THE IMPACT OF GESTALT PLAY TECHNIQUES ON THE AGGRESSION LEVEL OF DIABETIC CHILDREN

By

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SUMMARY

The study was undertaken to investigate the impact of gestalt group work play techniques on the aggression levels of diabetic children between the ages of eight and twelve years. The sample comprised of two boys and two girls who attended the diabetic out-patient clinic at Parklands Hospital.

The motivation for the study developed from the researcher's interaction at the diabetic out-patient clinic at Addington Hospital, where staff indicated a need for group work sessions with patients at the juvenile diabetic clinic.

Discussions with staff revealed that there were an increasing number of false results from the patients, as well as complaints from the parents regarding the aggression levels of their diabetic children. The aggression was also encountered by the health team who managed the children.

These two aspects offered an opportunity for the researcher to investigate the effect of gestalt group work play techniques and its effects on the aggression levels of these children.

The shift in behaviour of the respondents was measured by means of the Single Systems Design. A pre-test and post-test questionnaire was administered. The pre-test questionnaire allowed the researcher to establish a baseline for working with the respondents. A literature study undertaken to investigate whether juvenile diabetics experienced traumatic psychosocial changes revealed that the complex nature of the illness and its effects on lifestyle played a major role in behaviour and educational problems.

The researcher selected gestalt group work play techniques to assist with decreasing the aggression levels of juvenile diabetics as the group situation allowed support and security for group members who experimented with new behaviours. The commonality of the illness also allowed shared experiences between members.

A comparison of the pre-test and post-test results of respondents suggest a strong recommendation for inclusion of gestalt group work play techniques in the management of juvenile diabetics. The researcher is of the opinion that the aim of the study was successfully achieved and inclusion of gestalt group work play techniques be recommended as part of the holistic treatment of juvenile diabetics.

KEY WORDS:

1. Gestalt
2. Gestalt Group Work
3. Play Techniques
4. Aggression
5. Juvenile Diabetes Mellitus
6. Gestalt Approach to Play Therapy
7. Psychosocial Issues Related to Juvenile Diabetes
8. Single Systems Design
9. Social Work
10. Multi-disciplinary Teamwork

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CHAPTER ONE

GENERAL INTRODUCTION

1.1 INTRODUCTION

According to Yousef (1993:29) there is a high incidence of aggression in diabetic children. The researcher, therefore, intended to investigate the effects of gestalt group work techniques on diabetic children, and whether these techniques were effective in decreasing aggression in these children.

1.2 MOTIVATION

The researcher undertook the research for a variety of reasons. These reasons stemmed from the researcher's work environment and her interaction in the diabetic clinic. This interactive process involved discussions with the medical officers at the diabetic clinic, who complained of high percentages of suspect results from the children, as well as visible aggression towards the medical officers themselves during the children's mandatory visits to the clinic. Also, further reasons stemmed from the fact that children who exhibited uncontrolled insulin levels, correspondingly exhibited high levels of aggression. A study done by Court, Sein, McCowen, Hackett & Parkin (1988:16), found that the behaviour of 127 children with diabetes mellitus aged eight to sixteen years were assessed by their parents and teachers, using a well established screening device and compared to that of 51 non-diabetic children. Twenty five percent of the diabetic children were perceived by their parents to be disturbed compared to only fourteen percent of the controls. The above researchers go on to discuss further in their article that if the effects that the disease has on lifestyle and the complex nature of the condition is considered, it is therefore not surprising that diabetic children have behavioural and educational problems (Court, *et al.* 1988:16). A random questionnaire that extracted demographic details as well as details surrounding the coping mechanisms of the diabetic child was conducted by the researcher at the clinic. This was done while the children attended their prescribed medical physicals. The results revealed that 80% of the children experienced aggression at home as well as at school.

Studies focusing on aggression in diabetic children emphasized a positive relationship between aggression and the illness, however there was no focus on how this aggression can be managed in the diabetic child. This was highlighted in a comparative study between asthmatic children and diabetic children done by Nelms (1989:657-668). It was found in his study that both groups of children showed empathy, emotional responsiveness and depression. Children with asthma scored lower on self-concept and children with Insulin Dependent Diabetes Mellitus (IDDM) were more aggressive. The extensive amount of available literature based on diabetic children and the associated aggressive tendencies, and the inability of medical doctors to assist, enabled the researcher to locate a point of entry into this field of study. The researcher hoped to assist where the multi-

disciplinary team had failed to curb these aggressive behaviours in these children. Primary care of children continues to reflect a disease oriented approach rather than developing capacities within the children to understand the emotional ramifications of disease within the context of the child's life. This subsequently resulted in the interest of the researcher being heightened, to pursue this particular area of study. Group work would be the most effective technique as it allows the children an inside look into their illness and to draw on support from other children who have the disease. This approach allowed the children to offer solutions, regarding coping mechanisms and alternatives to each other within a safe environment and helped them see that there are peers out there who are experiencing the same emotional problems associated with the disease.

1.3 PROBLEM FORMULATION

The researcher has been exposed to literature that focused on the chronic physiological illnesses of children and the effect of these chronic illnesses, that is diabetes, on the psyche and mental health of the child. Some of the behaviours described or experienced by parents of diabetic children are for example, irritability, fearfulness and disobedience. Children who have experienced some form of chronic illness, exhibited behaviour problems. Close, Davies, Price, and Goodyer (1986:337-340), in a descriptive study found a quarter of the diabetic children to have "appreciable" emotional or behavioural difficulties. Again however, solutions or alternatives to help these children and parents cope with the behaviour have not been documented or offered.

Time spent at diabetic clinics by the researcher revealed that the clinics are understaffed, busy and do not have a social worker attached to their unit to deal with questions that the children might have. This immediately increased the number of diabetic children that live in fear of the disease, because they are not given an opportunity to verbalise their concerns and fears in an environment where they feel comfortable and where they do not feel pressured into giving test results that please the doctor and the parents. The doctor makes diagnoses, however the family unit and the child are not prepared for what the disease has in store for them. The child is not prepared for the eventuality that his/her physical, emotional and academic lifestyle will change. The researcher is of the opinion that it is no wonder that these children then develop negative ways of coping with this new invader in their lives. This ultimately manifests in rebellious behaviour, childhood depression and power struggles between child, parent and teacher, because the child feels that he/she has to hold on to whatever little control that has not been taken away from him/her.

Court, *et al.* (1988:252), in their study demonstrated the prevalence of disturbance amongst diabetic children as much higher than is clinically apparent, yet again no solution was offered to help health professionals and those individuals who deal with the diabetic child. In the same study conducted by Court, *et al.* (1988:252), they also state that the aetiology of the problems experienced by the children are clearly complex and probably result

from an interaction between physical, psychological, social, family and environmental factors. The researcher is of the opinion that the psyche of the child is of utmost importance as a healthy mind and approach to the illness will clearly impact on the well being of the child and his/her handling of the illness. This research hoped to offer health professionals an answer to their question, *"We know diabetic children exhibit aggressive behaviour, however, what do we do about its management?"* It will also help to provide health professionals with a greater understanding of the emotional aspects of the illness, leading to more effective management.

1.4 GOAL

The researcher aimed to investigate the impact of gestalt play techniques on the aggression level of diabetic children.

1.4.1 OBJECTIVES

The researcher aimed to achieve the following objectives:

- To conduct literature studies on:
  (1) The impact of juvenile diabetes on the child and on
  (2) Gestalt group work play techniques.
- To do an empirical study to investigate the impact of gestalt group work techniques on the aggression levels of children with diabetes.
- To make recommendations on the use of these play techniques regarding the holistic treatment of diabetic children.

1.5 HYPOTHESES / ASSUMPTIONS

Bless & Higson-Smith (1995:23) define hypothesis as a guess about the nature of the relationship between two or more variables. The hypothesis for this research is: ***If gestalt play techniques are utilised in therapy with diabetic children there will be a decrease in aggression, rebellion, conflict, fear of the illness and there will be a better understanding of the illness.***

1.6 RESEARCH APPROACH

This particular research lends itself to both a qualitative as well as a quantitative approach. The goal of the quantitative researcher is to answer a specific research question by showing statistical evidence that the data may be addressed in a particular way (Bailey, 1997:60).

The goal of the qualitative researcher is to try to verify or generate descriptive theory that is grounded in the data gleaned from the investigation (Bailey, 1997:134).

1.6.1 FEATURES OF QUALITATIVE RESEARCH

The 'lived experience' allows the researcher to identify the meanings people place on the events, processes and structures of their lives (Bailey, 1997:39).

This feature of qualitative research allows the researcher to learn about the participants within the context of the participant's own world. Qualitative researchers are concerned with the process as well as the outcomes of their studies (Bailey, 1997:39). One of the advantages of qualitative research is that it gives us a good handle on what 'real life' is like for the participants in the study (Bailey, 1997:39). The data collected from qualitative research is rich and powerful. This in turn has a strong impact on the reader. This allows the reader to see why things happen the way they do and to assess causality as it occurs in a particular setting (Bailey, 1997:40). The characteristics of the present study are such that the study is qualitative in nature because of the following: the researcher will be concerned with the outcome of the study, (that is whether gestalt techniques will be effective in addressing the behaviour problems in diabetic children), be able to identify the meanings the children attach to their environment and also allow the researcher to see why aggression is more prevalent in diabetic children.

1.6.2 FEATURES OF QUANTITATIVE RESEARCH

The purpose of quantitative research is theory testing: to establish facts, show causal explanations and relationships and allow prediction (Bailey, 1997:49). Quantitative research designs are predetermined and structured and do not change during the course of the study. They are formal and specific according to a defined model and are used as a detailed plan of operation. The data gathered in quantitative research is quantifiable and statistical, using counts and measures. Variables are defined ahead of time (Bailey, 1997:40). The quantitative researcher has circumscribed contact with the subjects on a short-term basis; this is so with this research as the children attended limited sessions. A measuring instrument was also used to gauge the childrens' change of behaviour (See Appendix 3). The variables that were measured were identified before the start of the study. The preceding factors make the study partially quantitative in nature.

1.7 TYPE OF RESEARCH

McKendrick (1990:249) explains two types of research:

- Applied research is knowledge about the practice of social work.
- Basic research is knowledge of a discipline about its subjects.

Bailey (1997:22) supports McKendrick (1990:249) stating that " research can be classified as applied or pure. Pure/basic research involves developing and testing theories and hypotheses that are intellectually interesting to the investigator and might thus have some social application in the future, but have no application to social problems in the present time".

Applied research seeks to develop principles that enable people to resolve problems or to obtain desired objectives. The emphasis is on knowledge for use; the researcher will be using applied research as the results yielded

from the research will contribute to the medical facet of social work and will have future implications as to how social workers involved in medical settings, dealing with diabetic children will effectively manage these children. This effective management will also fulfil the aspect of human betterment that is a focal point in applied research.

1.8 RESEARCH DESIGN

The researcher proposed to use the quasi-experimental design. It is imperative that the researcher who is using such a design be thoroughly aware of the specific variables the design fails to control and take these into account when interpreting the data (Leedy, 1993:302). Data collection methods in quasi-experiments can be questionnaires, indexes and scales which are not necessarily standardised (De Vos & Fouché, 1998:79). Purposive sampling was applied in the research. Some limitations of the quasi-experimental design are that biases can easily slip in because of the lack of randomly allocated subjects and a control group (De Vos & Fouché, 1998:79).

1.9 RESEARCH PROCEDURE AND STRATEGY

The researcher applied the techniques of gestalt group play to the four children included in the study. This strategy allowed the researcher to make use of natural observation to determine whether change occurred as a result of the application of the techniques. The pre-test allowed the researcher to establish a base line working data, which indicated to the researcher where the children were with regards to the areas that the researcher wished to measure. The post-test allowed the researcher to gauge whether change, if any, had taken place from the baseline after the implementation of the play therapy techniques. It is the researcher's opinion that in using this design, the researcher will endeavour to add on to the limited knowledge base of handling children with emotional problems, which emanate from diabetes.

The program was conducted once a week for an hour per session. This was a short-term program of ten sessions. There was no cost involved. This design had no control subjects and there was no random assignment. The subjects or group of subjects were given a pre-test, therapy and then a post-test. Campbell and Stanley (1979:24) refer to this as a **pre-experimental design**. The group acted as their own control. This allowed for internal validity, as the researcher could be reasonably sure that changes that occurred were probably as a result of the program that was administered. The researcher explored a new area. There was a group of four children and intensive therapy sessions were implemented. These elements lend themselves to be qualitative in nature.

Research notation for this design is the following:

O1 X O2

O1 = measurements that occur at pre-testing

O2 = measurements that occur at post-testing

X = represents manipulation or therapy

Pre-testing and post-testing measurement was conducted by means of a questionnaire. The researcher, for her particular study adapted an existing questionnaire. In 1980, Dr. John F. Simonds, an associate professor at the University of Missouri Medical School, compiled it. It was designed to elicit information on the psychiatric status of diabetic youth who were in good control of the illness, as well as in poor control (Simonds, 1980:133-151). The purpose of the study was to determine reactions to diabetes and treatment regimens. The study undertook to investigate the psychiatric status of diabetic children and adolescents. The research results hoped to clarify statistically whether there were differences in the psychiatric status of youth who were in poor diabetic control as compared to children who were in good diabetic control and whether age, sex and duration of illness were significant variables. After the adaptation, the questionnaire measured the impact of gestalt play techniques on the aggression levels, conflict, rebellion, fear of the illness and understanding of the illness in diabetic children.

1.9.1 SINGLE SYSTEMS DESIGN

The single systems design consists of repeated collection of information on a single system over time. This "system" can be individual, family, group or community. Each is created as a single unit for this type of analysis. For specific intervention for this study the researcher used the experimental removal of intervention under the ambit of the single systems design; **A - B - A**. Following then, is a brief review of the basic characteristics of the single systems design, followed by an overview of the **A - B - A** and its characteristics (Bloom & Fischer, 1982:39-43).

- Specify the problem:

The key aspect of a single system design is specifying the problem that the practitioner and client system agree needs to be changed. Such problems might be overt behaviour, environmental barriers or a combination of these and other activities. For many practitioners, leaving problems too vaguely defined is a stumbling block to success. Single systems require that you have clarity on the problem you are working on.

- Measure the problem:

The next key of a single system design is finding a way to measure or observe the problem. Researchers and practitioners alike have developed a wide range of theoretical measurement tools that can be used by practitioners of diverse theoretical orientations to measure everything from behaviour and feelings, family communication and community activities.

- Repeated measurement of the problem:

The heart of single systems design lies in repetitive collection of information on the target problem. The researcher, client/system or relevant others observe the problem over regular periods of time to see whether any changes take place before, during and after the intervention program.

- Determination of a baseline before start of intervention:

A unique feature of single systems design is that of the baseline. The planned, systematic collection of data on the problem before intervention has been initiated. This is usually done for a period ranging from three to four days or three to four weeks. Baseline data (or the baserate) are used to help in the assessment and as a basis for comparison with data collected while the actual intervention program is carried and during follow-up periods.

- Clear definition of intervention:

One of the major contributions of the single systems design is that the practitioner / researcher has to be specific about the intervention program that is being used. There should be a logical approach between the intervention program and the problem being changed. You should be able to differentiate between the formal intervention period and periods where you may not have established a formal intervention program, such as during the assessment / baseline phase. The intervention that was utilised by the researcher was gestalt play therapy techniques.

- Analysis of data:

Unlike other forms of research, single systems designs often rely heavily on purely analysis of changes in the data rather that on complicated statistics. Data that is collected is placed on charts and graphs for easy visual inspection of changes in data patterns (level of data, trends and slope). The researcher relies on the use of graphs to record the client's progress of skill.

1.9.2 EXPERIMENTAL REMOVAL OF INTERVENTION DESIGN A-B-A

In the present design, the researcher decided however to return to baseline conditions, the second A - phase in the A – B – A. Now two adjacent comparisons are possible between the first baseline and the intervention and between the intervention and the second baseline. Presumably the B - phase of this design saw the client attain some stable and desired form of behaviour. Therefore, by removing the intervention we also find out whether or not the client's performance was learned, (that is, whether or not it became a relatively stable part of the client's behaviour, as is often desired by the researcher) (Bloom & Fischer, 1982:44).

1.10 PILOT STUDY

1.10.1 LITERATURE STUDY

Bless and Higson-Smith (1995:22) define literature study as "the process of reading whatever has been published, that appears relevant to the research topic". This process enables the researcher to be aware of existing knowledge on the prospective subject of study.

The literature study is important as it informs the researcher of what research has already been done in the chosen field of study, avoids repetitive publication and investigation of an issue and possibly, someone has already tried to investigate your question and was probably met with insurmountable problems. This information would definitely be useful before embarking on a similar project (Bailey, 1997:12).

The researcher focused specifically on the effects of diabetes on the behaviour of children; that is whether there was any significant behaviour change after the onset of the disease. This includes disobedience to parents/teachers, misery, and withdrawal from their normal life cycle functioning, fear, decreased self-esteem, confidence and rebellion. It was from the literature study that the researcher learnt that these behaviours have been clearly identified with the onset of the disease, however, medical and social disciplines are still at a loss as to what would be the most effective method of therapy for these children, which will complement the medical treatment of the illness.

Cleaver (1994:229) in her studies, stated that control of diabetes mellitus also seems related to psychological factors, that is effective and positive management of the illness will have to encapsulate the mind management, coping skills and acceptance of the illness by diabetic children, further emphasising the sustenance of a healthy mind. Among the common characteristics and behaviour of diabetic children is the denial of the illness by these children. Children may behave as though they were oblivious of the real dangers of the illness (Cleaver, 1994:230). Cleaver also observed another prominent behaviour, namely dependency. She suggests that the rigorous medical regime and imposition of restrictions on the child's activities, coupled with the adjustment of being sick, also allows the child to indulge the family in this way. This often leads to the child seeking secondary gain from the illness.

Other literature focusing on the effects of the illness on a child's behaviour indicate that psychological reactions such as resignation, blaming others for the illness, showing arrogance and rebellion, retreat (characterised by a sense of inadequacy, depression and withdrawal); emotional overreaction, an exaggerated sense of responsibility tends to make the child lose their sense of being a child and becoming a "diabetic". (Compare Barron, 1978:354-357 and Muldoon, 1978:348-353.)

Further studies have indicated that diabetes has negative effects on the self-concept of children inflicted with the illness (Nuvoli, Maioli, Ferrari, Pala and Schiaretti, 1989:83-93). Muldoon (1978:348-353), in his studies

asserts that since significant others treat diabetic children differently they treat themselves differently and find it difficult to feel a sense of continuity and similarity with others.

The researcher is of the opinion that acceptance of changes, where causation is chronic illness, involves a series of value changes, (that is, the feeling that the lost value is no longer needed and that the chronically ill child, although being different, has worth). Such important psychosocial changes further facilitate the healing, acceptance process of the child, thus allowing him to say "I am okay, if I have diabetes, and I will accept and acknowledge this illness".

Coeheler-Giarratana (1978:358-361) states that group therapy with children, who have diabetes, is a valuable tool for changing behaviours. Such therapy can often be helpful since it provides diabetic children with opportunities to share their feelings and experiences with other diabetics. De Villiers (1995:24) supports the suggestion of the above two researchers stating that group therapy allows the children to interact with others who have the illness.

When the researcher takes into account the preceding literature, it is evident that the psycho-social implications of the illness is an issue that is present, however, there is no effective management in this respect. The needs of diabetic children in dealing with the illness have been documented, however ways to deal with these needs have not been widely documented. The research aimed to provide a way forward in this respect.

1.10.2 CONSULTATION WITH EXPERTS

The researcher had contact with Mrs. B. Kruger, the head of the dietetic clinic at Addington Hospital. Mrs. Kruger works closely with the diabetic clinic, and assists with the correct diet for the diabetic children and adults. Consultations with Dr. Robertson, a consultant in private practice and Dr. Paruk, also a diabetic consultant have also voiced concerns regarding the behaviour of these children during their regular check ups at the clinic. Mrs. Kruger belongs to the Diabetic Association of South Africa (D.A.S.A) and being an expert in her field, that is presenting talks and information at pertinent gatherings, has also voiced concern for the effective behaviour management of these children.

1.10.3 FEASIBILITY OF THE STUDY

The researcher is employed as a senior social worker at Addington Hospital in Kwa-Zulu Natal. The subjects for the group were obtained from Parklands diabetic clinic. The study was not conducted during work hours, and there was no cost involved.

Consent letters were administered to the parents of the children that participated in the program, (see Appendix 1). Consent was obtained to conduct gestalt group work sessions in the therapy rooms of William Clark Gardens Children's Home, (See Appendix 2).

1.10.4 PILOT STUDY

The study of specific entities implies the process through which the researcher exposes two cases to exactly the same procedures as planned for the main investigation, in order to modify the measuring instrument (Strydom & De Vos , 1998:182). These two children did not form part of the sample.

In the researcher's opinion, this is an important process, as it allows the researcher to make modifications or adjustments to the instrument, before it is administered to the sample population for the study.

1.11 DESCRIPTION OF THE RESEARCH POPULATION, DELIMITATIONS, BOUNDARY OF SAMPLE AND SAMPLING METHOD

A research population is the set of elements that the research focuses upon and to which the results obtained by testing the sample should be generalised (Bless and Higson-Smith, 1995:87). This indicates that the research population is the whole set of elements from which the sample is drawn.

The research sample for this study consisted of four children; boys and girls, between the ages of eight and twelve years. The respondents were selected from the Diabetic Clinic at Parklands Hospital.

According to Strydom & De Vos (1998: 191), a sample is the element of the population considered for actual inclusion in the study. It can be viewed as a sub-set of measurements drawn from the population. The subjects of the sample constituted a group, that is a purposive discussion on the specific behaviours of the illness took place between four individuals of similar background and common interests, and whose diabetes were well controlled.

For the purpose of this study, purposive sampling as a method of non-probability sampling was used. The judgement of the researcher was utilised regarding the characteristics of the representative sample.

1.12 LIMITATIONS OF THE STUDY

- The literature study regarding effects of gestalt group work on the psycho-social aspects of juvenile diabetes was a difficult undertaking as recent literature was not readily available;
- During the empirical study the researcher experienced a poor response to invitations to participate in the group sessions;
- Parents of respondents thought that the group sessions were a form of "manipulative mind therapy" even though its aims and interventions were explicitly explained.

1.13 DEFINITION OF KEY CONCEPTS

The following key concepts are defined:

1.13.1 GESTALT

Perls (1977:277) states that the aim of gestalt therapy is to train the ego, the various identifications and alienation, by experiments of deliberate awareness of one's various functions, until the sense is spontaneously revived that, "It is I who am thinking, perceiving, feeling and doing this". According to Hardy (1991:3) gestalt therapy has to do with self-regulation through awareness enhancement. Gestalt therapy is an experiential therapy. In the researcher's opinion, gestalt is closing up the various "holes" of unfinished business or traumatic situations that clients experience in life. Pertinent in the diabetic child's life will be unfinished business of conflict, rebellion, fear of the illness and lack of understanding of the illness. Assimilating these will bring the child to a place of understanding and will close these gestalts, allowing him/her to deal with the illness.

1.13.2 GESTALT GROUP WORK

Gestalt group work is defined by Thompson and Rudolph (1992:293) as a challenge to the participants to become aware of how they are avoiding responsibility for such awareness and to encourage them to look for internal, rather than external support. Hardy (1991:83) states that gestalt group work enhances accurate awareness for the person working and facilitates the therapist beyond what would be accomplished individually. The researcher, for the purpose of this research, will define gestalt group work as a technique used to empower group members. The children are in a constant state of learning, as they experiment with different behaviours within the safety of a group setting.

1.13.3 DECREASE

The Collins English dictionary defines decrease as a "reduction or diminution" (1990:219). For the purpose of this study, the word will be used to describe a change in behaviour from a high incidence to a low incidence.

1.13.4 PLAY TECHNIQUES

Schoeman (1996:16) states four types of play techniques, relaxation play (aims at reducing tension in the child and opens him/her up to therapy), assessment play (is used to examine the child client's skills and his/her level of development), dramatic play (has various functions such as remodelling family life or expression of aggression or regression), creative play (is aimed at ventilation of feelings) and biblio-play (leads to the development of insight and working through of feelings). Oaklander (1988:53) states that play techniques enable the child to become aware of him/herself and their existence in the world. She also states that it helps the child establish an identity and provides a non-threatening way of them expressing their emotions, even those that the child may fear to express

because of the pain associated with these emotions. According to the researcher play techniques that will be used in the study will direct the child towards uninhibited and satisfying growth. These play techniques will involve the mediums of clay, puppets, sand and any other acceptable play that the researcher and child may bring into the group sessions.

1.13.5 AGGRESSION

Aggression is defined in the Collins English Dictionary (1990:15) as "a tendency to make unprovoked attacks, being quarrelsome or belligerent". Emotions and behaviours associated with aggression are misery, rebellion, conflict, lack of self-esteem and confidence, isolation and withdrawal. The preceding are the precursors for aggression to be initiated. For the purpose of this study the researcher will be defining aggression according to the above-mentioned behaviours.

1.13.6 DIABETES MELLITUS

Diabetes mellitus can be defined as a chronic disorder characterised by a level of glucose in the blood (Bloom, 1980:11). This condition is characterised by the inability of the pancreas to make insulin, which is required for normal metabolism (Atkinson & Maclaren, 1990:42).

1.13.7 JUVENILE DIABETES MELLITUS

Primary diabetes (juvenile-onset type one diabetes) starts most commonly in young adults or children, the cause is unknown. Yousef (1993:29) defines juvenile diabetes as a life long error of carbohydrate metabolism resulting from a relative or absolute deficiency of insulin caused by destruction of the beta cells in the islets of Langerhans. The researcher defines juvenile diabetes as an absence of sufficient insulin in the body, thus resulting in the diabetic condition.

1.14 CONTENTS OF RESEARCH REPORT

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Chapter 2: Literature study: Juvenile diabetes mellitus

Chapter 3: Literature study: Group work play techniques and gestalt

Chapter 4: Empirical study

Chapter 5: Summary, conclusions and recommendations

CHAPTER TWO

JUVENILE DIABETES MELLITUS

2.1 INTRODUCTION

Insulin-dependent Diabetes Mellitus (IDDM) also known as type 1 or juvenile diabetes is a chronic life-long disorder, which involves consistent teaching and support from the relevant professionals (Hillson, 1996:29). The preceding opinion by Hillson clearly emphasises that juvenile diabetes is an illness that requires a multi-disciplinary team approach. Yousef (1993:29) supports the above opinion, stating that, in addition to its impact upon physical development this condition may have various effects on psychological and behavioural development.

In this chapter the researcher will proceed to discuss the definitions of medical concepts, the different causes of juvenile diabetes, symptoms associated with juvenile diabetes, treatment of the disease and the psycho-social issues related to juvenile diabetes.

2.2 DEFINITION OF MEDICAL CONCEPTS

Yousef (1993:29) defines relevant medical concepts in the following manner: -

2.2.1 GLUCOSE

Glucose is produced by the breakdown of carbohydrates in the body, through metabolism.

2.2.2 KETOACIDOSIS

Ketoacidosis is when the body starts to breakdown muscle tissue to produce energy for the body. This results in ketones being present in the blood.

2.2.3 HYPOGLYCAEMIA

Hypoglycaemia is a rapid fall in blood glucose due to an overdose of soluble insulin in the blood. The symptoms are sweating, anxiety, restlessness, tremors, hunger, paraesthesia and palpitations. Decerebration or death can ensue if the hypoglycaemic state is allowed to persist.

2.2.4 HYPERGLYCAEMIA

Hyperglycaemia is an increase of blood glucose. There are many different factors that can influence blood glucose levels. They could be hereditary, environmental or hormonal.

2.2.5 BETA-CELLS

Beta-cells make up 80% of the cells in the pancreas. They produce insulin, which is vital in glucose breakdown. They are also called (B) cells. They are located in the islets of Langerhans.

2.2.6 GLYCOSURIA

Glycosuria is the presence of glucose in the urine.

2.2.7 POLYURIA

Polyuria is the production of large amounts of urine.

2.2.8 POLYDIPSIA

Polydipsia is the consumption of large amounts of liquids.

2.2.9 POLYPHAGIA

Polyphagia is the consumption of large amounts of food.

2.2.10 ISLETS OF LANGERHANS

Islets of Langerhans house the beta cells (insulin producing). These are found in the pancreas (Bloom, 1980: 26-70).

2.3 THE DIAGNOSIS OFJUVENILE DIABETES MELLITUS

Comprehensive multi–disciplinary care is essential for diabetic children. No professional is solely able to administer good care, so that nurses, social workers and dieticians should also be involved with the care of the patient (De Villiers, 1995:21). Juvenile diabetes mellitus (type 1), also termed insulin dependent diabetes (IDDM) is a life–long error of carbohydrate metabolism, resulting from a relative or absolute deficiency of insulin caused by the destruction of the beta–cells in the islets of Langerhans (Yousef, 1993:29). Type II or maturity onset type diabetes and the much rarer types of diabetes are usually associated with other hereditary disorders. The cause of some forms of diabetes is known and they are therefore known as secondary diabetes (Bloom, 1980:11).

2.3.1 JUVENILE–ONSET (TYPE I) DIABETES

Bloom (1980:11-12) states that the following characteristics are usually exhibited by individuals diagnosed with juvenile type I diabetes. This type of diabetes starts most commonly in children or young adults, but it may occur at any age, often in the very elderly. It is characterised by the rapid onset of symptoms especially thirst, polyuria and lassitude. There is usually considerable loss of weight and most diabetics of this type are underweight at diagnosis. According to Fajans (1996:252), who also supports this view, the affected patient experiences an abrupt symptomatic onset of disease secondary to severe insulin insufficiency (polyuria, polyphagia, weight loss and fatigue), is prone to ketosis and is thin. Insulin dependency implies that the administration of insulin is essential to prevent spontaneous ketosis, coma and death.

Occasionally however, type I diabetes can occur in the overweight. Other common symptoms include blurring of vision, paraesthesia, cramps in the muscles, pruritus vulvae, balanitis and a proneness to infection. The urine at diagnosis contains sugar and significant amounts of acetone, while

blood examination reveals evidence of dehydration (a raised urea and haematocrit), a tendency to ketoacidosis and a blood glucose exceeding 12 mmol /L. (Bloom, 1980:11).

2.3.2 PROCESS OF JUVENILE DIABETES TYPE– I

Yousef (1993:29), in his article explains the process of juvenile diabetes as the following. In this condition, the body cannot use sugar (glucose) normally. Consequently, the sugar level in the blood is elevated (hyperglycemia) and sugar appears in the urine (glycosuria). In an attempt to maintain normal concentration of blood, the kidneys excrete sugar and with it large quantities of urine (polyuria). Polyuria in turn, leads to dehydration and consequently to great thirst and drinking large amount of liquids (polydipsia). Since sugar is not utilised by the body cells due to lack of insulin, the child feels hungry and starts to eat excessive amounts of food (polyphagia), loses weight, gets tired and weak.

These clinical manifestations develop suddenly, usually between the ages of eight and twelve.

2.4 THE DIFFERENT CAUSES OF JUVENILE DIABETES

2.4.1 INHERITANCE

About 10% of children who develop diabetes have a sibling or parent with the disorder, whereas only 1% of non–diabetic children have a relative who is diabetic. Two conclusions therefore emerged from research carried out by Bloom (1980:12), namely, that there is undoubtedly a hereditary component in the transmission of diabetes, however since 90% of children developing diabetes have nobody in the immediate family with the disorder, the hereditary factor cannot be the only factor and is probably not the most important. His research further indicates that it is unlikely that the hereditary disposition to diabetes is due to a single recessive gene but rather that varying combinations of alleles are responsible. According to Eisenbarth (1996:288), who supports the allele theory, the natural history of diabetes mellitus begins with genetic susceptibility. Essentially everyone who develops type I diabetes mellitus has inherited susceptibility alleles, except for individuals with the autoimmune polyendocrine syndrome type I where a major portion of this susceptibility is mapped to the human leukocyte (*HLA)* region of chromosome 6.

2.4.2 ENVIRONMENTAL FACTORS

Bloom (1980:72) has also investigated environmental factors and their effects on the frequency of episodes of glycosuria. Evidence accumulated from this research points to viral infection, which when super imposed on genetic factors may lead to cell-mediated autoimmune destruction of Beta-cells and most likely to precipitate diabetes. This view is also shared by Fajans (1996:251) who states that acquired factors namely, certain viral infections, nutritional and chemical agents when combined with a pre-disposition towards having the disease can cause juvenile diabetes. Diabetes in children occurs more frequently in the summer months, than it

would in the winter months when virus infections are epidemic. However substantive proof is yet to be found.

2.5 PRIMARY DIABETES - AETIOLOGY UNKNOWN

Table 1: Primary Diabetes

(Bloom, 1980:11)

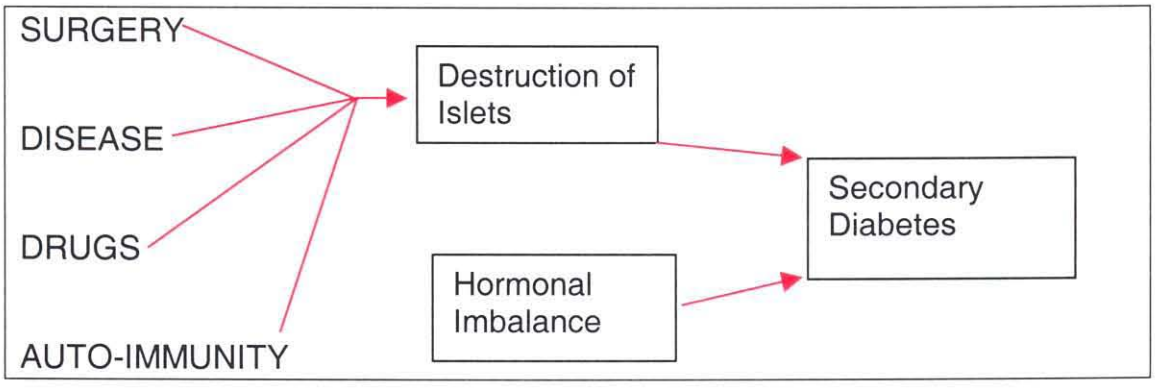
TYPE I:	JUVENILE – ONSET
TYPE II:	MATURITY – ONSET
TYPE III:	ASSOCIATED WITH OTHER GENETIC DISORDERS

The above table indicates that diabetes can develop in juveniles where the cause is unknown and it is commonly referred to as type I diabetes. The illness can also develop in adult life where it is referred to as type II diabetes and the cause is also unknown. One can also develop diabetes when one has inherited other disorders, which can subsequently cause the individual to be susceptible to developing the illness. The common trait in the above three types is that the onset and cause is unknown.

2.6 SECONDARY DIABETES - AETIOLOGY KNOWN

Figure 1: Causes of Secondary Diabetes

(Bloom, 1980:11)



The above figure indicates that the causes of secondary diabetes are known. The following are explanations of how secondary diabetes can be introduced into the body: -

2.6.1 SURGERY

The first cause of secondary diabetes is surgery, where a section of the pancreas is removed by disease. However, at least three quarters of the pancreas can be removed without diabetes resulting, providing that the remnant is healthy and not under stress by obesity, drugs or cortisone therapy. Since the pancreas is the sole source of insulin, diabetes inevitably follows total pancreatectomy.

2.6.2 DISEASE

Disease is the second cause of diabetes. This can occur in two ways, namely in alcoholics where pancreatitis occurs and in haemochromatosis, which is an inherited disorder in which excess iron is absorbed and deposited in various organs including the liver, heart, pancreas and testis.

2.6.3 DRUGS

The third cause of diabetes is from drugs which can exert a diabetogenic effect, probably by suppressing islet cell release of insulin.

2.6.4 AUTO-IMMUNITY

The fourth cause of diabetes is auto-immunity where there is a failure of the immune system. Here we find that diabetes can co-exist with illnesses such as Addison's disease, hypogonadism and thyroid disorders.

2.6.5 HORMONAL IMBALANCE

The fifth cause is hormonal imbalance. This occurs when hormones are introduced into the body by medication or produced in excess by the body. Here the action of insulin is submerged and secondary diabetes occurs usually when the hormonal stress is removed (Bloom, 1980:11).

2.7 SIGNS AND SYMPTOMS ASSOCIATED WITH JUVENILE DIABETES

The researcher's simple understanding of diabetes is that the endocrine system of the body has an imbalance. For some reason there is not sufficient insulin to cope and so excess sugar accumulates in the blood. This excess sugar blocks the whole energy system, and the body realising the shock to the system, attempts to create balance by excreting it through the kidneys. The extra sugar is thus passed out in the urine, frequently. This increase in loss of water causes the individual to become thirsty, and copious amount of water is consumed. The two main symptoms of diabetes are passing increased amounts of urine and feeling thirsty all the time.

2.8 TREATMENT OF THE DISEASE

It usually comes as a shock to parents when they find their child has developed diabetes. They may feel guilty about it and think that perhaps the fault may be theirs. Of course this is an emotional response and has no foundation in fact. According to Bloom (1986:30), there are four aspects of diabetes which are imperative in the treatment of the disease and which should be taught to children: -

- How to draw up and inject insulin – most children over the age of six or seven should be able to inject themselves,
- What the diet is and especially which foods are carbohydrate and how much can be taken at each meal,
- When and how to test the urine or blood for sugar,

- To recognise hypoglycaemic reactions, to know what is likely to bring them on and to take sugar in good time.

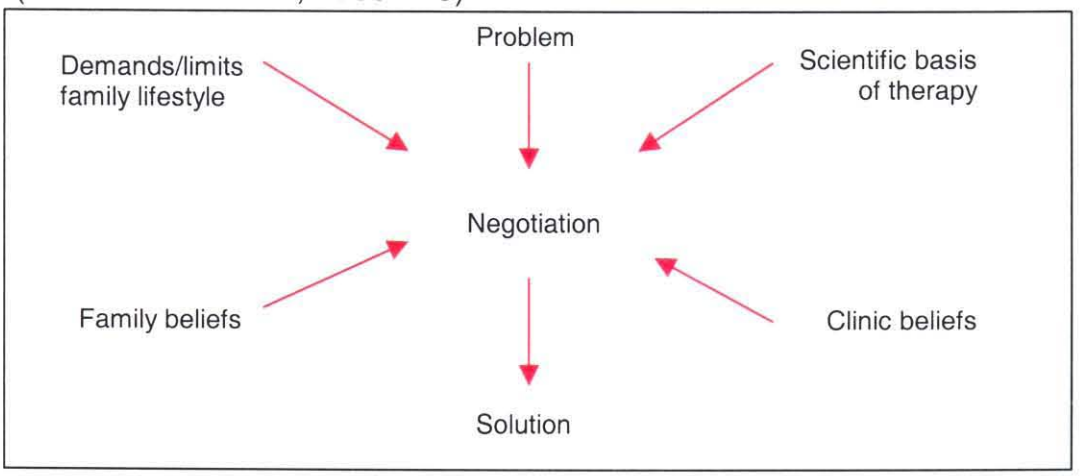
The above four factors is the foundation that should be built into every diabetic child's life. This will allow the child to lead a full and active life.

- *Dietary management*

The main rule to observe when one is diagnosed with diabetes is that if one is overweight, then one needs to lose weight. The diet according to Hillson (1996:48) is divided into three types of food categories, namely carbohydrates, fat, protein. In diabetes, however, the most important component is carbohydrates. This carbohydrate as well, has to be less refined, more natural and needs to contain a good deal of roughage and fibre. Carbohydrates like wholemeal bread, vegetables, peas, beans and lentils are good not only for the diabetes, but for the bowels as well. Hillson (1996:25) supports the above opinion, saying they take a longer time to eat and digest and do not increase the sugar in the blood. Jones (1998:115) also emphasises the distribution of meals within the day in amounts to balance the effects of injected insulin.

Figure 2: Dietary Management of Diabetes

(Baum & Kinmonth, 1985:113)



The above figure demonstrates that the dietary management of diabetes is not solely dependent on maintaining a proper diet. The diabetic diet is contingent on how the family perceives the diet and how it fits within the family's present diet, lifestyle and belief system. The dietician should be involved closely with the family in planning meals from the time of diagnosis. The dietician will also be most effective if she understands the current medical management of the child, and should also join the doctor on occasions during the clinic consultation before seeing the family herself to clarify the details of a dietary problem.

- *Exercise*

Before the discovery of insulin, diet and exercise were the principal therapies used in the treatment of diabetes mellitus. Horton (1996:395) states that insulin-dependent diabetic patients were severely limited

because of the associated metabolic abnormalities, including muscle wasting, dehydration and ketosis.

**Benefits of Exercise For Patients With Insulin-Dependent Diabetes Mellitus (Horton, 1996:395).*

- Lower blood glucose concentration during and after exercise.
- Improved insulin sensitivity and decreased insulin requirement.
- Improved lipid profile.
- Increased energy expenditure.
- Improvement in mild to moderate hypertension.
- Cardiovascular conditioning.
- Increased strength and flexibility.
- Improved sense of well-being and enhanced quality of life.

**Risks of Exercise For Patients With Insulin-Dependent Diabetes Mellitus (Horton, 1996:396).*

- Hypoglycemia.
- Hyperglycemia after very strenuous exercise.
- Hyperglycemia and ketosis in insulin-deficient patients.
- Precipitation or exacerbation of cardiovascular disease.
- Worsening of long term complications of diabetes.

**Checklist Before Starting Exercise*

Horton (1996:395-402) advocates the following checklist for insulin-dependent diabetics before exercise can be initiated.

- **The Exercise Plan**
  - Will the exercise be habitual or unusual?
  - What is the anticipated intensity of exercise?
  - How does it relate to the level of physical training?
  - How long will it last?
  - Will it be continuous or intermittent?
  - How many calories will be expended?

- **The Plan For Meals And Supplemental Feedings**
  - When was the last meal eaten?
  - Should a high carbohydrate snack be eaten before starting?

- Should supplement carbohydrate feedings be taken during exercise? If so, how much and how often?
- Will extra food be required after exercise to avoid post exercise hypoglycemia?

- **The Insulin Regimen**
  - What is the usual insulin mixture and dosage?
  - Should it be decreased before or after exercise?
  - When was the last insulin injection?
  - Should the injection site be changed to avoid exercising areas?

- **The Pre-Exercise Blood Glucose Concentration**
  - Is the blood glucose concentration in a safe range to exercise (100-250 mg/dL)?
  - If the blood glucose concentration is less than 100 mg/dL, a prerequisite carbohydrate snack should be taken to decrease the risk of exercise-induced hypoglycemia.

2.8.1 MONITORING OF GLUCOSE LEVELS

Seedat (1998:15-20) recommends the following procedure when home blood glucose levels are done, when a patient begins insulin therapy and when insulin is being administered to a patient.

2.8.2 PROCEDURE

- Patient to wash hands thoroughly with soap and water and dry them.
- Patient to hang arms for 30 seconds at side to increase blood flow to the fingers.
- Test strip to be placed on flat surface.
- Select the site on the side of any fingertip.
- Puncture site using the monojector machine and a lancet.
- Gently squeeze the finger in downward motion to obtain a large enough drop of blood to cover the reagent pad on the test strip.
- Leave drop on the strip for 60 seconds before wiping off the blood, wait for another 60 seconds before reading.
- Read and record the results accurately.

2.8.3 EQUIPMENT NEEDED FOR HOME MONITORING

- Reagent strips
- Blood letting devices
- Cotton wool swab
- Watch with a second hand
- Record chart or diary

2.8.4 ADVANTAGES OF HOME BLOOD GLUCOSE MONITORING

- Patients are more secure and better able to control hypoglycaemia.
- Patients are able to vary their insulin dose.
- Patients are better able to handle emergencies.

2.8.5 INSULIN TREATMENT

According to Seedat (1998:15-20), insulin treatment should only be introduced when patients have been on a diabetic diet and tablets for many years and do not respond to either. The blood glucose is usually above 12/*mmol /l.*

However, even before insulin therapy is initiated, the researcher is of the opinion that the patient should be re-assured and anxiety dispelled. This is supported by Seedat (1998:17) where he states that interest relieves anxiety and encourages motivation of the patient to better self-care.

2.8.5.1 Insulin treatment begins

The importance of three big meals and three snacks is explained. The duration of insulin action is shown simply over 24hours by illustrating it or using an insulin action duration chart. Signs of hypoglycaemia are explained simply and the patient is instructed that sugar/glucose sweets should be at hand at all times. The nursing sister discusses sites of injection, uses of insulin, the proper injection technique and the patient is also taught how to utilise the home blood glucose monitoring with "sticks". Seedat (1998:15-20) suggests the following requirements for patients who are insulin dependent.

2.8.5.2 Requirements for insulin regime

- Must provide flexibility and adaptability.
- Must suit or fit the needs of an individual, example pregnant, old or young.
- Must suit the patient's situation.

2.8.5.3 Types of insulin

- Rapid acting
- Intermediate acting

- Intermediate long acting

2.8.5.4 Care and Storage of insulin

- Keep insulin in the refrigerator, but not to be frozen.
- If a refrigerator is not available, store in a cool place away from direct sunlight.
- Extra bottles of insulin to be kept in the refrigerator.

2.8.5.5 Duration and Peak Action of Different Insulins

Hillson (1996:77-78) describes the different types of insulin as the following:

❖ *Short-acting insulin*

Short-acting insulin is made by the normal human pancreas. This is a clear, colourless fluid which, when released into the blood stream via the portal vein, produces an effect upon the blood glucose within minutes. All short-acting insulins are clear and colourless. The main difference between insulin in a non-diabetic and the insulin in the diabetic person is its route of delivery into the bloodstream and the lack of control. Even continuous insulin infusion cannot mimic the finely tuned response of the normal pancreas, and its role in insulin production.

❖ *Intermediate-acting And Long-acting Insulins*

Intermediate-acting and long-acting insulin suspensions are modified to reduce their solubility and hence to prolong their absorption from the insulin injection site. There are several methods of modifying insulins. Isophane (NPH) insulin is produced by adding protamine and a small amount of zinc at body pH. This produces insulin which last for about 12 hours. Short-acting insulin can be mixed with isophane insulins and the mixture will remain stable. This is the basis of the fixed proportion mixtures, or of mixtures made by the patients themselves.

❖ *Combination or Pre-mixed insulins*

Combination or pre-mixed insulins are stable mixtures containing proportions of short-acting insulin and isophane (NPH) insulin. There are mixtures containing as little as 10% or as much as 50% short-acting insulin. These mixtures are inflexible and if the dose is increased both the short-acting and the iosphane insulin dose is increased. However they have gained popularity because of their simplicity and their avoidance of drawing-up errors.

2.9 RELATED DISEASES OF JUVENILE DIABETES

2.9.1 VASCULAR DISEASE

Jones (1998:49) states that diabetics are liable to develop changes both in the large and small vessels. The term arteriosclerosis includes both atherosclerosis (formation of fatty plaques, which may ulcerate and calcify providing a surface suitable for thrombus formation) and medical calcification (Monckeberg's sclerosis; this is liable to occur in longstanding diabetes irrespective of age, but it does not necessary impair circulation or function). The thrombus formation heralds the onset of acute myocardial infarcation (Brunzell & Chait, 1996:772-780).

2.9.2 THE FEET

Especially in the diabetic, care of the feet plays a crucial role in the prevention of disability. The diabetic often becomes divorced from his/her feet: poor vision prevents his/her seeing them and loss of sensation precludes his/her feeling them. Consequently only a conscious programme of regular inspection and care can avoid the vascular damage by trauma or heat. Occlusion of the vascular supply causes ulceration of the skin or gangrene of the area can occur (Jones, 1998:40).

Photograph 1: Superficial Ischaemic Necrosis

(Jones, 1998:42)

Superficial Ischaemic Necrosis of big toe caused by the diabetic patient wearing an ill fitting shoe.

The above photograph depicts the big toe of a diabetic patient who has developed gangrene due to the patient wearing a tight fitting shoe. The ulcers are usually shallow and indolent.

Photograph 2: Ulceration of Metatarsal

(Jones, 1998:38)

Ulceration of metatarsal
due to pressure of footwear.

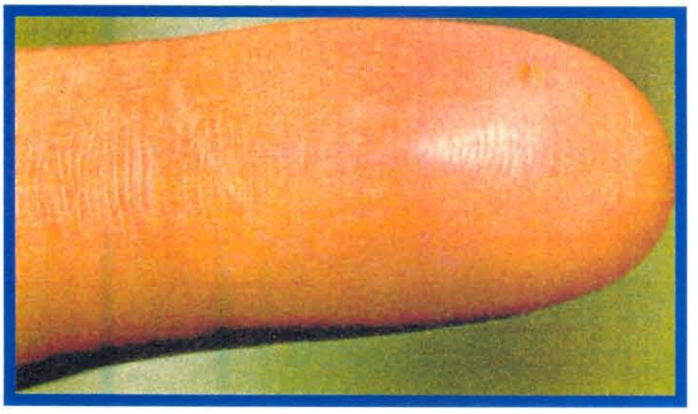
The above photograph depicts the ulceration of a diabetic patient's metatarsal due to the pressure exerted on this area of the body.

2.9.3 THE SKIN

Examination of the skin may reveal important information regarding diabetes. Infection of the skin is common in the untreated patient and insulin may cause changes in the skin and subcutaneous tissues at the site of infection. According to Bloom (1980:42) *Candida Albicans* is a yeast infection that thrives in moist areas of the skin and particularly in uncontrolled diabetes with raised glucose levels in the tissues. Another common condition is *Epidermophytosis, which* is commonly called athletes foot. The infection here occurs between the toes and leads to sogginess and maceration of the skin in the toe clefts. It may also be present in the groins as reddened, moist and irritating areas (*tinea crusis).*

Photograph 3: Septic Pulp

(Bloom , 1980:57)



Septic Pulp in young diabetic girl who has been using the finger to test her own blood sugars.

The above photograph depicts a soft, moist mass (septic pulp) at the point of blood glucose testing, in a teenage female.

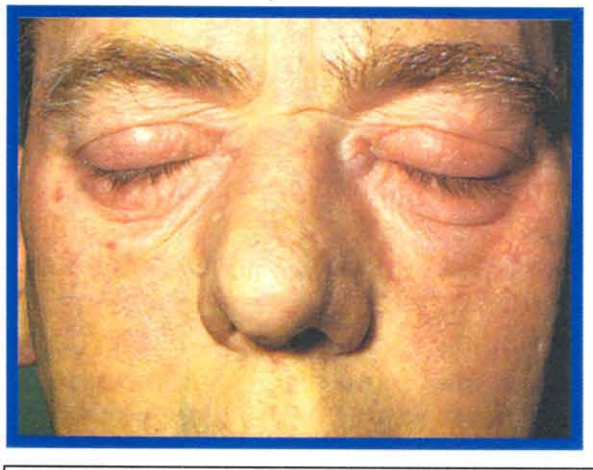
2.9.4 THE NERVOUS SYSTEM

Diabetes can be responsible for disorders of the nervous system because of treatment. Some of the systems that diabetes can affect are the cardiovascular system, renal system, gastro–intestinal tract and also the reproductive organs of male suffers although this is most common after 20 years of diabetes (Bloom, 1980:71).

2.9.5 THE EYE

Photograph 4: Blepharitus

(Bloom , 1980:86)

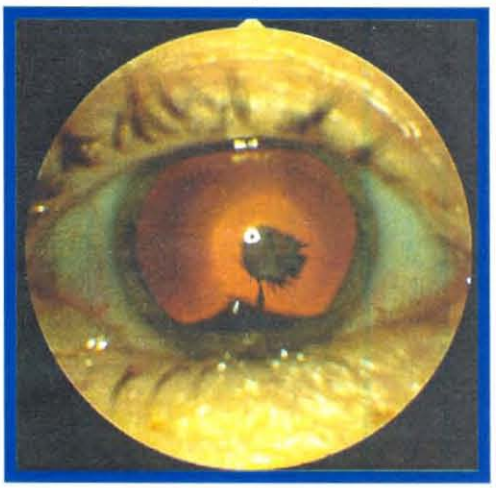


Blepharitis: Inflammation and swelling of both upper and lower lids with encrusted eyelashes. 56 year old patient with history of recurrent styes, found to have glycosuria and hyperglycaemia at eye clinic.

The above photograph depicts an adult diabetic. The patient presented at the diabetic clinic with a history of recurrent inflamed swellings on the eyelid (styes). Subsequently he was found to have glucose in his urine and elevated sugar levels in his blood.

Photograph 5: Cataract in Diabetes Mellitus

(Jones, 1998:22)



The above photograph shows a central cataract or lens opacity obscuring full view of the fundus and interfering with the normal "red reflex."

Some young people with Type 1 diabetes may develop an acute form of rapidly developing lens opacity known as "snowflake cataract." This typically, though not invariably follows a period of particularly poor blood sugar control and the cataract may appear and mature in the space of a few weeks (Jones, 1998:23).

2.10 PSYCHO-SOCIAL ISSUES RELATED TO JUVENILE DIABETES

2.10.1 INTRODUCTION

In the researcher's opinion, there are multiple assessment issues relevant to the treatment of children with diabetes. Ollendick (1998:421) states that youngsters with diabetes usually function adequately in the classroom with IQ scores in the normal range, however hypoglycemia is clearly associated with cognitive and motor impairments, even when the child is not hypoglycaemic. He suggests further that there is subtle evidence of neuropsychological effects that may interfere with some children's cognitive functioning. Ryan (1990:58-84) extends this idea by stating that frequent school absences related to the illness may also contribute to the problem.

Chronic illnesses, like diabetes, require the patient to manage the disease on a daily basis. According to Ollendick (1998:422) and Lorenz (1985:875-

876) the most consistent findings are the inadequacy of patient knowledge, whether the patients are children or adults. In the researcher's opinion, it is therefore not surprising that diabetic children exhibit behaviour problems, arising from lack of understanding and knowledge about the illness.

Diabetic children have been found to have a higher rate of psychiatric disorders than children without diabetes (Blanz, 1993:5). A longitudinal study by Kovacs (1996:32) found that half of the children with juvenile diabetes followed for average of nine years, met the criteria for one or more psychiatric disorders, the most common being depression, anxiety and disruptive behaviour. Capra (1998:536–541) noted that the large number of anxiety disorders, especially simple phobia, social phobia and separation anxiety disorder, is especially important to note because of their possible mutually influencing relationship with episodes of repeated illness and subsequent hospitalisations. In the researcher's opinion it is common knowledge that children with chronic illnesses have a complex array of medical, educational, emotional and social needs. Self–awareness and realisation of illness present a major source of stress for diabetic children (Yousef, 1993:30). A study done by Cleaver (1994:263) on the effects of diabetes mellitus as a chronic illness on the emotional state of children, found that the presence of chronic illness may produce an at risk state which results in some children losing confidence in themselves because they are unable to accept being "different" by others.

The researcher is of the opinion that it thus follows that the occurrence of stressful events may influence adaptation to the diabetic regimen. This idea is supported by Lorenz (1985: 872–876) who states that adolescent patients appear to be particularly vulnerable to adherence difficulties in stressful events.

Tattersall and Louwe (1981:872–876) eloquently describe how diabetes often interferes with most of the goals of normal adolescence:-

- During this developmental period when it seems so important to conform to peer standard, youngsters with diabetes may feel "different" because of disease associated delayed sexual maturation as well as numerous unusual behaviours (example injections, glucose testing), associated with their daily management regimen;
- Dietary demands require frequent meals and snacks and the avoidance of food high in fat and concentrated sweets;
- The adolescent with diabetes is faced with the paradox of needing to eat foods when no one else is eating and needing to avoid foods everyone else consumes.

De Villiers (1995:24) states the importance of emotional nurturance of the diabetic child. She advocates group therapy and individual therapy for diabetic children and emphasises the importance for diabetic children to meet with other diabetic children so they can see that they are not alone and that other people also experience similar problems. To follow will be a

discussion of the different social systems that affect the diabetic child's life and how they influence the life system of the child.

2.10.2 THE DIABETIC CHILD WITHIN THE FAMILY

Cleaver (1994:272), in her study states that over-protectiveness from families does not promote independence resulting in the children withdrawing, their boundaries shrinking and horizons narrowing. She extends this thought by saying that the families who do not foster independence and are over-protective are those who contain members who are anxious, afraid and worried. However, the researcher feels that this response will be dependent on how the family perceives the history of diabetes.

Feelings that the family, associated with a relative who had diabetes and died as a result, may be displaced onto the child in the present. This type of pathologic displacement is evident when a family member dies from diabetes. It is this unspoken fear among family members that might get the family thinking erroneously that the child might die early as well, causing over-protection and smothering (Cleaver, 1994:272).

2.10.3 THE PARENTS OF THE DIABETIC CHILD

The researcher is of the opinion that children are their parents' immortality. The child's health is of utmost concern to the parents. The onset of any chronic illness is therefore a loss and a disappointment.

Diagnosis of chronic illness triggers the bereavement process in a parent, especially if a parent has the disease, there may be much self-blame. Hillson (1996:162) extends this thought. He says that feelings of grief, sadness, anger and regret will surface intermittently, especially during the first year and at special occasions. Parents shopping for Christmas for instance, may have to change their initial shopping patterns and may feel resurgence of their initial sadness or regret.

Anger may be directed towards the child for being diagnosed with the illness, although the parents know it is illogical. The anger could also be displaced onto a spouse, another child or any other detail that allows ventilation of this anger.

Another dynamic present within this dyad is that of independence. In the researcher's opinion the purpose of proper parenting is to enable the child to take on the job of future parenting. Independence from the parents is therefore the ultimate aim. Baum & Kinmonth (1985:49) states that the presence of diabetes makes this independence difficult to achieve. The primary reason being that the child is dependent on the parent for routine injection check-ups, diet and related responsibilities of diabetes care.

However, a critique of this by Hillson (1996:158) advocates that children and parents need to explore with diabetes and its limits so that flexibility can be introduced into the diabetic regime thus eliminating the dependency. One should also take note that financial aspects of management might also represent major sources of stress for parents,

which could occur through frequent admissions, mandatory check-ups and purchasing of insulin.

2.10.4 THE DIABETIC CHILD

One needs to bear in mind that without a chronic illness, the psyche of a child is impressionable and fragile, so it follows that extra care should be taken when managing the psyche of a diabetic child.

Children with diabetes often feel damaged. Cleaver's (1994:270) study on diabetes mellitus and its chronic effects on children, found that the pronouncement of the diagnosis of diabetes posed an even greater threat to the existence of the subjects. Her study further revealed that feelings of fear, uncertainty, vulnerability and hopelessness were reinforced amongst her subjects.

Although children have been told at the time of their diagnosis that they are not going to be cured of the illness, they still harbour a dream that they will (Baum & Kinmonth, 1985:52). Some become depressed, angry and anxious. This idea is taken up by Cleaver (1994:269) where she reports that her subjects lived their lives as if their symptoms did not exist, however as the symptoms took a greater hold of each subject and caused increasing physical and emotional distress, it gradually dawned on them that something was seriously amiss and that they could not avoid facing the bodily changes that had occurred.

The researcher is of the opinion that diabetes is an added stressor for an already overburdened family. Not only will the physical care be poor but the emotional care may be erratic and unreliable and thus relationships within the family may be distorted. It is therefore of utmost importance that a social worker be involved in the team that is responsible for the diabetic child. Problems mentioned above, need to be brought to the attention of the social worker, so that solutions can be reached.

The researcher provides the following reasons as to why diabetic children exhibit behaviour problems: children do not fully understand the illness and each child will have his/her own perception of diabetes. There may be times however when these perceptions interfere with the understanding of diabetes, or make the child feel frightened and unhappy. It is then that the child should be encouraged to talk about them to obtain a better understanding.

Another important factor that the researcher feels is a major source of distress and worry for children and their parents, is monitoring. Whatever decisions are made about monitoring should be discussed with parent and child to ensure that what is decided, is the best for that particular family.

2.10.5 THE JUNIOR SCHOOL CHILD AND DIABETES

The junior school child and diabetes is an issue the researcher felt that required discussion, as the subjects for the research occupied this category. The start of school coincides with the child's need to distance himself/herself from the family. Du Toit and Kruger (1996:116-119) state

that the affective development of the primary school child is specific, diverse and sophisticated. One of the characteristics of affective development is fear. This stage of the child's life is pre-occupied with supernatural powers, contemporary issues, that is, HIV/AIDS and it follows that diabetes would be approached with the same mind frame. In this stage the child is also prone to bedwetting, anxiety, psychosomatic problems, noisy behaviours and suppressed fear.

According to Du Toit and Kruger (1996:116-119) the child has to experience the following stages: mastery of the physical skills necessary for play; the forming of a positive attitude towards their body; the mastery of the basic skills (scholastic); formation of conscience and morality; stabilisation of personal independence in order to achieve normal developmental milestones. The researcher is of the opinion that the rebellion, non-compliance to regimes, cheating on results, depression, anxiety, withdrawal and anger will be dominant as the primary school diabetic child battles to create his/her independence, while simultaneously being instructed to by parents, clinicians and the like, regarding adherence and treatment of the illness. This constant battle produces a child of low self-esteem.

Parents should express concern and affection for the child, but at the same time autonomous decisions regarding the child's illness should be allowed, thus enhancing self-esteem.

2.11 SUMMARY

One can thus surmise that in treating the child with diabetes, a network of factors contributes to their healthy development. One has to acknowledge the school, family, diet, exercise and developmental stage of the child in order to implement an effective treatment plan.

The information presented in this chapter highlights the importance of consultation, an adequate knowledge base, functional familial relationships and most importantly the validation of the diabetic child.

The importance of the team cannot be over emphasised. Knowledge that the parents and child acquire regarding the illness, arms the family with tools for the control of blood glucose, but it is motivation that puts these tools to work.

The team has the unique opportunity to help the parents to look after their children with diabetes and the children to look after themselves. The contact that the family have with the clinic may enrich their lives because of the understanding they gain about themselves through help that they get on all aspects of diabetes. The information in this chapter highlights a need for greater collaboration between the different health teams so that holistic and effective management of the juvenile diabetic can be achieved.

CHAPTER 3

GROUP WORK PLAY TECHNIQUES AND GESTALT

3.1 INTRODUCTION

According to Schneibel (1991:3) gestalt is a German word that has no exact translation into English. The closest one can come in translating gestalt is wholeness, configuration, or completeness of form. This phenomenological existential therapy founded by Fredrick Fritz and Laura Perls in the 1940's teaches therapists and patients the phenomenological method of awareness in which perceiving, feeling and acting are distinguished from interpreting and reshuffling pre-existing attitudes. The goal is for clients to become aware of what they are doing, how they are doing it, and how they can change themselves while at the same time, to learn to accept and value themselves. The major goal in gestalt therapy is awareness. This includes greater awareness in a particular area and also greater ability for the patient to bring automatic habits into awareness as needed (Schneibel, 1991:4). In the researcher's opinion solving problems is a chief concern with many new patients, the issue thus for the gestalt therapist is how patients support themselves in solving problems. Perls compared the therapeutic relationship to that of the "I-thou" relationship in which the therapist accepts and respects the unique personhood of the client (Congress, 1995:1117). The researcher understands the "I-thou" relationship as one in which there is self-awareness by both parties involved in the relationship, thus minimising the barrier between them. The elimination or minimisation of the barrier allows the client to achieve awareness of his/her situation.

Gestalt therapy offers an approach which encourages the therapist to be direct and active with clients, while at the same time encouraging concentration on the client's own present experience of himself/herself. Gestalt therapy focuses on the integration of cognitive, kinesthetic and emotional experience (Lammert,1986:43). In the researcher's opinion the most important thing for the therapist to be, is curious. This will help the therapist to determine at what point the client is in his/her life. This requires putting aside beliefs about objective reality and looking with fresh eyes each and every time one works with someone .

The assumption in gestalt therapy is that resistances are to be respected; they are old survival mechanisms which demonstrate the person's way of dealing with the world while maintaining a sense of personal integrity (Lammert, 1986:47). Resistance thus encompasses both self-caring, in the sense of protecting one's integrity and self- destructiveness (Stratford & Brallier, 1979:98-99).

In the researcher's opinion, healthy gestalt of an individual is reached when a person is able to get what he/she needs from the environment.

3.2 RESISTANCES EXPERIENCED IN GESTALT THERAPY

Gestalt therapy does not label individuals in terms of their problems. These may be alcoholism, a welfare mother or schizophrenic, to name but a few. Congress (1995:1118-1120), in her article on gestalt states that there are four types of dysfunctional boundary disturbances: - confluence, introjection, projection and retroflection, which can be identified and become the focus of therapy.

- ***confluence***

  Confluence in gestalt therapy is when a client pretends that there are no differences between two individuals or systems. The role of the gestalt therapist therefore is to help the client distinguish individual needs from the needs of a confluent relationship. This distinction enables the client to achieve awareness, thus the client is able to work on his/her problem.

- ***introjection***

  Introjection involves the incomplete assimilation of information from the environment. Gestalt therapists view introjection as being between the environment and the object of the introject in the "here and now".

- ***projection***

  Gestaltists view projection as a disturbance. The researcher's understanding of projection with regard to gestalt therapy is that this particular disturbance is a result of individuals experiencing significant losses of important parts of their personalities, by disowning them and projecting them onto others.

- ***retroflection***

  A fourth disturbance of contact is retroflection. This process occurs when individuals do to themselves what they would like to do to someone else, or when they do to themselves what they would like others to do to them.

3.3 LAYERS OF DEFENCE MECHANISMS INDENTIFIED IN GESTALT THERAPY

The gestalt therapist, in order to be effective in his/her therapy, needs to identify the resistances and maladaptive coping behaviours of the client. Maladaptive coping behaviours, like anger, fear and rebellion can give rise to conflict. The researcher is of the opinion that conflict management skills are needed for successful conflict resolution. The rational intuitive conflict management model as outlined by Scott (1990:27-31) can be implemented to teach the adolescent diabetic patient conflict resolution skills. The model assists individuals with knowing when and how to walk away from conflict situations that have escalated out of control. It further teaches individuals how to listen and respond to others' anger and fear. The model also focuses on ways that individuals can decrease their anger and get rid

of it. The identification of maladaptive coping behaviours enables the therapist to determine if the client is at an impasse in his/her life and is unwilling to move to the explosive layers where the client gets in touch with his/her sense of reality. The layers of neurosis or modes of defence as discussed by Corey (1990:299) are also central to gestalt therapy. The researcher will proceed to discuss these further:-

- ***phoney layer***

  The phoney layer is where individuals behave in ways that are not authentic to their selves. They try to live up to a fantasy that they or others have created. Once they become aware of the phoniness of their position, they experience unpleasantness and pain. In the researcher's opinion, once a child discovers that he/she has diabetes, they try and pretend or wish away the illness. This pretence goes as far as not taking medication prescribed, resulting in non–compliance and increased hospital admissions. However, once the symptoms persist, the child realises that they have to take the routine insulin injections, they realise that they are chronically ill and begin to experience feelings of anger, fear and rebellion. Close, Davies, Price and Goodyer (1986:337-340) support the above behaviour patterns in diabetic children as their descriptive study found a quarter of the diabetic children in their study to have "appreciable" emotional or behavioural difficulties.

- ***phobic layer***

  The phobic layer is where individuals attempt to avoid the emotional pain that is associated with seeing aspects of themselves that they would prefer to deny. Individuals believe and have fears that if they recognise who they really are and present that side of themselves to others, they will surely be rejected. The researcher feels that this particular layer is also characteristic of diabetic children. They fear rejection, obstracisation and stigmatisation from revealing to their peer group that they are diabetic. They fear that they will not be part of a sporting event as team members may feel that this illness will prejudice their position. They cannot eat everything and anything their peer group is consuming, but do so none the less, to avoid teasing and humiliation.

- ***impasse layer***

  The impasse layer is where individuals become stuck in their own maturation. Individuals begin to internalise that they do not have the necessary resources within themselves to be able to survive, and to move beyond the stuck point. It is absolutely important that the individual move beyond the impasse layer, to achieve full awareness of his/her situation. The aforementioned thought is supported by Yousef (1993:30) who states that self-awareness and realisation of illness present a major source of stress for diabetic children. The impasse layer, the researcher feels, is an important layer to be dealt

with, when dealing with a child who has diabetes. The child begins to realise that he/she has diabetes, however, the fear and anger that results from the "why me" question, prevents the child from moving forward. Instead of channelling the anger and fear into positive energies the child channels into negative energies for example, rebellion against parents who are exercising control over the child's diabetic regime, against peers who do not have the illness and are leading unaffected lives and against siblings who do not have the illness. The above negative behaviours are a cry for help, revealing that the child does not have the inner resources to assist him/her in moving beyond these behaviours, because he/she does not know how.

- ***implosive layer***

  The implosive layer is where the individuals allow themselves to experience their deadness. This experiential state allows the individuals to expose their defences and thus enable them to make contact with their real selves. A diabetic child in the implosive layer is a child who is in touch with his/her illness. The child is in touch with his/her anger, fear, anxiety and realises that these feelings are emanating from frustrations that come from having the illness. The researcher feels that by identifying with the emotions that are associated with the illness, the child will be able to identify with the defences that he/she exhibits, thus enabling the child to make contact with his/her real self. Working through these defences also allows the child to pull away the "layers" of "pretence" and allows the child to be his/her real self.

- ***explosive layer***

  The explosive layer is where the individual lets go of the phoney ways of functioning. This allows the individual to release a tremendous amount of energy that was otherwise being used to maintain the phoney existence. This explosion of energy can be in the form of pain, joy, anger or sexuality. In the researcher's opinion the explosive layer is where the diabetic child drops his/her defences and allows family and friends to see that they are having a difficult time in conforming to the diabetic regime as well as falling in with peer group pressure. They will ventilate their frustrations, anger, anxiety, fear and find that the negative energy used to maintain the phoney existence can be turned into positive energy to resolve feelings that are associated with pain. For the diabetic child in the explosive layer the medium of clay is an excellent form of therapy to allow the child to project the negative energy onto the clay. To pummel, squash and squeeze the clay allows the release of suppressed angry emotions, onto a safe medium in a safe place (Corey, 1990:299-300).

3.4 GESTALT GROUP WORK

Gestalt leaders in groups, pay special attention to where the energy is blocked in the group, how it is used and how it can be unblocked (Corey, 1990: 300). In the researcher's opinion, one of the most effective methods of determining blocked energy is to observe the client's non-verbal behaviour. By inviting clients to experiment with a new posture group leaders can facilitate awareness.

The gestalt group process presents the members as human beings who are unique individuals and social beings. The expertise of the gestalt leader involves his ability to work at both individual and group levels and the ease in moving smoothly back and forth between the two levels (Schneibel, 1991:4-5). To increase the chances that members will benefit from gestalt techniques, group leaders need to communicate the general purpose of these techniques and to create an experimental climate (Corey, 1991:293). Hardy (1991:vii) states that there are certain myths that should be dispelled about gestalt therapy. These are that it is a quick and instant cure; that it consists of the use of multiple tricks and techniques and that it is exemplified by the gestalt prayer as an example of radical self-centeredness.

3.5 THE RECOMMENDED APPROACH FOR GESTALT GROUP WORK

The recommended approach in gestalt group work is a counselling group in which gestalt techniques are utilised. Such groups differ from gestalt groups in several ways according to Corey (1990:290). Firstly, not all of the interventions or approaches used by the researcher will be of a gestalt nature, instead the researcher will selectively use gestalt approaches as they are appropriate in the development and focus of the group. Secondly, the researcher will not be the principle figure in the group such that the majority of interventions will not be between the researcher and a single respondent. Instead the researcher will at times engage a respondent in a gestalt approach. Finally the researcher will be concerned with facilitating interactions among the group members.

The researcher feels that from this point gestalt approaches in group counselling can serve a dual purpose. Further more the approaches can be used to help individuals attain greater awareness of their own behaviours. This awareness, the researcher feels is reinforced in the group setting where the individual is in the midst of other individuals who are also becoming more aware of themselves. Corey (1990:344) states that with the support of the group members and leader members can allow themselves to experience feelings that was sealed off from awareness and can work through some of these feelings that keep them stuck. A second important element in the group counselling is the interaction among group members. The gestalt group work approach contributes to facilitating the development of the group process and encourages trust, cohesion, understanding, acceptance and respect to emerge among the group members (Corey,1990:345).

The researcher feels that although gestalt group work encourages the aforementioned, a respondent should never be forced to participate in any individual or group experiment. It is important that this be communicated as early as appropriate to the group members. Forcing a member to confront an emotional issue that he/she is not ready to confront, will force the member to push the emotion even deeper resulting in greater resistance. The above in the researcher's opinion should also be extended to the total group.

Corey (1990:333) states that respondents can choose to take part in experiments but they can also decide to stop when they want to, causing them to move at different paces in their participation. The counsellor's demonstration of respect for these differences will serve as an important model for the respondents and act as a deterent to the forces of conformity that sometimes emerge in groups.

There are several ways that awareness approaches can be used in group counselling. Firstly, it can be a means through which individuals can come to a better understanding of themselves, secondly experiencing the present awareness of others can expand the respondent's understanding of other members, as well as their own selves in relation to the members. Finally, focusing on the present awareness of individuals or the group as a whole can serve as a means to facilitate interpersonal contact and movement within the group (Corey,1990:322).

3.6 AWARENESS APPROACHES IN GESTALT GROUP THERAPY

3.6.1 SELF- AND ENVIRONMENTAL AWARENESS

Self-awareness, in the researcher's opinion is a major factor that contributes to growth and development of the group members and assists group members in achieving the goals of the group. Self-awareness allows the group to establish areas of 'stuckness' and what interaction in the group allows for more positive ways of functioning. This awareness of the environment and of the members in the group is important as it orientates the member to the 'here-and-now", the focus point of gestalt therapy. The counsellor could engage the members by having each group member complete the sentence fragment "Now I am aware of ....." several times in succession. Corey (1990:323) states that present-centered 'here-and-now' awareness of the members' existence alerts them to what is here now. This, the researcher feels will be important in her group sessions, as sensory awareness of children is important. This indicates to the researcher at what level of sensory awareness the child will be functioning. A healthy level of sensory awareness tells the researcher that the child is in touch with his/her environment and will be open to deal with their emotions in the 'here-and-now'.

3.6.2 PRESENT AWARENESS AND THE GROUP

Present awareness and the group can serve several purposes. Firstly, it requires each person to focus on the present, which can help get the respondents tuned into what is occurring in the group. Secondly, the counsellor has a chance to help clarify present awareness. Thirdly, each person has an opportunity to speak, which serves to affirm his/her presence in the group (Corey,1990:322). The aforementioned points allow healthy developmental interplay to occur among the group members (Corey, 1990:323). The researcher feels that this approach is also useful when a group member has disclosed and dealt with something which may also be of significance to the other group members. This will be an important aspect for the researcher to note, when doing the empirical study, as awareness of the illness by diabetic children in the group will enable each to state how they cope with the illness. The awareness and support of other diabetic children in the group will allow those children who ignore that they have the illness, to work through the impasse layer. The support generated in the group will enable them to become 'unstuck'.

3.6.3 INTERPERSONAL CONTACT

The researcher is of the opinion that interpersonal contact is a very important factor. The group the researcher feels can be a place where it is safe for respondents to learn about how they make and avoid contact with others. Corey (1990:323) states that using the technique of "speaking to" allows some group members who are shy to disclose their difficulty. According to Corey (1990:324) experiencing dreaded emotions leads to integration and growth. He further suggests that movement beyond our avoidances will enable us to dispose of unfinished business that interferes with our present life and allow us to move towards health and intergration (Corey,1990:324). 'Speaking to' allows introverted members of the group to engage a member and that they are more likely to get a response. Finally it allows the group members to be in a "here-and-now" interpersonal contact situation , which encourages exploring how they approach others.

In summary, gestalt approaches employed in group counselling can serve a dual purpose of enhancing individual self-awareness and promoting interaction among the group members. This self-awareness and interaction of group members is a key factor in the success of groups, as new information is being generated and members do not feel that they are the only ones with problems. This holds true for the diabetic child whose main pre-occupation is the "why me" question.

3.7 TECHNIQUES USED IN GESTALT GROUP WORK

Oaklander (1988:157-158) used the following gestalt techniques successfully with children in the five to twelve year age group.

"I" Language

The changing of the word "you and your" to "I" in childrens' sentences assist them in taking responsibility for their feelings, thoughts and behaviours. This allows them to work on their feelings in the 'here-and-now".

Incomplete Sentences

These exercises help children become aware of how they help and hurt themselves. For example "I help myself when I_____," or "I block or hurt myself when I_____".

Bipolarities

One of the most common bipolarities is the topdog and underdog. The topdog is righteous and authoritarian; he knows best. The underdog manipulates by being defensive or apologetic, and works with "I want" and makes excuses such as "I try hard". The topdog is a bully and works with "you should" and "you should not". The researcher will be utilising this technique in her therapeutic intervention.

The Empty Chair Technique

The empty chair technique is often used to role-play a conflict between people or within a person. The child sits in one chair and plays his/her own part, then sitting in the other chair, the child can play out a projection of what the other person is saying or doing in response. The advantage of the above technique is that it allows children to integrate splits in existence and allows the development of an integrated personality. The researcher will also be utilising this technique in her therapeutic intervention.

The researcher is of the opinion that the preceding techniques will serve the purpose of her study as "I" language will encourage the respondents to take responsibility for their behaviours in the 'here-and-now'. The bipolarities will enable the respondents to integrate splits in their personality towards the illness and the empty chair technique will allow respondents to deal with individuals with whom they are in conflict.

3.7.1 DEFINITION AND DESCRIPTION OF PLAY

Oaklander describes play in the following way (1988:160): "Play is how children try and learn about their world. Play is therefore essential for healthy development. For children, play is serious, purposeful business through which they develop mentally, physically and socially. Play is the child's form of self–therapy through which confusion, anxieties and conflict are often worked through. Through the safety of play, children can try out their own new ways of being. Play performs a vital function for the child. It is far more than just the frivolous, light-hearted, pleasurable activity that

adults usually make of it. Play also serves as a symbolic language, children experience much that they cannot as yet express in language, and so they use play to formulate and assimilate what they experience."

In the researcher's opinion play therapy is the most important way through which children make sense of their world. Children learn and respond best in a relaxed atmosphere that caters to their specific needs, play offers them this opportunity (Schoeman, 1996:198). Oaklander (1988:160) states that play is a developmental process which passes through the stages of embodiment play, by the use of a transitional object to projective play and then to the development of role play. Through this process, the child can discover symbols and metaphors to make some sense of his/her world and these metaphors are embodied, projected and enacted through the medium of play. The medium of play will be utilised in the diabetic group to achieve closure on difficult emotions that are experienced by the children. The medium will allow the children to confront their feelings of anger, anxiety and rebellion in an environment that is safe and conducive to the therapeutic experience. The manipulation of different mediums of intervention by the researcher, namely being creative play, bibliotherapy and fantasy will allow projection from the children to proceed naturally as play is already a constituent of their existence.

Some ways in which the gestalt group leader can initiate experimental behaviour is by means of the following techniques namely, dramatic play, creative play, biblio-play, exaggeration, reversals, fantasy, metaphor and imagination. The dominant issues that the researcher will be dealing with in the confines of the diabetic group, will be unfinished business relative to the illness. These are emotions that the child was unable to achieve closure on regarding the illness.

Unfinished business

Unfinished business makes reference to the unresolved feelings or emotions that individuals have from past experiences. The therapist helps the client to face unfinished business associated with unfinished situations. Most people would rather avoid experiencing painful emotions than do what is necessary to change. In the researcher's opinion unresolved feelings or emotions, are the dominant issues in a diabetic child's life. The child is suddenly made to deal with an illness that affects his/her whole being. The statements of "Why me?"; "Maybe if I wish it away, I won't have it anymore" are the dominant questions in the child's mind. Unfinished business can be dealt with using the following techniques:

- ***dramatic play***

  Dramatic play has various functions, such as the remodelling of family life, expression of aggression or regression, playing out of feelings concerning a certain incident that occurred in the child's life or working through traumatic situations. To help in achieving these Schoeman (1996:16) suggests a variety of play material, such as a play phone, finger puppets, clothes for dressing up, doctors'

instruments, dolls' houses with enough dolls for at least two families, in fact anything the therapist feels would develop and enrich the therapeutic milieu.

The researcher, in the diabetic group will utilise dramatic play to work through aggression and feelings regarding the effects of the illness on the child's home, schooling and peer environment.

- ***creative play***

Creative play is another medium that the researcher would be utilising. This is aimed at ventilation of feelings. For this clay, sand, water, paint, paper, wooden blocks, emotional barometers, calendars and maps can be used (Schoeman, 1996:17). Clay is an excellent medium through which aggression of the diabetic child can be channelled. The medium allows the child to pummel, stamp, shred and twist it, allowing simultaneously prevention of injury to the child and release of suppressed emotions.

- ***biblio- play***

Schoeman (1996:17) suggests that biblio-play leads to the development of insight and working through of feelings. Materials that may be used are books, comics, magazines, diaries and life-books.

Exaggeration and reversals can be utilised in the following ways, according to Schneibel (1991:5):-

- ***exaggeration***

Exaggeration involves asking a group member to exaggerate a body movement he/she may have previously been unaware of. This technique enables the group member to become aware of the movement.

- ***reversals***

Reversals consist of asking group members to behave in a way contrary to their feelings. This enables individuals to experiment with new behaviour, for example, an individual who feels that they should be in charge of everything should imitate the shy, quiet follower.

- ***fantasy , metaphor and imagination***

Fantasy approaches could include dramatic play, where the group is involved in acting out a specific situation experienced by another group member. These could also include dream work, drawing, clay and sand (Schneibel, 1991:5). Fantasy forms a central part of the child's development. The word fantasy is derived from the latin word '*phantasticus'*, which in turn forms a greater word, meaning " to make invisible". It is therefore suitable that this concept is used to describe the making of a mental image to the child (Schoeman, 1996:39).

- ***fantasy as a metaphor***

  Schoeman (1996:41) defines a metaphor as way of communicating symbolically. Metaphors have been in use for centuries and their main function is to communicate a message as effectively as possible. The most important function of metaphors for the therapist is that their use affords the child the opportunity of reasoning out alternative ways of behaving and of choosing the best alternative.

  Furthermore, the metaphor is a valuable aid because it can be adapted to suit each child's unique needs. The researcher feels that the metaphor serves as a useful carrier of messages. Sometimes, children have visual pictures in their heads that they find difficult to verbalise. Yet one metaphor will offer the child an opportunity to portray numerous non-verbal images and emotions. Schoeman (1996:42) states in her book that children can therefore use metaphors to give the therapist insight into what is happening in his/her world. Fantasy as a metaphor in the group setting with diabetic children, the researcher feels, will be valuable. Telling a story about a little boy/girl who has chronic illness, and how they feel to be ill, will allow the children to identify with the story and emotions experienced by the characters, thus allowing them to see that they are not alone. Also, verbal identification with the emotions experienced by the characters will allow the children in the group to see that realistically other diabetic children also feel sad, frustrated, angry and rejected. The happy ending of the story will allow the children to see that they also can be hopeful, understood and supported.

In the researcher's opinion the above play techniques allow the group members to deal with the issues that are causing them pain in a non-directive and less threatening way. Gestalt therapy focuses on current behaviours in "here-and-now" (Schneibel, 1991: 9). The group members have an opportunity to do their own seeing, feeling, sensing and interpreting in the "here-and-now" (Jones, 1982:20). The dominant emphasis on the "here-and-now" is an idea that is supported by Wyley (1996:7) who states that the gestalt group work method offers people respect but resists dependency and supports responsibility for the client's own activity and process by dealing with painful issues in the "here-and-now".

3.8 GESTALT APPROACH TO PLAY THERAPY

Gestalt therapy does differ somewhat from other therapies in its major focus on bodywork. Its usefulness with a wide variety of clients, from those severely mentally ill to those who are functioning at high levels; its directness with emotions; its drawing much from theatre, dance and the area of physical health; and its ability to accommodate other theories give it great therapeutic importance. Gestalt psychotherapy is a dynamic psychotherapy (Hardy, 1991:vii).

Effective integration for the benefit of the client can be accomplished through the cautious blending of gestalt principles (Hardy, 1991:viii). In the researcher's opinion the ability of gestalt therapy to blend with other principles gives it great value in terms of implementation with play therapy. Corey (1990:318) states that by individuals re-experiencing past conflicts as if they were occurring in the present, clients expand their level of awareness, sometimes gradually and sometimes explosively and are able to face and integrate denied and fragmented parts of themselves thus becoming unified and whole. Hardy (1991:5) is of the same opinion and states that formulation and completion in terms of gestalt wholes is a continual process when an individual is open to awareness of the environment, in contact with self and others in the general environment and integrating information and experience.

In the researcher's opinion the allowance of open space in play therapy, and the techniques of gestalt render the two approaches highly compatible. Gestalt allows the therapist to achieve his/her aim with the play therapy techniques, guiding the child towards projection of his/her painful emotions.

3.9 SUMMARY

The researcher is of the opinion that the aforementioned information will allow one to detect a clear relation between gestalt group work and play techniques. The interplay of the two assists the therapist in helping the child project his/her inner most fears enabling him/her to deal with them saliently.

One would also see that in dealing with the fears of a diabetic child the above techniques would be appropriate in its application. Play therapy allows the child to externalise his/her emotions and to work on them using the techniques of gestalt therapy. This externalisation allows the child to achieve "wholeness" and close the gestalts that are open. The researcher is of the opinion that as each gestalt is closed organisimic regulation of the body is achieved and the body moves towards stabilisation and effective positive interaction with the environment. The achievement of this by the diabetic child bodes a healthy development and psyche impacting positively on his/her illness. This culminates then in the holistic care of the diabetic child's health and growth in his/her best interest.

CHAPTER FOUR

4 EMPIRICAL STUDY

4.1 INTRODUCTION

To implement the empirical study, projection techniques within the gestalt framework were utilised. These techniques were used to assist the researcher in assessing the effects on the variables that were being measured in the study. These variables were anger, rebellion, understanding of the illness, fear of diabetes and situations of conflict.

The four respondents were recruited from the out-patient diabetic clinic at Parklands Hospital. The group comprised of two boys and two girls, between the ages of eleven and thirteen years. Each of the respondents attended different schools and did not know each other.

The respondents attended ten sessions on a Saturday, which spanned three and a half months. The sessions lasted an hour and the therapy rooms of William Clark Gardens Children's Home were utilised as the venue. The first session concentrated on completion of a pre-test questionnaire with the group (See Appendix 3). The questionnaire was completed by means of clarification of each question with the respondents, before they were asked to respond. The questions ranged from simple identifying details to their functioning at home and school to the more complex and pertinent questions which focused on the effects that diabetes has on their life, emotions, interpersonal and intrapersonal relations as well as the relationship between the parents and the siblings.

Joint sessions with the respondents and parents were conducted before the start of the group to clarify the aims and goals of the sessions. These joint interviews lasted an hour and content material of these sessions focused on discussing confidentiality, consent and the acknowledgment that the children were part of a research study, which involved publication of results.

Following the completion of the sessions, the parents were given feedback regarding the progress of the children and feedback was also encouraged from the parents regarding noted changes in behaviour.

This chapter will comprise an intensive study of each respondent and their development through the group sessions. The data will be tabulated to facilitate understanding of the results. A comparison of the pre-test and post-test results for the respondents will be discussed at the end of this chapter following discussion of the group work sessions. Withholding their real names ensures the anonymity of the respondents. To follow then will be a discussion of group sessions two through to ten, as session one focused specifically on completion of pre-test questionnaires with no therapeutic intervention.

The themes of the group sessions were as follows: -

Group session two: - Establishment of group rules by the respondents (See Appendix 4). Clarification of individual goals within the group. Session two was terminated by means of progressive body relaxation exercises.

Group session three: - Awareness continuum assessment. The sensory modalities of the respondents were assessed. The internal process of the respondents, that is their feelings regarding being diagnosed as a diabetic and how they dealt with these feelings were assessed by means of drawing. Oaklander's fourteen-step model was utilised to gain insight into the feelings that were projected on the drawings. The respondents following verbalisation of feelings and owning of projections were nurtured and comforted with the aid of a fantasy flight to ensure that heightened emotions were dealt with before termination of the session.

Group session four: - Awareness continuum assessment. The sensory modalities of the respondents were assessed. The researcher utilised creative play in the form of two mediums, that is drawing and clay. Oaklander's fourteen-step model was utilised for gainful insight. The respondents were asked to draw the monster in their lives and give it a name. The feeling projected onto the monster was then dealt with by the use of clay, where an object from the drawing was sculptured to allow ventilation of aggressive feelings. Progressive relaxation techniques were utilised simultaneously with the fantasy flight to a safe place to ensure a calm emotional state when the respondents left the session.

Group session five: - Session five was a continuation of session four. The awareness continuum of the respondents were assessed again, that is the sensory modalities. Creative medium of clay and drawing was utilised with Oaklander's fourteen step model. The same procedure from session four was utilised when dealing with clay work. Respondents who did not get a chance to discuss their monsters did so in this session. Progressive relaxation techniques were utilised simultaneously with the fantasy flight to a safe place to ensure nurturance of the respondents.

Group session six: -The purpose of session six was to increase the respondents' awareness and understanding of the illness. The awareness continuums of the respondents were once again assessed. It is felt that continual assessment of sensory modalities alert the researcher to any abnormalities that may occur with the senses. Biblio-therapy was the medium that was utilised with the story-telling technique. Progressive relaxation techniques were utilised simultaneously with the fantasy flight to a safe place to ensure comforting and nurturance of the respondents.

Group session seven: - Externalisation of rebellion was the purpose of session seven. Awareness continuum of respondents was once again assessed. Creative play in one medium was utilised. The respondents were requested in the previous session to bring along any materials that they would like to build their diabetic monster with in this session. Progressive relaxation was utilised with the fantasy flight to safe place to ensure a calm emotional state when respondents left the session.

Group session eight: - The completion of the diabetic monster occurred in this session. Awareness continuum of respondents was assessed. Respondents were requested to write their feelings towards the monster on the sheet that the monster was constructed on. Conflict resolution was also done with the respondents. Progressive relaxation was utilised with the fantasy flight to a safe place. The fantasy flight ensures heightened emotions are dealt with before respondents exit the session.

Group session nine: - The purpose of the session was to teach respondents to release their anger in a non-threatening way. The model of Scott (1990:37) was utilised to achieve this end. Progressive relaxation was utilised with the fantasy flight to a safe place, ensuring that respondents were nurtured and comforted before leaving the session. Respondents were reminded that the next session would be the final session. However the researcher at the conclusion of each session asked respondents to mark off each session so that respondents were visually and mentally aware of the termination session. This avoided issues of separation anxiety and malingering of old behaviours in the hope of continuation of therapy. The post-test questionnaire was administered.

Group session ten: - Termination session. A party was arranged with the handing out of certificates of attendance to respondents (See Appendix 5). No therapeutic intervention occurred in this session.

4.2 IDENTIFYING DETAILS AND PRE-TEST RESULTS OF RESPONDENTS

4.2.1 CHILD A

Child A is in grade seven and is twelve years old. She is the middle child in her family and the only child to have diabetes. Child A's mother is an insulin dependent diabetic as well. The family resides in a suburban area and is of middle class socio-economic standing. Child A was diagnosed with juvenile diabetes at age nine and was compliant on medication on joining the group. Child A's parents were extremely excited and committed to the process of group therapy for their child. Some of the problems experienced by child A after being diagnosed with diabetes was the following: deviation from the diabetic diet, being treated differently at school by her friends, being admitted to hospital and taking her daily insulin injections. According to pre-test results Child A has a poor relationship with her father, fair relationship with mother, fair relationship with friends and a very good relationship with siblings. Child A had the following pre-test results on the variables:

Table 2: Pre-Test Results of Child A

Anger	80%
Rebellion	60%
Understanding of the illness	50%
Fear of the illness	50%
Situations of conflict	70%

4.2.2 CHILD B

Child B is an eleven year old and is in grade five. He was diagnosed as a diabetic when he was just four years old. Child B is the middle child of his family and the only member of his family to have diabetes. The family belongs to the middle class socio-economic strata. He was compliant on medication on joining the group. The parents of child B were ambivalent regarding their child's attendance, but attendance at group sessions continued, until termination. The problems experienced by child B after being diagnosed with diabetes were the following: being a diabetic, having high sugar levels, aggression which is experienced at home and at school, the daily insulin injections, discrimination at school and at sporting activities because of the illness. According to pre-test results Child B has a fair relationship with his father, good relationship his mother, very good relationship with his friends and a good relationship with his siblings. Child B had the following pre-test results on the variables:

Table 3: Pre-Test Results of Child B

Anger	60%
Rebellion	50%
Understanding of the illness	60%
Fear of the illness	50%
Situations of conflict	70%

4.2.3 CHILD C

Child C is a thirteen year old and is in grade seven. She was diagnosed as a diabetic ten years ago, and has been diagnosed as a diabetic for the longest period, as compared to the other respondents. She is the eldest child in her family and the only member of the family to have diabetes. The family is middle class and resides in a suburban area. Child C was compliant on medication on joining the group. The parents of child C were relieved that such group therapy was been offered for juvenile diabetics, and stated that such options were not available. Child C experienced the

following problems after being diagnosed with diabetes: being a diabetic, being marginalised by peers because of the illness, adhering to the diabetic diet and rejection from sporting activities. According to pre-test results Child C had a very good relationship with her father, good relationship with her mother, poor relationship with her friends and fair relationship with siblings. Child C had the following pre-test results on the variables:

Table 4: Pre-Test Results of Child C

Anger	70%
Rebellion	70%
Understanding of the illness	30%
Fear of the illness	90%
Situations of conflict	70%

4.2.4 CHILD D

Child D is a twelve year old and is in grade six. He was diagnosed as a diabetic three years ago. Child D is the oldest child in his family unit, and the only member that is diabetic. Child D presented as quiet and introverted during initial assessment interviews. The family is middle class and resides in a suburban area. The parents were committed to the course of group therapy. Child D was compliant on medication when he joined the group. Some of the problems experienced by child D after being diagnosed as a juvenile diabetic, were the following: taking the daily insulin injections, admissions to hospital, adherence to the diabetic diet, being marginalized by peers at school and anger. According to pre-test results Child D has a good relationship with his father, very good relationship with his mother, good relationship with friends and very good relationship with his siblings. Child D had the following pre- test results on the variables:

Table 5: Pre-Test Results of Child D

Anger	70%
Rebellion	60%
Understanding of the illness	40%
Fear of the illness	80%
Situations of conflict	60%

4.3 DISCUSSION OF GROUP SESSIONS

Responses and assessments of respondents from session three to session nine will be tabulated (Compare Groenewald, 1997:64-73).

4.3.1 GROUP SESSION TWO

4.3.1.1 Aims/Goals

- Structuring the group, identifying group rules ;
- Creating an environment in which respondents feel free to actualise and identify with each other ;
- Creating a supportive growth climate in which creative learning and growth could occur ;
- Developing a norm of flexibility in order that changing individual and group needs could be appropriately addressed.

4.3.1.2 Responses and assessments of respondents

The structuring of group rules was a group effort. Respondents were requested to give feedback, with regards to what rules should govern the group. The rules of the group were then formulated (see Appendix 4).

4.3.2 GROUP SESSION THREE

Technique: Creative play

Medium: Drawing, Oaklander's fourteen step model for drawing interpretation ;

Progressive body relaxation ;

Awareness continuum assessment.

4.3.2.1 Aims/Goals

- Relaxation of respondents before therapeutic intervention;
- Helping respondents with the aid of sensory stimulation, to make contact with the therapeutic environment and themselves. Engaging the respondents in the following activities: -
  - ❖ *Respondents, after being engaged in progressive body relaxation were asked to describe textures that were touching their hands (tactile stimulation).*
  - ❖ *Respondents were asked to describe smells in the air around them (smell stimulation).*
  - ❖ *Respondents were asked to listen and describe sounds around them (auditory stimulation).*
- Assessing of feelings and coping skills of respondents in dealing with the illness.

Table 6: Contact with self and environment – Assessment of feelings and coping skills

Contact with self and environment	Assessment	Role and participation in group therapy
CHILD A: Child A is in contact with the environment and herself. The child enjoyed her progressive body relaxation thoroughly. She is in contact with her touch, smell, and hearing faculties. She is comfortable with the group and its present process.	The therapeutic relationship between researcher and child A is interactive. Child A enjoys being part of the group, more so because of the commonality of the illness that links the respondents. Child A exhibits unfinished business with regards to the illness. She has not accepted that she is a juvenile diabetic. Child A is in the phoney layer of the gestalt defence mechanisms. From the projection on the drawings, it is also clear that child A is not coping sufficiently with the feelings associated with the illness. It is clear that the admissions to hospital were on her figure ground. Projection took place with externalisation of sadness and anger, accompanied with the associated body language. The congruency between body language and her emotions emphasised contact with herself and the environment.	Child A exhibited strong personality traits. She was the first to volunteer discussion around her drawing and accept feedback of support from the other respondents. She also enjoyed the progressive body relaxation before and after the group. Child A felt comfortable within the group structure.
Feelings and coping skills of respondents		
Drawings were used as the medium of assessment. Respondents were asked to volunteer their responses to drawings with the headings, "Look through the key hole and see what upsets you the most", and "Press the special key on my computer, it will show you my biggest secret". On the latter the child drew a hospital scene and on the former, the words," I hate being a diabetic" were written.		

Contact with self and environment	Assessment	Role and participation in group therapy
CHILD B: Child B is in contact with himself and his environment. He enjoyed the progressive body relaxation thoroughly. He is in contact with his touch, smell and hearing facilities. He is comfortable with the group and its present process.	The therapeutic relationship between the researcher and child B was interactive. The child trusted the researcher with discussing his feelings, that is, anger and rebellion. Child B also proved by now to be the most extroverted of all the respondents. The child according to his projections from the drawings did not identify with the diabetes. From the drawings and the projections it was clear that child B had worked through the phoney layer because of his non-compliance had brought him unpleasantness and pain. He has also worked through the phobic layer because he was presenting an attitude of wellness to prevent rejection. However he was stuck at the impasse layer because he realised that although he did not want to take medication, he had to. He still had feelings of anger and rebellion towards his parents and the illness, because the conditions were dictated and he was not an active participant. The extroverted nature of the child was incongruent with his body language during discussion of his projection. He presented slumped shoulders, down cast eyes and a sad tone of voice.	Child B had strong leadership qualities and openly supported other respondents when discussion ensued around their projections. He actively enjoyed the relaxation exercise. He was called to order when other respondents were discussing their drawings. In fact child A mentioned that he was breaking the group rules. Child B accepted this and apologised for his actions.
Feelings and coping skills of respondents Child B responded remarkably to the medium of drawing. His main concern of his projection was that of his peers. Peers, because of the illness rejected him and this made him rebellious against taking the medication, as this indicated to his peers that he was ill. He felt that if he stopped the rejection would stop. This made him more ill requiring hospital admissions. Medication was thus taken grudgingly because he had to and not because he wanted to.		

Contact with self and environment	Assessment	Role and participation in group therapy
CHILD C: Child C is in contact with herself and the environment. The child enjoyed the progressive body relaxation exercises. She is in contact with all her senses and is comfortable with the present group process. **Feelings and coping skills of respondents** Child C responded positively to the medium of drawing. Her response to the drawings was that she wants to be a nurse and assist others with diabetes. Her projection also showed that she was tired of individuals probing into her illness. The child also discussed her friend who was in hospital at the time, and the feelings that her friend may be experiencing. The researcher asked the child if she sometimes feels the way her friend does, and she stated yes. Discussion ensued regarding this issue and feelings and coping skills were discussed. Advice was volunteered from the other respondents and researcher.	The therapeutic relationship between child C and the researcher is good. Child C enjoys immensely being part of the group and what it has to offer. Child C has a healthy interaction with other respondents and acknowledges the group rules. Her projection was strong and emotionally charged, indicating that she was in touch with the "here-and-now" aspect of the projection. Child C like child B presents in the impasse layer because she realises that she has to adhere to the medication and the diet but the feelings of anger and rebellion and the inability to cope with these feelings blocks the child from progressing to the explosive layer. Child C was accepting of the advice and support offered by the other respondents and the researcher. Child C presented with a healthy gestalt as she projected what was on her figure-ground, that is, her friend who was in hospital. However she also felt safe projecting the emotions on somebody else and when she felt safe to own her projections, she did.	Child C exhibited low-self esteem and lack of confidence as compared to the other respondents. She also however was the first to offer peer support to the other respondents.

Contact with self and environment	Assessment	Role and participation in group therapy
CHILD D: Child D is in contact with himself and the environment, although he experienced difficulty closing his eyes through the relaxation exercises. He was told to keep them open through the duration of the exercise if it made him feel comfortable. **Feelings and coping skills of respondent** Child D responded positively to the drawing. He is the quietest of the respondents. His response to the drawings is that he wishes that the diabetes would be taken out of his body and life forever so he will not have the feelings that he has. These are feelings of anger and rebellion. It is evident from the projection of the child that his coping skills are ineffective. The other respondents and the researcher offered suggestions and advice.	The therapeutic relationship between child D, the researcher and respondents is fair. Child D presents as frightened and untrusting of the respondents and the researcher. This is further emphasised by the unwillingness to close his eyes, during the relaxation exercise. Child D did not volunteer discussion on his drawings, but was requested by child A to do so. She further supported him by stating that they were all diabetics and he need not be afraid. Child D was asked to remain after the session to discuss any problems he may have with being part of the group. The researcher supported the child by saying that he must identify his own time when he would like to join in the group process and share issues with the group when he is ready to. He stated that he enjoyed being in the group and would continue to attend. He was supported and thanked for his efforts of disclosure in the session. Child D presented in the impasse layer as his feelings of anger and rebellion towards the illness prevented him from progressing to the explosive layer.	Child D exhibited very low self-esteem and lack of confidence. The above traits were congruent with his limited participation in the session. Child D had to be encouraged and supported to participate in the group activities. He did adhere to group rules and was respectful of respondents' experiences.

From the presented information it is evident that the respondents had healthy awareness continuums. It is clear that the human sensory system is a highly complex system that enables human beings to experience the world. It is therefore essential that the child's sensory skills be developed in order for him/her to make meaning of his surroundings (Schoeman, 1996:42). Reference to chapter three of the research would find a concise discussion on defence mechanisms utilised by clients, preventing movement forward and healing of gestalts. All the respondents in the group experienced one of the layers of defence and thus experienced the emotions of anger, rebellion and fear preventing movement forward. It is also evident that support from the respondents to each other affected the therapeutic climate positively. Corey (1990:321) supports the above by stating that group members can serve a catalytic purpose for each others' self-explorations as well as provide support and encouragement. Respondents will move at different paces in their participation, this was evident from child D who presented as quiet and withdrawn. The researcher allowed the child to maintain his process. This functioning of the child within the group indicated the functioning of the child outside of the group.

Present awareness and the group is an important factor as discussion of feelings towards having the illness generated support and workable solutions between respondents.

4.3.3 GROUP SESSION FOUR

Technique: Creative Play, Dramatic Play

Mediums: Empty Chair, Drawing, Clay

4.3.3.1 Aims/Goals of group session

- Externalising the issues in terms of drawings, that is, the monster in the child's life;
- Utilising of clay to project the aggression generated from the drawing and offer release of suppressed emotions;
- Ensuring a calm disposition when children leave the session by implementing progressive body relaxation.

Table 7: Contact with self and environment - Externalisation of illness and aggression

Contact with self and environment	Assessment	Role and participation in group therapy
CHILD A: Child A is in contact with herself and environment. She again enjoyed the progressive body relaxation. **Externalisation of illness and aggression** Immediately on completion of the progressive body relaxation exercises the respondents were asked to draw the monster in their lives. The respondents were asked to own their drawings by stating, "This is my drawing it belongs to me, and this is my monster it belongs to me and only me". Following that the respondents were asked to volunteer discussion around their monster drawings. The child projected a healthy monster. Its favourite food was sweets. Her monster ate anything it desired and everyone liked it. It also helped everyone.	The implementation of the progressive body exercise placed mind and body of respondents at a relaxed state. This allowed the thoughts of the respondents to be brought to the figure-ground of the child. This allowed a healthy externalisation of the child's monster. Questions were asked regarding the child's monster (Schoeman, 1996:69). The projection of a healthy monster revealed the emotions of child A. When asked, after owning her projection, if she sometimes behaved and felt like that monster she stated yes. Her one wish was to be well like her monster and not have diabetes. Child A is still in the phobic layer regarding acceptance of the illness. Following verbalisation of the emotions child C offered support to child A regarding her desire to eat sweets and be free of the illness. Child C shared her skills in coping with the diet. The child enjoyed the progressive body relaxation and safe place exercise.	Child A felt comfortable in the group at this point and openly shared her emotions. She listened to advice from child C and interesting, supportive dialogue transpired between all respondents.

Contact with self and environment	Assessment	Role and participation in group therapy
CHILD C: Child C is in contact with herself and the environment. She enjoyed the progressive body relaxation and stated she wished she could be relaxed all the time.	Child C has been interacting and integrating well in the group. The child's figure ground is healthy. The issue on her mind is the ketone monster that was projected in her drawing. Her anger towards the monster released on the clay showed a cathartic effect on the child. She presented as relieved following this externalisation. The researcher incorporated the top dog and under dog approach as she felt that the child needed to realise that this illness is chronic and the child needs to make peace with it. The above technique allowed the polarities of the child to be integrated so that the reorganisation of thoughts towards the illness can occur without exclusion of either side. The child enjoyed the feedback from the respondents. This exercise also offered enlightenment to other respondents regarding their anger towards the illness.	Child C played an active role in the session. She projected her monster safely and enjoyed the exercise and externalisation tremendously. She was not afraid to pummel the clay and scream at it. She stated she felt calmer at the end of the session and was looking forward to the next session.
Externalisation of illness and aggression The child externalised her aggression towards having the illness onto her monster. She named her monster the ketone monster that always worried her and prevented her from having fun and was often responsible for hospital admission. She stated that she was frightened and angry at the monster and wished she did not have the monster. The researcher asked the child to mould the ketone monster out of clay. She stated that when her ketones were high, she required hospitalisation. The researcher asked the child to place the monster in the empty chair. The group was divided into the top dogs and under dogs. The top dogs were asked why they think they should be angry and the under dogs were asked why they want to be angry. The child belonged to the under dogs. During the debate the clay was flattened, punched and squeezed.		

Session four was the "Ha Ha" session for the researcher. She, along with the respondents enjoyed the active and healthy projection of the respondents. The session could only accommodate two projections and the remaining two would continue in session five. Present awareness and the group was a focus point in this session as projective techniques allowed ventilation of aggression towards the illness, while simultaneously garnering support from the respondents.

The use of creative play allowed latent aggression of the respondents to be externalised. A brief discussion on the usage of clay and its advantages in releasing suppressed emotions can be found in chapter three. The empty chair technique allowed the respondents to experience their anger in the "here-and-now" which is the focus of gestalt therapy (Schoeman, 1996:17). This allowed the respondents to become unstuck and reach the explosive layer. The use of clay enhanced attainment of this layer as it allowed the child to pummel, squash and squeeze the clay. A discussion on the explosive layer in chapter three with regards to diabetic children supports the outcomes of this session, which was rich and rewarding.

4.3.4 GROUP SESSION FIVE

Technique: Creative Play

Medium: Drawing, Clay

4.3.4.1 Aims/goals of group session

- Externalising the illness in terms of drawings, that is, the child's monster in his/her life;
- Utilising of clay to project the aggression generated from the drawing and offer release of suppressed emotions;
- Ensuring a calm disposition when respondents leave the session by implementing progressive body relaxation;
- Continuing of discussion of the respondents' monsters.

Table 8: Contact with self and environment-Externalisation of illness and aggression (Continues)

Contact with self and environment	Assessment	Role and participation in group therapy
CHILD B: Child B is still in contact with himself and the group environment. He enjoys the progressive body relaxation. **Externalisation of illness and aggression** Child B was taken through the process of owning his projection. He was asked questions by the researcher and respondents that led to the development of a character and personality for his monster. He said that his monster lived alone in the mountains and had diabetes. His was a sad monster because people were afraid of him even though he loved having friends. This made his monster angry. When the researcher felt that the child had owned his projection sufficiently she asked if he sometimes felt like his monster and he said yes. He was angry with his peers and family for treating him differently because he had the illness.	Child B, in the researcher's assessment is the extrovert in the group. Child B always presented a happy and stable emotional state and this was conveyed to the researcher by his parents. However this assessment was questioned in this session. The child in describing his monster had the associated emotions, that is sadness and anger, displayed the associated body language of slumped shoulders, down turned head and a pained expression on his face. The researcher commented on this change of body language and the child responded by stating that his parents expect that he cope with the illness. He laughs and jokes but is sad inside. The other respondents supported him and nurtured him by stating that he does not have to feel like he is alone because they also have the same problem. The researcher reinforced this train of thought and nurtured the positive aspects of the child, by asking the respondents to applaud his sharing of his monster and feelings with the group and commented on his bravery in doing so. The progressive body relaxation also brought the child in touch with his emotions and enabled him to externalise them and work on the incongruence between behaviour and emotions. The child reached the explosive layer within a safe and structured environment.	Child B had a happy mask in the early sessions of the group. This mask was in the researcher's opinion constructed to pacify his parents. His participation and role has changed and he is in the nurtured and supported role. He displayed more relaxed and congruent behaviour.

Contact with self and environment	Assessment	Role and participation in group therapy
CHILD D: Child D is still in contact with himself and his environment. He now closes his eyes on his own accord. **Externalisation of illness and aggression** Child D was taken through the process of owning his projection. His monster was also diabetic and was sad and lonely. His monster hated having diabetes. When his monster was angry he would punch a rock. The researcher enquired when these times were. He said the following, when the monster was rejected from sporting activities, told not to eat sweets and when he hated having the illness. The researcher asked the child to mould the rock out of clay. He was asked if he sometimes felt like the monster and he said yes. He pummelled the clay and screamed that he hated having diabetes as he is treated differently.	Child D improved remarkably since session one. He closed his eyes on his own when he was ready to trust the process of the group. He is now in contact with his self and his environment. Child D's externalisations are congruent with his body language. He struck the clay repeatedly stating that he should not be treated differently. He presented as a confident child who was ready to accept his illness and talk about the sadness he experienced. He identified with the respondents and their loneliness and said he felt much better knowing he was not experiencing it alone.	Child D improved drastically with regards to his participation and role in the group. He has become more verbal, interactive and confident in the setting. He is comfortable in his dual role of nurturer and being nurtured.

Session five was a continuation of session four. The aims of session five were accomplished by assisting the respondents to move towards the explosive layer. There was a dramatic change in behaviour in child B and child D. Child D had developed from being an introverted and non-participant to a confident and participatory individual. He closed his eyes willingly on the progressive body relaxation exercises, volunteered discussion on his monster and offered support to other respondents. Schniebel (1991:9) supports the thought that gestalt therapy focuses on current behaviours in the "here-and-now ". The above behaviour shift in child C is clearly supportive of this as the child dealt with his behaviour in the "here-and-now". Cleaver (1990:278) states that children with diabetes often feel damaged; the researcher felt this was exhibited in their drawings and comments. The researcher supports this idea as respondents depicted their diabetes as the monster in their life who is sad, lonely and damaged by juvenile diabetes.

4.3.5 GROUP SESSION SIX

Technique: Biblio-therapy

Medium: Story telling

4.3.5.1 Aims/Goals of group session

- Assessing of awareness continuum by means of progressive body relaxation;
- Increasing the respondent's awareness and understanding of the illness with the technique of biblio-therapy;
- Ensuring a calm disposition when respondents leave the session by implementing progressive body relaxation.

Table 9: Contact with self and environment - Awareness and understanding of the illness

Contact with self and environment	Assessment	Role and participation in group therapy
CHILD A: Child A is still in contact with herself and the environment. Her awareness continuum is still in tune with the process of the group.	Child A is still in contact with herself and the group process. Her positive identification with the story highlights the issues on the child's figure ground. She dealt with her anger in session five allowing her to close this gestalt and open her gestalt relating to her awareness and understanding of the illness. This child was able to close this gestalt as well, for she identified with the end of the story and internalised the behaviours that had to be present to facilitate her well-being.	Child A is actively involved in the group process. Her inhibitions are relaxed and her quest for knowledge regarding the illness is promising for development.
Awareness and understanding of the illness Following the progressive relaxation the respondents were asked to continue listening to the researcher with their eyes closed. A story focusing on a little boy and girl, their experiences with juvenile diabetes, their symptoms, their visits to the doctor and relevant treatment was related to the respondents. Following completion of the story the respondents were asked to keep their eyes closed for a little longer, enhancing identification with the story. The researcher, with the respondents eyes open asked if any of them felt like the characters in the story. Child A volunteered an association with the little girl in the story. She said that the girl was just like herself who did not like taking medication but realised she had to if she was going to feel better. A positive identification was made with the ending of the story where the little girl was no longer afraid of the illness now that she understood it better.		

Contact with self and environment	Assessment	Role and participation in group therapy
CHILD B: Child B is still in contact with his environment. He appears more relaxed after the issues from the last session were dealt with.	Child B has settled more comfortably in the group. He is in tune with the group process. His identification with the characters in the story emphasised that experiential learning was taking place. He was able to identify his emotions and behave accordingly. His body language revealed a more relaxed and happy child.	Child B enjoyed his role in the group. He is no longer intrusive while respondents are verbalising projections. He offers support and comfort.
Awareness and understanding of the illness		
Following the projection of child A, child B was the next to volunteer a projection. He stated that the characters were just like him, especially the boy who pretended to be happy but was not. Child B now understood that he was just like everybody else, even with the diabetes. He also said that he was no longer angry with God for giving him this illness. He understood the hospital visits and the reasons he would get sick. Child B stated that his awareness no longer made him afraid and angry.		

4.3.5.2 Child C And Child D

The above respondents still exhibit contact with themselves and the environment. Child C and child D did not project as they offered support and comfort to those that did. The above two obviously had dealt with the awareness and the understanding of the illness, as this was not on their figure-ground. They did identify to a certain degree with the respondents that verbalised their projections. Their interaction with the group dynamics is still active and the curiosity of all respondents within the group stimulates a healthy and productive process.

Session six was again a successful session. The respondents entered with zest and enthusiasm. Their awareness continuums are intact and they are displaying healthy figure-grounds. The researcher is of the opinion that the release of suppressed anger in session four and five unblocked the pathway for release. The anger was released and the

respondents could now identify with the illness thus allowing them to accept and question information that involved awareness and understanding of the illness.

Child A is functioning as one with his own process and with the environment. He is moving towards the explosive layer and a healthy gestalt. Schniebel (1991:4) states that greater awareness in a particular area allows greater ability for the patient to bring automatic habits into awareness as needed. The researcher is also of the opinion that the contact boundary between respondents and researcher is a positive one as this contact is allowing healthy verbalisation of projections and awareness of feelings that are associated with these projections. In support of the above Congress (1995:1117) states that the "I-thou-relationship" is one where the therapist accepts and respects the unique personhood of the client, enhancing awareness.

4.3.6 GROUP SESSION SEVEN

Technique: Oaklander's fourteen step model for drawing interpretation

Medium: Drawing

4.3.6.1 Aims/Goals of group session

- Assessing of awareness continuum by means of progressive body relaxation;
- Externalising rebelliousness of the respondents by constructing the diabetic monster;
- Ensuring a calm disposition when children leave the session by implementing progressive body relaxation.

4.3.6.2 Results And Assessment Issues In Session

The respondents were requested in the previous session to bring material that will be utilised to construct the diabetic monster. A flip chart was utilised and the different materials were pasted onto the chart. The respondents were so eager to begin construction that they requested the progressive body relaxation exercise be omitted from this session. The respondents in their construction developed a complementary relationship with each other. Every one was allowed to add their piece of material to the monster. The researcher supplied scissors, glue and drawing material. Oaklander's fourteen step model for drawing interpretation allowed a structured guideline for the therapist. Effective and meaningful interpretation of projections could be made by the therapist. The monster was not completed in this session and respondents were told that completion would take place in the next session. In this session the leadership role was balanced equally between respondents. All respondents presented as confident and each one took pride in the construction.

4.3.7 GROUP SESSION EIGHT

Technique: Oaklander's fourteen step model for drawing interpretation

Medium: Drawing

4.3.7.1 Aims/Goals of the session

- Assessing of awareness continuum by means of progressive body relaxation;
- Externalising of rebelliousness of the respondents by constructing the diabetic monster;
- Ensuring a calm disposition when children leave the session by means of progressive body relaxation.

Table 10: Contact with self and environment-Externalisation of Rebelliousness

Contact with self and environment	Assessment	Role and participation in the group
CHILD A: Child A still remains in contact with her self and the environment. The child still enjoys the progressive body relaxation. **Externalisation of rebelliousness** Child A assisted other respondents enthusiastically in completion of the diabetic monster. The researcher requested volunteers to write their feelings towards the monster on the chart. Child A volunteered. Child A's response to the monster was that she was no longer afraid of the diabetic monster and that he could not harm her anymore. She now also had friends who had the same illness and she did not feel different anymore.	Child A still enjoys the progressive body relaxation. Her contact between fellow members and herself is healthy. Her enthusiasm to create the diabetic monster was positive and channelled towards completing the task at hand. Her written response is in keeping with her verbal response in session six where she identified with the girl in the story. Her written response and verbal response are congruent with each other. This highlights that the child has reached the explosive layer. She has dropped her defences and is allowing the researcher and the group to see her fear towards the illness.	Child A is actively involved in the group process. She enjoys the interaction and feedback she receives from the members and the researcher.

Contact with self and environment	Assessment	Role and participation in the group
CHILD B: Child B still enjoys the progressive body relaxation. His body language, while engaged in the relaxation depicts enjoyment and peace. **Externalisation of Rebelliousness** Child B's contribution to the construction of the monster was one which occurred silently and introspectively. His response to the monster was that he had made new diabetic friends and he did not have to be afraid anymore.	Child B is in touch with the group process. He still enjoys the progressive relaxation. His contribution to the completion of the monster resolved many issues for him. It was a quiet, peaceful communication that transpired between him and the monster. Each piece of material pasted to the chart had deliberate actions. His verbalisation in this session is congruent with session seven where he stated that his awareness no longer made him afraid and angry. Child B had also attained the explosive layer where actions and verbal responses are congruent.	Child B has developed positively in the group. His attainment of the explosive layer allows him to be at peace with himself and the group.

Contact with self and environment	Assessment	Role and participation in the group
CHILD C: Child C remains in contact with herself and the group's therapeutic environment. The progressive body relaxation is thoroughly enjoyed. **Externalisation of rebelliousness** Child C, in completion of the monster exhibited the most energy and enthusiasm. There was much interaction between the other respondents and the child. There was deliberate planning and execution of tasks. Child C's response was that this was the ketone monster who caused her to be ill frequently. She was no longer afraid of falling ill frequently as she now knows how to stop the monster.	Child C enjoyed the progressive body relaxation and associated group interaction depicted a more confident child. Her quest for knowledge through the sessions regarding the illness and its associated implications has resulted in the child attaining the explosive layer. Child C's projection in this session is linked to session four where she projected the ketone monster in clay work. The child has reached the explosive layer where she was no longer hiding the emotions felt towards the illness.	Child C played a participatory and productive role in the completion of the monster. Her task execution was aligned with the other respondents resulting in successful goal attainment.

Contact with self and environment	Assessment	Role and participation in the group
CHILD D: Child D now closes his eyes through the progressive body relaxation exercises. He has grown to trust the therapeutic environment, thus creating stability with himself and his environment.	Child D developed dramatically within the group. Child D's written externalisation in this session is linked to session five where the child's externalisation of having the illness was explosive. He had experienced catharsis in session five and was experimenting with new thought patterns and actions that were congruent with each other. The inner conflict which resulted in his aggressive display in session five resulted in a closed gestalt. He was ready to accept the illness but on his own terms and conditions which did not compromise his health status. The child had attained the explosive layer and was experiencing congruency between his actions and emotions.	Child D's role developed in the group from an observer to an active participant. He is instrumental in the development of his healthy gestalts and thus in control of his inner process.
Externalisation of rebelliousness		
Child D's contribution to the construction of the monster was one of skill and mastery. He would paste his materials and stand away to observe if his contribution added to the positive construction of the monster. His response to the monster was that he was now the monster's friend and they both would be living together on the child's terms and conditions.		

The researcher was exhilarated at the progress of the respondents. Their externalisations revealed that they were coping with the monster in their lives. They had made peace with the diabetic monster, ending the emotional war inside of them. The enthusiasm to construct the monster heralded the attainment of the explosive layer for all the respondents.

They were thus all functioning in the explosive layer. Corey (1991:293) states that individuals will ventilate their frustrations, anger, anxiety, fear and find that the negative energy used to maintain the phoney existence can be turned into positive energy to resolve feelings that are associated with pain. This supports the researcher's conclusion of the level of functioning of the respondents.

Corey (1990:344) states that the" gestalt group work approach contributes to facilitating the development of the group process and encourages trust, cohesion, understanding, acceptance and respect to emerge among the group members ". This was clearly more pronounced in sessions seven and eight, as utmost respect, understanding and acceptance were depicted among respondents in the finalisation of the monster .

The unfinished business aspect of gestalt therapy was accomplished in the previous sessions with the use of dramatic play, creative play and biblio-therapy. Creative play was the pre-dominant medium utilised, incorporated with the different techniques to gain insight. The utilisation of different mediums yielded a wealth of information and initiated healing in all the respondents. Corey (1991:18) states that "unfinished business makes reference to unresolved feelings or emotions that individuals have from past experiences". The questions synonymous to a diabetic child, "Maybe if I wish the illness away, I won't have it anymore," "Why me?" were definitely answered in the group sessions. The respondents were able to successfully close the unfinished gestalts formed in their psyche.

4.3.8 GROUP SESSION NINE

Technique: Dramatic Play

Medium: Role-play

4.3.8.1 Aims/Goals of the Session

- Assessing of awareness continuum of respondents by means of progressive body relaxation;
- Conflict resolution;
- Ensuring a calm disposition of respondents on leaving the session by implementing progressive body relaxation;
- Reminding respondents of termination session to prevent malingering of old behaviours and omit separation anxiety;
- Completing of post-test questionnaire.

4.3.8.2 Implementation

The researcher, for the purpose of the above utilised the rational intuitive conflict management model as outlined in Scott (1990:27-31). The model assisted the respondents with the following:

- When to put your anger aside
- How to put your anger aside
- When to listen to someone else's angers and fear
- How to respond to someone else's anger and fear

- When to let go and walk away
- How to let go and walk away.

The researcher then discussed and role-played rituals for decreasing their anger. These rituals are the following:

- Getting rid of anger by grounding it out
- Cleansing your energy to shake off your anger
- Releasing the anger by cutting the person, who makes you angry down to size.

Table 11: Contact with self and environment- Conflict resolution

Contact with self and environment	Assessment	Role and participation in the group
CHILD A: Child A still remains in contact with herself and the environment. This is depicted through the enjoyment of the progressive body relaxation exercises.	Child A enjoys the group process and the interaction of respondents. The atmosphere in the group at this point in therapy is comfortable and didactic. Child A enacted her role in the "here-and-now', engaging in dialogue with her parents. Child D enacted his role, also in the "here-and-now", engaging in dialogue with his parents. The first role-play presented child A as angry, upset and out of control. The second role-play involved the researcher talking through the technique with the child in communicating with her parent (child D). This role-play proved more successful than the first. The child was much calmer, she understood the point of view of the parent. She stated that she really enjoyed the role-play because she hated having to fight with her parents and she will utilise the technique at home. Her dealing with the emotions in the "here-and-now" will help her deal with the situation when it arises at home and achieve positive outcomes.	Child A was comfortable with the group process and the role-play. She participated in the role-play in the "here-and-now" and had good comprehension and understanding of what was required of her with the utilisation of the technique.
Conflict resolution: Role- play		
Child A assumed the "resolver" and the "aggressor" role in her role-play scene enacted with child D. In the role-play child A was the diabetic child who did not adhere to the diabetic diet while child D was the concerned parent. They were requested to engage in role-play regarding adherence and without the utilisation of the rational intuitive conflict model. They were then requested to engage in role-play utilising the model. Feedback regarding their emotions was then requested following completion of each role-play scene.		

Contact with self and environment	Assessment	Role and participation in the group
CHILD B: Child B remains in contact with his environment and himself. His awareness continuum is still intact. **Conflict Resolution- Role play** Child B played the role of "resolver" and the "aggressor". He was asked to respond to a concerned parent who was played by child C. The same procedure was utilised as with child A, with the first role-play excluding the conflict resolution technique and the second including it.	At this stage child B is comfortable with the group dynamics and the respondents' feedback. According to his parents, the child on joining the group was not exhibiting any behaviour problems. Subsequent sessions however confirmed that the child was experiencing more than the parents noticed. This session was also one where the issues in coping with the illness came to the fore. The child experienced his response to the role-play in the "here-and-now". His response to child C in the role play was filled with emotion and anger and focused on his parents not understanding him, expecting him to cope with the illness, independent of their support. The role-play was then re-enacted with implementation of the conflict resolution techniques. The child was then able to problem-solve, remain calm and communicate his feelings of isolation and anger. He also stated that this allowed him to view another's point of view.	Child B still experiences the interaction in the group as positive and interesting. He still maintains a strong leadership role in the group.

Contact with self and environment	Assessment	Role and participation in the group
Child C: Child C is still enjoying the progressive body relaxation and the therapeutic mileu of the group. Her sense of awareness is still in contact with the group and the process.	Child C being one of the most verbal and extroverted in the group welcomed the idea of role-play. She prepared to take on her roles namely, as child and as parent with commitment and enthusiasm. Child C also had a chance to be a parent therefore polarities in this child would be balanced. She would be able to approach the conflict scene at home with hindsight and judgement. She did enact her child role in the "here-and-now" and following implementation of the technique, presented a calm and rational response to child A who was the parent in this role-play. The researcher is also of the opinion that the catharsis in session four also assisted this child with release of her latent anger, therefore her response at this point was controlled. She enjoyed the progressive body relaxation and safe place exercise following the role-play.	Child C is still actively involved in the group process. She responded positively to her roles as parent and as child and enjoyed the acting in both roles.
Conflict Resolution: Role-play		
Child C played the child role in this role-play after having also played the parent role with child B. The role-play was initially enacted without the implementation of the conflict resolution techniques and then repeated with implementation.		

Contact with self and environment	Assessment	Role and participation in the group
CHILD D: Child D has developed positively through the group sessions. He has grown to trust the group process and its participants. This is confirmed by the voluntary closing of his eyes during the relaxation exercises. He is now in total contact with himself and his environment.	Child D being the quietest and the most introverted, initially took a few minutes to verbalise his anger and emotions at child A , who was the parent. With prompting and guidance by the researcher the child proceeded to verbalise his discontent with his parents, who nagged him constantly about his diet. He stated in the role-play that it made him feel that he could not be trusted and this made him feel sad. He also verbalised his unhappiness with being treated differently from the other siblings and at school. His anger with and without the technique showed neglible difference. The researcher attributes this to session five where child D pummelled and punched the clay releasing suppressed emotions and anger. Child D enjoyed the progressive body relaxation and safe place exercise at the conclusion of the session.	Child D's role in the group has grown positively. His initial hesitation with the role - play was only momentarily. Once comfortable with the role-play he presented confident and out-spoken in the ensuing role- play and all other activities.
Conflict Resolution: Role-play Child D played the child role in this role - play after having played the parent role with child A. The format of enactment was utilised with child D.		

The researcher enjoyed the role-play exercises in this session. The respondents were each given a chance to be a "child " and a "parent" in the role-play. The researcher felt that this emphasised the polarities by enhancing to the respondents the view and feelings of the child as well as the parent, so that conflict situations would be resolved having a knowledge base of both sides.

Oaklander (1988:157-158) states that an integration, reconciliation or synthesis of one's opposing sides, positive and negative is a pre-requisite to a dynamic and healthy life process. This session focused much on integration of polarities with views of both child and parent being verbalised, allowing for integration.

Oaklander (1988:158) is also of the opinion that polarities are an inherent aspect of everyone's personality. The researcher is of the opinion that with increased awareness, self–actualisation and acceptance of one's self comes greater inner strength and opportunity for self-determination.

4.3.9 GROUP SESSION TEN

4.3.9.1 Aims/Goals Of The Session

- Termination party;
- Handing out of attendance certificates to respondents (See Appendix 5).

4.3.9.2 Discussion Of Session

There was no therapy implemented in this session. The researcher did the rounds by asking respondents to share their experiences as being part of the group. Responses were positive and encouraging. There were requests from respondents and parents for continued therapeutic intervention.

4.4 POST-TEST RESULTS FOR THE RESPONDENTS

Following the progressive body relaxation exercises the respondents were handed the post-test questionnaires for completion.

4.4.1 CHILD A

Table: 12 Pre-and Post-Test Results for Child A

VARIABLE	BEFORE	AFTER
ANGER	80%	30%
REBELLION	60%	20%
UNDERSTANDING OF THE ILLNESS	50%	90%
FEAR OF THE ILLNESS	50%	10%
SITUATIONS OF CONFLICT	70%	40%

A comparison of pre-test and post-test results for child A reveal the following: Anger had decreased from 80% to 30%, rebellion had decreased from 60% to 20%, understanding of the illness had increased from 50% to 90%, fear of the illness had decreased from 50% to 10% and situations of conflict had decreased from 70% to 40%.

Child A's post-test results indicate that therapeutic work rendered in the sessions impacted positively on the child and her emotional development, regarding the illness. A significant decrease in anger and rebellion was noted. This indicates further the successful attainment and mastery of the different layers of neuroses. The progression of the child from the phoney layer to the explosive layer within a controlled, therapeutic environment allowed safe and supportive guidance through the different layers. Gestalt group work techniques enabled the child to close gestalts regarding the illness thus facilitating closure and organisimic control.

4.4.2 CHILD B

Table 13: Pre- and Post- Test Results for Child B

VARIABLE	BEFORE	AFTER
ANGER	60%	20%
REBELLION	50%	10%
UNDERSTANDING OF THE ILLNESS	60%	90%
FEAR OF THE ILLNESS	50%	20%
SITUATIONS OF CONFLICT	70%	30%

A comparison of pre-and post-results for child B reveal the following: anger had decreased from 60% to 20%, rebellion had decreased from 50% to 10%, understanding of the illness had increased from 60% to 90%, fear of the illness had decreased from 50% to 20% and situations of conflict had decreased from 70% to 30%.

The post-test results for child B indicate that anger and situations of conflict were significantly affected by the therapeutic group process. The techniques allowed the child to progress through the different layers of neuroses and deal with unfinished business regarding the illness. The eventual attainment of the explosive layer by child B allowed the child to experience significantly fewer situations of conflict. For child B the group sessions allowed him to experiment with behaviour which was congruent with the presenting emotions. It allowed him to balance his polarities and face the difficulties that the illness presented.

4.4.3 CHILD C

Table 14: Pre- and Post- Test Results of Child C

VARIABLE	BEFORE	AFTER
ANGER	70%	20%
REBELLION	70%	40%
UNDERSTANDING OF THE ILLNESS	30%	80%
FEAR OF THE ILLNESS	90%	30%
SITUATIONS OF CONFLICT	70%	40%

A comparison of pre-and post-results for child C reveal the following: anger had decreased from 70% to 20%, understanding of the illness had increased from 30% to 80%, rebellion had decreased from 70% to 40%, fear of the illness had decreased from 90% to 30% and situations of conflict had decreased from 70% to 40%.

For child C gestalt group work techniques played a major role and assisted with her understanding of her anger towards being a juvenile diabetic, as well as having a better understanding of the illness. The sessions allowed the child to understand the effects on her physical and psychological well-being. The techniques assisted the child simultaneously with release and experience of her anger thus showing a marked decrease in this aspect. The positive interaction of the child allowed her to progress through the different layers of neuroses and attain the explosive layer. The techniques allowed the child to achieve awareness regarding her anger towards the illness and the ways in which this anger hindered her development. The group sessions enabled the child to close gestalts relating to the illness.

4.4.4 CHILD D

Table 15: Pre- And Post-Test Results for Child D

VARIABLE	BEFORE	AFTER
ANGER	70%	20%
REBELLION	60%	10%
UNDERSTANDING OF THE ILLNESS	40%	90%
FEAR OF THE ILLNESS	80%	10%
SITUATIONS OF CONFLICT	60%	20%

A comparison of pre-and post-test results of child D reveal the following: anger had decreased from 70% to 20%, rebellion had decreased from 60% to 10%, understanding of the illness increased from 40% to 90%, fear of the illness had decreased from 80% to 10% and situations of conflict decreased from 60% to 20%.

Child D showed marked improvements in all aspects of the variables. Gestalt group work provided a two-fold function for the child. It provided him with the necessary skills required to cope with the illness and increased his self-esteem and self-confidence. This conclusion is supported by his pre-test and post-test results and his positive progressive development in the group. A study of his interaction within the group will show that he had developed from an introverted and withdrawn child to an individual who was confident and contributed significantly to the group process. Gestalt group work techniques facilitated the closing of open gestalts. The negative energy that was utilised for these open gestalts was converted to positive energy which resulted in a stronger self.

4.5 SUMMARY

The initiation of the group sessions proved a difficult task as subjects were unresponsive to invitations by the researcher. However, continual contact with Parklands Diabetic Clinic proved successful in identifying subjects for the group. The comparison of the pre-and post-test results of the respondents indicate that therapeutic group intervention for juvenile diabetics should be recommended as part of the diabetic regime. It is of utmost importance that psycho-social aspects of the juvenile diabetic is dealt with as stress presents a major obstacle in terms of adherence and control.

Oaklander (1988:285) states that groups have the advantage of being a kind of insulated little world in which present behaviour can be experienced and new behaviours tried out. This was true in this group, as each session involved trying out new behaviours amidst individuals they had come to trust.

This atmosphere of trust and experimentation allowed the respondents to become what they are and did not foster unrealistic expectations to be nurtured, thus allowing healthy and positive change to occur within the respondents.

The results from the empirical study clearly emphasise the need for therapeutic intervention with juvenile diabetics. Conclusions and recommendations will be discussed in chapter five.

CHAPTER FIVE
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In this study the researcher aimed to investigate the impact of gestalt play techniques on the aggression level of diabetic children. Further to this, the following objectives were formulated:

- To do literature studies on the impact of juvenile diabetes on the child and on gestalt group work play techniques;
- To do an empirical study and investigate the impact of gestalt group work techniques on the aggression levels of children with diabetes;
- To make recommendations on the use of these play techniques regarding the holistic treatment of diabetic children.

In chapter one the researcher aimed to explain the motivation for conducting such a study and gave a descriptive account of research procedure and its implementation, the methodology that would be utilised to achieve the goals and hypothesis and finally working definitions of key concepts and their specific meaning in this study. In chapter two an intensive literature study was undertaken on juvenile diabetics, which included the process, treatment and most importantly and pertinent to this study, the psych-social aspects of the illness. A literature study was undertaken in chapter three to equip the reader with a working knowledge of gestalt group work play techniques, resistances experienced in gestalt therapy, techniques utilised in the therapy process and lastly the importance of the gestalt approach to play therapy. This would equip the reader in understanding the therapy process utilised in the empirical study. Chapter four of the study consolidated the knowledge gained in the preceding chapters allowing implementation and understanding of the empirical study. A comparison of pre-and post-test results was also included in chapter four as it indicated movement and development of the respondents in the group. This further indicated the success of the implementation of the techniques.

5.2 SUMMARY

❖ *CHAPTER ONE-INTRODUCTION*

Chapter one provided an outline and guide to the study. The implementation of the study and the objectives stated in this chapter provided the guideline for the following chapters. The researcher is of the opinion that the goals stated in this chapter were conclusively attained.

The hypothesis stated in this chapter :" If gestalt play techniques are utilised in therapy with diabetic children there will be a decrease in aggression, rebellion, conflict, fear of the illness and there will be a better understanding of the illness", was proven to be true. This was evident from the literature and empirical study undertaken.

❖ ***CHAPTER TWO-JUVENILE DIABETES MELLITUS***

The content material of chapter two allowed the reader insight into the lives of juvenile diabetics and the impact of the illness on their psycho-social status. The literature study conclusively proved that juvenile diabetics require some form of therapeutic intervention due to the impact of the illness on their psyche. The objective for chapter two namely, " to undertake a literature study on the impact of juvenile diabetes on the child" was accomplished.

❖ ***CHAPTER THREE-GROUP WORK PLAY TECHNIQUES AND GESTALT***

The content material of chapter three aimed to educate the reader on gestalt group work and the techniques utilised within the group setting. These techniques were ultimately used to verify the hypothesis for the study. The literature study conclusively proved that these techniques would impact positively on diabetic children and their coping with the illness. The objective for chapter three namely:" to undertake a literature study on gestalt group work play techniques" was therefore successfully achieved.

❖ ***CHAPTER FOUR-EMPIRICAL STUDY***

The empirical study was the culmination of the preceding three chapters. The behaviours described in chapter two were evident in the therapy sessions and the techniques described in chapter three were utilised in dealing with these behaviours. The post-test results of the respondents indicate that the empirical study was positively and conclusively implemented with the integration of all chapters achieved. The objective for chapter four namely:" to undertake an empirical study to investigate the impact of gestalt group work techniques on the aggression levels of children with diabetes ", was achieved. The post-test results conclusively prove that gestalt group work techniques affect the psycho-social aspects of the diabetic child's life positively.

5.3 CONCLUSIONS

The researcher having implemented gestalt group work play techniques with the respondents derived the following conclusions;

- Gestalt group work allowed group members to experience feelings that were related to the illness and were sealed off from awareness thus facilitating closure regarding these feelings;
- Self-awareness, interaction and generation of new information allowed painful emotions to be shared among the group members;
- Gestalt group work combined with play therapy has the following effects on juvenile diabetics: decrease in rebellion, increase in their understanding of the illness, decrease in situations of conflict, decrease in anger and decrease in their fear of the illness;

- Play therapy is an excellent form of therapeutic intervention for effecting behaviour change in juvenile diabetics;
- Organismic control in gestalt and the technique of integrating polarities in play therapy allows the child to achieve a balanced view of the conflict situation;
- Gestalt group work contributes to facilitating the development of the group process and encourages trust, cohesion, understanding, acceptance and respect to emerge among the group members;
- Members were able to achieve closure on unfinished business relative to the illness.

5.4 RECOMMENDATIONS

On the basis of the literature and empirical study undertaken, the researcher would like to recommend that:

- Behavioural and therapeutic intervention be included in the juvenile diabetic's treatment programme;
- Supportive groups be offered for the parents of juvenile diabetics;
- A social worker skilled in appropriate therapeutic intervention be assigned to the diabetic clinics of hospitals;
- Gestalt play techniques and gestalt groups be integrated in the diabetic treatment programme at hospitals;
- Play therapy within a group setting should be utilised as a form of therapeutic intervention with juvenile diabetics.

5.5 CLOSING COMMENTS

The researcher's study provides an answer to the question asked by health professionals, "We know diabetic children exhibit aggressive behaviour however, what do we do about its management?" It will further enhance the treatment programme provided by health professionals and offer quality service and holistic treatment to juvenile diabetics and their families.

The therapeutic intervention would have to be consistent for effective change to occur. The motivation and commitment levels of respondents would have to be assessed before joining the group. Parents of the respondents play an integral role in the course of therapy. Gestalt group work play techniques and its positive effects on the psycho-social aspects of juvenile diabetes has been studied in this research and an integrated framework for the management of juvenile diabetes has emerged. This will allow understanding of the illness and efficient self-management. Diabetes care therefore has much to gain from the collaborative efforts of physicians and social workers.

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CONSENT LETTER FOR PARTICIPATION IN DIABETIC THERAPY GROUPS

We, Mr & Mrs _____ , hereby give consent for our child to participate in the diabetic therapy groups presented by Mrs Marshree Doorgapershad. We are aware that the results from the group sessions will be used for research purposes and will also be published. We have also been informed that our child's name will remain anonymous to protect his/her identity. We acknowledge the compulsory attendance of the group sessions. We will also not hold the researcher responsible for any untoward and unsafe behaviour by our child during or after the group sessions.

Signed: _____ Date: _____

(Parents)

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Durban Children's Society

William Clark Garden
Othandweni Children's Home
23 Garbutt Road
Sherwood 4091
Tel: (031) 207 1366/7
Fax: (031) 208 7511

Mrs M Doorgapershad
37 Maple Road
No.10, Ascot
Morningside
DURBAN
4091

8 May 2000

Dear Madam

Your request to utilise one of the rooms at William Clark Othandweni has been accepted.

The room allocated to you is the flat 2 boardroom.

The key will be left at the security gate on those days for collection.

Yours Sincerely

ACD MOFOKENG (MRS)
MANAGER

QUESTIONNAIRE TO DETERMINE LEVELS OF AGGRESSION IN DIABETIC CHILDREN

1. NAME: .....

2. GENDER: MALE FEMALE

3. AGE: .....

4. STANDARD IN SCHOOL :

5. YEARS BEEN A DIABETIC : 1YR 2YRS 3YRS MORE

6. PROBLEMS EXPERIENCED SINCE BEING DIAGNOSED AS A DIABETIC:

.....
.....

7. WHAT MAKES YOU HAPPY?

.....
.....

8. HOW DO YOU KNOW WHEN YOU ARE HAPPY?

.....
.....

9. ARE YOU HAPPY MOST OF THE TIME?

.....

10. WHAT MAKES YOU SAD?

.....
.....

11. WHAT DO YOU DO WHEN YOU ARE SAD?

.....
.....

12. ARE YOU SAD MOST OF THE TIME?

.....

13. WHAT MAKES YOU ANGRY?

.....
.....

14. HOW DO YOU KNOW WHEN YOU ARE ANGRY?

.....
.....

15. ARE YOU ANGRY MOST OF THE TIME?

.....

16. DO YOU THINK YOU ARE WELL BEHAVED MOST OF THE TIME?

.....
.....

17. WHAT CAUSES YOU TO MISBEHAVE SOMETIMES?

.....
.....

18. WHAT IS THE WORST THING THAT EVER HAPPENED TO YOU?

.....
.....

19. WHAT DO YOU LIKE MOST ABOUT YOUR FAMILY?

.....
.....

20. WHAT DO YOU LIKE LEAST ABOUT YOUR FAMILY?

.....
.....

21. IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR FAMILY?

.....
.....

22. HOW DO YOU GET ALONG WITH YOUR FATHER, MOTHER, SIBLINGS AND FRIENDS?

POOR FAIR GOOD VERY GOOD

FATHER.....

MOTHER.....

FRIENDS.....

SIBLINGS.....

23. DO YOU HAVE MANY FRIENDS?

.....
.....

24. ARE YOU HAPPY AT SCHOOL?

.....
.....

25. HOW DO YOU GET ALONG WITH YOUR CLASSMATES?

.....
.....

26. HOW DO YOU GET ALONG WITH YOUR TEACHERS?

.....
.....

27. DOES ANYONE MAKE FUN OF YOU AT SCHOOL? IF SO FOR WHAT REASONS?

.....
.....

28. WHAT IS THE HARDEST THING ABOUT BEING DIABETIC?

.....
.....

29. DO YOU FEEL DIFFERENT BECAUSE OF YOUR DIABETES?

.....
.....

30. DO YOU FEEL RESTRICTED BECAUSE OF YOUR DIABETES?

.....
.....

31. DO OTHER CHILDREN MAKE IT DIFFICULT FOR YOU BECAUSE OF YOUR DIABETES?

.....
.....

32. IS THERE ANYTHING ELSE YOU WOULD LIKE TO SAY?

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.....
.....

GROUP RULES

1. Attendance is compulsory for ten sessions.
2. Be yourself, do not be afraid.
3. If you have problems, talk about it.
4. Confidentiality.
5. Have fun, learn, behave and be open.
6. Respect group leader and members.
7. Comfort, help members. Be part of the group. Remember you are not alone.
8. No interrupting while someone else is talking; do not be a boss.
9. The length of the group is one hour.

Name: _____ Sign: _____