

PLAY IN PSYCHOTHERAPY  
WITH HIV / AIDS-AFFECTED CHILDREN AND FAMILIES

BY

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Dedicated to my best playmate in the world, my beloved husband Alcus.

### Declaration

I declare that: “Play in psychotherapy with HIV / AIDS-affected children and families” is my own work, that all the sources used or quoted have been indicated and acknowledged by means of complete references, and that this dissertation was not previously submitted by me for a degree at another university.

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## Summary

Can psychotherapeutic interventions be introduced in a playful manner to families and children affected by HIV / AIDS? Working from an ecosystemic worldview, this dissertation undertakes an investigation into the possibilities of working with HIV / AIDS affected children and families in South Africa in a playful manner in psychotherapy. Through a process of co-creating and reflecting, the narratives of four psychotherapists are used to describe their experiences of playfulness and psychotherapy with HIV / AIDS affected persons. These narratives are presented against a background of a research literature discussion of HIV / AIDS and play in therapy. It is argued that playful psychotherapeutic interventions with HIV / AIDS affected children and families are possible, given four criteria. Firstly, the basic resource requirements, food, clothing and transport, of the children and family members must be in place before emotional needs can be adequately addressed. Secondly, children should be allowed in the therapeutic space with the rest of the family. Thirdly, psychotherapists should be trained to make psychotherapy more child friendly. Lastly, these therapists should be willing to engage in a playful manner with their clients, and not fall prey to the stigma of HIV / AIDS.

Key Words

Children

Ecosystemic worldview

Families

Family structures

HIV / AIDS

Play therapy

Playful therapy

Reflexivity

Therapy with families

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CHAPTER 1  
INTRODUCTORY LETTER

Dear reader,

Allow me to introduce myself as the author of this dissertation. During my formal training as a psychotherapist, I worked at several government hospitals and institutes. I had the opportunity of working with HIV / AIDS affected and infected families and children. I often went to look for literature to support my initiatives in the field, but constantly ran into a wall of Western based theory, which mainly concentrated on the biological model, or the homosexual model. In my experience the literature was sombre, and left me feeling very un-enthusiastic about working with children and families affected by HIV / AIDS.

Whilst being trained in family therapy during my internship, it annoyed me when my fellow training and supervising therapists were wondering who would baby-sit the children in the playroom while we did so-called family therapy! I started reading about the topic of including children in family therapy, and found that my frustrations were shared by a number of other authors since the 1970's.

I also volunteered at a support group for HIV / AIDS affected people at a government hospital, and it struck me how few children attended these sessions. I wondered if only adults affected by HIV / AIDS needed therapy and support? I wondered where the children were. I wondered if the seriousness of the subject did not make therapy a closed space, which excluded children. If we included playfulness in psychotherapy, could this open up the therapeutic space for children?

This led me to my research question: Can psychotherapeutic interventions be introduced in a playful manner to families and children affected by HIV / AIDS?

To answer my research question I divided my research process in three sections. In the first section, I did a literature study on my epistemology (chapter two) and research design (chapter three). I also explored the literature on HIV / AIDS and families (chapter four), and on play in therapy (chapter five). For section two of my research I interviewed psychotherapists that have experience working with HIV / AIDS affected children and families in South Africa. I asked them to tell me their stories of psychotherapy with children and families affected by HIV / AIDS, and used these stories to make up chapter six. Section three of my research is compiled from reflections. For this, I handed chapter six back to my research participants and asked them to reflect on it. These reflections were

used to make up chapter seven. Throughout the document, I included my own process of reflection in the form of my own works of art, which was inspired by this research. The rationale behind the reflective process is captured in chapters two and three.

In this document, I used the term psychotherapy, implying both counselling and therapy within the psychology context. I also chose to write in the first person, since the topic and the reflexive process are very personal. As English is my second language, the use of language in the dissertation might appear to be somewhat unconventional to the reader, depending on the reader's stance (or sits) of observation.

I hope that your stance or sits is comfortable.

Kind regards,

Elrika

## CHAPTER 2

### IN THE WATER, IN A MIRROR

This chapter will explain the epistemology from which I conduct my research. Before embarking on our journey, allow me to explain why I chose the specific research vessel, qualitative research, to use when engaging in battle with the effects of HIV / AIDS.

The vessel I refer to is the analogy for the research methodology. This will be discussed in chapter three. In this chapter, I explain my epistemology in two parts. First I will investigate how worldviews have changed in such a manner that we need not operate from absolute truths anymore, but are able to view ourselves as part of a storied world. Next, I will discuss how writing within this storied world positions me in a reflexive stance as a researcher, and the implications thereof for my research. This will guide us into the next chapter, where the research design will be discussed.

### Toward an ecosystemic worldview

For me, planning the journey in research is partly theory and partly historic exploration - all intertwined. Since I plan for us to cruise towards an ecosystemic worldview, it might be valuable to investigate where this worldview comes from. For the purpose of this chapter, I will start at the Newtonian world.

The Newtonian worldview holds three central assumptions: reductionism, lineal causality and neutral objectivity. In the middle of the 1950's, the systems approaches developed. In the process, two of the three central assumptions of science, the concepts of reductionism and lineal causality, were discarded (Auerswald, 1985; Becvar & Becvar, 1996; Fourie, 1996).

#### *Reductionism*

Reductionism refers to the traditional view that objects and processes can be understood better if they are reduced to or broken up into their basic components, assuming that once the components are analysed, an understanding of the whole can be achieved through a process of re-synthesis (Becvar & Becvar, 1996). In my study this view would hold that if I could study children and families, HIV / AIDS, therapy and playfulness as four separate entities, I would be able to come up with a dissertation. Human systems



processes, however, are too complicated to make this kind of analysis viable. Playful therapy with children and families affected by HIV / AIDS is a much greater concept than the sum of its parts. The Gestalt principle, synergy, that the whole is greater than the sum of its parts, typifies the rejection of the Newtonian notion of reductionism (Becvar & Becvar, 1996; Fourie, 1996).

### *Lineal causality*

Lineal causality has to do with the connections between the components to which objects or processes are reduced, traditionally conceptualised in terms of cause and effect and as influencing each other in a direct, unidirectional, lineal way. Systems theorists expanded this notion in favour of the idea of circular causality, meaning that sub-systems influence one another in an ongoing, reciprocal way (Becvar & Becvar, 1996). In the case of my topic, HIV / AIDS does not only cause therapy with children to be less playful, as would be assumed in causality, but children, HIV / AIDS, playfulness and therapy affect one another in different ways, since they form part of a more complex social situation. This view of causality fits better with the complexity of social situations (Becvar & Becvar, 1996; Fourie, 1996).

*Neutral objectivity*

The third notion, neutral objectivity, was initially retained. Systems were observed as if they were separate from the observer, as if the observation was assumed to be objective (Becvar & Becvar, 1996). If I took this stance with my study, I would rather have used an experiment to show “objectively” how playful therapy can influence HIV / AIDS affected children. The study of systems was also perceived to be real and uninfluenced by either the observation itself or the observer’s way of thinking about systems, or in the case of research, the researcher could still do “neutral” research. The boundaries and rules early family-therapists “saw” in and between systems and subsystems were later described as concepts in their own minds and not objective at all (Becvar & Becvar, 1996; Fourie, 1996).

Drift away from first-order cybernetics

In the early 1980’s, dissatisfaction with the cybernetics or interactional approach started to surface. The movement away from what was called first-order cybernetics, towards second-order cybernetics, made systems theorists relinquish the traditional notion of objectivity. The observer was now seen as part of the observed. No statement could be made about a system without taking into account the observer’s idiosyncratic ideas and ways of thinking. This

observation of the observation was to become known as second-order cybernetics (Anderson, 1997; Becvar & Becvar, 1996; Fourie, 1996; Keeney, 1979).

The move from first order to second order cybernetics changed the whole view of system functioning. Systems were not seen as interacting as machines trying to reach homeostasis any longer. Like winds that change the course of a sailboat, three influences steered the vessel into a place where there was a completely different view of systems. The three influences came from the works of two Chilean biologists, Maturana and Varela, the work of an anthropologist, Bateson, and lastly the constructivists (Fourie, 1996).

*First wind of influence: the works of Maturana and Varela*

The two Chilean biologists, Maturana and Varela, found in a classic experiment that the way a frog catches a fly depended on the way the frog's eye functioned, and not merely on the presence of the fly. This experiment and other similar ones, led to the principle of structure-determinism, assuming the actions of a living system are determined by the structure of the system concerned and not by occurrences outside of the system. Radical social constructivists therefore see living systems as self-organized and autonomous (Becvar &

Becvar, 1996; Efran & Lukens, 1985; Efran, Lukens & Lukens, 1992; Le Roux, 1987; Penn, 1986; Simon, 1992).

In the social constructivist point of view, these independently functioning systems can be disturbed by outside influences, but the reaction of the system to such perturbation is determined by the system itself. Two or more systems can even get together, such as a therapist and a client. When the two systems couple with each other, they form a composite system, as determined by the structure of each system. The composite system is in turn autonomous in determining its own actions (Becvar & Becvar, 1996; Efran & Lukens, 1985; Efran, Lukens & Lukens, 1992; Le Roux, 1987; Penn, 1986; Simon, 1992).

In human systems, this coupling is by means of the exchange of ideas, for instance during an interview process in research. Autonomous systems function as self-sufficient systems, and are therefore able to function as closed systems without input from other systems. Social constructivists assume human systems are autonomous closed systems, and therefore the systems can exchange nothing but ideas, even though concrete objects might symbolize these. Strictly speaking these ideas aren't exchanged but symbols such as verbal and other sounds, visual stimuli and marks on paper are presented by one system to another: such as the words the reader is reading and I, the writer, am writing. From these symbols, the second system does not extract precise meanings, but autonomously creates its own meanings. These meanings are often

idiosyncratic, and may resemble the original, intended meanings only superficially. The presented symbols perturb the receiving system, which in turn autonomously creates its own meaning regarding the perturbation (Becvar & Becvar, 1996; Efran & Lukens, 1985; Efran, Lukens & Lukens, 1992; Le Roux, 1987; Penn, 1986; Simon, 1992).

*The second wind of influence: Bateson*

The second influence in the movement away from first order cybernetics came from the work of the anthropologist Gregory Bateson. Bateson described the functioning of human systems in terms of ecologies of ideas (Bateson, 1979; Becvar & Becvar, 1996). This implied that a family or a social system could develop an unspoken network of interlinked ideas about itself as a social system, as a family, as individuals, about its place in the world and about life in general. These ideas are not necessarily shared between the members of the system or family members, and disagreements in the shared ecology might exist (Fourie, 1996). Relating these ideas to my study, the psychotherapeutic community might have a shared ecology of ideas on working with children and families affected by HIV / AIDS. Introducing a concept such as play and playfulness in psychotherapy into the shared ecology may elicit disagreements between the members of the system or perhaps become part of the unspoken network.

*The third wind of influence: The constructivists*

The third influence in the development of second order cybernetics was constructivism. Constructivists argue that it is impossible for human beings to observe reality as it really is, or even assume that a fixed reality exists (Anderson, 1997; Elfran, Lukens & Lukens, 1992; Niemeyer, 1999). When an observation is made, ideas around the object represent itself in the brain, not the object itself. The perceiver of the object thus generates the ideas about the object from his or her existing ideas and attributions, and constructs the concept for him- or her self. For the radical constructivist this implied that no “real” reality existed and that the observer constructed all “realities”. Later constructivists however, retain that realities are co-constructed by the observer and by the observed, and that co-construction takes place in language (Anderson, 1997; Elfran, Lukens & Lukens, 1992; Fourie, 1996; Niemeyer, 1999). In terms of research it might indicate that realities are co-constructed by researcher and research participant, or between researcher-as-writer and the reader.

Using personal constructs or meanings, in my case my academic and personal background, the observer has to distinguish between what is observed, in my case, what I have read in the literature or heard in the interviews, and what is known, and meanings are non-linearly co-created through verbal and non-verbal language (Anderson, 1997; Elfran, Lukens & Lukens, 1992; Fourie, 1996;

Niemeyer, 1999). Verbal language might be the written research, and non-verbal language could refer to my artworks (Figures 3 – 9). These theories are discussed again in chapter five, linking with ecosystemic play therapy.

### Social constructionism

Social systems that exchange meaning in time lead to the co-construction of a distinct shared reality for those systems (Anderson & Goolishian, 1988; Freedman & Combs, 1996; Hoffman, 1990). Research is also such a shared reality created by us and in doing this we are co-creating the idea of research. Freedman and Combs (1996) explain the social constructionist worldview as based on four assumptions: realities are socially constructed, realities are constituted through language, realities are organized and maintained through narrative and there are no essential truths. “If the realities we inhabit are brought forth in the language we use, they are kept alive and passed along in the stories that we live and tell” (Freedman & Combs, 1996, p. 29 – 30). During my research I chose to use stories that I might find relevant in co-constructing my reality of play, therapy, HIV / AIDS, children and families.

Next, we will step off the boat onto an island, and discuss my position as a researcher and a co-creator of stories.

## Researcher and stories

“After a century of remarkable psychotherapeutic explorations, it is time for psychotherapists to overtly acknowledge that we are therapists because we love stories too” (Gonçalves, 1995, p. 195).

As a therapist in training and researcher I also have an insatiable appetite for stories. I find stories within literature when I do research and I hear stories in conversations when I speak to fellow therapists and to clients. To me, life is a narrative and human beings are inherent narrators, storytellers and participants in their own emerging plots.

The emerging plot for the next part of this chapter will be a discussion of how using stories and narrative therapy leads me to a perceived reflexive stance in research. I choose to use the term “narrative therapy” rather freely in the fashion of Morss and Nichterlein (1999), to include the later developments of the systemic approach, as discussed above, the non-expert approach of Goolishian and Anderson (1992), as well as the more creative and hopeful approaches of White and Epston (Epston, 1998; White and Epston, 1990). I hope to maintain the essence of the narrative approach within my research: to keep it respectful to the research subjects, to pay attention to the power dynamics surrounding it, and to listen openly to both literature’s and respondents’ stories (Morss and Nichterlein, 1999).



Life is a narrative, a story without a clear-cut beginning or end, but with meaning and structure that keeps changing through a series of strange, recursive loops and creative cycles (Gonçalves, 1995). Writing a dissertation is a construction or creation of a new story, but it is also the writing down of my own story, a mirror-like reflection.

#### Reflexive stance in research

There was a lucid spring, gleaming like silver,  
Which neither shepherds nor the mountain goats  
Nor other herds had touched: no savage beast  
Nor bird had troubled it, nor falling branch.  
Around, the grass which the spring water fed,  
And woods which kept the place from burning sun.  
Here once the boy, tired with hunting and heat,  
Stretched out to rest, charmed by the lovely spring.  
He strove to quench his thirst, but other thirst  
Was born – he was bewitched by his own beauty:  
Loving a bodiless dream, and a body's shadow.  
He saw himself with wonder, motionless  
Poised, like a statue carved of Parian stone . . .

Now he desired himself and loved his lover,  
And sued his suitor, kindling his own flames.

(G Highet in Grant, 1962, p. 382)

*To investigate the unknown and question the known*

For me, thinking about doing research, encompasses the idea that I will tread upon fields untouched and will go into pastures not troubled before. However, as the word research suggests, it is also a re-search into that which has already been searched, and questioning what has already been constructed. Doing this is an audacious act. “Daring as it is to investigate the unknown, even more so it is to question the known” (Kaspar, in Watzlawick, Weakland & Fish, 1974, p. xi). In questioning the known, we dare to re-construct new understandings of our topic, and give voice to new stories that we constructed about HIV / AIDS, children, families and therapy. “As inquirers and researchers, we create worlds through the questions that we asked coupled with what we and others regard as reasonable responses to our questions” (Steier, 1991, p. 1).

The world of HIV / AIDS, therapy, and children, that I create with this dissertation is a research process that can be seen as my own social construction of the world. Not only am I co-constructing new stories about this

world, but I agree with Steier (1991) who pointed out that reflexivity is the guiding relationship allowing for circularity, an unfolding spiral that acknowledges how issues of self-reference can inform methodologies and the research process in general. Steier (1991) asks a question that I have contemplated all through my research: does the inclusion of the researcher make all research autobiographical?

In this research I aim to look at the stories in the literature and told by psychotherapists about psychotherapy with HIV / AIDS affected children and families. In writing it up I am telling myself a story about myself, a stance that agrees with second order cybernetics. Second order cybernetics deals with observing, as opposed to first order cybernetics that merely observe (Epston, 1998; Gergen, 2000; Steier, 1991).

### *Co-creating and reflecting*

There is an awareness that doing research must be expanded to include those artist-like processes that are often filtered out of ordinary research writing (Steier, 1991). I decided that to be more reflexive within my research, I would include my reflection process as works of art. This starts the circularity process as my works of art might also inspire new interpretations from the reader. This could lead to a loop between self-reflection and dialogue, between the language

of my community (the university) and my own passion and experience (Steier, 1991). I might thus be reflective in showing myself to myself, and reflexive in being conscious of my self as I see myself.

I can see the writing of research as playing with the metaphor of Narcissus, in the same way Gonçalves uses the Narcissus metaphor to explain the therapeutic hour. Fischer (cited in Gonçalves, 1995) used the Narcissus metaphor to explain the emergence of a third-level intentional system that allows the beginning of the narrative in human beings:

In the Narcissus motif, Narcissus recognizes himself in the reflection of a pool as an object: “Iste ego sum,” “I am the one,” he exclaims when seeing the moving lips of his mirror image but does not hear any speech. In this very moment, Narcissus becomes an *observer*. Were he to hold up another mirror which reflects him as a *subject* that is looking into the pool which reflects him as an object, then he would evolve from an observer to a *narrator*. (p. 197)

I am thus part object or observer, part subject or observed, and part transcending subject-object, a narrator, or, a project (Gonçalves, 1995; Steier, 1991). The stories we tell about ourselves need not to be trivial, indeed, that research tells a story about ourselves is an important point since this implies that our knowledge is embedded within a constructing process (Steier, 1991). I can

then assume that in this work I am co-creating reality, according to social constructionism (Anderson, 1997; Elfran, Lukens & Lukens, 1992; Fourie, 1996; Niemeyer, 1999). The co-creation of reality might happen through stories, but also through theories.

### *Theories and vignettes*

“My theory is that all theories are bad except for preliminary game playing with ourselves until we get the courage to give up theories and just live” (Whitaker, cited in Neill & Kniskern, 1982, p. 367).

Theories can also be referred to as stories and metaphors, as aesthetic representations of environments (Gonçalves, 1995). I aimed to gather stories as the artistic portrayal of the environment of HIV / AIDS in therapy with children and families in South Africa. I looked for a special kind of story specifically in the interviews with psychotherapists, a vignette, to further describe the theme at hand. In this instance vignettes are “stories about individuals, situations and structures which can make reference to important points in the study of perceptions, beliefs and attitudes” (Barter & Renold, 1999).

I use the vignettes as they unfolded in the interviews I had with therapists whom have worked with children affected by HIV / AIDS, as a way of negotiating

a shared meaning between the research participant and myself, and the reader and myself. I use theory and stories to co-construct new ideas around therapy and the possibilities that therapy can be playful with children affected by HIV / AIDS.

In play therapy children tell stories as container for their experiences, constructed into the fictional narration of a story. There is a playfulness in the communication, whatever the horror of the story, and an equality in the relationship. (Cattanach, 1997, p. 3)

In my dissertation, I hope that the vignettes can serve as pictures of the experiences of the therapists who told them. I believe that my dissertation and accompanying art works will serve as a mirror in which I can see myself looking at my reflection in the water. I hope that reflecting on the topic the way I do, helps the reader create new ideas about doing playful therapy with serious problems, such as HIV / AIDS.

All aboard?

The aim of this research is to re-search something beyond myself, and in doing so, perhaps, to discover some knowledge about myself, and interweave my reflection in a dissertation, that is both academically acceptable and true to

my Self. I live in a storied world, and my research is to tell new stories together with the voices of psychotherapists and other researchers in the literature.

In this chapter, we have reached the ecosystemic worldview, and explored on a symbolic island the reflexive stance in research in a storied world. In the next chapter I will illustrate the research design.

### CHAPTER 3

#### RESEARCH DESIGN: CONTEMPLATIONS AND CONUNDRUMS

Combining meticulous technique, subtle humor, and rigorous attention to the physical behavior of imaginary substances, M.C. Escher (Dutch, 1898-1972) linked the surreal and the scientific with his strangely logical manipulations of space, dimension, and perspective. Through an artistic sleight of hand, he created works in which up and down have no meaning and seemingly inert patterns suddenly metamorphose into living creatures. Escher's ingenious designs reflect a reverence for the order and beauty of the universe, even as they mock humanity's rigid structuring of reality. (Pomegranate, 2002, p. 25)

I would like to compare research from an ecosystemic point of view to the artworks of Escher (Figure 1), specifically to one of his more famous works in which two hands are illustrated as illustrating one another. It is a portrayal of co-creation, and at the same time commenting on the process of making the artwork: the artist illustrates two hands holding pencils drawing one another.



This chapter will investigate how the storied world, described in chapter two, and the scientific world of research, can be linked in a process of qualitative research.

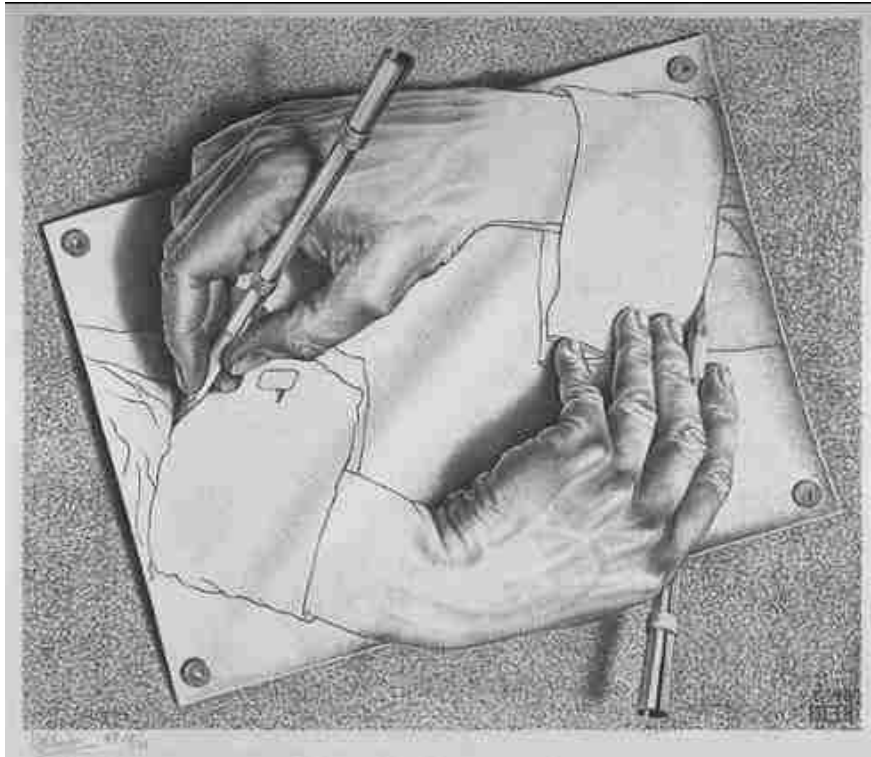


Figure 1: Hands Drawing<sup>1</sup>

### Contemplations on qualitative research

In chapter one I introduced myself to the reader. In chapter two I explained my epistemology of the storied world, admitting that life can be seen as being a narrative without a clear-cut beginning or end, but with meaning and structure that keeps changing through a series of creative cycles. In creating my dissertation I chose to work from a qualitative point of view, not because I discard

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<sup>1</sup> Note. From <http://www.mcescher.com>, retrieved November 30, 2004.

quantitative research but because the more expressive style associated with qualitative research seemed more suitable to my topic. Working from a second order cybernetics point of view I am

now able to see the quantitative as itself inherently qualitative, given that the nonlinear and emergent character of social and other significant systems means that we can never establish general non-contextual laws and that the quantitative account itself is simply, but very usefully, a way of describing local contexts and transformation of systems as a whole.

(Byrne, 2004)

My study is conducted in the tradition of qualitative research, since “the intentional nature of human practices is well captured by qualitative methods” (Kvale, 1992, p. 51). The key instrument of data collection was myself, aided by a tape recorder and later on works of art that had emerged from the study. The interviews were analysed inductively by listening carefully for stories and vignettes that transpired. I shared the collected data with my research participants and included their feedback in the research process. All these are characteristics of qualitative research (Creswell, 1998; Mouton, 2001).

#### *Exploratory design within qualitative research*

De Vos (1998) states that the goal in exploratory studies is the exploration of a relatively unknown research area. The focus areas for this study, children

affected by HIV / AIDS, and families and children and playfulness in therapy, seemed to be a rather uninvestigated area (Barolsky, 2003; Cooklin, 2001; Freeman, Epston & Lobovits, 1997; Kotzé & Kotzé, 2002; Schoeman & Van der Merwe, 1996). Therefore, an exploratory research design was used.

### *My role as researcher*

I took on the role of the researcher-as-interviewer, and that can be seen as a co-constructing interviewer. “Interviewers embody multiple identities in the research context” (Jorgenson, 1999, p. 223). I embody many different identities. One is that of researcher, whilst writing up my research. Another is that of artist, when I am busy expressing my own process through works of art, some of which are included in this document. These artworks were included in an attempt to make the research process transparent and to enrich it for my reader and myself.

Doing art is a way of playing with my topic and expanding my ideas on it. Allen (1995) explains that “art making is a way to explore our imagination and begin to allow it to be more flexible, to learn how to see more options” (p. 4). The horrifying content of some of the research that I encountered, specifically regarding HIV / AIDS and children, have sometimes threatened the spirit of playfulness and creativity that I wanted to make part of my research process.

However, art allowed me to explore and express some of the areas that touched me personally.

### *Sampling and interviewing*

The research participants were selected by purposeful sampling as described in Babbie and Mouton (1998). Purposeful sampling is also known as judgmental sampling (Terre Blanche & Durrheim, 1999). The principle in such sampling is to select cases with a specific purpose in mind, in this case, to reach a population in the psychology community that has specific experiences of working with HIV / AIDS and children. I obtained my research participants by enquiring in the psychology tearoom among my colleagues who had working experience of working with children and families affected by HIV / AIDS, and was willing to engage in the research process. Four colleagues volunteered and they all fitted the profile.

The participants are all South African psychotherapists, and have had their experience of working with children and families affected by HIV / AIDS in the South African context. Claire and Joan are both intern psychologists and in their late twenties. Lindiwe is a registered psychologist and in her early thirties. Richard is also a registered psychologist and in his fifties.

All four interviews was structured in the same manner: I started by explaining to my research participants what my study was about and asked them to tell me about their experiences of working with children and families affected by HIV / AIDS. This led to diverse conversations in which I searched for their stories and their experiences of using playfulness in therapy. Afterwards I transcribed the entire interview from the audio tape recordings I made during the interviews. A copy of all four transcriptions was handed back to each participant, and I requested their feedback on it. The feedback I received was unique to every participant, and was used to engage the reader and the research participants into further conversations about using playfulness in therapy with HIV / AIDS affected families and children.

My research method is thus qualitative, following an exploratory design with me as a co-constructer of research. Qualitative research methods are sometimes considered controversial, leaving the researcher facing conundrums.

#### Conundrums in qualitative research

Qualitative research offers rich and rewarding explorations available in recent social science, and has been described as brimming with energy, with space for societal critique and political activism as well as an open canvas for literary, artistic and dramatic expressions (Gergen & Gergen, 1999). This

allowed scholars from diverse arenas to search ways to bring new vitality to their customary pursuits, to research and express in a different way in qualitative research. A myriad of theoretical and metatheoretical debates have produced profound challenges to the ways in which the social sciences are understood and practiced, and as a result of these amalgamations the field of qualitative inquiry is abounding with enthusiasm, creativity, intellectual ferment and action (Gergen & Gergen, 1999).

In my pursuit of doing research in social sciences and expressing myself honestly, I came across three areas of controversy identified by Gergen & Gergen (1999), namely the crisis of validity, the rights of representation and the place of the political in qualitative investigations. Working with a controversial topic such as HIV / AIDS, playfulness and children and families in therapy, made me aware of the risks involved in my research. Is the research I am doing valid? Who have the right to representation in my research? What is the place of the political with regards to my research?

### *The crisis of validity*

The crisis of validity, of proclaiming something true and certain, is much discussed in qualitative research.

To say that the findings of social scientific investigations are valid is to argue that the findings are in fact true and certain. “True” here means that the findings accurately represent the phenomena to which they refer and “certain” means that the findings are backed by evidence. (Schwandt, 1997, p. 168)

In this case the research findings are the compiled document, which will have the phenomena to which it refers, the interviews of the research participants, backed by evidence, the feedback that they give on the document, in which they can state if they perceive it to be an accurate representation. “The present understanding of validity starts in the lived world and daily language, where issues or reliable witnesses, of valid documents and arguments, are part of the social interaction” (Kvale, 1995, p. 20).

Kvale (1995) mentions three approaches to validity and reliability. He sees validity and reliability as expressions of craftsmanship, with the emphasis on quality of research. Secondly, Kvale suggests that a justification of the knowledge be replaced by pragmatic validation. Pragmatic validation is verification in the literal sense, and implies that the effectiveness of our knowledge beliefs is demonstrated by the effectiveness of our actions, which in this study are the unstructured interview research process. Lastly, Kvale also stresses the value of conversations about research and sets a communicative conceptualisation of validity and reliability. In this study the conversations were

held between the participants and the researcher, and enriched by including their feedback on the research process.

Validity also lies embedded within the nature of language and the capacity of language to map or picture the world to which it refers, challenging the pivotal assumption that scientific accounts can accurately and objectively represent the world as it is. The intelligibility of our accounts of the world derives from our immersion within a tradition of cultural practices, inherited from previous generations' ways of communicating about the world. It is thus from our relationships within interpretive communities that our constructions of the world derive (Gergen & Gergen, 1999). My relationship with the interpretive community of research participants assists my construction of the world of HIV / AIDS, children and families in therapy.

Gergen and Gergen (in Steier, 1991) note that language is not only a symbol system for mapping the worlds as it is, but is performing coordinating activities. In my understanding language is thus not only a tool in which I can reflect, but the use of language also influences my way of observing. A large amount of the play therapy literature were written in a very linear, modernistic way, and in writing it up, I might have reflected that mode in my writing style.

Denzin and Lincoln (1994) claim that if there is no means of correctly matching word to world, then the warrant for scientific validity is lost, and



researchers are left to question the role of methodology and criteria of evaluation. There is no rationale by which qualitative researchers can claim that their methods are superior to quantitative ones in terms of accuracy or sensitivity. A thousand word description is no more valid a "picture of the person" than a single score on a standardized test (Gergen & Gergen, 1999).

Language, however controversial, should thus not affect the validity (in a social constructionist sense) of the research that has been done. Other factors that should be taken into account are the questions of who has the right to be represented within research, and what is the place that the political plays within qualitative research.

#### *The rights to representation*

The rights to representation have to do with asking who are eligible to be represented in a research study. Who decides whom to include and exclude, what are the power dynamics behind these decisions? Deciding on whom to represent in my research to answer my research question was a process, rather than a decision.

In the months before commencing the official study I tried to locate a family with children dealing with HIV / AIDS to do therapy with. It was almost

impossible, and the few leads I had on such a family, did not realize. Initially I wanted to give the children and family members affected by HIV / AIDS a voice by undertaking psychotherapy myself whilst trying to include playfulness in the psychotherapy.

This, however, led me to an ethical concern. Can I hand out therapy for the sake of research? Or should I rather use therapy that has already been done by other psychotherapists and speak to the therapists about that process? I decided on the latter. The rights of the therapists to be representing their own experiences and ideas on therapy with children and families affected by HIV / AIDS, might also make them ambassadors in representing a small piece of the current psychotherapy practice methods in South Africa. With my study I try to give a voice not only to the HIV / AIDS affected children and families in South Africa, but also to the psychotherapists who might be working with them, or want to work with them. With this research I also attempt to create a space for therapy and playfulness to intersect and create opportunities for new conversations in and around psychotherapy.

### *Power and knowledge*

Keeping in mind Foucault's (1980) disquisitions on power and knowledge I may ask to what extent does research convert the common sense, unexamined realities of the culture to disciplinary discourse and in what ways does research

empower the discipline, psychology, in favour of those under study, those represented. I may also ask when am I, the researcher, exploiting my subjects for purposes of personal or institutional prestige; does my research serve agencies of surveillance in increasing their capacities of control over the research subject (Gergen & Gergen, 1999)?

Three types of research were developed to counter these questions: empowerment research, conjoint representation and distributed representation (Gergen & Gergen, 1999). My representation in this dissertation is a combination of the latter two. In allowing my research participants to give me feedback on what I have written about them, I blurred the line between researcher and subject and shared the control over representation, much in the conjoint representation fashion of research done by Lather and Smithies in 1997 described in Gergen and Gergen (1999). I also include my own reflections in the dissertation alongside those I receive from my participants, thus I am also doing distributed representation.

### *Ethical concerns*

The rights to representation also include questioning the ethical aspects of my research. Aristotle distinguished scientific reasoning from ethical reasoning, maintaining that because of the complexity of human behaviour, ethical reasoning requires deliberation and making decisions on a case-by-case basis

(Flinders & Mills, 1993). The ethical considerations with regard to this research were discussed with the participants involved in the study. It followed the standards set by the Professional Board for Psychology, of the Health Profession Council of South Africa (HPCSA, 2002) and the recommendations made by the Ethics Committee of the Faculty of Human Sciences of the University of Pretoria.

Moch and Gates (2000) urge qualitative researchers to obtain the necessary consent from all participants in the research. They warn against even subtle coercion during interviews, and urge on making sure all participants involve are fully aware of the risks and benefits, protecting voluntaries, and suggesting alternative options if an issue is sensitive or affect laden.

Informed consent was obtained in written format from the participants before commencing the interview (See Appendix A). They were informed in a language, English, familiar to all participants. All of the participants had their tertiary education in English. The consent form was compiled in such a manner that it was reasonably explanatory as to what the nature of the research was, and gave the participants a choice to participate or refuse participation. The participants consented to the way the data collection and documentation would take place, via audio recording and in writing.

The participants had the option to undergo a debriefing session after the interview, but chose not to. They received a written document in which the

compiled themes of the interviews were discussed and combined with existing literature (chapter six). Their responses to this document was recorded and included in the research (chapter seven). They had the option of obtaining a copy of the completed research document once it has been finished and submitted to the university. Writing a document for a specific institution, such as a university, also led me to question what the place of the political will be in my research, since it might be dictated by the institution that this research is subjecting to.

### *The place of the political*

The place of the political is a third site of controversy and though closely related to issues of validity and representation, also raises issues of a distinct nature. The focal point in this case concerns the political or valuational investments of the researcher as it has become increasingly clear that there is no simple means of separating method from ideology (Gergen & Gergen, 1999).

A poststructural social science project seeks its external grounding not in science... but rather in a commitment to a post-Marxism and a feminism... A good text is one that invokes these commitments. A good text exposes how race, class, and gender work their ways in the concrete lives of interacting individuals. (Denzin & Lincoln, 1994, p. 579)

For others, however, such cementing of the political agenda threatens to remove them from the dialogue. There are many whose humane concerns turn toward other groups or who find much to value in the longstanding traditions and use their research to enlighten policy makers, organizational leaders, and so on (Gergen & Gergen, 1999).

HIV / AIDS worldwide, and in South Africa, is a politically burning issue, as will be discussed in chapter four. In my opinion any social science research related to or concerning HIV / AIDS, raises concern about race, class, and gender – be it the more homosexual oriented research done in the 1980's and 1990's in the United States (as will be discussed in chapter four) or the more recent African based research. During my quest I often came across cultural issues with regards to HIV / AIDS, and found them to almost overshadow the creative potential that might be hidden in the convergence between working with families and playfulness in therapy.

#### Innovations in qualitative methodology

Escher used certain methods and techniques to create his works of art. In some of it we can clearly see what has happened, such as *Hand with Reflecting Sphere* (Figure 2) where we see the artist holding a reflecting sphere and drawing what he sees in its reflection.

In the same manner, I want to make clear some of the methods and techniques in qualitative research that are relevant to my dissertation. These innovations, reflexivity, multiple voicing, literary representation, and performance, will be discussed next.



Figure 2: Hand with Reflecting Sphere<sup>2</sup>

### *Reflexivity*

Within reflexivity investigators seek ways of demonstrating to their audiences their historical and geographic situatedness, their personal investments in the research, various biases they bring to the work, their surprises

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<sup>2</sup> Note. From <http://www.mcescher.com>, retrieved November 30, 2004.

and "undoings" in the process of the research endeavour, the ways in which their choice of literary metaphors lend rhetorical force to the research report, and / or the ways in which they have avoided or suppressed certain points of view (Gergen & Gergen, 1999). This relates closely with Escher's artwork of one hand drawing the other.

Such forms of self-exposure have more recently led to the flourishing of autoethnography, where investigators explore in depth the ways in which their personal history saturates the ethnographic inquiry, where the investigator relinquishes the "god's eye view" and reveals his or her work as historically, culturally, and personally situated (Gergen & Gergen, 1999). Ultimately the act of reflexivity asks the reader to accept him or herself as authentic in a conscientious effort to "tell the truth" about the making of the account (Steier, 1991). More than one voice, can however, be part of reflexivity.

### *Multiple voicing*

Multiple voicing is the second significant means of disclaiming validity. It removes the single voice of omniscience and relativise it by including multiple voices within the research report, for example the research subjects or clients may be invited to speak on their own behalf - to describe, express or interpret within the research report itself, or use different voices or perspectives on a



subject, or the researcher may choose not to reach any single conclusion (Anderson, 1997). Multiple voicing is especially promising in its capacity to recognize the problems of validity while simultaneously providing a potentially rich array of interpretations or perspectives.

One of the complexities of multiple voicing questions is how the author/researcher should treat his/her own voice: as one among many or that of professional training, or maybe as multiple voices, since each individual participant is polyvocal, or ultimately as the author, the judge of inclusion, emphasis, and integration. These arts of literary rendering are often invisible to the reader (Gergen & Gergen, 1999). In my study I find myself speaking with multiple voices: that of researcher, interviewer, artist, human, women, and much more. I also include the voices of my research participants who spoke to me in a multitude of voices: psychotherapists, interviewees, and so forth. The way I chose to portray these voices is part of my literary styling.

### *Literary styling*

Literary styling is the third important reaction to validity critique, according to Gergen & Gergen (1999), and particularly the replacement of traditional realist discourse with forms of writing cast in opposition to "truth telling". The researchers' descriptions may take a different form, for example fiction or poetry

or an autobiographical invention. This writing form offers a greater expressive range and an opportunity to reach audiences outside the academy, which makes it appealing for many qualitative researchers (Gergen & Gergen, 1999).

However, creative expression might be perceived as a very personal expression, and such writing is vulnerable to the criticism of singularity of voice.

Non-traditional writing might bring forward several of the same issues about reflexivity and multiple voicing, despite the fact that certain pitfalls of traditional literary forms are avoided in these innovations. Traditional literary forms seem to some more appropriate for scientific representations (Gergen & Gergen, 1999).

### *Performance*

Performance is the fourth reaction that removes the thrall of objectivity while sustaining a voice (Gergen & Gergen, 1999). Performance is used more as a mode of research / representation, justified by the notion that if the distinction between fact and fiction is largely a matter of textual tradition, then forms of scientific writing are not the only mode of expression that might be employed. Film and photography have generally been viewed as supplementary means within the writing tradition. The entire range of communicative expression in the arts and entertainment world can be seen as forms of research and

presentation in which the investigator avoids the perplexing claims of truth, and concurrently expands the range of communities in which the work can inspire dialogue (Gergen & Gergen, 1999).

In order to avoid the judgements stated in Gergen & Gergen (1999) that I might “drift from conventional scientific standards” (p. 26) and become “narcissistic, overly personal, naval-gazing, exhibitionistic” (p. 26) I included both a more traditionally written text and my reflexive artworks. In the text I reframed validity as to what is valid to myself in social research. I asked myself if my research or my representation would contribute towards society in any way? The answer lies in my situated knowledge.

Situated truth is "truth" located within particular communities at particular times, and used indicatively to represent their condition. Descriptions and explanations can be valid so long as one does not mistake local conventions for universal truth (Gergen & Gergen, 1999). I might use descriptions for my explanations knowing that they are my truth in a particular time-frame, the early twenty first century, in the community of people such as psychotherapists and family and children affected by HIV / AIDS. In order to avoid making the stance that everything can be valid for someone, sometime, somewhere, I encouraged feedback from my research participants, the psychotherapists. This feedback was used to state diverse answers relevant to my situated truth, instead of a single answer to my research question.

Although I might ask whether self-reflexivity and autoethnographic reportage function in such a way that individual experience is privileged over social or communal renditions, I also have to keep in mind that this dissertation is merely a representation of my conceptualisation of playful therapy with HIV / AIDS affected children and families.

### Facing the conundrums

Qualitative research is a somewhat controversial form of research, filled with controversies such as validity, the rights of representation and the place of the political. This has led to some innovations that sprung from qualitative research to reaffirm its importance in research, as has been discussed.

This chapter investigated how the storied world, described in chapter two, links with the world of qualitative research. In the next chapter the story of HIV / AIDS and how it affects children and families in South Africa, will be told.

CHAPTER 4  
HIV / AIDS AND FAMILIES

And sometimes when  
our fights begin  
I think I'll let  
the Dragons win...  
and then I think  
perhaps I won't  
Because they're Dragons  
and I don't.

(Milne, 1988, p. 7)

Sometimes when I think about HIV / AIDS, it reminds me of a dragon. Dragons can invade our society and destroy human lives with its scourging breath. Sometimes I think there is no hope and fear that the dragon might win. But then I think perhaps it won't, because it is just a dragon, and I pick up my sword of hope...

The previous chapters explained my ecosystemic vantage point from where I conduct qualitative research. This chapter will describe HIV / AIDS in South Africa as portrayed in research literature, and compare it to some literature across the world. It will look at the picture of HIV / AIDS as it affects the individual on a biological level and in society. Also, this chapter looks closely at the changes and challenges HIV / AIDS brings to existing family structures. At the end of the chapter we have to wonder how playfulness in psychotherapy can aid HIV / AIDS affected families.

### The Dragon: HIV / AIDS

The dragon first came to South Africa in the early 1980's. The first recorded case of HIV in South Africa was in 1982. Since then, South Africa has become the site of one of the fastest growing HIV epidemics in the world (Marais, 2000). The effects of HIV / AIDS is far reaching. It impacts on the well being of the individual, his or her family, the community and society at large.

#### *The biological effects of HIV / AIDS*

HIV is the acronym for the Human Immune-deficiency Virus, and is generally believed to be the virus that causes AIDS (Acquired Immune Deficiency

Syndrome). The virus attacks the immune system of the body and weakens it to the point of becoming insufficient at protecting itself against opportunistic infections. The detrimental effect of HIV / AIDS on the individuals' body can cause death (Brouard, Maritz, van Wyk & Zuberi, 2004; Whiteside & Sunter, 2000).

An HIV infected person can live a healthy, positive and productive life with HIV for a long time. However, the effects of HIV / AIDS on an individual can also be living a life filled with chronic illness, negatively affecting quality of life (Brouard, Maritz, van Wyk & Zuberi, 2004; Doyle, 1994; Whiteside & Sunter, 2000). The symptoms of primary infection are fever, tiredness, rash, sore throat, muscle and joint pain and some swollen lymph glands. Some of the symptoms developing in the minor symptomatic phase, the symptomatic phase and the AIDS phase are even more detrimental. These include: fungal nail infections, recurrent upper respiratory track infections, weight loss, recurrent thrush, cold sores, persistent diarrhoea, nausea and vomiting, peripheral neuropathy, headaches, fits and other neurological conditions, tiredness, fatigue and weakness, memory and concentration loss and mental deterioration and confusion (Brouard, Maritz, van Wyk & Zuberi, 2004).

The medical discourses surrounding HIV / AIDS sometimes objectify an HIV-positive person leaving no space for personal agency (Renwick, 2002). However, for those living with HIV, dying from AIDS-related illnesses is a harsh

reality (Kotzé & Kotzé, 2002). This reality does not only affect the individual but also larger systems, challenging health professionals in South Africa on two levels: prevention and dealing with the impact of HIV / AIDS (Whiteside & Sunter, 2000). The impact on the infected and affected community is furthermore influenced by the narratives surrounding HIV / AIDS.

### *HIV / AIDS as portrayed in literature*

The story of HIV / AIDS as told by literature depends very much on the literature one reads. I came across the pure American- / European- versions (Anderson & Wilkie, 1992; Barnes, 2004; Buckingham, 1992; Cameron, 1993; Chambers, 1995; Doyle, 1994; Hitchens, 1989; Schoeneman, Schoeneman & Obradovic, 2002; Sprang & McNeil, 1995; Willemsen & Anscombe, 2001), and western studies on African countries (UNIAIDS, 2002a; UNAIDS, 2002b). There were also a few scattered mentions as to what is happening in the East and Far East (D’Cruz, 2002; Renwick, 2002), and more recently and increasingly available, the South African literature (Barolsky, 2003; Jewitt, 2002; Jones, 2001; Kisoona, Caesar & Jithoo, 2002; Marais, 2000; Nelson Mandela, HSRC study of HIV / AIDS, 2002; Ramogondo, 2002; Walker, Reid & Cornell, 2004). Although a large amount has been published in terms of medical research on the virus, it seems as if the human side to HIV / AIDS is eluding the magnifying glass of the researcher (Barolsky, 2003).



*American- / European research literature*

The American- / European- versions were written from the 1980's. A recent study conducted on the social representations of AIDS according to pictures found in American abnormal psychology textbooks in the period 1984 – 2001 (Schoeneman, Schoeneman & Obradovic, 2002), concluded that in their study, textbooks might inadvertently present AIDS as a disease of homosexuals and as associated with mental disorder. A qualitative analysis of the pictures revealed a number of themes: the sick, skeletal, hospital patient; an information source such as a person handing out pamphlets; the faceless drug junkie with a needle in his / her arm; the support group; the celebrity with AIDS; the innocent African-American child victim; the protestors in marches and parades; the condom dispensary; and the invasion of the helper T-cell, AIDS under a microscope. The representation of the HIV / AIDS affected family in these pictures shows interesting trends: there were no white heterosexual couples in the sample, most of the individuals coded as heterosexual were African American, and all the gay males in the sample were white.

These picture-findings were in concordance with my findings in the literature on American and European research. Anderson & Wilkie (1992) and Buckingham (1992) have written about hospice care for people with AIDS – linking with the skeletal hospital patient pictures. Buckingham (1992) reason that

the care and sense of community created by the hospice team may be very beneficial to the persons with AIDS and concerned family members. It is important for terminal patients to live the rest of their lives to the fullest, to maintain their identity, and to have the capacity to contribute as full human beings. (p. 40)

Although the focus in American and European research on the categories of people living with AIDS might differ from the African focus, common grounds are found in the sense of community and support that might benefit persons affected or infected by HIV / AIDS.

Cameron (1993) also touched on a universal topic for those affected and infected by HIV / AIDS, namely ethical concerns. These were present since the beginning of HIV / AIDS. Because of the stigmas surrounding the transmittance of HIV / AIDS (through for example sex or drug abuse) AIDS has been politicised through the years. Guest (2003), a British author investigating AIDS in African countries, has highlighted this extensively. She asks:

How would rich countries respond to a similar crisis? Perhaps the question is futile. In Western Europe, Japan and North America the basic needs of the poorest – enough to eat, a roof and a pair of trainers – are largely taken care of. Governments in rich countries have the time and money to concern themselves with the psychosocial impact of their much smaller AIDS epidemics. (Guest, 2003, p. xii-xiii)

*East and Far East research literature*

The scattered mentions on the East and the Far East mentions mostly progress in their school-system prevention campaigns, and HIV / AIDS as a disease affecting homosexual men (Mason, 1995). I expect this might change after the 2004 International AIDS Convention in Bangkok.

*African and South African research literature*

The South African, and Africa south of the Sahara, literature focus mainly on the statistics and the psychosocial issues that are being highlighted by HIV / AIDS. Psychosocial issues are closely related to the political side of research, as discussed in chapter three. The psychosocial issues include poverty, hunger and the oppression of women. What the literature boils down to, Guest (2003) describes in her working with children affected by AIDS: “Before you can worry about a child’s mental state, you have to make sure she has something to eat, and maybe some antibiotics” (Guest, 2003, p. xiii).

## The politics surrounding HIV / AIDS

### *The “scandal” of HIV / AIDS*

The reasons as to why HIV / AIDS are being treated so differently from any other disease, could perhaps be found in the history / developmental story of what has been called by Jones (2001) “the scandal of HIV / AIDS.”

The first signs of a fatal new disease, linked to a particular virus, were seen in the United States of America in 1981, and initially mainly in gay men. This led to the misunderstanding that AIDS is a gay men’s disease and a wave of prejudice and discrimination against the homosexual community followed (Brouard, Maritz, van Wyk & Zuberi, 2004; Doyle, 1994; Mokhoka, 2000). It was believed by some that HIV / AIDS was a way of chastising the homosexual communities. However, the virus is not only spread by gay sex but can also be transmitted through any kind of unprotected penetrative sexual contact, contact with infected blood or through mother-to-child transmission.

The process of transmission of the HI-virus makes infection more prevalent in lower socio-economic groups. Reasons for this includes both scarcities of resources to aid protection, for example condoms, and poverty forcing high-risk life-styles, for example being a sex-worker, which increases the possibility of infection (Brouard, Maritz, van Wyk & Zuberi, 2004; Mokhoka,

2000). This leads me to presume that besides infection, the onset of AIDS after HIV infection might be faster in lower socio-economic groups where there is possibly limited access to health care, to nutritional food and adequate protection against the environmental hazards like cold or rain. In South Africa, this accounts largely for the black community, which makes HIV / AIDS in South Africa not known as the “gay disease”, but is perceived through the eyes of minority groups as the “black disease”.

#### *HIV / AIDS and human rights*

In the history of South Africa, across most if not all cultural groups, women were not encouraged to use their voices. In his inauguration speech for his 2004 – 2008 term, South Africa’s State President, Mr. Thabo Mbeki, proposed that no government in South Africa could ever claim to represent the will of the people if it failed to address the central task of the emancipation of women in all its elements, and that includes the government we are privileged to lead. (Mbeki, 2004)

His words were not limited to parliament or the workplace but also with regards to a woman’s preferred methods of sexual protection and the choice to have intercourse or not. The issue of HIV is not only a concern of human rights but also a matter of gender.

Much of the existing human rights concepts, language and practice are fundamentally flawed by male bias (Kisoon, Caesar & Jithoo, 2002). Ideas and expectations regarding male and female sexual behaviour neither encourage men to act responsibly and protect themselves and their partners from infection, nor stimulate women to challenge notions of female inferiority and social structures which keep women vulnerable (Brouard, Maritz, van Wyk & Zuberi, 2004; Kisoon, Caesar & Jithoo, 2002). Women in many communities, in developing and developed countries, still have a lower social status and economic dependence that may prevent them from controlling their own risk for negotiating for safe sex, as they often rely on sex for survival (Brouard, Maritz, van Wyk & Zuberi, 2004; Kisoon, Caesar & Jithoo, 2002). These women might have more than one unwanted pregnancy due to lack of birth control methods.

It is only recently that the South African government started advising pregnant woman to have HIV testing done in order to prevent mother-to-child-transmission during birth or after birth through breast-milk (Brouard, Maritz, van Wyk & Zuberi, 2004). Because the legislation is new, currently, many parents carry the burden that their children are already carrying a disease that will probably kill them before they reach school-going age. HIV / AIDS can rob a parent of the hope of seeing their children grow up strong and healthy.

Prevention of the spreading of the HI-virus has been the topic of several research projects and campaigns like “Break the Silence!” (Collins, 2001) and the

musical “Sarafina II”, have been designed to warn people about HIV / AIDS and promote the use of condoms during sex. Campaigns like these were especially popular during the post-1994 regime. Guest (2003) believes that

The new government felt pressurised to deliver quick, tangible results. In 1996, the Department of Health spent over R14 million (£1.4 million), a big chunk of the annual AIDS budget, on *Sarafina II*, a lavish musical to raise awareness of AIDS. Scandal broke when it became apparent that tendering procedures hadn’t been followed. A high ticket price kept poor audiences out. It was an embarrassing, expensive flop. (Guest, 2003, p. 65)

Although prevention is a very important field within the HIV / AIDS phenomenon, it should be noted that according to antenatal clinics there are already 26.5% of reported infected people in South Africa (Du Plessis, 2004, p. 3). Some of these people may want to disclose their status to families or communities in which it is not acceptable to have a “black disease” or a “gay disease” or to bring shame and bad luck into their communities.

In terms of HIV / AIDS there are many people, not infected themselves, or still healthy, who have become a marginalized community through wanting to assist in the fight against HIV / AIDS. I see myself as part of that community, attempting a similar process in this research document. We combine our arts

and crafts, skills and wishes for an HIV / AIDS-free future in art campaigns like “Break the Silence!” (Collins, 2001).

Education and prevention is an important place to start, yet it is once again a story told about HIV / AIDS that is far removed from the impact HIV / AIDS has on a human being living with death. Psychotherapists might be part of that community, also feeling unsure how to tread on the terrain of HIV / AIDS – therapy since it is a highly unexplored ground. Psychotherapists might have to deal with HIV / AIDS that can rob children and families of their hope, health, dignity, sense of community and ultimately, their lives.

#### Family structures and HIV / AIDS

Plagues there have been, plagues of woolly-bear caterpillars, of black beetles, of the giant Gripewoort, a pretty climbing plant with pink flowers that could pull down a castle, but the plague of dragons was really the worst. (Postgate & Firmin, 1977, p. 26)

The family as an establishment is profoundly complex and ambiguous in nature (Barolsky, 2003). It simultaneously holds the potential for the deepest nurturance and also the potential for the greatest damage and violation. People are born into families and it is in families that they make sense of themselves in



the world around them. “The family combines in unique and sometimes volatile ways, the economic and the intimate, through ties of blood, sex, money, tradition, need and desire” (Barolsky, 2003, p. 14).

Families are commonly plagued by some problems: ranging from sibling rivalry, domestic violence and abuse to illness and death. When the dragon of HIV / AIDS comes into a family, it might highlight old wounds, and possibly bring many new ones.

The HIV / AIDS epidemic is felt acutely on the level of families. Within families, people may need to or want to disclose their HIV status, ask for care and be supported. Support might include material resources such as food, shelter and medication, but could also include being cared for on an emotional level. Adults living with HIV and AIDS might contemplate leaving behind their children to their own parents or other caretakers, causing strain on the extended family. In South Africa this is particularly difficult since the economic reality makes it difficult for the economic system to endow welfare grants (Barolsky, 2003; Guest, 2003).

South Africa's child welfare system is caught between two worlds. Under apartheid a formal fostering and adoption system, imitating British and American practices, was developed for needy children amongst the country's five million whites. ... Since the first democratic elections in

1994, ... services are not, in theory at least, available to 42 million South Africans. Even without AIDS, the system would not be able to cope.

(Guest, 2003, p. 57)

The lack of a child-support network means that many children, possibly distressed and traumatized by the death of their parents, end up at extended families. These families may be willing to provide help, but often are unable to give the children the psychological and physical care and support they need (Barolsky, 2003; Chambers, 1995; Guest, 2003; Ramogondo, 2002).

Jewitt (2002) reports on a study conducted in Kwa-Zulu Natal, South Africa, which found that the secrecy and stigma that surrounds an AIDS death in a family sees the child not able to obtain answers on the reasons behind the illness and eventual death. The child is often left feeling isolated, angry and without emotional recourses. Even very young children grieve in bereavement and in other experiences of loss (Griffith, 2003). Through therapy they can possibly begin to normalise what is happening around them if they are given truthful information and support (Chambers, 1995; Griffith, 2003; Schaefer & Carey, 1994; Ramogondo, 2002; Zilbach, 1994).

Due to a lack of trained teachers, the education system has not been able to respond to this need either. On every level children and families dealing with HIV and AIDS are left on their own to battle against the system or to find ways in

which they can support family members to cope with the change HIV / AIDS brought into their families, community and social structures (Barolsky, 2003; Du Plessis, 2004).

“Ways of being *family* as well as the socio-political contexts shaping family have changed significantly in South Africa” (Kotzé & Kotzé, 2002, p. 197). Families can be constituted in many ways, varying from the nuclear family to the wide extended family. Families might even be defined as smaller groups within group housing like Sparrows Nest and SOS Children’s Village. Street children often form gangs that function as families. However, when HIV / AIDS is affecting a family, these families can be headed by single parents, grandparents, by children or by adoptee parents or foster parents (Barolsky, 2003).

### *Women and HIV / AIDS*

Most HIV-positive women have been infected through heterosexual intercourse (Austen, 2002; Mokhoka, 2000). In South Africa, most women at risk of infection still find themselves in a position where they can do very little to protect themselves from infection, since, to date, the condom is still the only physical barrier used for prevention of HIV-infection from male to female. Mokhoka (2000) is of the opinion that the sexual and economic subordination of women fuels the HIV pandemic:

The fact that a woman in some communities has no effective control over her own body means that she cannot be expected to make responsible decisions about her sexuality. Women may want to stipulate fidelity, safe sex, or no sex at all, but where society defines the male's needs as paramount, it is very difficult for women to negotiate strategies to protect their health. (Mokhoka, 2000, p. 9)

Not only do women have to protect themselves physically, but they might also be caught in a network of obligations and duties rooted in the extended family where they might struggle to exercise autonomy. They might become the objects of blame since in some cultures, as a woman living with HIV / AIDS explained: "men don't die, women cause male illness and death" (Barolsky, 2003, p. 32). These beliefs leave women extremely vulnerable after the death of their spouses, and they might be ostracized. Her in-law family might take healthy or presumably healthy children away from their mother, as the children are seen as 'assets' to the family since they could perform some kind of labour or household duty (Austen, 2002; Barolsky, 2003).

The blaming of women for illness extends to a complete denial of ownership of disease for men, and is linked to framing the women as property objects: dishonoured, diseased property that needs to be getting rid of. Although there are exceptions, the gendering of the disease remains pervasive and has

detrimental consequences for the family unit as a whole (Austen, 2002; Barolsky, 2003).

One of the most central results is that gendering HIV / AIDS denies the family the opportunity to care for each other. According to community workers cited in Barolsky (2003) men might not disclose their status for years, and when they fall apparent rapidly ill a quick death follows, making medical treatment impossible. The women do not leave these men to die alone, despite the fact that when they visibly become ill themselves, they are sent back home to the rural areas to die quietly and invisibly. Even if this was not true, many women have become single by losing male partners through separation or divorce preceding illness (Austen, 2002; Barolsky, 2003; Mokhoka, 2000).

Being single might constitute an untenable financial and emotional burden on women (Barolsky, 2003). Women are also increasingly choosing not to marry because they argue that this strengthens their economic situation (Mokhoka, 2000). Sometimes single woman receive money as payment for a sexual favour, and are therefore in a lesser position to negotiate safe sex. Mokhoka also points out that women may have multiple partners for other reasons than the material benefits, and it is not the number of partners but specific sexual practices that increase risk of infection. These practices include female circumcision, widows having to have sexual intercourse with their deceased husband's brother as part of "widow cleansing" and infidelity from their husbands, or polygamy

(Edemikpong (1990) in Mokhoka, 2000). “When AIDS strikes a polygamous family, things can get complicated” (Guest, 2003, p. 28).

### *Child-headed households*

“Arrows just bounced off them and nothing could frighten them except other larger dragons” (Postgate & Firmin, 1977, p. 30).

“*Child-headed families or households*, due to AIDS-related deaths, have become a new family structure” (Kotzé & Kotzé, 2002, p. 199). HIV / AIDS contributes to orphanhood and therefore, in South Africa, 13% of children aged 2-14 years had lost a mother, father, or both (Nelson Mandela / HSRC Study of HIV / AIDS, 2002). No national data on child-headed households have yet been reported, and it is unlikely that this data will be accurate. Many child-headed household children do not attend school, as they have to care for each other.

Children living in families affected by HIV / AIDS are becoming increasingly vulnerable well before the death of a parent. The emotional anguish of the children begins with their parents’ distress and progressive illness, forcing the children into the role of caretakers and breadwinners. With the death of the parent or parents, they might have little or no support. This might cause measurable declines in nutritional status and reductions in schooling, reducing

these children's abilities to acquire skills and knowledge to escape deprivation (Barolsky, 2003). "African's AIDS orphans could grow up to become vulnerable and volatile adults. Some will learn to survive through theft or prostitution, numbing their pain perhaps by sniffing glue" (Guest, 2003, p. 12).

An increasing number of children are pushed prematurely into the role of caregiver during the crisis of sustaining the household and keeping parents alive, and withdraw with the parents from social connections (Barolsky, 2003). "When breadwinners sicken, families can rapidly become impoverished as they can use up their savings and sell off their possessions to pay for health care and funerals" (Guest, 2003, p. 20).

If they have depleted all their resources, financial and emotional, an increasing number of children appear to have been compelled to perform the extraordinarily harrowing task of physically burying their dead parents in the backyards of their homes without public ceremony (Barolsky, 2003).

Crewe (in Barolsky, 2003) challenges the basis for the ongoing existence of child-headed households, namely, to keep the siblings together:

Other ways can be found, not only of keeping siblings together and protecting their inheritance and property, but also of ensuring that young people bereaved by AIDS receive post-trauma counselling, education, care, food and clothing, love and parenting, and social affirmation. (p. 57)

Legally child-headed families are also in a difficult position, since young people under the age of 21 are not legally recognized as adults, and can therefore not apply for a child-care grant, despite the fact that they might need to care for several siblings. The responsibilities of child rearing deprive the older siblings of the opportunity to explore and experiment with relationships and burden them to a point where they might abandon the family. In a setting where everything is shared with siblings, ensuing pregnancies may constitute an important source of fulfilment for a teenage girl, leaving her to care for her own child and her siblings at once (Barolsky, 2003).

Although government and non-governmental organizations are forming child-care committee's to head the problem of child-headed households, "when an orphan is knocking at the door, starving, he can't be made to wait while communities slowly organize themselves into childcare committees" (Guest, 2003, p. 69).

#### *Grandparent-headed households*

HIV / AIDS does not only affect children within the nuclear family, but also affects the extended family across generations. This phenomenon is not only found in South Africa. In the United States of America HIV / AIDS is the third leading cause of death among African American and Latina women aged twenty-five through forty-five. It is estimated that in the



United States, the AIDS scourge has already orphaned as many as 80,000 children and adolescents. Of that number, more than 80 percent are the offspring of African American and Latina women, the majority of whom will be parented by their grandmothers or “othermothers”.

(Winston, 2003, p. 351)

The grandparents, who might have relied on their children to take care of them, might now have the burden of looking after their orphaned grandchildren and having to continue to work into old age, to make ends meet.

AIDS is accelerating the breakdown of the traditional African family.

Grandmothers have always been involved in the socialization of their grandchildren, enabling many mothers to leave their children for long periods in order to find work and support all three generations. AIDS orphans are going to raise their own children without the loving support and free childcare that grandmothers used to provide. (Guest, 2003, p. 27)

Grandmothers inheriting the care of their grandchildren due to HIV / AIDS face unique challenges. The conventional assumption that grandparents are elderly is not necessarily true in the South African context, because of the relatively youthful average childbearing age. Although they have a physical advantage of being healthier, they are not eligible to apply for government pension funding, and are often not aware of the social grants which they can access (Barolsky, 2003).

Social grants are commonly given only if the grandmothers have adequate documentation of her diseased child, and the father of the children has been contacted and proven not be able to provide for the children. This is often virtually impossible and could heighten the emotional, social and economic responsibility of the grandparents affected by HIV / AIDS. Lack of knowledge might also cause grandparents to become infected with HIV. Possibly, the grandparents do not know how to take proper care against infection when caring for an ill child or grandchild (Barolsky, 2003).

#### *Other family options*

Article 20 of the Convention on the Rights of the Child, adopted by the United Nations (UN) in 1989, promotes the responsibility of the UN to children. “But making rights a reality is much harder” (Guest, 2003, p. 11). Building and maintaining orphanages would be prohibitive because the number of AIDS orphans is expected to be so large. Although most people agree that the best place for children is in a family, if this is not possible, the next best thing is to provide some form of a family within their community of origin, making sure that siblings are kept together. A loving family outside their community could also be sourced, and as a last resort, residential care (Guest, 2003).

What HIV / AIDS is showing is that the assumption that families will automatically be able to give care when family members need it, is often not what is happening in reality. The reality of the epidemic, together with South Africa's complicated history through colonialism, apartheid, migration, poverty and social unrest, which did have a complicating impact on family structures, might force us to re-evaluate what we mean by family and community (Barolsky, 2003).

Guest (2003) is of the opinion that "adversity can make people strong, but it will be an unusual AIDS orphan who gains anything from the epidemic. The damage from growing up alone will be deep and, in some cases, permanent" (p. 157).

Creating new family structures for families can prevent these orphans growing up alone. Strengthening these families means finding new definitions of and solutions to family, this could possibly enrich communities that can embrace a wide range of social formations (Barolsky, 2003). We must protect families of whatever structure, as an important means of belonging, a sense of place and intimacy and connectedness for adults and children.

I won't let the dragons win...

“Luckily the dragons were short-sighted and when Olaf the Lofthe approached them with a huge dragon with a furnace inside to blow fire they were filled with fear and departed at once” (Postgate & Firmin, 1977, p. 30).

In this chapter we saw that HIV / AIDS can have detrimental effects on possibly every aspect of individuals' lives, and we looked in depth at the effects it might have on families and children. Can psychotherapy and a sense of playfulness aid children and families affected by HIV / AIDS? The grim picture that was painted might leave us shortsighted in saying no: but one-way of scaring off a dragon is introducing a yet bigger dragon to scare it away!

In the next chapter we will look at play and playfulness in psychotherapy to help creating space for dealing with the effects of HIV / AIDS on children and families.

## CHAPTER 5

### PLAY IN THERAPY

Using qualitative methods in an ecosystemic world, we looked at the effects of the scouring breath of HIV / AIDS. Now we will explore how play in psychotherapy has developed over the years to become a weapon with which serious problems, such as HIV / AIDS, can be combated.

But why play? Winnicott (1971) explained that play “is universal, and that belongs to health; play facilitates growth and therefore health; play leads to group relationships; psychoanalysis has been developed as a highly specialized form of playing“ (p. 47).

Play within therapy is mostly understood from the context of play therapy, a well-developed genre of therapy done mostly with children (Cooklin, 2001). This chapter will examine the development of the genre play therapy, and look at the broader meaning of the word play and playfulness within the therapeutic context. It will also examine the epistemology underlying the theory of how a

playful approach within therapy can be used when dealing with HIV / AIDS affected children.

### The development of play in therapy

The development of play within therapy is a well-documented history running from the works of the psychoanalysts through to postmodern approaches. The Association for Play Therapy in the United States of America (Ray, Bratton, Rhine & Jones, 2001) defines play therapy as the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development. “The goal of play therapy is to assist children to identify and express their feelings in healthier, non-symptomatic ways, and to encourage the working through of difficult emotions while finding and using alternative, non-problematic behaviors” (Gil, 1994, p. 33).

“A child’s mind is different from that of an adult, but is influenced to a large degree by adult imagination” (Freeman, Epston & Lobovits, 1997, p. 7). Adult imagination is often a product of creativity and playfulness. This exploration will aim to portrait the growth of play therapy as a vine through the trellis of adults’ imagination and creativity. “Adult story-tellers provide a trellis on which children’s

imaginations and narratives flourish like vines” (Freeman, Epston & Lobovits, 1997, p. 7).

Some developmental theories of play divide play into three stages: solitary play, followed by parallel play, and finally, interactive play (Handler, 1999). Play therapy might be seen to have developed in more or less the same fashion: first solitary play observed by the psychoanalyst, then parallel play in family systems, and finally interactive play in post modern therapies. This chapter will be divided accordingly, ending with a discussion of the value of playful communication in therapy.

With regards to the development of play in psychotherapy, I would like to quote from the introduction given by Freeman, Epston & Lobovits (1994):

Every new approach develops within a certain context and at a particular point in history. And each paradigm, even if it is critical, owes much to those who came before. There has been a bountiful history of many waves of discovery and enthusiasm in the field of family therapy. We value those waves that came before us and look forward to those that are now forming way out at sea. (p. xvi)

*Solitary play*

“Childhood is the sleep of reason” (Rousseau in Lebo, 1982, p. 65).

The roots of the play therapy vines were planted by J.J. Rousseau in the 1730's, who were one of the first people to advocate studying the play of children in order to understand them, and expressed the belief that childhood was a period of growth and that children were not tiny ladies and gentleman. Rousseau even suggested that the adult become a child him- or herself in order to join the child in games and thus become a proper companion (Lebo, 1982). However, the first recorded case of play in therapy was by Sigmund Freud in 1909, in the case of five-year old Little Hans (Gil, 1994; Lebo, 1982).

In the case of Little Hans, there was very little playfulness initiated by the therapist, Freud. Freud merely instructed Hans's father to observe his son closely, and report in detail his observations to Freud. Freud then gave the father some advice as how to interpret Hans' behaviour, and the father would in turn give these interpretations to Hans. Little Hans played out his “neurosis” in his playroom by himself, and eventually the problem resolved (Lebo, 1982). This is very much in accordance with what is believed today of children's ability to solve problems themselves (Freeman, Epston & Lobovits, 1997).



Freud himself saw the shortcomings of classic psychoanalysis for children (Gil, 1994; Lebo, 1982), and he, together with some of his followers like Hermine von Hug-Hellmuth (in papers published in 1919 and 1921), reported that play was an essential part of analysis in children seven years and younger (Lebo, 1982). In 1927 Melanie Klein published her formulated psychological principles for infant analysis and Anna Freud developed the classical Freudian theory into another, different system of child analysis (Lebo, 1982). The main difference between Klein and Anna Freud was that Klein started to interpret all the actions of play immediately; whereas Anna Freud would first build rapport before she started to interpret. Critique against their work resided in the fact that children do not come to therapy with the intention that their play will heal them, and because of this, play cannot be equalled to the free-association of psychoanalysis (Lebo, 1982). The major contribution of psychoanalytic use of play in therapy is the clear delineation of play as a tool that facilitates a child's working-through of internalised difficulties (Gil, 1994).

Besides side-branches of psychoanalytical play therapy, most of whom were just variations on the works of Klein and Anna Freud, there were also other developments, such as release therapy and relationship therapy. Release therapy is part of the more structured play therapies. These therapies were goal-oriented in recreating traumatic events for children in order to help them "assimilate the negative thoughts and feelings associated with it" (Gil, 1994, p. 8).

Relationship therapy was the predecessor of nondirective therapy. In relationship therapy, based on the works of Otto Rank, special techniques are properly classed as active play therapies. They utilize the relationship between the therapist and the child primarily as a quick diagnostic indicator, rather than a major therapeutic element. In the 1940's and 1950's Carl Rogers evolved relationship therapy into nondirective therapy (Gil, 1994; Lebo, 1982).

Nondirective therapy originally grew out of working with children's problems, and emphasizes the belief that the client contains within himself or herself the necessary ability to solve his or her own emotional problems, within a therapeutic situation which provides experiences that make changes possible and leaves to the individual the freedom to decide the nature and direction of the change (Gil, 1994; Lebo, 1982). Virginia Axline, the mother of nondirective play therapy, applied Rogers' client-centred philosophy. This allows the child to play freely, but in solitaire. The therapist makes no attempt to be playful with the child, but merely provides the child with "a relationship that will enable him [sic] to utilize the capacities that is within him for a more constructive and happier life as an individual and as a member of society" (Axline, 1982, p. 121).

In the 1960's the behaviour therapies were developed based on the principles of learning theory. Within this framework, play is used as a means to an end, and is not viewed as inherently valuable in and of itself. Concepts such

as positive and negative reinforcement and modelling were used to relieve problematic behaviour in children.

The vines of play in therapy seemed to grow firmly onto the trellis of adults' imagination and creativity: sometimes with less pruning and direction as in non-directive play therapy, and sometimes within very strict boundaries, tied closely to the trellis with rules instigated by behaviour therapists. Although the degree of playfulness depends on each individual therapy session, it seems as if there was a lot of solitary play up to this point, with very little room for interactive play. The climbing plant grew according to the shape of the framework.

### *Parallel play*

The development of family therapy evolved out of a frustration and dissatisfaction with the inability of the traditional psychoanalytic approach to adequately address factors not of an intrapsychic nature. A creative initiative made therapists play with therapy beyond the individual.

*Development of parallel play*

Nathan Ackerman, frequently called the grandfather of family therapy, was an analytically trained child psychiatrist who began functioning as a family therapist in a child guidance clinic (Miller, 1994). Ackerman noted that “a strange paradox marks the question of the participation of children in the family therapeutic interview ... without engaging the children in a meaningful interchange across the generations, there can be no family therapy” (Ackerman in Zilbach, 1994, p. 27).

In family systems theory, the problem was seen as playing parallel between people, and not within them. The uniting principle for all schools of family therapy is the notion of focusing on the family system rather than on any one individual's pathology or inner world (Miller, 1994). Any one person's symptomatology is seen as the result of the processes in the family system, and the resultant stress upon the individual. Family therapy changes the focus of diagnosis, the treatment relationship and the means of therapeutic intervention (Miller).

Adlerian family counselling demonstrated another evolution of analysis as they moved away from the drive theory, to an awareness of the importance of social roles. Harry Stack Sullivan's interpersonal theory also influenced family

theorists who viewed disturbed family relations as the basis for personal dysfunction (Miller, 1994).

The Bateson group focused on schizophrenia and styles of family communication, developing concepts like awareness and classification of metalevels of communication between people, like the infamous double-bind. Don Jackson added to this the idea of family homeostasis, and Jay Hayley viewed communication as a means of power and control (Miller, 1994).

Virginia Satir (1967) defined the emotional system of the family as paramount, and put emphasis on awareness of the feelings implicit in communication. She is, contrary to many other family system therapists, aware of fully including the whole family in the therapy. Satir believes “that the family therapist can do a great deal of preventative work by including all the children in the therapy process” (Satir, 1967, p. 137). She barely mentions play in her original works, but includes expressive exercises such as dance and games in her revised work, which can be seen as potential playful interactions between family members (Zilbach, 1994).

Structural family therapists, as represented by Minuchin, saw the task of the therapist as restructuring the family system. The family system is seen as a hierarchically organized subsystem organized by boundaries ranging from disengaged to enmeshed. The therapist would play with such a family through

interventions such as escalating family stress, exaggerating the symptom, creating the potential for clear, healthy boundaries and the clarification of hierarchical relationships (Miller, 1994).

Milton Erickson, the Palo Alto group, and the Milan group influenced strategic and systemic family theorists. They focused on a highly directive, behavioural and problem-oriented approach. Murray Bowen has been classified as both structural and systemic in literature (Miller, 1994) and has been seen as developing multigenerational family theory. Bowen based his work on the concept of differentiating the self, and developed concepts of triangulation, where the poorly differentiated self were caught in emotional trap between two people (Miller).

#### *Including children in family therapy*

A great criticism against family therapy has been their exclusion of working with children. It is only recently that psychotherapeutic work with children and particularly play within the family context is seen. Children, especially younger children, are often excluded from this, or separately dealt with in play therapy sessions (Cooklin, 2001; Freeman, Epston & Lobovits, 1997; Gil, 1994; Schaefer & Carey, 1994; Zilbach, 1994), if they are dealt with at all. Possible reasons for this, according to Gil, is firstly a lack of working with young

children in clinical training programs. Also, the founders of family therapy developed an insufficient number of techniques which included children, and thirdly the highly abstract theory of family therapy eluded the nitty-gritty concerns of clinical work.

A therapist who was not afraid of nitty-gritty work was Carl Whitaker. His work revealed openness to being playful, and he is explicit and particularly empathic about the importance of play. He stated “A family must learn how to play ... and that the function of play is not as a leftover for spare time but that play must be present to maintain health and facilitate growth” (Whitaker & Keith in Zilbach, 1994, p. 34).

Whitaker developed a “psychotherapy of the absurd” (Neill & Kniskern, 1982) expanded from the works of Milton Erickson and Jay Haley. He described it as a tongue-in-the-cheek positive-feedback, a therapy where the pathology is exaggerated to the point where it will self-destruct. Although Whitaker used and introduced a lot of playfulness into therapy, it was the exception and used mainly for therapy with families, not individual children.

During the time of parallel play the vines of therapy with children were only seen in relation to the vines around it. The growth of the vine was determined by the growth of the vines around it, and the trellis of play and adult imagination was the playfield of the experimenting family therapist.

Cooklin's (2001) viewpoint is that a period of avoidance and neglect of children in therapy during the last decade is ending due to concerned family therapists, and there are now developments recognizing the roles played by children in family therapy. Cooklin describes different approaches to including children in therapy with families. These include descriptions of combined individual psychodynamic and family approaches, the use of "role-plays" and "enactments", and the approach that defines the child as the therapist's "consultant". Some therapists may choose to focus on whichever approach will help the child to experience the therapeutic context as "safe", while others simply adapt their particular model to make it "child-friendly". Moreover, there are those stressing the use of "play".

More recent views of children, play and therapy allowed us to see the vine in relation to its own growth potential. It can also be seen in relation to the other vines, the sunshine, the ground that it's anchored in, and most importantly, we can now see how the vine can co-create the trellis it grows on.

### *Interactive play*

Not all trellises look the same, and not all climbing plants aspire to climb towards to sky. Some trellises can be viewed as lattices, some as framework and others as traps. In fact, some might not even be trellises, but be seen as a



network constructed by a creative adult and a resourceful client, playing with opportunities and possibilities.

In chapter 2 the ecosystemic systems theory was explored and explained. Ecosystemic play therapy builds on the ideas discussed in chapter 2. O'Connor & Ammen (1997) have defined ecosystemic play therapy as an amalgam model that integrates biological science concepts, multiple models of child psychotherapy, and developmental theory. This is not an eclectic model but an integration of multiple models to create a freestanding model that is different from the sum of its parts. Ecosystemic play therapy differs from the models of family or systemic therapy in that the basic unit under consideration is the individual, and not the family or some other system. It focuses on optimising the child's functioning in the context of that child's ecosystemic world. Ecosystemic play therapy is also based on a more phenomenological perspective of the world in which absolute truth does not exist and events are mostly the result of the interaction between our internal processes and our experience in the world (O'Connor & Ammen, 1997).

The second generation of systems theory is that of the biologist Humberto Maturana, as described in chapter two. This radically changed and expanded many of the theoretical assumptions of earlier systems theories. Some elements contained in Maturana's theory coincide and compliment ecosystemic play therapy. These include that the individual is identified as the basic systemic unit

relative to the family system or other social systems. Furthermore both see behavior defined as being adaptive relative to the environment. Development and historical processes are thoroughly integrated. The definition of human experience includes biological, intrapsychic, and interactional experiences that are complementary and interdependent ways of being (O'Connor & Ammen, 1997).

Additionally, as explained in chapter 2, Maturana identified the way we know and operate in our world as always subject-dependent, implying that everything we experience and understand about our world is always from the perspective of ourselves as participants in and observers of our experience in that world. The implication of being subject-dependent is that information is not received directly from the environment, but instead, each individual person involved in the eco-system, in the case of therapy with a child, the child's ecosystem, operates out of his or her own subject dependent reality (O'Connor & Ammen, 1997).

The therapist and the child, and all those involved, interact with each other through language and actions. Children do not rely exclusively on verbal communication as meaning making medium (Cattanach, 1997; Freeman, Epston & Lobovits, 1997; Gil, 1994; Landereth, 1982; Oaklander, 1988; Schaefer & Carey, 1994; Zilbach, 1994). When adults limit themselves to demanding and responding only to verbal cues from children, they are imposing their own subject

dependent reality of the adult world on them (Gil, 1994; O'Connor & Ammen, 1997). Children are inherent explorers, and have a gift of fantasy of which they make full use of by creating fantasies and stories (Cattanach, 1997; Freeman, Epston & Lobovits, 1997; Gil, 1994). These stories can be told with verbal language and actions.

Through language and action occurring between therapist and child, they establish a degree of congruence between their separate understandings of the world, which can lead to a consensual system of meaning. That meaning is called the therapeutic relationship, a relationship in which the therapist wants to understand as much from the child's meaning making as possible. The danger exists that the greater the lack of a common mode of communication, the greater the likelihood that the parties involved will be experiencing vastly different realities based on their interpretations of their experiences (O'Connor & Ammen, 1997).

What is thus needed is a common language or mode of communication in which both therapist and the rest of the family, including the children, can communicate together and have similar experiences within the situation.

When children and adults meet, play provides a common language to express the breadth and depth of thought, emotions, and experience – in this way, we share a lingua franca. Moreover, playful communication isn't totally dependent on cognitive development, having the capacity of being

highly contagious and inclusive of all ages. (Freeman, Epston & Lobovits, 1997, p. 4)

Playful communication seems to be a possible common language between children and adults, between therapists and their clients. The creativity and playfulness shared by children and adults might grow like vines on a trellis, drinking from the sea spray of a new wave of development on the theoretical ocean of therapy.

#### Play and playfulness within therapy

Arthur Koestler said of the creative act: “It is always a leap into the dark, a dive into the deep, and the diver is more likely to come up with a handful of mud than with a coral” (Papp, 1984, p. 25).

Working from a subject-dependent reality is similar to dive into the deep with diving goggles manufactured only to recognize certain shapes in the sea life. Although we all seek the coral of resolution in the therapeutic context, that coral might look different for psychotherapist and client, and even more different if that client is a child. The aim in psychotherapy might not be for the therapist to search for the coral, but for the therapist and client to play in the mud until they

have found whatever they needed, assuming they needed something, be it a coral or maybe just the experience of playing in the mud.

Play in psychotherapy is not separate from or opposed to play therapy, but rather an extension of the existing genre. Playfulness in psychotherapy is more about creating space for growth and exploring (Freeman, Epston & Lobovits, 1997). Play can be about doing and being what one has not done or been before, spontaneous excursions into new roles, new actions, new thoughts, ideas, and emotions (Handler, 1999). Playing with roles, actions, thoughts, ideas and emotions, might require some creativity.

The freedom to play is an essential ... condition for any creative act, including the creative assimilation of the unfamiliar in the expansion of one's relations to the world. Play ... contrasts not with seriousness, but with repressiveness, [with] too-narrow goal directedness and regimentation, and with conventional concepts of efficiency. (Schachtel in Handler, 1999, p. 210)

Different ways of being creative within therapy can constitute as being playful. "Cancer, Courage, and Creativity" (Ferris & Stein, 2002) is an American based program using expressive arts in ten-week workshops to assist cancer survivor's search for meaning. Art, drama, poetry, movement, ritual, myth, and mask making is used collaboratively in a process where "creativity becomes a

companion and assists each person to go beyond their cancer into new life” (Ferris & Stein, 2002).

Using alternative methods in psychotherapy to express emotions might seem to convey the actuality of feelings, but in turn, Papp (1984) describes how tasks, rituals, metaphors, and stories are devices that protect people from being blinded by the truth. “They allow analogous messages to be communicated and absorbed according to the family’s own tolerance level” (Papp, 1984, p. 24). Children also have their own tolerance level from their own subject dependent reality.

Assuming that we operate from a subject dependent reality, the meaning of the tasks, rituals, metaphors and stories used in psychotherapy might be perceived as playful by the therapist, but it depends on the clients’ experience of reality whether this is true for the client as well. In working with children, we have so much authority as adults, and as psychotherapists, that we can easily take over and run the conversation (Freeman, Epston & Lobovits, 1997). Although a child’s perception might be different from that of an adult, it might be influenced to a large degree by adult imagination, since most of the stories, songs and fairy tales children enjoy were written by adults imagining worlds for children (Freeman, Epston & Lobovits, 1997). Allowing children in psychotherapy to create their own worlds by “having a different kind of conversation about a problem or playing with us in fantasy, the child often finds a

“solution” we could never have anticipated” (Freeman, Epston & Lobovits, 1997, p. 7).

Having different kinds of conversations or playing in fantasy might require some creativity, a word that has as its base word: create. What does a creative process then look like?

According to Carlsen (1999) a creative process challenges assumptions by daring to question what most people takes as the truth, and recognizes new patterns by perceiving significant similarities or differences in ideas, events or psychological phenomena. Carlsen (1999) furthermore describes such a process as something seeing new ways to take the ordinary and to transform it to the strange, and the strange to the ordinary, and make new and unusual connections in bringing together seemingly unrelated ideas, objects, or events in a way that leads to a new conception. Such a process takes risks in daring to try new ideas or ways with no control over the outcome, and grab the chance to take advantage of the unexpected. Such a process constructs networks to form associations between people for an exchange of ideas, perceptions, questions and encouragement (Carlsen, 1999).

Allowing a client to dive into the darkness of creativity in search of his or her own coral can be a goal for playful therapy. “When a therapist trusts the creativity available in the mutual interaction of the imaginations of adults and

children, their encounter will be fresh, exciting, and full of the unexpected.”

(Freeman, Epston & Lobovits, 1997, p. 33)

Every client or person might have his or her own idea of what the coral is, and the meaning of the coral can be as unique to the person as his or her own personhood. Lakoff and Johnson (in Carlsen, 1999) assert that people’s conceptual systems play a central role in defining our everyday realities and are largely metaphorical. “The way we think, what we experience, and what we do every day is very much a matter of metaphor” (Lakoff & Johnson in Carlsen, 1999, p. 131). The dive into the dark might have more important value for some clients than finding any coral – it is all a matter of the client’s own perception of reality, and perception of experience of playfulness.

### Playing in the water

This chapter played with the metaphor of the stages of play to examine the development of play in therapy over a chronological time span as perceived by the researcher. The adult’s imagination and creativity were explained as a trellis on which the vines of play can grow. Furthermore, the chapter looked at play in therapy through the metaphor of diving into the deep dark in search of a coral, and discovered that the coral and meaning of coral might be different if looked at from a subject-dependent point of view.



The next chapter tells the vignettes of psychotherapists who have had experience of working with children and families affected by HIV / AIDS.

## CHAPTER 6

### FOUR PSYCHOTHERAPISTS TELL THEIR STORIES

HIV / AIDS has far reaching implications for individuals and families, as discussed in chapter four. Chapter five explored ways in which therapists can deal with working with children and families in psychotherapy, giving special attention to playful manners.

Chapter six will tell the stories of four psychotherapists. They have been chosen, as described in chapter three, for their unique experiences of working with children and families affected by HIV / AIDS. The stories are written as they unfolded during the unstructured interviews. After the initial conversations were transcribed, the participants each had the opportunity to read and alter the transcript as they saw fit. Some grammar mistakes in the conversations were retained in the hope of maintaining the authenticity of the conversations. One conversation, Joan's, was translated from Cape-Dialect Afrikaans to English. Joan read the translation. Lindiwe chose not to change anything. Richard and Claire corrected and added to their interviews as they saw fit.

The stories of four psychotherapists

*Richard*

*“I will be honest with you I haven’t had experience with young children.”*

Richard started his story of working with children and families affected by HIV / AIDS. *“I’ve had experiences of parents who are HIV positive and their concerns about their children and what is going to happen when they get really ill and what is going to happen to their children. I’ve seen one or two young people who could be teenagers who were HIV positive. So my experience of children per se or their experience of being HIV positive is vastly limited.”*

*“What I have done is I’ve read a book by Elizabeth Kubler Ross. And I’ve forgotten the name of the book but it’s a book devoted to children with AIDS where she set up a farm in America specifically for the care for children who are HIV positive. And she looked after these children and she was literally kicked off the farm because the farmers found out she was looking after AIDS babies and children and they didn’t want the environment polluted and they forced her off the farm and this project came to an end which was very sad.”*

*“It was in the eighties ja, just basically when it started. And these were very similar to our aids orphans, they were rejected by their parents, they had no*

*place to stay, and she decided that this was one of the projects in her life, and she bought this farm and she started the AIDS care centre. And she took a whole lot of staff with her and took care of these babies until the community found out and they basically forced her and the children off the farm. And what she wrote about as she writes in all her books is finding out about the process of finding out about death, going through phases of depression, acceptance, bargaining, this sort of thing, and she also kind of brought this into the processes the children went through. Almost similar processes dealing with illness and eventually finding peace in the sense that they were getting more and more ill and coming to point of acceptance of their illness.”*

Richard could recall experiences of working with children who were dying. *“I think I’ve had one or two experiences of children who were dying when I worked at a hospice, and with one little boy who was dying. I spent some time with him. And the way I could explain to him that he was dying was to tell him a story about a plant. And this plant lived with half of its stalk underneath the water. And little creatures lived under water inside the stalk. And the part of the plant that was above water was the flower of the plant. And one day the little creature who lived inside the stalk, decided he wanted to go further up the stalk, and investigate what was above water in this plant. And he went up the plant, and he discovered it was quite light above the stalk, and when he got to the top of the stalk, he decided he wanted to investigate the leaf of the plant, and when he got to the leaf, he was actually a caterpillar. And all of the sudden he stayed*

*on the leaf and he became a pupa. And one day this pupa developed and it had the most beautiful wings and it looked into the sky and it spread its wings and it took off and it flew into the light. And I think on a certain level the little boy understood that he was going to transform from his physical body into something else. And this became the way of telling him this was what was going to happen to him. He was going to transform into something else.”*

Richard also had experience of working with parents who were dying. *“I think the parents that I’ve worked with had an immense amount of apprehension of losing their children. And I’ve met them at that level, where they were extremely anxious and extremely desperate that they had the HI virus and that they were going to die, or they saw themselves as dying and one of the things that was on their minds that was unbearable to them was “who was going to look after their children?” They were in a situation where, at the point in time I was seeing them for counselling, they felt they could not share their HIV status with anyone, particularly their families, particularly their parents, and that they had to keep all this information to themselves. And what was going to happen to them when they died? They couldn’t share this information with their families. How were their families going to know they were dying? How would their families know they were HIV positive? And who was going to look after their children? So emotionally they were very stuck at this point. They couldn’t bare the thought of dying and leaving their children behind and not seeing them growing up. And they were extremely apprehensive about the fact that “who is going to look after*

*my children?” So they weren’t in fact dealing with the situation. They didn’t know how to deal with the fact that they were dying and that their children were going to outlive them.”*

*“Then there was another encounter with a women who was dying of cancer, who had a teenage boy and a teenage girl and a boy of about eleven. And she prepared herself fairly well that she was dying. She had a sarcoma of the bone. And through myself and two other psychologists who were doing family therapy with the whole family and surrounding her death, she managed to communicate to us to facilitate her dying process with her children. And we then managed to communicate to her children with her help how she was dying, what was happening to her, the fact that she was going to be in a hospice and probably become unconscious when she was dying, which she did, eventually, and how the children were to communicate with her physically, and what was going to happen after her death, and that she was going to be around them communicating with them in a certain way, and what was to happen to them. That they had to go to their father and their aunts and uncles for support and this sort of thing, and that’s exactly what happened.”*

Richard explained how they communicated all of this with the children.

*“We talked about this process in family therapy. There were a lot of tears, holding and touching, and the children almost went through the mourning process while she was alive, and because they knew she was going to become*

*unconscious at some point. And she said to them, “when I’m in a coma squeeze this finger, and I’ll know that you’re there.” And when it actually happened, when she ended up in Hospice, and she did go into a coma, and her children went in and squeezed her finger, although she couldn’t speak, she was in a coma, we could actually see her heartbeat in her neck would go up, her heart would start beating quicker when her children touched her fingers, and when they soothed her hand it would go down. So her children knew she was actually communicating with them through her heartbeat and her breathing and this sort of thing. And after her death, she had discussed with her children what to do at her funeral, what sort of rituals to go through, and this sort of thing. And they did that. So the whole mourning process had been discussed with her and her children before she died. And they went through this. And I think because it had been well structured, and because it had been discussed, the children had discussed it with her, it was very meaningful for the children and for her husband. It was almost a containing experience for the children when she died. And I saw the children afterwards, after her death, and they are doing very very well. And they are very grateful for that kind of experience.”*

Richard found that talking about death did not take the playfulness away. *“There was playfulness, there was laughter, and there were jokes. What we did with the family was a Life Review. With the children, and with her. Where you discuss your life, with the children and with her. Where they would discuss the good times and the bad times, the funny times as well. Where they would say*

*“mom do you remember the time you baked the rusks and the stove set alight and we came rushing in with hoses” and this sort of thing, and then everyone would all laugh about it. And we took various stages of her life and we would discuss them. Some times were sad, other times were very comforting other times were very funny and everyone would laugh. And Kubler-Ross were talking about a life review when discussing death, and we would use that as part of the family therapy. A life-review, reviewing the life of the person who is dying, reviewing all the things that happened in the past until the present moment. As a way of closure, closure for the children, closure for the husband and closure for the person that is dying. And talking about issues in the past so that you can close off and say goodbye to the people in the here and now and say, okay that was my life, we’ve talked about it, we’ve discussed it together, in a very loving and accepting kind of way, we have discussed and resolved any situation that hasn’t been resolved between us, we’ve finished unfinished business and now we can start saying our farewells to each other. And there was a lot of playfulness in our discussions.”*

With regards to HIV, Richard suspected that the problem *“in South Africa at the moment is that we don’t have Hope. We don’t have a lot of hope where HIV is concerned, because at the moment we don’t have antiretroviral drugs that are sort of freely available to the population. I think there is still a lot of hopelessness attached to HIV. There is hopelessness because there is not the possibility of a cure, and there is hopelessness in the sense that there is still a*



*tremendous stigma attached to the disease. I think there is a lot of sadness and a lot of tragedy about dying and the whole aspect of having HIV and dying of the disease. For me, I think it's a lot more hopeful to be dying of something like cancer, or a more socially acceptable terminal illness. And possibly there is a lot more hope in talking about and negotiating the end of your life if you've got cancer than if you were HIV positive. I suspect that this might be the case. I think the reason for this if you're HIV positive one of the first things you are taught is not to communicate this to other people, because there is a stigma attached to it. And one of my experiences of counselling HIV positive people is the first thing that happens and the first thing that they learn is "don't talk to anyone else about your illness: because they will reject you, and they will ostracise you and they will label you." And the first thing you must do is to crawl into a corner and hide there with you're disease. Don't communicate this to any one. So I very often wonder how many people having HIV actually have the opportunity sharing it with their friends, their families, and with the community, and who actually go through a phase of acceptance by their friends in the community and acceptance of themselves by themselves. That's my feeling about it."*

*"I still get the feeling that in South Africa despite the number of people who are dying, there is still a kind of a secret about that!"*

Richard also has seen many HIV positive people in therapy. *“I’ve seen a lot of them in therapy. Most of the people, when I was initially getting involved, were dying. And I got involved more in a kind of a hospice setting. People who were really very terminal, people who had wasting disease with oral thrush, and this sort of thing. It was more kind of counselling people who were actually in the process of dying, which was very very difficult, also my first experience of doing that sort of thing. Then it moved on to people who had just tested HIV positive, how they were going to handle their disease, what their first reaction was to the disease, and all the complications of coping with this brand new thing, the scourges, the sexual thing, and all it’s connotations, and how they were actually going to survive this thing, how there was no treatment available, how they were going to share it with their partners, how they were going to share it with their families, how they needed to deal with these years of waiting, what kind of symptoms were going to develop. And I found it a very difficult kind of supportive therapy. A lot of people were suicidal when they tested HIV positive, and one had to schedule two or three sessions immediately, just to kind of make them hold on, and give them time to build up the courage to live with the disease. So, it was, it was, it was, really... You know, one thought that one was qualified as a psychologist, and trained to deal with any thing, until you came across this kind of illness. And then you realized, that you, that there were so many resources that you didn’t have as a psychologist, to deal with this kind of thing, and that you had to learn all sorts of new things to be able to help people who were in this kind situation. You almost go into a kind of a counselling situation where you had to*

*literally tell people that their disease meant that there was a new meaning in life. That their struggle was to find a new meaning in life. To learn to live with death, to live with death far closer to home than it would have been if they were not HIV positive. And It changed the whole concept of living and dying.”*

I wondered if Richard had a playful way of working with HIV. “Yes. *It was a way of trying... What we realized very quickly was that people needed to be in control of the disease. If you could explain the mechanism of the disease in a way that they could have control over it, they would be far more empowered to be able to fight the disease. So we drew up a kind of a scenario where we explained the pathology of the disease in terms of the t-cells were the Generals in the body. They were fighting as in the army. And I think the analogy of the army was very familiar to every one: the analogy of a general and soldiers and fighting the enemy, which were this virus and this sort of thing. And basically it was this scenario where the AIDS virus was attacking the generals by paralysing their ability to send out signals to the soldiers to fight the virus. And how these soldiers would take the virus to the generals and say “Generals, here is this virus! What do we do with it?” And before the general could say “Fight this virus!” The virus would go into the Generals’ mind and paralyse the general completely, and the soldiers would sit there, useless, and the virus would take over the generals and this sort of thing.”*

*“And then we came up with an analogy, and we told the patient to put this virus in a chair and say to him: “Listen, your whole object in life is to live inside me and to produce your children. But if you kill the generals in my body you’re eventually going to kill me and kill yourself. So if you really want to continue functioning and creating babies you have to keep me alive. So you better not kill me, because if you kill me then you will kill yourself!” And this empowered patients a hell of a lot. That they could take this speech home with them, visualize themselves going into the bloodstream and say: “Listen Chum, if you are going to kill all my generals in my blood, my T-cells, then you’re going to kill yourself. So get wise. Save my T-cells, and you will be able to survive for as long as you want to.”*

*“And people then got this “aha” experience. I have the power to fight this virus. I have the power to use my immune system to empower my T-cells to say to this virus “Watch it, don’t kill too many of us, keep me alive.” And I think just with this kind of equipment that they’ve had, they were able on a emotional level, and maybe on a psycho-neuro-immunological level, empower themselves and feel there is something to look forward to. I have got a weapon that I can actually use that can fight this stuff. And I think that actually helped, the fight against the virus. And we developed quite a few of these things, where we told people: “You are not a victim to this thing. You have got areas of your brain that you can use, and your immune system that you can use to actually fight of this virus.” And a lot of people were discovering that when no treatments were available, they lived*

*for ten, twenty years, and still continue to survive. They are obviously on antiretroviral treatment now, but they put up a hell of a battle. And they looked after nutrition, they found ways of relaxing, and they empowered themselves mentally, to fight the virus.”*

*“It was very playful. It was like playing games with the virus. Imagining yourself going, using visual imagery, going into a space ship as a way of going into your arteries, and going around with a zap machine, and finding these T-cells in your blood. And going: “Zap! Zap! Look at the T-cells in your blood and going Zap Zap Zap Zap Zap!” And spending about half-an-hour every day, going through all the arteries, and getting and feeling “Wow! Today I killed about ten million viruses! I feel good!”*

Richard also had an idea of how to incorporate this when working with a family affected by HIV / AIDS.

*“I think that in a family context one would encourage the family to help the individuals with the virus, for instance to get the family to sit around the chair of a HIV victim in the family and put their hands and their arms around this family and say come-on were all going to fight this together. And I think my experience of HIV people is that they need to be touched, they need to be held, they need to be contained in a physical sense, because one of the things that happen to people who become HIV positive is that they regard themselves as physically*

*unacceptable that people can't touch them physically that they are repulsive that they are going to infect everyone around them, that their bodies are poisonous, and they literally go through a process where they imagine that other people around them can see inside them and can see that they're infected with the virus. As a result they don't want anyone to touch them that they feel that they're poisonous and they feel contaminated. And I think what happens then is that they become intensely lonely and they don't have physical contact with people."*

*"So my focus in family therapy, one of the basic things, would be to try to get the family members to hug and protect them and help them with these visualisation exercises and say "I'm the gunner, Ta-da-da can you feel that? I'm shooting the virus! And the other one saying "I'm the aircraft, can you feel me I'm coming I'm coming! That kind of thing!"*

*"You know I rely very much in therapy – and I have been taught that by my teachers in psychology – that a sense of humour in therapy, which in a sense is a way of being playful. It is very very important. So I think even when you're dealing with death and dying, it is very important. I can't think of anything specific at the moment, but I can certainly think that when you are talking to someone, even in the most drastic of circumstances... one just has to look for something that can be turned into a humorous situation."*

*“I can’t think of a situation of a child at this moment where I have used it in any specific way. But I will always look for a situation that I can turn into a situation that is fun or enjoyable. If I were dealing with a situation that was very drastic, I would, absolutely.”*

*“I think if you can take the anxiety out of the situation, and for example reassure the person that the process of dying is a very relaxing process, it is not a catastrophic process, and you can reassure someone of that, then it can be a playful situation. For example, there are some religions, that while you are dying, explain to you that you are leaving your body. And they will explain to you, right now you can feel that you are rising above your body and you can see your body. And it is a very interesting and a very relaxing process. So, you know, even the most dramatic of situations, one can make into a relaxing and non-catastrophic situation. And I think it is possible with everything.”*

*“And I think, what I know is Kubler-Ross has written about people who are dying of HIV and particularly in America, where they get a death partner who help them die. Where this person actually gets into bed with them and holds them, right from the process where they start dying, towards the end. And where they hold them, and physically contain them through the death process. So a lot of these things are there and people have tried them and they are available. And I think, you know, people just have to think about them, and use them, and use*

*fundamental things like physical contact and relaxation and this sort of thing and humour...”*

For Richard, some of the problems of HIV and fear limit people. *“I think a lot of the time it has to do with fact that it is a sexually transmitted disease, and all the old laws and regulations and prejudices that go along with sex and sexually transmitted diseases and the fact that there is still a stigma attached to it. And I think in South Africa we just come from a very Calvinistic kind of past, which still today is present, particularly amongst the white population. I think this is still part of the stigma attached to HIV. Not only amongst the white population but also in the black population as well, that says: Sex is wrong! Too much is wrong, to have pleasure and fun and to play, particularly in a sexual way is wrong. And that is where it all comes from. It is the equivalent of saying, if you enjoy yourself sexually too much, you will get punished with HIV.”*

*Claire*

The story told by Claire was about a female client she had met during her work at the psychiatric rotation.



*“At that point she was very ill, she had, I think TB (tuberculosis) and that, she was initially in one of the other wards, but they thought that she was suffering from depression, so they transferred her to psychiatry.”*

The client learned about her status through the blood tests done for her TB, and Claire suspected that that was where her depression came from. *“She was a very thin, fragile woman. She looked about 65, but she was only about 40. So she looked very old for her age. I don’t think it was necessary the HIV. It has a lot to do with her personal life. She was experiencing very unsupportive kind of relationship.”*

Claire went on to explain that this client was mother to two daughters, 16 and 7. She married the father of her youngest daughter. The client was working as a sales representative. Nobody in her family was aware of her status, except her husband.

*“He kind of didn’t want really anything to do with it, I think he was in denial. He would come and visit her, but wouldn’t really be with her. He’d find other people in the ward to visit. He knew she was sick and he loved her, but I think the big difficulty for him was that if he had to face that she was HIV positive, that he would have to face the possibility that he was also HIV positive. Especially since, according to her, she had no affairs, she was not HIV positive when she had a child with this man, and since then in her marriage she’s always been very*

*faithful. He, on the other hand is the one who had many extra-marital affairs, through playing around. He's even had a child with another woman, which she only found out about three years ago. So the likelihood that he was the one that gave her the virus is quite good, but he won't go there, and even later on in couples therapy we never went there because he wouldn't acknowledge it. He'd kind of stay on her and what the disease is doing to her and their relationship."*

During her stay in the ward, Claire worked mainly with her on issues of bereavement and feelings of loss. Her concern was mainly for her youngest daughter. She *"brought a lot of light into her life, when she would come and visit. And her daughter was very aware that her mom was sick, but obviously not that sick that she was going to die. And so she would look forward, she would smile a lot, her daughter would speak. She would speak about her daughter who would come visit. She was very negative and angry, I think she held a lot of anger against her husband for not really supporting her and for giving her this disease, because in her mind, and her reality, that's how she received it."*

Claire continued to work with this client in therapy, and support seemed to have been her greatest need. A lot of the therapy went around feeling unsupported by her husband, and the client came to a point where she decided to involve her sisters in supporting her, instead of her husband. *"Because she felt she couldn't trust her husband to look after her daughters, she needed to start making plans. So, she spoke to her sisters, and they were pretty shocked,*

*they were very sad, but they just reaffirmed how much they loved her, and they would do anything to support her. So that was really nice for her, that was, that gave her a lot of encouragement, her mood lifted a lot after that.”*

After the client was discharged, Claire saw her for follow up sessions. *“She brought in difficulties in relating, especially in a sexual relations, and found it very difficult to engage sexually with him, because of all the stuff that has happened to him.”*

As a therapist, Claire found it hard to work with this client and her family and HIV / AIDS. *“It was probably the first real therapy I did with HIV. Sometimes I was a bit lost as a therapist, I was a bit lost as to what to do, but I think it wasn’t just about her coming to terms about HIV, it was about her family coming to terms with it, and how it’s very difficult for her to come to terms if the person closest to her could not come to terms with it. Her husband wouldn’t really acknowledge it and keeps it always at a distance. I think that also created a dilemma for me. Because in order to keep HIV / AIDS away from him, he had to keep his wife quiet.”*

Time was also spent speaking about her daughter. *“I think a lot of the time just to bring kind of relief from the heaviness, we talked about her relationship with her daughter, especially the younger daughter. What’s she’s like, what they do together, and that kind of stuff, just to kind of lift the mood in*

*the sessions and bring in a bit hope – there is still a lot to live for. And what can she do to make remaining part of her life more positive.”*

*“I think her daughter, her younger daughter was very aware of what was happening, although she did not know it was HIV, she was very aware that her mom was sick, and I think her daughter was a big comfort to her. And then obviously that gave her that hope.”*

To Claire’s knowledge the client never told her daughter her HIV status. *“She told me that she felt that she was young, she didn’t want to... Her daughter, I think because of that, was aware of what was happening. Her mom was sick and she was aware that her parents weren’t, things weren’t right, and I think her daughter started having problems at school as well, so the plan was to move her daughter, to move to Jo’burgh from next year and put her daughter in a boarding school, somewhere where she could still come. So although there was that playfulness, I think her mom was also very concerned.”*

Claire was not sure if there was any playfulness in the sessions. *“We would sometimes, we would try keep it more light-hearted at times. We would sometimes do something funny, and joke about it. And sometimes we would have more, but then it would be more supportive for me, we would keep it light and focus on the positive stuff. I think I did some visualisations with her. I don’t know if you would define that as playful... But ja, there was a bit of fun in it. And*

*I think what was nice about it, it help to relax her. Helped to distract her attention..."*

I mentioned to Claire that during my interview with Richard we defined playfulness almost as anxiety not being there. *"If you take that definition, I would definitely say we definitely were playful in certain sessions!"* Claire exclaimed. She also mentioned that HIV highlights relationships for her. *"And I think one of the saddest things, I think from a systems point of view, was that the playfulness between her and her husband wasn't there. There was just always anger, and although in couples therapy I facilitated a process where she could express her anger, and that helped a lot, enabled them to kind of get a bit closer, and do more couple things. But that didn't last; there was so much anger. He never reciprocated by trying to make things different. So, he was very distant from therapy and that I think made it difficult to do playful therapy with them together. Despite that he played with other people. But for whatever reason he just couldn't play with her."*

*"And I think the positive, the nice part of it was that there was a bit of a balance, because her sister accepted it and her father accepted it. And I think it just reconfirmed for me how important it is to have relationships, and I mean caring relationships."*

*Lindiwe*

As Richard and Claire, Lindiwe did not have that much experience of working with children. She thought it might have been because of the places she worked at besides the HIV / AIDS centre at the hospital.

*“Basically it was in prison so there are no children involved, and it’s very different. But in a way, if I think, I am involved; I’m working with some children. These children are not going to school, which would have been a form of social contact. They die quicker. That’s what I’ve seen. They don’t stay longer because now the parents are so protective, they don’t want their children to play with other children, don’t want their children to visit other children, so the child doesn’t develop, even the mindset doesn’t develop, they do just what the parents say.”*

*“The moment the only two children that I see come with their parents. In school they do very well. The one child in particular, she’s always in hospital but she’s doing very well at school, very brilliant, and she speaks apparently 5 or 6 languages. It’s possible for them to do well. If they take care of them, and they interact very well, they tend to be okay, and what’s the most negative impact is that if they aware that everyone is dying.”*

Lindiwe thought there might be a need for children and families to be together in therapy. *"I think so, depending on the maturity of the child, some children may not even understand what is happening and what you're talking about, but I think, it is necessary. Some woman who come to me say: Should I tell my child or should I hide it from my child. What I say is that it's up to you. If the child is very inquisitive and asking questions I think she is ready to know, then it's fine but I'm not sure. I think I'll treat them like any other problems or challenges that children have when they come for therapy. Certain children wouldn't. Because of their maturity and mental state. So I wouldn't treat them differently, because this is one of the problems they may have."*

*"It's really difficult, It is important for me things I have taken so far with a child or adult is that you treat this disease as not separate, because if you treat it as separate, I think I'm emphasising that this is different. If a person with cancer or high blood or any other illness that is not easily cure-able comes to me, I ask myself how would I treat that person."*

We discussed using playfulness in therapy. *"I usually just use humour and ja, it also depend on the clients mood, adjust it very well. I'm not sure about play therapy because I always think of play therapy as related to children."* I explained to her that I view play therapy differently from playfulness in therapy (as discussed in chapter five). Playfulness was definitely part of Lindiwe's therapy.

*“Definitely, yes. I think there was a time when I had to talk about my co-transference with a client, and we end up laughing about our problems. I don’t usually do that, I don’t usually tell my story to client. At some stage I had to say, you know what, you remind me of myself, because I was going through the same thing. ... So we end up talking about cultural issues and we were laughing at: What were we doing? And we end up laughing and its part of it and I’m not sure how the person afterwards felt, but this was a depressed person that came to me, crying that he wants a divorce and we end up laughing about it. So basically the playfulness is there.”*

Lindiwe also mentioned that being playful could be culture sensitive.

*“Maybe there is something that you do in certain cultures, that maybe to us you can make it to you, it’s not a joke. So basically, I think you have to be culturally sensitive and know before you can apply that, or else you can end up hurting the other person. But I also believe as a therapist you need to know different cultures. Generally its very good for you.”*

I have attended a few of the support groups that Lindiwe runs for HIV / AIDS affected people, in which I could recall how she would use playfulness. She would, for instance, initiate a communal song to give voice to the members of the support group. *“I didn’t know that it was that obvious,”* she laughed.



Joan

*“Well, when it gets to AIDS and children I don’t think there is a lot of insight (for the children) since they are more removed from AIDS than adults, and I think it is definitely the place for play with children because I think their interpretations of AIDS is different than our interpretation of AIDS. And if I think of the case that I had, the parent was taken away from the child and they didn’t understand why is our dad not here anymore. It created more uncertainty when they don’t understand what is happening. And there is not really something like insight, perhaps its because people just don’t explain to them what HIV is and what it means, and how you will die, eventually. But I think it is necessary for them (the children) to explain on their level what it means so that they can understand what is happening and how they should interpret things.”*

*“Yes, I think it necessary for HIV to be made more understandable on their level. Whether it is through play or what ever of fantasy, but they also need to understand.”*

*“I have seen this family in therapy at Agape (a community psychology clinic). The mom came in for therapy since she was HIV positive. What happened was he started to get ill and his family took him away because they believed that she was the culprit. They had two children. The one girl, she was about ten years old, and then the other girl was around four years old, and I think*

*it was very disturbing for the children. Why, why is our daddy not here any more? What I also think is that they were not really told about the AIDS story or the HIV story, but I think it was probably to protect them. It must have been confusing for them because they could not understand why they could not see their dad. And, it was difficult; I think it was very difficult for them. It was as if the adults talk it out and I can't do anything about it. And yet I miss my dad, I want to see my dad, I want to be with my dad."*

*"I have worked mainly with the mother, more about her fears about rejection and how she felt about the HIV. And it was surprising because she was so very positive and optimistic, and she thought about her children. She thought as long as she can live she can take care of them so she will live as long as possible."*

*"And I have played a bit with the little girl of ten. But it was more just play about things she found interesting, because it was really difficult to access her. I could pick up that she missed her father a lot and was in shock about his family that came and took him away. Yes, although I have spent time with her it doesn't feel as if we have done much, because she didn't know much about the situation. I think if I had more training I would understand how to access her world and understand her emotionally. You see, it is difficult to work with children, they have to trust you and so forth. So I think if I had more opportunity I would have liked to work more with her, because I already found it so heartbreaking. It is*

*easier for the parents to understand, it is easier for older people to understand what is happening with them.”*

Joan did not actually work with the mom and child together, but saw them separately for approximately five or six sessions. She never saw the youngest girl, because of transport problems, and it was too far for her to walk. She felt in hindsight that the ten-year-old girl really missed out of an opportunity to receive therapy because of Joan's own inability of working with children at that stage. Joan also felt excluding the girl from the knowledge of her mother's HIV status, excluded her from an opportunity to work with this reality.

*“I think that is what happens often. In an effort to protect children we often hurt them, because we think they won't be able to handle it.”*

Joan found it difficult to be playful with the mother during therapy. *“It was very serious. It was much more serious. Because I felt sad for her, and I found it difficult to digest that this woman is in this situation, she is HIV positive, and I don't know how she will handle it.”*

Joan thought a big part of the threat of HIV came from the personal power it took away. *“I think a great part of the threatening side of the disease is our ignorance around the disease. People do not see beyond the death sentence, if you can only find a way to look after yourself well, and you can become positive*

*and not experience this as a death sentence, then you will find the disease less threatening, but if people have not seen that side of HIV, I really don't think they can find it less threatening. And if you look at people around you, at people that are healthy and go on with life, the stigma or fear around the disease is lifted. But if you see people around you that don't have food everyday, it makes playfulness in therapy difficult because obviously the disease will kill you if you don't have basic resources."*

Joan is not sure if she will ever be able to include playfulness in her therapy with families and children affected by HIV / AIDS. *"It depends on where the family is, you know, if they are positive, how they see the disease, etc. It will probably take some time and work with the family to see it in a less negative light, and then I will introduce playfulness, because play is part of life. It is the part of positive life."*

Joan felt that it might make therapy easier for her as the therapist as well. *"It is very heavy to know that you are HIV positive and any form of life, of joy, that will give you appetite for life, you must be open for that."*

I wondered if there was any such thing in the story that Joan told me. *"I think what made it easier for her was the support of her own family, you know, as if they made space for her, for the fact that she is HIV positive. She didn't feel rejected with them, she felt accepted and she felt she could trust her family. In*

*the situation where she was believed to have caused her husbands illness, it made a world of difference for her. She could continue to live positively, and also for her children. I think they were her driving force.”*

## Conclusion

The conversations with all four therapists were very different, as their realities are structured by their diverse experiences and backgrounds. All of them were affected by the effects HIV / AIDS had on their clients and their experiences in therapy, although these experiences have been different for each one of them. In the next chapter we will look at their reflections on these conversations, as well as my own reflections.

## CHAPTER 7

### REFLECTIONS FROM RESEARCH PARTICIPANTS

This chapter contains the feedback that the research participants gave me. The feedback came after the research participants received the initial version of chapter six, and had the opportunity to edit it. I invited the psychotherapists to give me feedback in any form they want to. Claire wrote me a page on her meditations about working playfully with children and families affected by HIV / AIDS in psychotherapy, and in addition sang me a song. Joan composed a poem that expressed vivid feelings about HIV / AIDS. Lindiwe chose not to give feedback, although she felt that what she intended to say was not entirely portrayed in her conversation. Possibly this occurred since English is a second language to both of us. Richard gave his feedback to me verbally, after editing the initial version of chapter six.

Since I am inherently part of the research process, I have also included my reflections in the form of works of art.

Reflections from four therapists

Richard said

*“I think I have said all that I want to.”*

Claire wrote

*Upon reflecting on our stories the following ideas came to mind:*

*Playfulness does not only revolve around focusing on the positiveness and hope as in my story. It also includes the difficult part too. I feel it's about a therapist's ability to explore both.*

*If I look at a child's play, it's about exploring both his / her external and internal worlds in a way that make sense for that child. Further, in order for a child to play, the environment / context needs to be perceived by the child as safe. If I take this idea and apply it to therapy, our ability as therapists focuses on our ability to facilitate the above process. Further, perhaps our playfulness can be found more in our attitude towards therapy and our clients, rather than in what we actually do in this context.*

*For me, playfulness is about the freedom we have to be creative with others. Guided imagery as used by Richard, is a playful (and asocial way) of exploring a client's reality, so that he / she can gain some control, find a different perspective and make sense out of the HIV experience.*

*Playfulness in therapy can only take place if both the therapist and client allow it. It seems that it is difficult for a client to be playful or to explore in a playful manner, if playfulness is not part of his or her world and relationships.*

Claire concluded with singing me a song, which I could hum along.

*The Rose*

*Some say love it is a river  
that drowns the tender reed  
Some say love it is a razor  
that leaves your soul to bleed*

*Some say love it is a hunger  
an endless aching need  
I say love it is a flower  
and you it's only seed*



*It's the heart afraid of breaking  
that never learns to dance*

*It's the dream afraid of waking  
that never takes the chance*

*It's the one who won't be taken  
who cannot seem to give  
and the soul afraid of dying  
that never learns to live*

*When the night has been too lonely  
and the road has been too long  
and you think that love is only  
for the lucky and the strong*

*Just remember in the winter  
far beneath the bitter snows  
lies the seed  
that with the sun's love  
in the spring  
becomes the rose*

Lindiwe

Lindiwe chose not to give feedback.

Joan wrote

*In a slump you wonder*

*How then shall I escape*

*This creeping death*

*Eating away at my sanity, until*

*There will be nothing left of me*

*The fighter is gone,*

*Only a dullness which pervades*

*My entire being*

*A certain death of the flesh*

*An uncertain death of the spirit*

*Giving forth a thrust for Life*

*To light up the darkness*

*Which longs to claim omnipotence*

*A beautiful thing to behold*

*This Light, guiding the*

*Way forth to that which*

*Is timeless and transient*

*Can we adopt a different attitude towards the disease? Taking for granted the inevitability of death, and thus how we die becomes less important. Dying is thus no longer seen as this incredible blow to life, for example being diagnosed with HIV, the certainty of death is brought closer; does this not give the person a sense of freedom of the things which he/she can do? To pack as much Life he/she can in the remainder of their lives?*

Reflections from the researcher

My reflections are captured in figures 3 – 9.

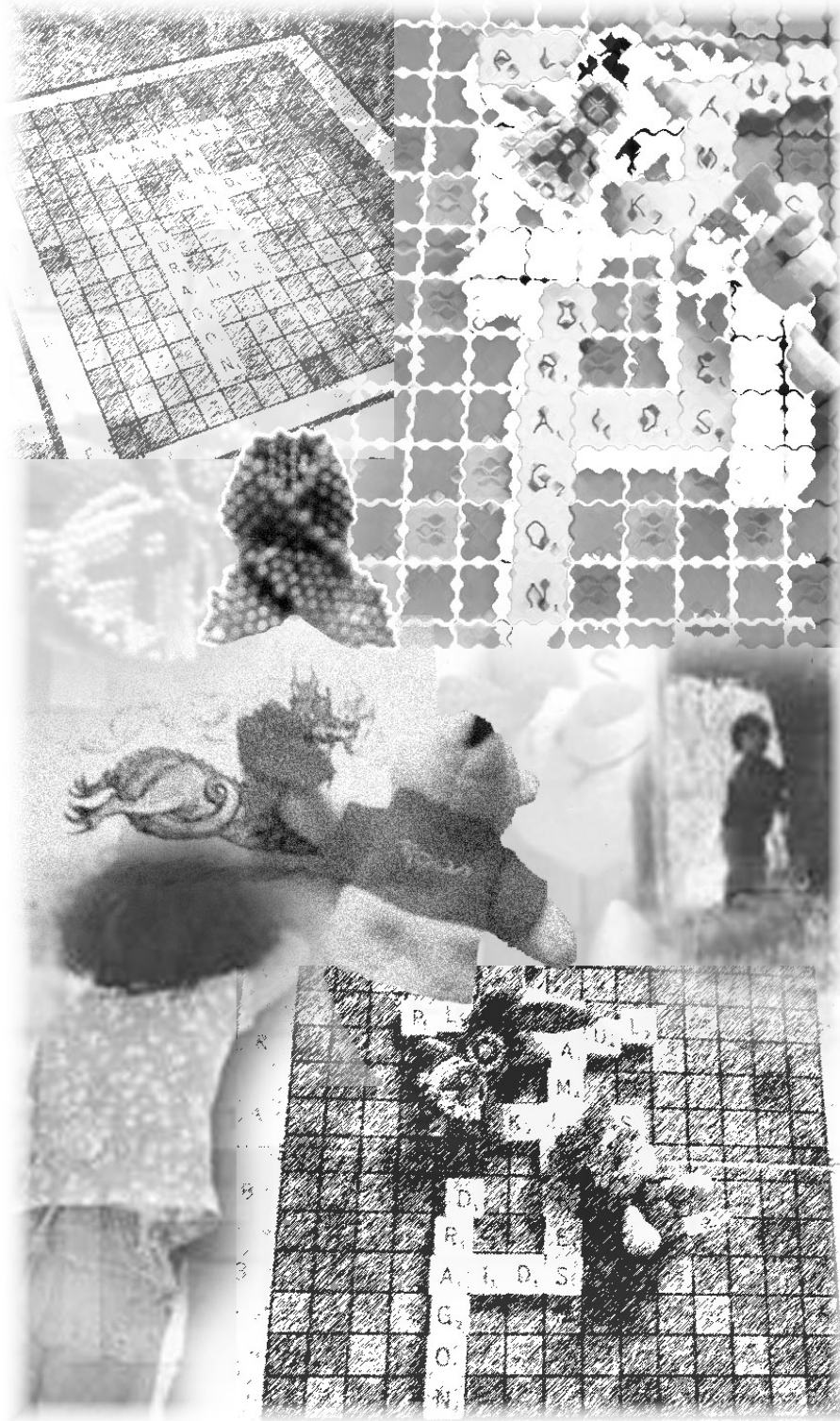


Figure 3: Scrabbling AIDS

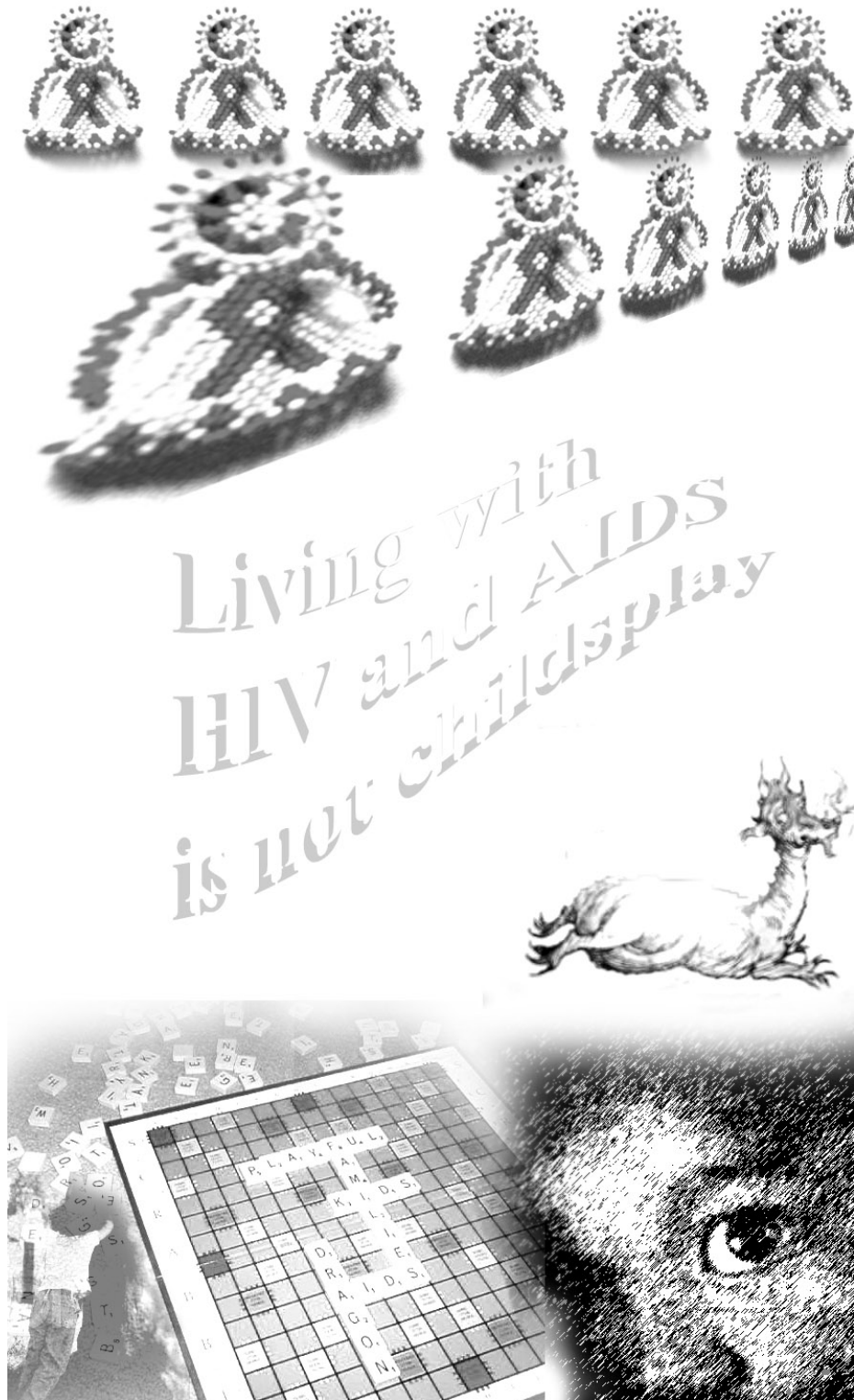
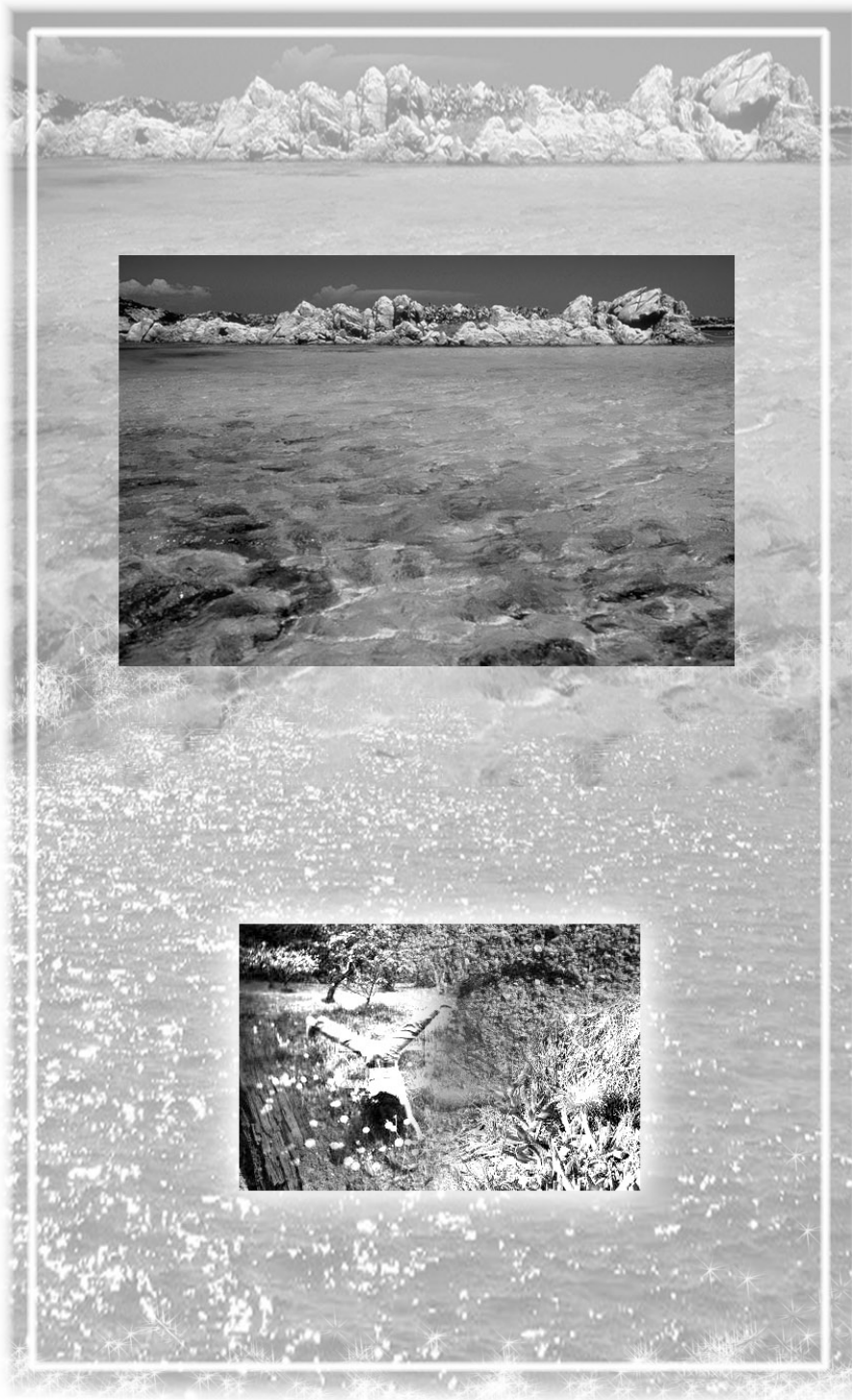


Figure 4: Not chilsplay



*Auguries of Innocence - To see heaven in a grain of sand...*

Figure 5: Diving into the Coral

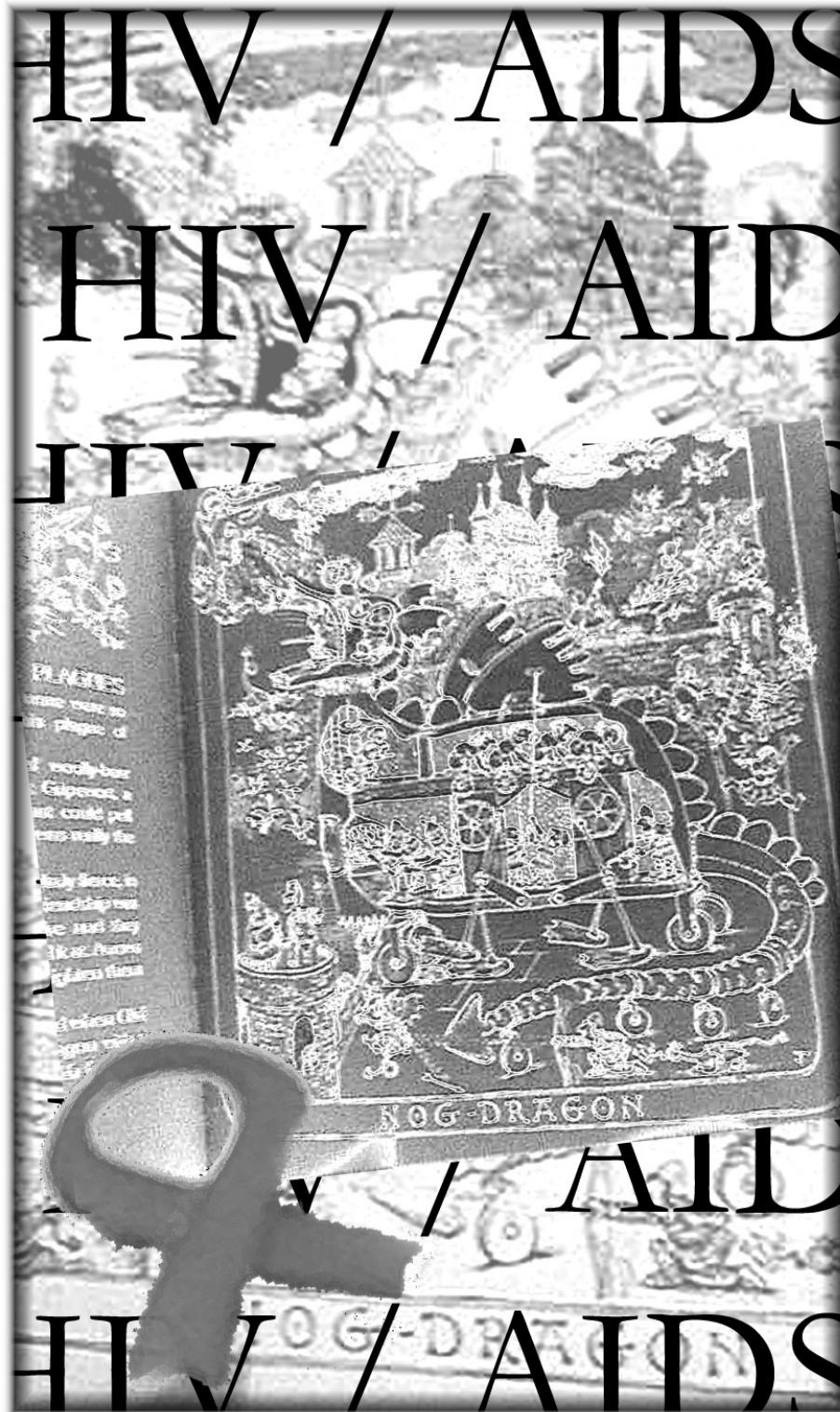


Figure 6: Nog-Dragon

# JOURNEY



Figure 7: Journey





Figure 8: Co-construction

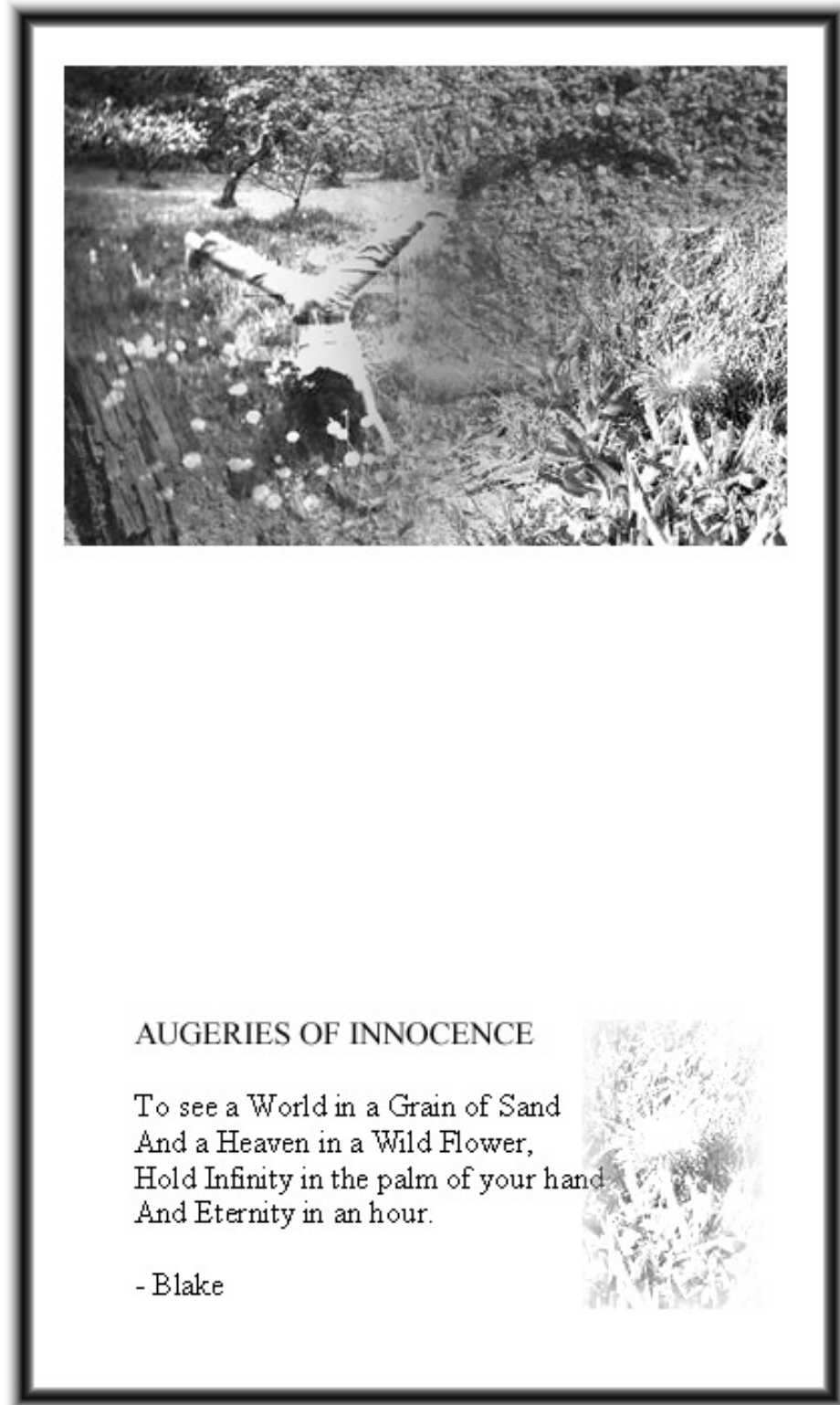


Figure 9: Innocence

## CHAPTER 8

### CONCLUSIONS AND RECOMMENDATIONS

#### Conclusions drawn from the interviews and feedback

Conclusions and assumptions can be very dangerous to make. It may put the writer in a position of power, dictating what the reader should accept as the truth. However, I would like to highlight some of the themes that I have recurrently come across in both the literature and the interviews.

Firstly, it seems as if not many psychotherapists have experience of working with children together with families in psychotherapy with regards to HIV / AIDS. Reasons for this vary. Some, like Joan, feels that they were not adequately trained, and wished they had more opportunity to see the children. Others, like Lindiwe, have seen how the parents are sometimes overprotecting these children and not allowing them to continue to develop and grow. Authors, such as Guest (2003), have mentioned that poverty often prevents children from receiving psychological assistance.

Secondly, psychotherapy with HIV / AIDS affected children and families is often hampered by a lack of basic resources, such as clean water and food. Joan mentioned this, as did Guest (2003) (quoted in chapter four). Richard echoed this, and mentioned that the stigma surrounding HIV / AIDS and sex in general is feeding the disease.

The third theme has to do with playfulness in therapy, and the different interpretations for it. Lindiwe linked this to humour and laughing, though cautioned that this type of playfulness might be culture sensitive. In her initial interview Claire did not really remember much playfulness with her client, but remembered sometimes talking about her daughter to bring in a sense of the positive. In her feedback, she seemed inspired by the way Richard was playful with his clients, using guided imagery to tackle the more difficult parts of the disease. For Richard, playfulness went beyond psychotherapy into our general attitudes about death and dying, which he describes as an interesting process, and about sex and sexuality. Both Lindiwe and Richard mentioned that a positive attitude and social contact helped HIV / AIDS infected people to survive longer and continue to live a fuller life.

The fourth theme that caught my attention was captured in Joan's poem, in Claire's song, and in all the stories. It is about the trust of the psychotherapists that their clients will be able to transcend past the physical difficulties that HIV / AIDS causes in the lives of children and families affected and infected by it. At

the end of chapter four a suggestion is made that new types of caring families should be created to help children and families affected by HIV / AIDS to survive. Therapists might fall prey to the stigmas surrounding their HIV / AIDS affected clients, and this might influence their ability to be playful with their clients. Richard mentioned that there is a belief that it is much more dignified dying of any other life threatening disease such as cancer, than dying of AIDS.

All these psychotherapists believed in their clients' ability to excel and grow despite or perhaps, because of, the presence of HIV / AIDS in their lives.

#### Reflections from the researcher

I am in awe of these brave psychotherapists that I have spoken to. They are the spirit of psychotherapy, as playfulness in therapy can only take place if the therapist and the client allow it, and playfulness is not only about the nice and comfortable. It is also about seeking the dragon in the mud, between the corals. It is not easy working with children and families affected by HIV / AIDS, especially working from an ecosystemic model (as discussed in chapter two and five) where your own feelings are taken into account, together with the circumstances surrounding your client. Yet, playfulness in psychotherapy might produce some creative weapons of co-creation to fight the effects of the HIV / AIDS dragon.

### Conclusions and tentative answers

I started this dissertation asking: Can psychotherapeutic interventions be introduced in a playful manner to families and children affected by HIV / AIDS?

After reading the literature, and listening to the psychotherapists whom have had experiences of working with children and families affected by HIV / AIDS, my answer is not clear yet.

I would like to answer, “Yes!” However, based on my research in the South African context, I am of the opinion this “Yes!” is subject to certain criteria. Firstly, the basic resource requirements, food, clothing and transport, of the children and family members must be in place before emotional needs can be addressed. Secondly, children should be allowed in the therapeutic space with the rest of the family. Thirdly, psychotherapy should be made child friendly by having adequately trained psychotherapists. Lastly, these therapists should be willing to engage in a playful manner with their clients, and not fall prey to the stigma of HIV / AIDS.

## Recommendations

I hope this research serves the purpose of making the reader aware of the necessity for psychotherapy for HIV / AIDS affected children and families in South Africa. To be able to do this, we need to have an infrastructure that allows clients to come for therapy without having to use their food and clothing money for transport and therapy fees.

We need to have psychotherapists that allow and welcome children in the therapy setting, not only because babysitters are largely a luxury in South Africa, but also because these psychotherapists have been trained to engage with children and enter children's worlds. In my opinion a lack of training to work with children is one of the shortcomings of psychotherapeutic training in many institutes in South Africa, and inhibits a lot of psychotherapists to engage with their own inner child in therapy. It is useful for therapists to expand their view of "play" as shown through the literature discussion, beyond limited technical modernist views. To allow playfulness to occur in psychotherapy we need to think of play not only as laughter and being positive, but also as ways of creatively working with existing methods such as guided imagery to address the issues at hand.

Psychotherapists should be aware that their willingness to engage in play will allow for the creative space to open up, but in the same manner stigmatising

their clients as HIV / AIDS victims or infectious viral carriers, might close the space for growth and hope.

HIV / AIDS is a subject matter that is frequently under the magnifying glass of many different researchers. With my research I hope to inspire future studies to consider larger samples of psychotherapists with experience of working with HIV / AIDS affected children and families. Future research might also ask what the need and expectations of children and families affected by HIV / AIDS are with regards to psychotherapy and playfulness. I also sincerely hope that future studies might investigate why some training programs in South Africa are lacking training in play therapy and children. Karter (2002) even suggests that psychotherapy training should be a space where “the student can learn how to play and be creative on his [sic] way to his [sic] individuation as a therapist” (p. 4). Being able to play with one self might open up pathways to the discovery of more diverse ways of interacting with oneself as a therapist, and with clients from diverse backgrounds and family structures. The possibilities of working playfully might then aid a therapist even further in working with children and families affected by HIV / AIDS.



CHAPTER 9  
DRAGONS IN THE MUD

Dear reader,

At the end of what seems as a life-time of writing, I still have the jabbing feeling that this dissertation is a mere drop in the research-ocean. Have I really sailed anywhere? What difference will four stories make?

I started the research by boldly asking: Can psychotherapeutic interventions be introduced in a playful manner to families and children affected by HIV / AIDS?

Working from an ecosystemic worldview, this dissertation undertook an investigation into the possibilities of working with HIV / AIDS affected children and families in South Africa in a playful manner in psychotherapy. Through a process of co-creating and reflecting, the narratives of four psychotherapists were used to see what their experiences of playfulness and psychotherapy with HIV / AIDS affected persons was. These narratives were used against a

background of a research literature discussion of HIV / AIDS and play in therapy. The conclusion is that playful psychotherapeutic interventions with HIV / AIDS affected children and families are possible, given certain criteria.

In hindsight, I might have approached a larger community to hear the stories of many more psychotherapists. A broader selection of participants might have included a sample of psychotherapists with more experience in this field. I imagine that future studies might obtain written stories from a myriad of psychotherapists! Although some research participants might prefer an oral interview to writing, receiving some of the stories in written format might possibly prevent some research participants from feeling that the full essence of their story have not really come across in the interview.

I would like to invite you, the reader, to go out and play within your own context! You may find a dragon in the mud... or perhaps a coral!

Kind regards,

Erika.

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APPENDIX A: CONSENT FORM

I \_\_\_\_\_ (name) have been informed of the following and understand it:

Title of the study:

“Play in psychotherapy with HIV / AIDS-affected children and families”

- The purpose of this study is to explore and describe playing in therapy with families and children affected by HIV / AIDS.
- Research will be conducted in an interview format.
- The interviews will be audio recorded, and recordings will be stored for research purposes.
- There are no known risks to participating in this kind of study.
- Any uncertainties or risks that emerge during participation will be met on an ad hoc basis.
- The research participants have the opportunity to withdraw from the study should they feel so.
- No fee will be paid for participation in this study.
- Confidentiality will be respected. Participants have the option of choosing a pseudonym and not have their identities revealed in the study.
- Participants will have the opportunity of reading through the documented material and give their advice and comments concerning it.
- Any questions can be directed to the researcher: Erika Erasmus  
Tel: 012 xxx xxxx Address: PO Box xxx, Hatfield, Pretoria, 0028, South Africa.
- A copy of this form and any other documentation will be available to participants if they wish for it.

Participant Name and Signature

Contact Number

Preferred pseudonym

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Researcher: Erika Erasmus

Date

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