu@sun.ac.za. Use the Harvard system for references. Short references in the text: When word-for-word quotations, facts or arguments from other sources are cited, the surname(s) of the author(s), year of publication and page number(s) must appear in parenthesis in the text, e.g. "... (Berger, 1967:12). More details about sources referred to in the text should appear at the end of the manuscript under the caption "References". The sources must be arranged alphabetically according to the surnames of the authors. Note the use of capitals and punctuation marks in the following examples.

In terms of SANSO-014 our journal is classified as an approved research journal for the purpose of subsidy by the State. The Editorial Board has therefore decided that an amount of R100.00 (hundred Rand) per page is to be paid for published articles by authors who are lecturing or doing research at Universities in the RSA.

Die Tydskrif publiseer artikels, boekbesprekings en kommentaar op reeds gepubliseerde artikels uit enige gebied van die maatskaplike werk. Bydraes mag in Afrikaans of Engels geskryf word. Alle artikels moet vergesel wees van 'n Engelse opsomming van nie meer as 100 woorde nie. Alle bydraes sal krities deur ten minste twee keurders beoordeel word.

Beoordeling is streng vertroulik. Manuskripte sal na die outeurs teruggestuur word indien ingrypende hersiening vereis word of indien die styl nie ooreenstem met die tydskrif se standaard nie. Artikels van minder as 2,000 woorde of meer as 10,000 woorde sal normaalweg nie oorweeg word vir publikasie. Stuur die manuskrip in 12 pt "Times Roman", dubbel-spasiëring as 'n Microsoft Word dokument, elektronies aan hsu@sun.ac.za.

Verwysings moet volgens die Harvard-stelsel geskied. Verwysings in die teks: Wanneer woordelike sinate, feite of argumente uit ander bronne gesitueer word, moet die van(ne) van die outeur(s), jaar van publikasie, en bladsynommers tussen hakies in die teks verskyn, bv. "... (Berger, 1967:12). Meer besonderhede omtrent bronne moet alfabeties volgens die vanne van die outeurs aan die einde van die manuskrip onder die opskrif "Bibliografie" verskyn. Let op die gebruik van hoofletters en leestekens by die volgende voorbeelde.

Volgens Sanso-014 is **Maatskaplike Werk/Social Work** 'n goedgekeurde navorsings-tydskrif en ontvang universiteite 'n subsidie ten opsigte van artikels van personeellede wat daarin gepubliseer word. In die lig hiervan is besluit dat bladgelde van R100-00 (honderd Rand) per bladsy vir gepubliseerde artikels van die betrokke universiteit gehef word.

TWO AUTHORS/TWEE OUTEURS: SHEAFOR, B.W. & JENKINS, L.E. 1982. **Quality field instruction in social work**. Program Development and Maintenance. New York: Longman.

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SECTION E: CONSOLIDATED LIST OF REFERENCES

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