

Chapter 3

Gestalt play therapy

3.1 Introduction

In this chapter the researcher will investigate how therapy with survivors of CSA is conducted. Attention will be given to Gestalt therapy, the modality play therapy and a directive as opposed to a non-directive approach. The Gestalt *Healing tasks* and *9FPS*, which will be applied experientially, will be described.

3.2 Gestalt therapy

“The truth is that she didn’t transform – instead she found herself”
(Oaklander: 2006: 15).

The Oxford dictionary (Hawkins & Allen, 1994: 1536, 1500) states that the word ‘therapy’ originated from *therapeia*, meaning healing. Trauma therapy thus aims to heal a psychological wound. In this section Gestalt healing will be discussed.

Not all children who survive trauma need therapy: sometimes the parents and social system are sufficiently supportive, and sometimes the child is particularly resilient. Perry (2000: 6) explains that during the acute posttraumatic period a survivor will naturally begin to make sense of what has happened. A variety of mental processes is applied to master the trauma. This may include thinking about it, “telling the story over and over again to friends” or re-enacting it in play or drawings (Perry, 2000: 6). On the other hand, Perry (2000: 6) reminds us that a trauma event is per definition “outside the range of normal experience”; therefore it is more difficult for normal mental mechanisms to process such an event. Not having mastered the trauma, the organism is always in danger. “[I]n the absence of any true external threat, the abnormal persistence of a once adaptive response becomes maladaptive” (Perry, 2000: 6). Terr (quoted in Schaefer, 1994: 306) asserts, “untreated, all but the mildest of childhood traumas last for years”.

‘*Gestalt*’ is a German word which means wholeness, “a complete pattern, form or configuration which cannot be broken without destroying its nature” (Mackewn, 2004: 15). Perls coined this apposite name for a new therapeutic theory in 1951 (Bowman, 2005: 6). The model professes that humans are inherently inclined to spontaneously complete, pattern and make meaning of their perceptions and experiences. Therapy can accordingly be conceived as a whole-making endeavour.

The goal of Gestalt therapy is to restore the sexually abused adolescent’s “capacity to make full use of her senses, her body, her emotional expressions, her intellect” (Oaklander, 2006: 6), and subsequently to regain the “lost parts of self” (Oaklander, 2006: 19). By means of Gestalt therapy the unfinished business can be assimilated and can recede to ground. In short, Gestalt therapy aims for

the client to progressively accept the self, unconditionally (which requires the integration of the CSA experience and linked emotions), and to bolster self-support and self-nurturing. As a consequence, the organism's own curative power is released (Ryan & Needham, 2001: 440).

This restoration process is not achieved by 'informing' the client about what she should do and shouldn't do. Awareness could be considered the core of Gestalt philosophy and the "true purpose" of Gestalt therapy (Yontef, 2005: 94; Perls, 1972: 16). Gestalt formation can only be successful if the individual is aware of the entire given organism-environment field and when contact-making with both her internal and external experiences is optimised. The Gestalt therapist and client will therefore collaboratively investigate the client's "ways of being" (Mackewn, 2004: 66). Only through awareness of the field can alternatives be generated and choices developed. Moreover, Perls (quoted in Houston, 2003: 18, original emphasis) asserts that "*awareness per se – by and of itself – can be curative*".

Whereas other therapeutic models are predominantly verbal, interpretive and/or content therapy, Gestalt therapy is holistic, sensory, experiential, process-focused and present-orientated. It also proclaims an equalitarian relationship between the therapist and client. These aspects will be explained next:

- (a) "Wholism" (Houston, 2003: 6) relates to the inseparable nature of things. As mentioned, one of the most pressing needs of an organism is to experience itself as unitary (Claveaux, *sine anno*: 8). Fragmenting off a sexually abusive experience and its emotions will affect the whole self. Gestalt therapy creates conditions to enhance awareness of that which has been desensitised, disowned, dissociated or deflected. Moreover, the organism and environment are one; during therapy awareness of oneself as part of a relational system is encouraged (Mackewn, 2004: 47).
- (b) Claveaux (*sine anno*: 8) reminds us that awareness is always "zintuiglijk-lichamelijk"; it is through the senses and body that contact is established with the world. Unfortunately, "Many children have learned to cope with trauma by desensitizing the body" (Reynolds, 2005: 170). Gestalt therapists will encourage the sexually abused adolescent to "tuning in to or tuning out bodily sensations" (Reynolds, 2005: 170).
- (c) "In Gestalt circles, *experience*, *experiential*, and *experiment* are cherished words" (Woldt, 2005: xvii, original emphasis). Gestalt therapists do not offer interpretations or analyses (Lampert, 2003: 84). Instead, they and the clients co-create experiences and experiments to enhance awareness and exploration. Experiments are techniques that might concretise a polarity (the empty chair technique), assist assimilation (between-session assignments), raise awareness (dream work) or recall unfinished business (Houston, 2003: 7; Mackewn, 2004: 131-134; Melnick & Nevis, 2005: 108).
- (d) Being process-focused refers to the fact that therapy is a cyclic excursion towards homeostasis, unfolding from moment to moment (Mackewn, 2004: 133). 'Becoming' is discovery-based; not only with reference to the goal, but also to the 'how' and 'what' along the way.
- (e) In the Fifties depth psychotherapies focused on the causal status of the 'then' and 'there'; in contrast, Gestalt proclaims "contemporaneity" (Philippon, 2005: 2). Awareness takes place

here and now, just as unfinished business can only be completed here and now. Yontef (2005: 89) explains, “The act of remembering the past or anticipating the future occurs in the present”.

- (f) The most important therapeutic agent of Gestalt therapy is said to be the healing client-therapist connection, an equalitarian and inclusive togetherness (Joyce & Sills, 2006: 48-49). The relationship is collaborative and dialogic; in this respect Greenberg, Korman and Paivio (2002: 505) and Joyce and Sills (2006: 41) refer to a working alliance. These relational aspects make Gestalt therapy particularly suitable for adolescents. Additionally, both Schaefer (1994: 308) and Claveaux (*sine anno*: 12) declare that such a therapeutic relationship should counteract retraumatisation.

“Gestalttherapie is niet gericht op symptoom-bestrijding” (Claveaux, *sine anno*: 12). Gestalt therapists claim that, if the natural process of organismic regulation is allowed, then all clients will have the resources to grow and to change. This relates to the paradoxical theory of change. Rather than say, obtaining relief through ‘forgetting’ the sexual abuse, “the client needs to enter as fully as possible into all aspects of his own experience, bringing it into full awareness” (Joyce & Sills, 2006: 37). Regarding all the emotions associated with the abuse, the client is encouraged to do the opposite of what she wants to; that is, rather to release than suppress them (Schaefer, 1994: 308-309).

Gestalt theorists hypothesise that, if the organism is unable to assimilate and disengage from an experience, unfinished business results. Serok (2000: 42) proffers that full experiential contact with unfinished business (and concomitant sensations, emotions and beliefs) is imperative, “The past, of course, cannot be relived, but since the ‘unfinished businesses’ are experiences that occurred in the past, we must create in the therapeutic setup conditions that will stimulate as closely as possible the original ‘unfinished business’ in order to enable an individual to reach completion in the therapeutic setting”. Exposure seems to be a major aspect of the treatment of sexual trauma and PTSP (Cohen, 2002: 3).

Cohen (2002: 3) is of the opinion that Gestalt techniques are particularly valuable to help the unfinished business surface from the past and to resolve it in the present. One of these techniques is the experiment. The goal of an experiment is, according to Oaklander (2006: 46), to direct a client’s awareness toward her particular process (such as behaviour, underlying emotions or thoughts). It enables the client to “experience near” (when the event is brought into the here and now) instead of “experience far” (when the client talks about something from the past) (Crocker, 2005: 67; Joyce & Sills, 2006: 24). Through the experiment – such as the *9FPS* – the CSA experience can be relived in the here and now. In doing so, the clients can gain control of and insight into their actual experiences and are able to complete unfinished business.

In this section it was shown that Gestalt therapy for adolescent survivors of sexual abuse is a creative, engaging process. In the next section play therapy will be attended to, seeing that the empirical study involves Gestalt play therapy.

3.3 Play therapy

Play is the “royal road to the child’s conscious and unconscious inner world”
(Bettelheim quoted in Webb, 2007b: 46).

In this section the value of play therapy will be explored. Play therapy is defined by Hall, Kaduson and Schaefer (2002: 515) and Webb (2007b: 46) as the systematic use of the curative powers of play to help clients resolve their psychological difficulties and to relieve their emotional anguish. Play therapy is not necessarily non-verbal therapy (Malchiodi, 2008a: 13; Webb, 2007b: 47); verbal work, such as discussions, clarifications and explorations of the *objets d’art*, is used to a greater or lesser extent.

The reader is referred to the meta-analysis of the efficacy of play therapy by Bratton, Ray, Rhine and Jones (2005: 380-381). Moreover, play therapy has been incorporated within most conceptual frameworks: Gestalt Therapy (Blom, 2006a; Lampert, 2003; Oaklander, 1988 and 2006; Reynolds, 2005: 170-175), Cognitive Behaviour Therapy (Shelby & Beck, 2009: 17-40; Neubauer, Deblinger & Sieger, 2007: 107-132; Paul *et al.*, 2006: 263; Pretorius & Pfeifer, 2010: 64; Scott & Stradling, 2001: 45-85), Non-Directive play therapy (Ryan & Needham, 2001: 437-453) and Child-Centred play therapy (Paul *et al.*, 2006: 264-265). Play therapy could consequently be considered a modality, rather than a conceptual framework.

The value of play therapy, specifically as it relates to trauma survivors, has been well documented:

- (a) Play absorbs clients “at all levels of mental and bodily functioning” (Ryan & Needham, 2001: 439).
- (b) The client uses play to express things that she may not have the vocabulary for, might find too difficult to verbalise directly, or which have been processed in non-verbal sensorimotor modalities and affective states (Dalenberg, 2006: 294-295; Ryan & Needham, 2001: 439; Sweeney & Homeyer, 2009: 308). According to Pretorius and Pfeifer (2010: 67) survivors may feel engulfed and scared by verbal expressions of the CSA. Through externalisation, projection unto and symbolisation of play material, distance from the actual trauma is maintained so that the adolescent can express herself and still feel safe (Marvasti, 1994: 319; Schaefer, 1994: 301-302).
- (c) The psychological distance from the trauma enables the client to clearly see, examine and revise cognitive material – particularly unhelpful thoughts (Cohen & Mannarino, 2004: 826; Haen, 2008: 229).
- (d) During play therapy catharsis of emotions can be achieved verbally and kinaesthetically in non-judgemental surroundings (Cohen & Mannarino, 2004: 825; Marvasti, 1994: 334).
- (e) According to Malchiodi (2008a: 18) art activates the physiological relaxation response.
- (f) Importantly, through play the therapist-client relationship can be greatly augmented (Webb, 2007b: 49).

The adolescent's creating and creations become a microcosmos of her world (Schaefer, 1994: 301) where she can regain control. During play passivity is transformed into activity, helplessness into agency, avoidance and numbing into expression, and fixation into flexibility.

Lampert (2003: 12) mentions that a product-process differentiation is often made by play therapists. Gestalt play therapy – which focuses on enhancing the client's awareness, contact and own meaning-making by means of playing – is process-focused.

The researcher has used play therapy for children, adolescents and adults to great effect; its value is not restricted to younger people. Next, the issue of whether to direct or not direct the therapeutic process, will be explored.

3.4 Directive *versus* non-directive therapy

“In longer-term situations, the sessions become a sort of dance: sometimes the child leads and sometimes the therapist does” (Oaklander, 2006: 119).

Practitioners usually proclaim to be either directive or non-directive therapists, depending on their conceptual framework. In this section these divergent approaches will be discussed.

Thompson and Henderson (2007: 432) and Webb (2007b: 50-52) explain the difference between directive and non-directive therapy as follows: In directive therapy the goals and programme components are preset according to the diagnosed disorder and developmental level of the client. It is believed that the therapist's direction is needed for the client to resolve issues related to the CSA. In contrast, non-directive therapy is client-centred, strength-based, spontaneous, without an agenda and is often a long-term intervention. Unless the client chooses to talk about or play out the CSA, the non-directive therapist will not raise the referral reason.

Even though Bratton *et al.* (2005: 380) determined that, for generic difficulties, play therapy was effective regardless of whether it applied a humanistic-nondirective or nonhumanistic-directive approach; evidence-based studies seem to support a more directive approach to the treatment of traumatised children (Cohen *et al.*, 2000: 38-39; Paul *et al.*, 2006: 271). Shelby and Felix (2005: 85) posit that clients may avoid the traumatic event during non-directive therapy, Thompson and Henderson (2007: 435) forward that purposeful interventions serve maximum efficiency, and Malchiodi (2008b: 37) cautions that children – particularly those who were submitted to the chaos of trauma – need structure, security and consistency. In contrast, Ryan and Needham (2001: 449) assert that direct confrontation with the trauma event may precipitate negative affective reactions and possible withdrawal from treatment. Webb (2007b: 52) asserts that no definite conclusion has been reached and that only a few therapists work purely directly or purely non-directively.

The polarity ‘directive *versus* non-directive’ poses a theoretical dilemma in Gestalt therapy, but should perhaps be seen as a continuum rather than distinct and divergent poles. Reynolds (2005: 169-

170) proposes that the role of a Gestalt child therapist is both directive and non-directive. The non-directive component involves being fully present with the client in the here and now and being a “witness [to] what unfolds”. The directive part would entail selecting a play medium in advance or designing experiments to provide clients with specific awarenesses. Oaklander (2006: 46) – the doyen of Gestalt play therapy who generally works non-directively – acknowledges that the approach should always be dependent on the organism-environment field. For example, Joyce and Sills (2006: 133) suggest that during the *impasse* more directive work may be indicated, i.e. finding “a way to surface that which was not expressed”.

According to Oaklander (2006: 122), two matters have to be heeded when working directly: Firstly, the (verbalised or unsaid) expectations of the directive therapist could pressurise the client and breed failure. Secondly, the therapist must “tread lightly”, as forcefulness is bound to be counter-therapeutic (Oaklander, 2006: 119). In Section 4.4 the researcher will further explain why she engaged in a more directive way with the trauma narrative. Next, the *Healing tasks* – which will give form and direction to the empirical process of this research – will be discussed.

3.5 Healing tasks

In this section the frame, components and considerations related to the therapeutic process will be discussed. The *Healing tasks* are not proffered as a “prescriptive chart” (Thompson & Henderson, 2007: 432), but rather as “signposts or reminders of the special needs and risks which apply to this particular client” (Joyce & Sills, 2006: 72).

Kepner (2003: 3-7) suggests a series of *Healing tasks*¹² for adult survivors of CSA. These are *Developing support*, *Developing self-functions*, *Undoing, redoing and mourning* and *Reconsolidation*. His proposed phases of the therapeutic process permit for some direction and structure to the Gestalt therapeutic process. Kepner (2003: 149) allows for the singularity of each client, but asserts that some commonalities exist, hence the proposed phases. As it relates to therapy with children, Oaklander (2006: 20-49) and Blom (2006a, 49-178) propose comparable phases: *Building a therapeutic relationship and Assessment play*, *Strengthening the self*, *Emotional expression*, *Self-nurturing*, *Addressing the inappropriate process* and *Termination*.

In this study – drawing from Oaklander (2006), Blom (2006a), Claveaux (*sine anno*: 12-19) and Kepner (2003) – the researcher will refer to four cyclic phases: *Building a therapeutic relationship* (which incorporates developing support), *Strengthening the self* (which includes enhancing sensory

¹² The reader is reminded that the *Healing tasks* are not consecutive, as Gestalt therapy is considered linear (development from lower to higher and increased complexity of being), spiral (turning back to an issue and repeating therapeutic work on it, on a higher level), singular (the uniqueness of each client necessitates unique interventions) and holistic (during the process all the *Healing tasks* occur at the same time and all organismic aspects are forever present in the here and now). Refer to Kepner (2003: 3, 7), Mackewn (2004: 7) and Philippson (2005: 2).

and bodily awareness and self-nurturing), *Contact with the trauma* (which incorporates Kepner's *Undoing, redoing and mourning*) and the *End phase*. The *End phase* will include Kepner's *Reconsolidation*. *Assessment play* is an ongoing process and is therefore not phase-bound. *Parental involvement* and *Psychoeducation* will be explored as additional *Healing tasks*.

3.5.1 Parental involvement

“[Y]ou may be intervening with an individual child, but the family is always present psychologically. Children bring along their families in their hearts and minds; family beliefs, expectations, voices, images, and histories are fixtures of a child's inner world”
(Echterling & Stewart, 2008: 193).

By means of Gestalt therapy the withdrawal and associated isolation of CSA survivors are transformed into the polar opposite: support. Gestalt professes a field approach: parents are (probably the most significant) representatives of the environment field of children and adolescents. The inclusion or involvement of parents has been widely supported (Cohen *et al.*, 2000: 40; Cohen & Mannarino, 2004: 823; Bratton *et al.*, 2005: 381; Oaklander, 2006: 49; Paul *et al.*, 2006: 264; Shelby & Felix, 2005: 87). Parents are generally accepted to be the most influential determinant of the well being of children and the recovery of a child following trauma (Steele & Malchiodi, 2008: 265). However, parents themselves might be survivors too, or might be anxious and confused and lack information on how they can support their child. Involvement of parents is not only legally required, but is of utmost therapeutic value.

3.5.2 Psychoeducation

Confusion has been mentioned as a sequel to sexual trauma. The main reason for psychoeducation is to help the adolescent and her parents to move towards the polar opposite of confusion: understanding and security.

Psychoeducation is one of the main components of TF-CBT (Paul *et al.*, 2006: 262; Scott & Stradling, 2001: 50-53). Nevertheless, psychoeducation is not foreign to Gestalt therapy. Joyce and Sills (2006: 158) propose that it could be comforting if clients are given “straight-forward information about physical stress symptoms... post-traumatic stress phenomena reactions, [and] relaxation techniques”. Cohen *et al.* (2000: 32) found that *Psychoeducation* usually includes information on how frequently this type of event occurs, to whom these things happen (“it happens to all kinds of children regardless of their personal characteristics or behavior”), common reactions and coping strategies. Psychoeducational analogies, discussions and explorations normalise stress reactions (Cohen *et al.*, 2000: 32; Paul *et al.*, 2006: 262; Perry, 2000: 10; Steele & Malchiodi, 2008: 269-270), provoke the anticipation of a time when the client will not be afraid all the time (Webb, 2007b: 47), and encourage the survivor to take charge of her meaning-making and action (Scott & Stradling, 2001: 50). *Psychoeducation* is soothing and empowering.

3.5.3 Healing task 1: Building a therapeutic relationship

“When patients feel understood and cared about, the situation becomes safer to acknowledge their true selves, including true feelings, desires, and past experience” (Yontef, 2005: 96).

As shown, trauma of a sexual nature is alienating: “they adapted themselves to living without [support] in the past” (Kepner, 2003: 3). *Building a therapeutic relationship* is opposed to estrangement. The survivor may sever contact with herself, others, the world, God, and the therapist. Moreover, adolescents in their quest for self-reliance may be particularly obstinate. Houston (2003: 138) proclaims, “The relational aspects of therapy – what in Gestalt is ungraciously termed the management of the contact boundary – is probably the single most significant factor in much therapy”. Claveaux (*sine anno*: 12) asserts that a trust relationship is prerequisite to working with a “moeilijke gebeurtenis”. Trust will facilitate a working alliance (Greenberg *et al.*, 2002: 505; Joyce & Sills, 2006: 183). An invitational, collaborative approach, a respectful and authentic therapist and a safe and validating environment will foster an I-thou relationship.

3.5.4 Healing task 2: Strengthening the self

“Memory work *must* take place in the context of the person, not the other way around” (Kepner, 2003: 79, original emphasis).

When a survivor has a lucid sense of self, the other and the in-between, she can meet, join and separate appropriately (Toman & Bauer, 2005: 184). Sadly survivors of CSA often present with a fragmented self and reinforced or permeable boundaries: they are either isolated or confluent. Healing the self and self-functions promotes awareness of and interactions with the inner, middle and outer zones of the organism-environment field. The *Healing task: Strengthening the self* includes enhancing *Sensory and bodily awareness*, *Awareness of self*, *Empowerment and mastery*, and *Self-support*. This delineation into components is superficial; it is only used to serve conceptualisation.

(a) *Sensory and bodily awareness*

“The body keeps the score” (Van der Kolk, in Malchiodi, 2008a: 9).

A person is totally dependent on her senses for making contact with the field. Making contact is an id function and includes sensorimotor, physiological and bodily experiences (Lobb, 2005: 28-29). As shown, sexually traumatised children may become detached from their bodies to cope with the sensory overload (Reynolds, 2005: 170) and to counter the bodily experience of strong emotions (Oaklander, 2006: 26). They might also receive adult messages to disregard their inner zone (Reynolds, 2005: 170). Most importantly, they may feel unable to “trust the environment” which has become a dangerous place (Lobb, 2005: 29). Sensitisation is the polar opposite of desensitisation, and is perceived as an integral component of Gestalt therapy. Sensory and bodily awareness can be enhanced during a special sensitisation phase (Reynolds, 2005: 170) or could be a natural component of therapeutic activities (Oaklander, 2006: 27).

(b) Awareness of self

“To empower the self one must know the self” (Oaklander, 2006: 27).

Sexually abused children often engage in self-blame, self-criticism, self-anaesthesia and self-fragmentation (Oaklander, 2006: 157); working on a sense of self is consequently an important aspect of therapy. As seen, a survivor would often prefer not to assimilate the sexual experience into the self. Before exploring emotions, thoughts, the trauma and the field of the ‘not me’, it is imperative to explore the ‘me’. For adolescents – in the process of identity formation – the promotion of self-awareness is developmentally valuable.

The self includes the organism-environment field, it incorporates what was and what will be, it consists of the inner, middle and outer zones of awareness and the id, ego and personality functions; it is a “process, function and boundary event” (Lobb, 2005: 26). Oaklander (2006: 28) professes that she uses any technique that will assist the client to focus on herself: “‘This is who I am’ and ‘This is who I am not’ is what the child is learning and integrating into her awareness”.

(c) Empowerment and mastery

“[Y]ou can help children transform their crisis narrative into survival stories”
(Echterling & Stewart, 2008: 198).

It is quite understandable for an adolescent who has survived sexual abuse, unable to prevent it and powerless to stop it, to perceive herself as a victim. The ‘difference’ is so overriding that they overlook ways in which they are still the same, as well as the ways in which they persevered, were brave, supportive and resourceful. They disregard the fact that they are survivors.

Malchiodi (2008a: 18) asserts that recalling memories of affirmative events may reframe and eventually override negative ones. Giving recognition to the “art of surviving” could, according to Echterling and Stewart (2008: 198), lead to empowerment, reinvigoration and to posttraumatic growth. Those contact modifications which are applied to endure emotional pain, even if they are not helpful any more (Lampert, 2003: 10), should also be honoured. Importantly, this does not mean that the pain and helplessness should be disregarded, as such a stance is non-inclusive and non-validating.

(d) Self-support

“The healing tasks are like a pyramid: the wider the base of support, the higher the pyramid can be” (Kepner, 2003: 52).

Self-support means the ability to lovingly and healingly take care of the self (Oaklander, 2006: 144). Self-support does not mean that all organisms should become totally independent and self-sufficient; to the contrary, as Joyce and Sills (2006: 83) explain, self-support includes the ability to recognise when one needs environmental support. Systemic social support includes recognising and utilising supporting family members, friends and groups. Self-support is opposed to support that is missing (a detached, traumatised family), underused (a withdrawn survivor), or overused (a clinging survivor).

Self-support is interlaced in many other therapeutic facets. Oaklander (2006: 162) gives examples: developing a sense of self is nurturing; allowing oneself to feel and express emotions is nurturing; breathing and relaxation are tools for self-nurturing; and being able to fantasise and imaginatively withdraw to a 'safe place' is nurturing. Self-support and self-nurturing can be explored during a session (Oaklander, 2006: 162) and/or given as homework (Oaklander, 1988: 190).

Self-support also includes developing alternatives for containing negative energy (Schoeman, 1996a: 176). The application of skills to relax and manage stress is the polar opposite of posttraumatic hyperarousal. Both Gestalt and TF-CBT therapists endorse improving stress management skills. In their programme, Cohen and Mannarino (2004: 825) and Cohen *et al.* (2000: 33) include deep breathing, progressive muscle relaxation as well as thought stopping and replacement with self-affirming statements. Breathing and relaxation exercises are some of the ways by which the aroused sympathetic system can be calmed (Joyce & Sills, 2006: 156; Klein, 2008: 305; Scott & Stradling, 2001: 66-67, 72-73; Shelby & Felix, 2005: 93). Oaklander (1988: 124) comments, "Children sometimes need as much help in learning how to relax as we adults do". These skills could help to release physical and emotional tension.

3.5.5 Healing task 3: Contact with the trauma

"[T]he prevailing practice wisdom recommends that in order for traumatic experiences to be resolved, some form of retrospective review is usually necessary"

(Webb, 2007b: 51).

Contact with the sexual abuse consists of the therapeutic tasks *Undoing, redoing and mourning*. During *Undoing* the client works through the unfinished business (including feelings, attributions and behavioural patterns) "that all survivors carry" (Kepner, 2003: 109). *Redoing* has reference to establishing a proper relationship (that is without posttraumatic patterns) between the organism and environment. Through *Mourning* the "hurt child within" can be soothed (Kepner, 2003: 124). Contact with the trauma usually incorporates creating a trauma narrative, emotion work and cognitive work.

(a) Telling the story

"... many clients will find it a relief to be able to share their story with someone who is not afraid to ask (and hear) about distressing material. Indeed, listening with respect, openness and acceptance can in itself start a similar process towards himself in the client" (Joyce & Sills, 2006: 183).

Haen (2008: 239) proffers that a "loss of voice... occurs as a result of trauma" – which is claimed to have psychological, social as well as neurobiological origins and consequences. Oaklander (1988: 248) reminds us that "everyone has since 'protected' the child by not openly talking with him about it" and that the child himself might avoid raising the topic because "he doesn't want to cause [his parents] any more grief and unhappiness". There is no doubt that the story of trauma is difficult to relate, not only because of the underlying emotions, but also because of field circumstances.

A therapist who steers clear from helping a client to face the trauma story, grieving its losses and integrating the experience, is colluding with the (client and others') denial of reality. Joyce and Sills (2006: 183) acknowledge that a therapist might not want to re-expose a client to the trauma event out of compassionate reasons; however, holding back to protect an adolescent reveals the therapist's paternalistic belief that the client 'will not manage'. Oaklander (1988: 248, original emphasis) firmly states, "... since she survived the actual experience she could certainly survive the *memory* of the experience".

Many reasons for telling the story or creating the trauma narrative are forwarded. A treatment protocol often "dutifully goals... talking about the abuse" (Klorer, 2008: 52; also Cloitre, Cohen & Koenen, 2006: 55; Loumeau-May, 2008: 92). Cattanach (2007: 429) proffers that a story or narrative is a construal of reality, often with discernable differences between the internalised story-of-self and the reality. It is in this divergence that unhelpful cognitions often reside. Through the process of storying and re-storying the client can make sense of the senseless CSA experiences. By means of storying the memory is externalised, made conscious and reframed (Malchiodi, 2008a: 16). In addition, storying could contribute to desensitising the thoughts and emotions related to the trauma; stopping avoidance; contextualising the trauma in the greater plan of the client's life; and identifying and reframing cognitive distortions (Cohen & Mannarino, 2004: 826; Neubauer *et al.*, 2007: 121, 125; Paul *et al.*, 2006: 263). Urman *et al.* (2001: 422) note that the trauma narrative has an evaluation function in as much as it reveals which aspects of the experience are most important and what meaning the adolescent ascribes to the experience.

The role of therapist is "critical" to encourage and support a survivor to tell her story (Lampert, 2003: 78). The therapist should not only facilitate the process, but also model that hearing the story is not intolerable (Cohen & Mannarino, 2004: 826; Joyce & Sills, 2006: 183; Schaefer, 1994: 311). The therapist validates, gives choices (and in so doing demonstrates confidence in the survivor's judgement), accepts (rather than judge or try to convince her that she is 'not to blame'), checks (rather than finding), asks for clarification (rather than make pronouncements) and is generally very "nosy" (Marvasti, 1994: 326; Lampert, 2003: 84). Joyce and Sills (2006: 77) assert that until a "holding relationship" is established, no directive or intrusive activity should be attempted (also see Schaefer, 1994: 308).

If we accept that "We don't need to mention it; it will work out by itself" (Oaklander, 1988: 189) is false, the question arises: How do we raise the trauma event? Should the therapist keep the subject hidden "until the magic moment", bring it up periodically until the client is ready to talk about it, or raise it candidly (Oaklander, 1988: 189)? Oaklander (1988: 189) pragmatically states, "I believe strongly in openly confronting the problem. After all, we all know by this time why we are here together, so why not deal with it?"

Once raised, how is the trauma narrative handled? Cohen and Mannarino (2004: 825) propose that the client creates a personal book, a series of pictures, a poem, a comic strip or a song about what happened; Greenberg *et al.* (2002: 509) suggest revisiting the trauma by writing or by telling the story into a tape recorder. Included in the story would be the survivor's thoughts, feelings and bodily sensations (Cohen & Mannarino, 2004: 825; Joyce & Sills, 2006: 132).

(b) Emotion work

With regard to the painful and troublesome emotions trapped in the CSA memory, “the only way out may be to go through the emotional experience” (Greenberg *et al.*, 2002: 507); only then can emotional mastery be established (Greenberg *et al.*, 2002: 517; Pretorius & Pfeifer, 2010: 67; Thompson & Henderson, 2007: 435). Greenberg *et al.* (2002: 500) remind us that for Perls, Hefferline and Goodman “the ability to endure unwanted emotions was essential for mental health”. Emotional expression or catharsis is the polar opposite of the restriction associated with the unfinished business.

Greenberg *et al.* (2002: 509) claim that once a trauma narrative has been developed that makes sense of the emotions, clients will be better able to moderate the emotional intensity and to regulate their emotions. Greenberg *et al.* (2002: 516-517) suggest a framework for emotion work: (a) therapeutic inclusion; (b) evoking and exploring emotions, which includes catharsis, differentiating emotions, exposure of hidden emotions and exploring their expression; and (c) emotional restructuring, which encompasses the synthesis and restructuring of emotions towards “a more self-affirmative stance”. The recommended framework incorporates the indivisible functions of the self: id, ego and personality, and all the zones of awareness. The researcher-therapist also explores the rationale of working with emotions, ‘If you can name it, you can tame it’.

Emotion work might also have to include a psychoeducational component, such as developing an apposite emotion vocabulary (Joyce & Sills, 2006: 116) and the normalisation of emotions (Cohen *et al.*, 2000: 32). The therapist should also bear in mind that a survivor may “simply have no words” for what she is feeling (Greenberg *et al.*, 2002: 514; Dalenberg, 2006: 293). This does not only relate to being younger or a second language speaker; Ryan and Needham (2001: 439) explain that high arousal disrupts cognitive processing, consequently trauma memories are stored as sensorimotor and emotional modalities, not in a conceptual-linguistic way.

(c) Cognitive work

Correcting perceptions about the sexual abuse and attribution retraining are considered to be particularly important facets of therapy for survivors of CSA; specifically in cases of self-blame and family-blame (Celano *et al.*, 2002: 65). Cognitive destruction and restructuring are concepts that are generally accepted within the TF-CBT realm. But as Perls, Hellerline and Goodman (quoted in

Reynolds, 2005: 162) forward, “the process... by which one arrives at a differentiated unity is one by taking things apart and putting them back together”. Again the eating metaphor is fitting: only after the food has been chewed (destruction) can absorption (assimilation) of nutrients take place. Usually cognitive distortions are identified and investigated for their accuracy and helpfulness, and thereafter alternative thoughts are generated (Cohen & Mannarino, 2004: 826; Joyce & Sills, 2006: 134). In Gestalt, destructing and restructuring entail more than just the middle zone, it encompasses all human processes.

3.5.6 Healing task 4: End phase

“Once they begin to see a future, survivors gain a sense of direction and hope, become more motivated, and increase their momentum toward resolution”
(Echterling & Stewart, 2008: 205).

The opposite polar of a foreshortened future is hope; hope that someday one will be less afraid and hope that things will become better. Without such hope, the now is overwhelmed with avoidant manoeuvres and the future is uncertain; nothing is of consequence but the daily act of surviving. An adolescent may not expect to finish school or have a career (Schaefer, 1994: 298) and indulge in alcohol or substance abuse, or worse, suicide attempts. During the end phase *Reconsolidation* (assimilation of the sexual abuse as part of the self) and transcendent meaning-making (finding value in the experience) may be achieved (Kepner, 2003: 109; 132).

By exploring her achievements – fleeing, getting help, standing up for herself – the adolescent will discover “unknown strengths”, appreciate “unrecognized resources” and, in doing so, achieve a “sense of hope” (Echterling & Stewart, 2008: 205). Although future events, “planned or fantasized, are not given special status (as ‘goals’ or ‘incentives’)” in Gestalt therapy, it is part of the present field (Parlett, 2005: 49). Depending on field conditions, a therapist may invite the client to reflect on the future.

In this section the researcher has explored the four Gestalt *Healing tasks*. Next the *9FPS* will be described.

3.6 Nine Figure Picture Story

“[I]conic symbolization [is] a means of giving traumatic experiences a visual identity”
(Malchiodi, 2008a: 16).

In this section the *9FPS* will be explored. This experiment will be used in the empirical study to establish contact with the trauma and to create a trauma narrative.

As shown, the Gestalt paradigm is present-oriented (Yontef, 2005: 89). The survivor does not merely talk about how ‘it’ was ‘then’; “talking [is transformed] into doing, reminiscing and theorizing into presence and action” (Zinker, quoted in Melnick & Nevis, 2005: 107). The *9FPS* – similar to a

storyboard (Loumeau-May, 2008: 92) and *Draw a Cartoon* (Meijer-Degen, 2006: 59) – is an experiment with which the trauma history is brought to the immediacy of the present. It is a projection of nine prominent parts of the trauma in the form of a picture story. Subsequently a phenomenological “mini cooperative enquiry” (Mackewn, 2004: 59) is done as proposed by the Gestaltists Joyce and Sills (2006: 132-134) regarding unfinished business. The *9FPS* is thus a multisensory experiment: visual, kinaesthetic (the process of drawing) and auditory (expressive and receptive, in as much as the story is related first by the client and then by the therapist).

Reynolds (2005: 163) claims that, “I have seen how, paradoxically, children are able to better identify and own their feelings and experiences by first projecting them outwardly”. Moreover, Reynolds (2005: 163) asserts, “by first ‘taking apart’ their experience they are able to better put it ‘back together’ in a more complete and restructured whole”. The *9FPS* is valuable in that it facilitates the organisation of the fragmented trauma images (Dalenberg, 2006: 294-295; Klorer, 2008a: 50; Cattanaach, 2007: 429-430) and the creation of a multidimensional rather than a singular projection. Picture stories (comics) are particularly suitable for the experimental age group as they heighten and enliven the adolescent’s involvement.

The nine windows on an A3 page (folded into nine parts) are very small. According to Schaefer (1994: 301) the “miniaturization” of the experience and the fact that the adolescent determines what to draw and how to draw it, should enhance feeling in control. This is opposed to sexual abuse which ‘happens to’ someone, resulting in impotence and a loss of agency (Webb, 2007b: 50). During the *9FPS* the client, being the creator of a microtrauma, may reclaim mastery and power. “The survivor must be able to be ‘bigger than’ the memory...” (Kepner, 2003: 79).

Joyce and Sills (2006: 100-101) suggest that the client should feel “stretched but still competent”. During discussions about the *9FPS* with Elizabeth Jackson from the Manchester Gestalt Centre in 2007, a range of grading possibilities was thrashed out. First and foremost a relationship of inclusion should already have been established. Secondly, Oaklander (2006: 46) states that prerequisite to an experiment, the client’s self-worth, self-support and skills for emotional expression should already have been enhanced; the *Healing task: Strengthening the self* precedes the *9FPS*. Thirdly, performing the experiment is by invitation (Joyce & Sills, 2006: 100). Fourthly, explaining the rationale of the experiment acknowledges the client’s choicefulness. To this effect a metaphor – such as a stuck CD or a housebreak – can be used, as befits the client’s field experiences. Fifthly, should it become clear that the activity is too risky, it can easily be downgraded: Joyce and Sills (2006: 102) suggest asking the client, “Can you imagine someone strong standing next to you?” The *9FPS* could be done in one or over several sessions. By grading an experiment, the client is honoured.

The nine figures are drawn in a specific sequence:

- (a) In Window 1 – comparable to what Joyce and Sills (2006: 132) suggest, “Trace back with the person her best memory of the original situation or trauma” – a picture is drawn of the last time the client felt safe and good before the sexual abuse happened.
- (b) In Window 9, the last window, she is asked to draw a picture of the first time after the sexual abuse that she realised that things were just a little better.
These two pictures form pillars of strength for the more difficult parts of the trauma narrative. They form a visual *aide memoire* that things were better before and have started to become more bearable. Malchiodi (2008a: 18) refers to “remembered wellness”.
- (c) In Window 5, the middle window, the client draws the “worst moment” of the CSA (as proposed by Cohen & Mannarino, 2004: 826; Schaefer, 1994: 301; Shelby & Felix, 2005: 89).
- (d) In Windows 2, 3 and 4 three things which happened before the worst part are drawn.
- (e) In Windows 6, 7 and 8 three things which happened after the worst moment are depicted.

After the projection, the client is asked to tell the story of the ‘girl’ in the picture from the first to the last picture. Allowing the adolescent to relate the story in the third person allows for further projection and distancing and should, according to Schaefer (1994: 307), lessen defensiveness. Thereafter the therapist retells the story of the girl in the picture story. The repetitive sequencing of the trauma narrative should promote order, coherence and meaning-making.

The *9FPS* is not analysed by the therapist, but explored in such a way that it contributes to the discovery of personal meaning. The therapist does not ‘tell’ the adolescent how brave she was, but facilitates the exploration so that the client can discover that for herself (Ferreira & Read, 2006: 201; Shelby & Felix, 2005: 89). By means of the projection and the subsequent exploration the field is opened up: sensorimotor sensations, emotions, thoughts and beliefs of the inner, middle and outer zones are all brought to full awareness. *What are her strengths, or what is she doing right? What does the abuser do to trick and disempower the girl in the story? What is she feeling and what is she thinking?*

The exploration thus honours the self and helps the adolescent realise that under the circumstances there was nothing that she could do to prevent the tragedy. At this time the exploration should address unhelpful cognitions by “identifying the belief, articulating it, examining it against reality and generating alternative options” (Joyce & Sills, 2006: 134). The therapist might also bring up those emotions that the adolescent has not identified (often anger and guilt). At the end of the *9FPS* session(s) time is set aside to terminate the experiment and for debriefing and/or enhancing self-support.

In subsequent sessions the *9FPS* can be followed up with (play) activities to strengthen and consolidate awareness and insight. Therapeutic writing, or scriptotherapy, is an invaluable way to affirm the *9FPS* awarenesses; for example, a letter can be written to the perpetrator in which the client can say what she has never had the opportunity to verbalise (Celano *et al.*, 2002: 70).

The *9FPS* includes all the curative aspects of abreactive play as denoted by Schaefer (1994: 309): “power and control, insight, cognitive reappraisal, emotional release, repetition, and social support”. The researcher is of the opinion that this experiment is invaluable to facilitate the *Healing task: Contact with the trauma*.

3.7 Conclusion

Depending on the conceptual framework of the therapist, the goal of therapy for survivors of a traumatic event may be called “posttraumatic integration” (Shelby & Felix, 2005: 89) or “assimilation” (Kepner, 2003: 132) which may lead to “posttraumatic growth” (Clay, Knibbs & Joseph, 2009: 411) or to “organismic self-regulation” (Yontef, 2005: 84). In this chapter the researcher discussed the conceptual framework, phases and content of the therapeutic intervention which will be used to facilitate the clients’ growth in this study.

The researcher is of the opinion that structuring the therapeutic process according to *Healing Tasks* is valuable in as much as it steers the therapeutic process through all the complexities related to a survivor’s experience. Additionally, because the model is based on the developmental stages of healing, it promotes the strengthening of the client’s supports and capacities prior to dealing with the signs and patterns that are most troubling. The proposed therapeutic modalities also appear to be in accordance with neurobiological findings. The experiential, multisensory and multidimensional nature of play therapy (and specifically the *9FPS*) should facilitate the exploration, and ultimately the assimilation, of the traumagenic experience that was stored in a sensorimotor, unarticulated and disorderly way.

In the next chapter the research methodology and the empirical challenges encountered during the research process will be discussed. Self-reflexivity will be an important consideration in Chapter 4.