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A theoretical exposition of the concept "spontaneous healing in children": a SHIPiC™ perspective

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SHIP® (spontaneous healing intra-systemic process) (JOS 2002) as a psycho-therapeutic model has developed over many years during which the fascinating occurrence of spontaneous healing in clients was observed. In 2001 The SHIP® Foundation was launched to promote the schooling of registered psychologists in the art of facilitating healing in clients, which inevitably created more balance and integration in clients, families and communities. The development of the spontaneous healing therapeutic technique in children soon followed and SHIPiC™ (spontaneous healing intra-systemic process in children) was trade marketed in 2003. This article is intended to explain the core theoretical principles of this exciting therapeutic model with regard to children.

'n Teoretiese uiteensetting van die konsep "spontane heling by kinders": 'n SHIPiC™ perspektief

SHIP® (spontane heling intrasistemiese proses) (JOS 2002) het as 'n terapeutiese model oor etlike jare ontwikkel. Gedurende hierdie tydperk is die fassinerende verskynsel van spontane heling in kliënte waargeneem. In 2001 is The SHIP® Foundation gestig met die doel om geregistreerde sielkundiges in die kuns van die fassilitering van heling in kliënte op te lei, wat weer aanleiding gee tot groter balans en integrasie in kliënte, families en gemeenskappe. Die ontwikkeling van die spontane heling terapeutiese tegniek in kinders het kort hierna gevolg en die SHIPiC™ handelsmerk (spontane heling intrasistemiese proses in kinders) is in 2003 geregistreer. Die doel van die artikel is om die basiese teoretiese beginsels van hierdie opwindende terapeutiese model vir kinders te verduidelik.

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Since 2001, the SHIP® Foundation[1] has become a training school, in which in-depth training opportunities at the post-magister level have been created for registered psychologists. All the Foundation's activities are accredited by the Health Professions Council of South Africa, which allows it to expose psychotherapists to a continuous professional development programme of the highest quality. Currently, many psychologists are making use of this opportunity to undergo these programmes in personal and professional growth and developmental. A psychologist who has undergone the personal development programme, which entails supervision and personal therapy sessions, and has been trained in the more advanced theoretical concepts (which are discussed during supervision sessions or workshops) is permitted to register as a facilitator. The training starts as soon as the psychologist enters the therapy and individual supervision sessions.

After many sessions with adult clients, it became evident that there was a need for the development of a SHIP® model for children. Experience indicated to the facilitators that many of the Foundation's principles are applicable to therapeutic encounters with children, but that certain differences need to be emphasised during training.

This article is primarily intended to expose the core principles and working concepts of SHIPiC™, which form the basis of therapeutic engagement with child clients. Its second aim is to draw a concise comparison between the theoretical core principles of some dominant psychological practices and the SHIPiC™ theory. Its third aim is to discuss the role of the SHIPiC™ facilitator in facilitating healing in child clients and provide a brief discussion of the SHIPiC™ process and its important theoretical concepts.

SHIPiC™ has its origin in SHIP® and is firmly rooted in its theory. There are, however, certain instances in which the theory is applied differently when dealing with children. This article's main focus will be on the discussion of the core concepts and principles of SHIPiC™, with frequent reference to its roots in SHIP®.

1 Cf <http://www.ship.org.za/index.php>

1. Basic SHIPiC™ concepts

1.1 The Spontaneous Healing Intra-systemic Process

One possible definition of "spontaneous" is given by Reber (1995: 722) who views healing as one of the natural, unconstrained, unpremeditated processes of a life, which come from within and are totally unique, personal and endogenous. Like all inherent, spontaneous processes, physical and psychological healing is a perfectly normal and natural occurrence and is regarded in SHIPiC™ as a core theoretical principle. "Spontaneous healing" is inherent to all life since all life forms possess a tendency towards growth, balance and integration. Built into the human system is an innate wisdom that aims at achieving balance between the different sub-systems of the body (JOS 2002: 67-72). These intra-systemic and complementary sub-systems include the following: the physical, bodily system (the digestive, respiratory, neural, endocrine, circulatory, muscular, skeletal, excretory, reproductive, integumentary and immune systems) (JOS 2003: 1); the mental, conceptualising system; the socio-emotional system; the motivational system; the spiritual system, and the involuntary protective system (IPS, which will be explained later).

All of these systems form an intricate and interactive network aimed at maintaining balance and promoting systemic growth. This psycho-biological network creates an information sharing and energy distribution system which naturally follows the healing route set by the innate healthy blueprint residing in each human system (JOS 2002: 127-8). In SHIPiC™, the natural rhythm of each child is recognised, which renders the application of a pre-developed and structured therapeutic "plan" impossible. The child as client should never be boxed into a series of therapeutic steps to be executed. All SHIPiC™ facilitators are required to do during therapy is to follow the spontaneous healing route of each child by being sensitive to the signals of the innate healthy blueprint, and by following these natural beacons set by the inner system. Although this article is not intended to demonstrate how these healing beacons are followed, some reference will be made later to the theory behind this important principle.

The unobstructed interaction between intra-systemic bodily sub-systems is crucial to spontaneous healing, as many neuro and other scientists have indicated in recent years. Pert (1997: 271-3) states that

happiness (in SHIPiC™ terms, connectedness with all parts of the self) is what human beings feel when biochemicals of emotion, the neuropeptides and their receptors, are open and flowing freely throughout the psychosomatic network, integrating and co-ordinating our systems, organs and cells in a smooth, rhythmic movement. The free flow of these biochemicals creates in human beings a feeling of harmony, happiness and connectedness within the self.

Diepold (2002: 6) also refers to the flow of energy in the human system and describes how this flow, in the desired direction, can promote healing from the inside. A disruption or reversal of the energy flow by, for instance, physical or emotional conditions, incidents or stress may hinder or prevent physical and/or psychological healing (Diepold 2002: 6). According to Bremner (2002: 20-1) and Nemeroff (2004: 18), prolonged exposure to stress and traumatic experiences in early life predisposes children to the development of physical, anatomical, mood and anxiety disorders. These disorders indicate structural blockages in the bodily system (in SHIPiC™ terms called the bodily suitcase or psychobiological system, which can be linked to the description of the unconscious mind by psychoanalysts) which will hinder spontaneous healing. Etherington (2003: 11) refers to this absorption of unpleasant incidents in the life and body of a child as the trauma being "somatised". This solidification of unlived experiences in the body is acknowledged by theorists like Rothschild (2000: 32-3), who is adamant that the body has a memory and that there is place in psychology for fields like "the psycho-physiology of trauma" and "the psycho-biology of stress".

The final concept in the SHIPiC™ acronym to be discussed is the term "process". This concept signifies a reference to the continual nature of spontaneous healing, which is non-static and dynamic, constantly changing and proceeding through natural pathways created by the psychobiological system (JOS 2002: 178). Clients are allowed to experience their spontaneous healing as it is manifested in accordance with the unique inner rhythms of the individual (JOS 2002: 130). Children in SHIPiC™ will therefore never be exposed to the inhibiting label which a diagnosis imposes, but will rather be allowed to engage in living their spontaneous healing processes.

2. A comparison of SHIPiC™ with current theoretical frameworks in child psychology

Over the years, a number of child therapy models have been applied. The following are the most frequently used: the psychoanalytic, cognitive-behavioural, Jungian, filial, developmental, Gestalt, ecosystemic, Ericksonian, Adlerian, medical and integrated, humanistic models. As it is impossible to describe each of these theoretical models or to elaborate fully on their points of similarity or difference to or from the SHIPiC™ model, a summary of selected models will have to suffice. This comparison also encompasses an evaluation and critique of the core theoretical principles of the various models and how they resemble or differ from the SHIPiC™ model. The focus of this summary will be only on the core theoretical principles and treatment options of each model.

The following models will be scrutinised: the medical model, the psychoanalytic model, the cognitive-behavioural model and the biopsychosocial models.

2.1 The medical model

The medical model operates from the premise that a physical and constructional cause exists for pathology in children with emotional, educational and/or behavioural problems. According to this model, these problems may result in a child's becoming maladjusted, a function of psychopathology. In psychology, "psychopathology" is defined as the scientific study of mental disorders which should be treated by an expert (Reber 1995: 595). The treatment goal is to promote the development of a well-adjusted personality so that the child may again function "normally" in a "normal" environment (Jones 2003: 148).

Since the late 1970s, strong criticisms have been raised against the medical model of maladjustment (Laslett 1983). The idea that a medical doctor, psychiatrist or psychologist had to "treat" a child with a mental disorder or a maladjustment problem, has become unacceptable. Such practices made the professionals the experts on a mentally "sick" child. *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-IVTM-TR 2000) was the handbook which professionals would use to diagnose disorders and pathology. It adorned the shelves of professionals and enabled them to label children as "disturbed", "mentally ill" or "sick". The "cure"

of such diagnosed children lay solely in the hands of these professionals who would have to "treat" children according to controversial practices. The comfort of "identifying, categorising and labelling diseases" was criticised by Wolin & Wolin (1993: 13) in their endeavour to promote a movement away from the pathology-based medical model. In SHIPiC™, this move away from the medical model is supported. No child is labelled as having a mental disorder or a disease that has to be treated by an outsider. The "dis-ease" a child may feel from time to time is seen as an effort to complete unlived experiences from the past, which have been stored as incomplete experiences in the subconscious mind, what SHIPiC™ defines as the "bodily suitcase". The child is seen as the expert on his own body expected to connect with the emotional and physical discomfort he is undergoing. The SHIPiC™ facilitator facilitates this process, but can never become the master or expert of the child or of his inner processes. In SHIPiC™ the medical model is regarded as an arrogant and reductionistic approach as the child merely becomes a label or diagnosis to be treated by a god-like figure who overrides all the other aspects of a unique child with huge capabilities, inherent resources, essential assets and innate possibilities for healing.

2.2 The psychoanalytic model

The Viennese neurologist Sigmund Freud (1856-1939), who is considered the father of psychoanalysis, viewed personality development as a dynamic, multiply-determined process based on the theory of infantile sexuality, with a sequence of libidinal phases from whence instinctive drives and their energies are derived. All behaviour is thus motivated by the expression of these drives and their object cathexes (Lee in O'Connor & Braverman 1997: 46). Throughout the lifespan, psychic energy is cathected toward important object relationships, shaping and moulding the individual character as well as expressing the libidinal and aggressive drives, adaptive ego functions (the ego manages the personality), and superego (ethical and societal concerns) demands. While the child is thus trying to adapt to the demands of reality, the need to fulfil the pleasure principle becomes stronger.

Strongly emphasised in psychoanalysis is the theory that patients who suffer from symptoms resulting from the repression of forbidden mental content may develop personality disorders because their instinctive drives

urge them to seek gratification, which may evoke conflicts between the drive and the reality principle served by the ego. Psychoanalytic play therapy is aimed at resolving the fixations, regressions, and, where possible, developmental deficiencies and deviations that derail a child's normal development. The psychoanalyst provides a setting in which the child may play out and, it is hoped, express the intrapsychic concerns that have brought him or her to therapy.

Some experts (Emanuel 2004: 71; Cooper 2002: 95) are of the opinion that psychoanalysis fails to recognise the role of the body in past physical and emotional experiences and that "mental" experiences are overemphasised. Cooper (2002: 95) further states that Freud's revolutionary science of the mind resulted in the near-destruction of the spiritual/mystical model favoured by therapists who rejected the developing medical model. In SHIPiC™ the theories of Cooper (2002) and Emanuel (2004) are supported as the emphasis is on the child's being more than a mind driven by instinctive energies.

Although this is the main difference between SHIPiC™ and psychoanalysis, they also share some points of similarity, although different concepts are used to describe them. One example is the following: they both describe the unconscious mind, but SHIPiC™ refers to this part of the child as the "disconnected self", *i e* the physical self of the person, where any experiences not fully digested by the child are stored as emotional and physical discomfort. Both theories also believe that early experiences are the cause of later behaviours. SHIPiC™ does not claim that its theory is unique, or has not been influenced by important theories such as psychoanalysis. SHIPiC™ merely describes, in more detail, a positivistic child therapy model with a strong emphasis on what is stored in the bodily system.

2.3 The cognitive-behavioural model

Cognitive-behavioural theory supports a model of psychopathology which details intricate reciprocal interaction among cognitions, emotions, behaviour and environment. The primary goal of this approach is to identify and modify the maladaptive thoughts associated with the patient's symptoms. The father of this theory is Beck (1976) who emphasised the role played by cognitive distortions in human behaviour and thought, particularly as these relate to psychopathological development. For

children, these cognitive distortions are often considered maladaptive (Knell in O'Connor & Braverman 1997: 80).

SHIPiC™ theory differs substantially from the cognitive-behavioural in the following ways:

- The cognitive-behavioural theory operates from the premise that thoughts influence the patient's emotions and behaviours in response to events. SHIPiC™ theory does not refer to a child client as a patient. Secondly, in terms of this theory a child is believed to first experience an event and, if it is too traumatic or threatening, to store the unlived experience in the body, to be retrieved when the system is ready to face it. This is not seen as pathology, but as a natural process of spontaneous healing. If the child later experiences symptoms such as emotional or physical discomfort in the form of tearfulness, tension, sleeping problems, and so forth, the SHIPiC™ facilitator will know that s/he has entered the phase during which therapy can commence.
- The cognitive-behavioural theory also describes how perceptions and interpretations of events are shaped by the patient's individual beliefs and assumptions. In SHIPiC™ it is acknowledged that a child may have unique interpretations of an event which may influence its perceptions. However, it is not accepted that the young child already has a set of beliefs and assumptions in place to evaluate events. The child will live an event which, if experienced as threatening, will automatically "disconnect" it. For example, a child may develop the perception that it is not safe to run a race at an athletics competition, because the crowd will laugh if it trips and falls. The assumption that a child may then develop is that it is "not good enough" to perform in public. In SHIPiC™ this is called a chain statement.
- In the cognitive-behavioural model it is further stated that errors in logic or cognitive distortions are prevalent in individuals who experience psychological difficulties. In SHIPiC™, the very young child is not believed to have severe psychological difficulties. A child who is raised with warmth and acceptance and finds itself in a safe, nurturing environment should not develop psychological difficulties. A child who lives in a harsh, unloving, unsafe place where it is not cared for with acceptance, may feel rejected and may develop perceptions such as "all adults are cruel"/"I am always to blame"/

"to keep quiet is safer". But these beliefs are true for that child in the specific environment and can hardly be described as pathological or distorted. If a child is, for instance, constantly criticised by an adult, its reactions — for example, regression, temper tantrums or withdrawal — are normal behaviour in an abnormal situation; it is the environment that is pathological, not the child's behaviour.

2.4 Biopsychosocial models

In the literature, scientists are increasingly challenging established ways of "treating pathology in patients" (Grossman 2003: 492). Grossman advocates a movement back to listening to the body to obtain clues on how individuals are coping with and surviving life. This empowering, positivistic view is part of a larger shift in psychology to positive psychology where more emphasis is placed on aspects such as resilience and less on pathology, labelling and diagnosing psychological diseases. This new field is called *Salutogenesis* (cf RAU 2003).

The following three models serve as examples, linking with some of the principles of healing advocated by SHIPiC™:

- Virginia Satir's integrated, humanistic approach describes bodily, mental, emotional and spiritual processes as being part of the transformation of systems from the molecular to the cosmic. Her theories and techniques offer hope and possibility, her core principle being respect for the uniqueness and miracle of each individual (Haber 2002: 23-34). It is Satir's belief that the elevation of internal and external consciousness is a necessary ingredient for developing healthy individuals, families and communities. SHIPiC™ is also focused on the unique inner bodily and external environmental processes and their influence on the developing child, who constantly needs to grow and connect with all parts of the self to optimise healing experiences.
- The classic biopsychosocial mind-body model of Griffith *et al* (2003: 94-103) is an example of a holistic approach which encourages growth within the individual. It aims to empower people to lead longer and healthier lives by improving their lifestyle practices and equipping them with knowledge about their bodily, emotional and social processes. This approach, facilitating connection with all parts of the self, is supported by SHIPiC™.

- A theory which does not differ extensively from the above is the integral transformative theory or practice (ITP) which emphasises that all human dimensions (body, instincts, heart, mind and consciousness) should be co-creatively integrated in the personal growth. The ITP model of Albareda and Romero (Ferrer 2003: 21-42) is based on the creation of group retreat opportunities to allow access to the creative potential of all human dimensions by interaction between facilitators and participants. Although in SHIPiC™ no group retreat sessions are organised, family therapy sessions are facilitated to allow each member of a family to become aware of the information (words, gestures, attitudes) circulating in the individual bodily system and the broader family system and of how the effects of these influences are interlinked. The emerging knowledge about the self and others in the family is used to improve or transform the communicative and interactive processes in the family system.

In all of these models the role of the psychologist/therapist in the child's journey towards wholeness and psychological healing becomes apparent. SHIPiC™ acknowledges the importance of the role a trained psychologist can play, but as a facilitator, rather than in the leading role of an expert. This is not only true for SHIPiC™, but also part of the theory of the client-centred and humanistic schools of thought. The nature of this facilitation will be discussed in detail in the next section.

3. The SHIPiC™ facilitator

Before the role of the SHIPiC™ facilitator in the healing process of the child client is discussed, a brief explanation of the rationale of SHIPiC™, as described in terms of SHIP®, will be given.

3.1 The rationale of SHIPiC™

As a child grows up, it is expected to adapt to the adult world by accepting community and societal rules and rituals. In this endeavour to adapt and be accepted, the child loses parts of itself as it is too helpless to maintain its full self in relation to a commanding and conditional world (JOS 2002). The child then starts developing coping styles such as anger, passivity, manipulation, anxiety and many others in order to cope with the continual demands and the consequent loss

of parts of the self. Symptoms such as anger and anxiety are not seen as pathology, but are described as coping styles. On an unconscious level, by trial and error, one part of the personality (e g the child maintaining itself better by being rude or angry) becomes more dominant. If this coping strategy bears fruit, an increasing amount of life energy will be spent on developing this part of the self, at the expense of all its other parts. This results in an uneven distribution of energy among the different parts of the self, which creates an inner imbalance (JOS 2002: 5-6).

The child may also experience a sense of helplessness and of not being able to manage its own life successfully. These emotions, plus the overwhelming demands, compromises, expectations, trauma, and so forth, of life cause the sensitive parts of the self to disconnect (being submerged in the disconnected part — the unconscious — of the self). The child who experiences sudden or prolonged stress may disconnect the effects of the overwhelming incident, or its consequences, to protect the self. Straker *et al* (2002: 145) regard trauma as a radical disconnection which has a long-term effect on the child's psychological well-being. This disconnected self, for instance, becomes the harbouring place of denied identities, which eventually seek validation through chronic systemic stress reactions (JOS 2002). Each of these stress reactions has its origin in a particular physical site (a place in the bodily system which houses the disconnectedness) called a healing site. Chronic systemic stress reactions such as headaches, ulcers and many other physical ailments (which highlight the location of a healing site) indicate a system in need of integration and connectedness and can be described as the internal voice echoing the need for balance and healing. Theorists like Nanke & Rief (2004: 133) refer to this voice from the inner self as coming from body sites which house medically unexplained symptoms. They are of the opinion that the symptoms will disappear if biofeedback techniques, like focusing on, experiencing and controlling psychophysiological processes, are applied. Biofeedback is often used in therapy with children nowadays and is an acknowledged technique. This approach is supported in terms of the SHIPiC™ theory as is the belief that these psychobiological processes can be facilitated.

The SHIPiC™ facilitator can play an important role in facilitating spontaneous healing in the child client by accompanying it to these

healing sites and allowing it to "spend time" there. The idea is to assist the client in recalling early memory experiences. Marquez (2000: 147) feels strongly about the fact that healing will take place if prenatal, perinatal and early childhood experiences are recognised, lived and completed in full. This belief corresponds strongly with techniques used in psychoanalysis such as dreamwork and fantasy trips.

The SHIPiC™ facilitator has one optimal goal: to create a safe healing space where the living-through of these unlived experiences can be completed. This will allow the client's system to release the inherent, spontaneous potential of the self so that the child will become the person it was supposed to be in the first place. The SHIPiC™ facilitator does this by creating an optimal environment to enhance and sustain systemic integration, growth and balance. "Balance" implies equal distribution of psychological energy among all identities, life roles and systemic subsystems. Aftanas & Goloshekin (2003: 143) assert that the focus on internal processes and positive energy distribution may lead to bodily and psycho-emotional stability. "Integration" refers to the process during which the more sensitive, disconnected, unknown parts of the self are allowed to resurface, acknowledged and assimilated with the successful, known parts (the connected self).

One could almost describe this integration as a process of merging the unpleasantness of the old life themes of the past with the known of the present. In this regard Wheeler (2002: 249) refers to the healing of the dissociated parts of the self by allowing them to become part of the known self by owning old themes, not discarding them as mere bad memories. Menzies (2001: 227) identifies the child's need to make known parts of the self, the true self. If this does not happen, a child may feel hopeless and unknown. For hope to flourish again, one's true self must be made known. One can see this as helping the child client to move back towards the place where the innate healthy blueprint of hope originates, instead of moving away towards a place of hopelessness. The SHIPiC™ facilitator will thus aim to facilitate the process of integration between the connected and disconnected selves, which is movement towards the self and not towards the conditional world.

The SHIPiC™ facilitator also has a role to play as the child's ally, exploring with it the realities and subtleties of the inner and outer landscapes. SHIPiC™ describes three different levels of exploration in which

the child engages when undertaking the healing journey. The first level is the exploration of the inner landscape which represents the inner world of bodily experiences and feelings, emotions, memory traces, individual history and disconnected information. Brown (2001: 111) refers to this inner world of a person as the "inner space". This space represents the unique psychobiological components of the private self — the inner or internal world. Linden (2003: 245) posits that the inner world of the child is a community of archetypes potentially available for its healthy ego development, and that it is possible to access these archetypes by the use of playful metaphors.

In SHIPiC™, too, symbols and metaphors are used to visit these archetypal communities with healing potential. Many researchers support the use of metaphor when working with children (especially in story contexts), as children seem to prefer this to literal instructions and experience it as a safe and non-threatening way of engaging in the process (Oelofse & Weyers 2002: 161; Heffner *et al* 2003: 19).

The second level of exploration is that of the outer landscape or the external world. This external landscape is made up of all external influences on the spontaneous development of the child. The child has no choice but to cope with, and adapt to, the demands and strangeness of the outer world created by societies and cultures. The SHIPiC™ facilitator will facilitate the client's process of exploring the realities and interpretations of adult institutions, rituals and social interactions.

The third level of exploration is the journey across the genetic plane/landscape, which may give the child a sense of heritage, content and substance. During this exploration, the child may become aware of its roots and origins, which may help it to understand the manifestations of its chronic systemic reactions, which may be linked to a predisposed systemic weakness. If a child, for example, discovers that its grandfather also experienced problems with breathing it may better understand that its own asthma is not a weakness but merely a message from the system to pay attention to parts of the self which need recognition and which make themselves known through bodily symptoms. In SHIPiC™ the majority of illnesses have a psycho-emotional origin, but it is acknowledged that this needs to be researched further.

During these psychobiological excursions, the SHIPiC™ facilitator helps to create an inner scaffolding map that will enable the child to

explore the different landscapes safely. The emphasis is on facilitating the child's process so that it may become the expert of its own processes. The facilitator thus plays the role of guiding the child through the exploration without leading it in any specific way or direction. The concept of "scaffolding" will now be discussed briefly.

3.2 Scaffolding and the zone of proximal healing

"Scaffolding" is described by Callison (2001: 38) as temporary steps in the learning process where higher skills are built on mastering the more simple skills, often with the help of an expert. This concept is derived from work done by Vygotsky (Callison 2001; Bodrova *et al* 2000) in which the zone of proximal development is described. According to this theory, a child may perform well during learning exercises, but will exceed its own abilities if guided by an expert. This gap between a child's actual performance and his potential is called the "zone of proximal development" (ZPD). In the SHIPiC™ theory, this principle is made applicable to the psychobiological realities and potential of the child client. In many cases it may seem as if a child is coping with daily demands while experiencing inner constrictions and tensions. With the help of a SHIPiC™ facilitator, the child may reach its own psychobiological potential by means of scaffolding opportunities, also called mediated healing experiences (MHE), through the zone of proximal healing (ZPH). In Latin, *proximus* means "near" (Reber 1995: 585). In anatomy, "proximal" refers to points near to the centre of the body or an organ, or to the point of attachment of an organ or structure. The ZPH will, in SHIPiC™ terms, imply the child's journey towards attaching/connecting to his natural, core self.

In SHIPiC™, the child progresses, via scaffolding experiences, through the space of proximal healing (ZPH) to a space where it is closer to itself (more connected and integrated). The SHIPiC™ facilitator initiates the scaffolding experiences by erecting temporary symbolic maps towards healing and ultimate integratedness. Through the implementation of SHIPiC™ techniques (which fall outside the scope of this article) the child engages in temporary active and passive experiences during which imaginary problematic setups are analysed and successfully handled. If the child is exposed to the successful completion of these "play tasks" and events, the chances are good that it will

not easily disconnect incomplete events in its psychobiological system. By doing this, the client allows pain and other discomfort to surface more easily. An important difference from Vygotsky's ideas on ZPD is that the SHIPiC™ facilitator is not seen as an expert on the child's healing process, but as a mere facilitator. Through these ZPH experiences, the child learns more about its own healing and growth processes and becomes the expert on itself.

With regard to the SHIPiC™ facilitator, two final remarks suffice. The first is that SHIPiC™ will only be successful if the facilitator works from an external frame of reference. This means not engaging in interpretative, diagnostic or evaluative actions during which the client's way of thinking and doing is weighed and judged. The facilitator will engage in the healing journey with a child and endeavour to see this journey from the client's point of view, which implies listening with the third ear, seeing with the third eye. This is a universal principle in psychology and corresponds strongly with the work done by Jacobs & Vrey (1982) describing fine tuning into the client (really listening, hearing and feeling).

Secondly, the SHIPiC™ facilitator can only engage in facilitating children's healing journeys if he or she is committed to his or her own professional training and healing processes. A facilitator needs to pass through the initial training process first, during which his or her own healing process is facilitated by a SHIP® trainer. After this process (which actually continues), the facilitator is trained in more advanced theoretical principles of SHIP® during training workshops and individual supervision sessions. If a facilitator wishes to implement SHIPiC™, workshops and supervision sessions may be organised with a SHIPiC™ trainer. The facilitator must remain constantly aware of his or her own healing processes. Unless this is the case, contamination of the child's growth experience may take place. Provided the facilitator works from an external frame of reference, this will not happen.

4. The SHIPiC™ process

The SHIPiC™ process starts when the parents call the SHIPiC™ facilitator's practice for an appointment. A first appointment, without the child client, is set up with the parents to obtain a referral image.

4.1 Compiling a referral image

A referral image is obtained by determining the reason for referral, as well as taking the full history of the child. It is crucial to obtain a proper referral image since this will give some indication of the child's current life dynamics. Usually the parents complete a comprehensive questionnaire on the child's history. During the interview, the facilitator needs to determine whether the child's behaviour or emotional state has activated the parents (made them aware of some incomplete themes in their own lives) or if it really needs facilitation after severe interferences such as abuse or an unsettling accident. Sometimes the child is referred for both these reasons.

In other instances, the client is seen before any information is obtained from the parents, which in SHIPiC™ is called a "blind contact", because the facilitator engages with the client in an almost blindfold fashion. This is one of the most exciting contact sessions because the facilitator has a wonderful opportunity to "feel" his or her way through the facilitation process.

Parents are part of the child's external world, and if they seek help they do so because they are reacting to observations of their child's external behaviour or commenting on signs of its inner journey which appear to them to be painful, peculiar or inappropriate. It is obvious that siblings, grandparents and other family members can also be involved in the process. When listening to parents, the SHIPiC™ facilitator is aware of the different levels at which the parents may report on their child:

- Parents may tell their child's story as it really is, in other words they are objective about what is going on in its inner and outer worlds and are of the opinion that it needs some assistance or facilitation;
- Parents may also tell their child's story as they experience it, being more emotional and less objective, and elaborating extensively on the effect it has on them, the household, teachers and classmates;
- Parents may be selective and tell only what they feel is necessary — an edited or softer version of the child's reality. In this case, their fear or uncertainty about what is happening in their child's life prevents them from facing the full reality and they unconsciously disconnect painful realities.

The role parents or involved foster-parents play in the lives of children is so crucial that it is unthinkable to engage in any SHIPiC™ activities without working closely with the parents. Unless both parents are willing to take up their parenting responsibilities and become involved in their child's SHIPiC™ process, it is terminated. Experience has taught SHIPiC™ facilitators that the prognosis of engaging in a child's healing journey is jeopardised if the mother and/or father are indifferent to the distinctiveness and significance of the entire process. The success of SHIPiC™ also depends on both parents applying some very basic and simple healing endeavours at home. Furthermore, parents bring to the SHIPiC™ process a sense of the past, present safety and the hope of a wonderful future. If they are absent from the process, it is discontinued. If it is continued at the request of concerned grandparents or family members, the loss of all those parental themes, like not having a sense of history, not having both parents available or not having hope for the future, is itself incorporated into the therapeutic sessions.

With regard to the role parents play in children's lives, Apol (2002: 21) states that a sense of the past is a prerequisite for a sense of self. Parents represent this sense of having a past and a future, which contributes positively to the psychological well-being and development of the child's sense of self. The ultimate quality, character and results of self-concept development in early childhood (0 to seven years) depend mainly on the attitude and involvement of both parents (Uszynska-Jarmoc 2001; Schulze *et al* 2002). In SHIPiC™ terms we refer to parents who create a safe place for their children to grow and prosper in, as "harbouring" parents. Such parents are primarily emotionally available to their children and will, in the second place, protect them if the cruelty of the world becomes too much.

In SHIPiC™ a "harbour" is a safe place where children may seek shelter and nurturing, where they may cast anchor to reload adult perspectives and inputs and where they may stay to learn about their own inner rhythms and wisdom. Once they have recuperated and feel ready, the journey to the open seas may again be tackled, until a need for docking is again experienced.

During the first session with parents, the SHIPiC™ facilitator is very aware of the following:

- The language the parents use to describe their children — the SHIPiC™ facilitator takes note of the metalanguage the parents use, for instance taking note of the parent's own chain statements and distracters (these terms will be discussed later);
- Determining the parents' expectations;
- Establishing whether the parents reveal any incompleteness in themselves — a parent may for instance try to change a perfectly well-adjusted child into a performing child because of his or her own incomplete history.

During the first interview with the parents, the SHIPiC™ facilitator will start formulating hypotheses with regard to the child, the parents, the family and the school. The testing of these hypotheses is done throughout the contact sessions with the child, the parents and the family, and should at no stage interfere negatively with the child's therapeutic process. The testing of hypotheses becomes a natural part of the exploration journey of the child and is never an aim in itself. The formation and testing of hypotheses is not unique to SHIPiC™ and is common practice in psychology.

The first phase of the process is concluded with an explanation of what SHIPiC™ entails. Core principles are discussed briefly. Parents, however, usually have a need to discover more about the process at a later stage when they may understand better what it encompasses. The parents remain part of the child's healing process and should be informed of progress, changes, setbacks and new challenges that may arise.

4.2 Compiling a systemic image

During the second phase of SHIPiC™, the facilitator meets the child client and commences with the compilation of its systemic image. The main objective of this phase is to welcome the child into the safe, non-threatening world of SHIPiC™. The facilitator has about fifteen seconds to make positive contact. The facilitator should be spontaneous and willing to open up to the child. He or she will invite the child into a space where it needs to feel secure, accepted and valued. If the facilitator is activated by a particular client, it is best to refer the client to another facilitator. Activation of the facilitator occurs when the child serves as a stimulus that triggers the facilitator's own disconnected information. In such a case, the facilitation of the child's process would

be compromised as the facilitator would be preoccupied with his or her own inner processes.

The second objective of this phase is to draw up a systemic profile. This means making mental notes of what the child is experiencing, projecting, communicating (verbally and non-verbally), hiding, protecting and revealing; thus, like a psychological blood test or x-ray, giving an indication of the "state" of the child's psychobiological system. Notes of observations, comments and hypotheses are made in the facilitator's guide. During this stage the child is asked to make drawings of a person and a family. In some instances, the child is also requested to complete a sheet of short incomplete sentences or respond to SHIPiC™ activator cards. The activator cards (the explanation of which does not fall within the scope of this article) may be used during this phase as projection cards or during the play phase. No other psychometric material is used as there is no need for it. The SHIPiC™ facilitator is, during this whole process, very aware of the influences which other people, the television, stories and traditions may have on his or her use of language and way of expressing him- or herself. Gottfried & Jow (2003: 79) are of the opinion that all these influences may have a major impact on the way the child may experience its world and inner processes and the way this contributes to psychological expression.

The systemic profile is compiled by analysing all of the above, and also by being on the lookout for the following (the concepts will be discussed briefly below):

- What chain statements is the child using?
- What coping styles is the child using?
- What distracters are prevalent in the child's life?
- What activates the child?

The answers to these questions are obtained not only during this phase, but also during the play phase, and will indicate to the facilitator what factors may be inhibiting the child client's healing.

A "chain statement", as verbalised by a client, indicates a repeating pattern in the client which may be affecting quality of life (JOS 2002: 273). If the child constantly uses chain statements, the facilitator will immediately know that they are linked to disconnected information. JOS (2002: 32) describes this very aptly:

> Chain statements are the past interferences that are being projected onto the Now, indicating disconnected pain, which in turn is an indication of spontaneous healing potential.

Chain statements children often use include the following: "I can do nothing right; I am a loser; nothing is going my way; I am dumb; I will never get out of this; I am always to blame; everything that goes wrong is my fault". In SHIPiC™, the identification of these chain statements is crucial because they provide the link to the imprints (*i e* traces of the initial pain of loss of spontaneity that has become disconnected) currently taking place in the child's life. During play, the child is made aware of this by literally making a chain out of paper on which the statements are written. On the child's journey it is asked to load this "chain" onto the exploration boat. By being involved in the laborious task of constantly accommodating the chain, the child becomes aware of the extent to which the chain statements are holding him back.

A "coping style" can be described as a part of the self that has become successful in handling daily demands. JOS (2002: 273) is of the opinion that coping styles are established during the first ten years of life and represent the client's most successful way of being in the world. A coping style develops when one part of the personality becomes dominant through trial and error, at the expense of the other personality traits since there is now less energy to represent them, and a systemic imbalance occurs (JOS 2002: 6). A coping style can take the form of anger, withdrawal, tongue chewing, sickness, achievement, subservience, manipulation, passivity and many others (JOS 2002: 5, 6). The SHIPiC™ facilitator is in the fortunate position of observing the actual formation of these coping styles and can make the child aware of the dominance of some or more parts of the self. Through play, the child thus becomes aware of this dominance and is facilitated towards the insight that energy must be equally distributed among all the identities and parts of the personality.

In SHIPiC™, different ships or boats are used to serve as symbolic representations of coping styles. Gohm (2003: 594-607) identifies differences in the ways in which individuals experience and handle their emotions. Gohm (2003) describes four distinct reaction types, namely the type that feels overwhelmed by a situation, the type that reacts in a cognitive (cerebral) way, the type that reacts fiercely (hot) and the type

that appears to be very cool during an experience. These reactions are seen in SHIPiC™ as ways of coping with both emotional and physical demands and situations. The types may be linked to the symbolic coping styles described in SHIPiC™ in the following ways:

- The sinking ship (the child feels overwhelmed and disillusioned, almost paralysed);
- The thinking ship (the child uses rationalisation and reasoning as coping styles);
- The battleship (the child is described as "hot" and is very reactive), and
- The neutral/ghost ship (the child is described as "cool" as little response is observed).

"Distracters" are described by JOS (2002: 274) as a voluntary "taking control" by the client in an attempt not to experience the rising discomfort caused by activators (defined in the next paragraph). While a coping style is a person's long-term focus and way of being, a distracter has the short-term purpose of deviating from an uncomfortable focus, thereby allowing the coping style the necessary time and space to re-group (JOS 2002: 9). If a person constantly "distracts", it reveals an underlying fear of confronting that which might lead to change and healing (JOS 2002: 12). This may result in systemic rebellion which is manifested in chronic systemic reactions (bodily symptoms). In layman's terms, a person engages in distracting behaviour which bears the label of "too muchness", like too much eating, drinking, smoking, sport or achieving. In SHIPiC™, the child is again made aware, through play, of a character's distracting behaviour — or its own. SHIPiC™ techniques to neutralise these distracters have been developed, but will not be discussed here.

The final concept to be explained is "activators". An "activator" is any current stimulus triggering disconnected information (JOS 2002: 272). An activator is a catalyst for change and activates one to connect with experiences that have not previously been part of one's psychobiological awareness (JOS 2002: 28). For example, if a child is intensely affected by an experience, it is activated because it has come into contact with a part of the inner self that it was not previously aware of. In SHIPiC™ the effect of this encounter is fully explored. The aim is to bring the child into contact with uncomfortable realisations and facilitate the

successful handling of the full impact of the situation. If the child can be guided into handling situations successfully, the chances are good that it will not sustain the disconnected unlived experiences which compound as pain in the psychobiological system and re-surface later.

4.3 Compiling a play image

In the play phase, a play image is compiled by observing the child's ability to engage in spontaneous and facilitated play, thus engaging in its own healing journey. Zimmerman (2003: 25) regards play as a continuous and basic function in psychoanalysis. Play is a way of engagement, which implies that the child is intensely involved with its own processes. Howlett (1999: 91) defines this engagement more in terms of a journey, stating that healing can take place only if an individual sees the journey towards integratedness as a spiritual journey (a psychobiosociospiritual journey, in SHIPiC™ terms) during which all parts of the person are involved. SHIPiC™ supports these views. A facilitator will, in a respectful and non-intrusive way, facilitate a child client's healing process.

A child who is referred for facilitation may have begun to experience imbalances in the psychobiological system or to feel some kind of psychological draining or uneven distribution of the life force. Pecotic (2002: 41) refers to the "black hole in the inner universe" to describe the psychotic child's inevitable retraction into the self. SHIPiC™ borrows this metaphor to refer to clients who experience inner chaos and deal with it by slipping further and further into the quiet dark spaces of the inner universe where they feel safe and where they need not become attached to anything or anybody. Such children need to be anchored before the play phase can commence.

During "anchoring" encounters, a confused, traumatised child or "moving ship" — a very active child — is asked to lie face down on a carpet with its eyes closed. The facilitator will then put his or her hand on its back and, if necessary, speak in a slow, and soft voice. Anchoring is done during the play phase whenever the need arises for the child to be harboured and reassured. Although touching of the client is not part of SHIP®, in some cases appropriate therapeutic touch (as described by Törngren 2004) is permitted in SHIPiC™, with prior briefing of parents. If the child continues to show signs of insecurity, the SHIPiC™ facilitator will engage in a technique called "creating security ladders",

which entails preparing the child (by means of systemic inoculation and other techniques) for inevitable uncomfortable life events. The explanation of this technique is too elaborate to include here, but basically entails systematically empowering the child to deal with systemic discomfort in ann unpleasant, threatening situation and gradually facilitating its experience of control over itself and the situation. This is done by gradually introducing it to threatening situations in the context of systemic preparation for the effects of an expected uncomfortable event.

Another technique for anchoring a client is to make use of circling or energy looping. The use of circles is described by many ancient cultures and there are many depictions of communities which built their houses in circles, held meetings and conversations around fires and performed circle rituals. Taliaferro (1998: 122) is one of many researchers campaigning for the re-introduction of the use of circles for the therapeutic healing of organisations and relationships. In SHIPiC™, the use of circles is introduced by the facilitator during the facilitated play phase. It entails the client observing the facilitator joining in play and using circles to set up a fleet of boats, or packing the animals in a circle on the play sheet, or sailing in a circle on the "open seas". It does not take long for the client to grasp the healing value of circling activity, which in SHIPiC™ is also called "energy looping", as it represents the inner psychobiological processes of energy and information flowing through the body. The child is also involved in drawing circles, claying circle balls, rolling on the carpet, and so on, and in so doing completes many circles or energy loops. Circling activities take the child back to activities which have been part of children's experiences for many thousands of years. The circle, after all, is also the first picture a young child will draw.

4.4 The client's progress

As explained earlier, the healing journey entails the exploration, with the child, of the internal, external and genetic landscapes. During this journey, the SHIPiC™ facilitator makes use of certain criteria to establish whether progress is being made (Jacobs & Vrey 1982).

The SHIPiC™ facilitator first wants to establish whether the child is really involved in its own healing process. Involvement entails its being willing to engage in the processes of making choices and taking de-

cisions during play activities. In SHIPiC™, indications of the quality of the client's involvement are obtained by noting its ability to plan play activities and engage spontaneously and intensely in them. Involvement in external play activities may be linked to involvement in inner psychobiological processes. Secondly, the facilitator assesses "experience" — the sum total of emotional knowledge accumulated through lived events and situations. A client evaluates each situation in emotional terms and may label it as being "pleasant" or "unpleasant". In SHIPiC™, it really does not matter what the child is experiencing emotionally, but rather that it is able to acknowledge the effect of the experience on its system. The final criterion for assessing whether growth and healing are taking place is to establish the nature of the child's meaning allocation framework. During each event, a child will attribute unique meanings to the happenings around it, which it will use to interpret future events in its life. If unrealistic meaning attribution is experienced (even on an unconscious level), the child may gradually develop chain statements and start applying specific coping styles, which may prevent it from following its natural healing path.

4.5 The two play phases

Reference has been made to the two SHIPiC™ play phases, namely spontaneous play and facilitated play. Spontaneous play refers to the phase during which the child is allowed to engage with the toys in the play room in any way he wishes. There is no interference from the facilitator and the client is allowed to plan and execute his own activities. In SHIPiC™, clients enjoy the freedom of this phase, especially when they have been referred with no particular emotional problem but merely to involve themselves with their growth journey (nowadays, many parents want their children to go through SHIPiC™ as a preventative measure).

During the facilitated play phase, the child also has the opportunity to make use of spontaneous play, but the process is more directly facilitated. The facilitator helps the child to "map" the journey the chosen character wants to undertake to explore his world. During this journey, the child creates an eventful trip during which adventures are experienced. The "mapping" of this journey occurs when the child verbalises the route it is planning to take and explains the events it expects to happen. During these explorations, the child's mapping, the journey

itself and the effects on it are facilitated by allowing it to handle them with success, and gain control over the events. Handling imaginary situations successfully is a very powerful experience for the child because some of the wisdom gained during the external event is internalised, to be applied later.

During this phase, the facilitator makes use of activators to activate the client. The activators serve as stimulants which trigger the release of disconnected information (JOS 2002: 28-32). Some children are activated quickly as their disconnectedness is still floating and not yet crystallised in the system. These children find it fairly easy to act out inner feelings and disconnections. Airing these "bottled-up" feelings is regarded by Johnson (2001: 109) as an important part of psychological healing. Other children, though, are not as easily activated and find it more difficult to play spontaneously. With them, more facilitation is needed and activators will be implemented, some of which are:

- The SHIPiC™ play sheet or carpet, with various painted islands;
- SHIPiC™ stories especially written as stimulants, with themes carefully incorporated into the stories;
- Ordinary stories and fairy-tales available in the book market;
- Clients writing their own stories and making their own story books — Waters (2002: 343) feels strongly about the therapeutic value of story-writing;
- SHIPiC™ activation cards which can be used as activators or as projection cards;
- SHIPiC™ toys carefully selected and manufactured to serve the needs of the playing child, and
- Encouraging clients to see specific movies, such as the very touching "Monsters Inc" which portrays many SHIPiC™ activators such as doors (a metaphor for identities and new experiences), houses (housing the self of a person), paths (representing the journey of the client). Sharp *et al* (2002: 269) call this technique cinematherapy and maintain that it is a successful way of promoting change in clients.

The power of the experiences which clients have after being exposed to activators is aptly described by Hammer (2000: 155), who states that imaginative play, drama, ritual, music, breathing, dance, athletics and meditation are all practised with an emphasis on psychospiritual

energy (which represents quantum energy, demonstrating how everything is linked to everything else). All of these activators help clients to open their hearts so that they can begin the multivalent process of "living the soul".

Certain SHIPiC™ principles which are as important as the concepts already discussed still require definition.

5. Further SHIPiC™ principles

5.1 The child client in the imprint phase

The SHIPiC™ facilitator expects to have a fair amount of success when working with children as clients as they are still in the imprint phase. An "imprint" in SHIPiC™ indicates the first incidence of pain, disconnected because the event or situation could not be handled with success and was too great to be systemically handled or managed (all on an unconscious level). JOS (2002: 274) describes it as the first occurrence of loss of spontaneity, which forms the foundation for the development of a series or chain of disconnectedness. Swack (2002: 65) explains how an individual imprints a trauma in the body when first feeling shocked, surprised or frightened during a traumatic experience. This imprint is seen as the result of the innate response pattern, the fight-flight-freeze reflex (Swack 2002). At the moment of imprinting, anything present in the environment may become a stimulus to later trigger fight-flight-freeze reactions from the original traumatic experience. These bodily flashbacks may interfere with one's ability to function optimally.

5.2 The disconnected memory imprint centre

In SHIPiC™, the bodily flashbacks are stored in the disconnected memory imprint centre (DMIC) or the bodily suitcase (JOS 2002). That the body, and especially its cells, has a memory has been proved by numerous scientists (Synchronicity 2004). The bodily system will make the disconnectedness known by means of chronic systemic stress reactions (CSSRs) which are also detected in children. The SHIPiC™ facilitator has the privilege of witnessing the child during the imprint phase because in this phase the child is still "close" to itself. As interferences occur, the chain of disconnectedness gradually develops, slowly stripping the child

of spontaneity. During an interference, a child often experiences not having any choices and being left to weather the onslaughts of too many events and people much more powerful than itself. In many instances, adults play a major role in creating interference experiences as they may relentlessly implement senseless rituals in fabricated systems. The child quickly learns that it has to adhere to many set conditions and (if it is to find a place and acceptance in the world) to give up parts of itself in order to cope and survive.

5.3 The involuntary protective system

With each of these interferences, the child is propelled into unknown territory where it feels unsafe and unprotected. In this place, it has no map to follow, which will set the forces of the involuntary protective system in motion. The development of coping styles and the use of distracters are all part of the protective system. If too much energy is spent on the workings of the protective system, spontaneous expression of the self is inhibited. This complicates the free flow of energy and information in the psychobiological system. The disconnected memory imprint centre will capture more pockets of energy that will be encoded as psychological and physical symptoms.

In SHIP® therapy with adults, part of the therapeutic aim is to neutralise distracters and distribute energy among all the parts of the self. A child client is indirectly (by means of specific SHIPiC™ techniques) made aware of coping styles and distracters. The aim here is to create a space for exploration in which the child

- gains more knowledge about himself and his experiences;
- develops insights about his inner processes (personalises events);
- starts to trust what his body is making known to him (internalising the concept of a systemic wisdom residing in himself) — in SHIPiC™, this internal wisdom is symbolised referring to an imaginary "wise" friend;
- develops a sense of achievement after successfully handling imaginary events, and
- distributes psychological energy more evenly among the parts of the self.

In conclusion, it is necessary to stress an important difference between the SHIPiC™ and SHIP® therapeutic experiences. Adult clients remain passive in order to connect fully with the self. As the child is still in the phase of psychobiological development, SHIPiC™ requires it to be an active participant in play activities and a variety of play techniques. There are, however, instances in which the child will be exposed to "acting-in" activities, where it is asked to lie on the carpet with its eyes closed (LWEC). Here the child is passive and will only respond to the facilitator's verbal activators. In SHIPiC™, acting-in in opportunities are regularly created. This docking experience is seen as a time of reflection and focus for the child. These are important ingredients in continual growth.

6. Conclusion

Over many years it has become clear that one should never underestimate the power of a child's inherent processes, and that one can never say which play activity will "work" for which client. There are many instances when it seems as if nothing is happening — but something is always happening. Many children have been activated by merely unpacking the toy bag, or by unrolling the SHIPiC™ play sheet, or when saying goodbye after a session. Many parents have been amazed by the "positive" results one or two SHIPiC™ sessions have had on their offspring. Many other parents have been worried that little "progress" has been made after many SHIPiC™ sessions. The point is that there is no set time-frame for individual healing processes. The reflection of progress being made and of the light of hope being ignited again is in itself a positive experience for many a child client. Individual healing remains a mystery and the activation of innate healing mechanisms is an even greater mystery. SHIPiC™ acknowledges this ancient truth and respectfully stands back when working with the purest of all human creatures: the young child.

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