

**The effect of Gestalt group work on behavioural aspects of ADHD  
among adolescents in a school setting**

by

**MARIANA SERFONTEIN**

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**SUPERVISOR: DR H HALL**

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## DECLARATION OF ORIGINALITY

**Full Name:** Mariana Serfontein

**Student No.:** 87166926

**Topic of work:** The effect of Gestalt group work on the behavioural aspects of ADHD among adolescents in a school setting.

I declare that this research report is my own work. It has not been submitted for any other degree or examination, neither at the University of Pretoria or any other University. All the sources used or cited have been indicated and acknowledged by means of a complete reference in accordance with the university requirements.

**SIGNATURE**

**DATE**

## ACKNOWLEDGEMENTS

This work is a culmination of efforts from a range of individuals and entities, without whose inputs this study could not have been done.

I owe incalculable debt for accomplishing this research project to the participants who allowed me entrance into their living with, and diagnosis of ADHD, as well as their willingness to share intimate information of personal struggles with the group of participants. This work is dedicated to them all.

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To the loved ones in my life; thank you for your inspiration.

## ABSTRACT

### THE EFFECT OF GESTALT GROUP WORK ON BEHAVIOURAL ASPECTS OF ADHD AMONG ADOLESCENTS IN A SCHOOL SETTING

by

**MARIANA SERFONTEIN**

**SUPERVISOR: DR H HALL**

**DEPARTMENT: SOCIAL WORK AND CRIMINOLOGY**

**DEGREE: MSW (PLAY-BASED INTERVENTION)**

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Parents and educators are often the first to notice that a learner is not coping in the school setting and is displaying certain disruptive behavioural aspects associated with a diagnosis of ADHD. For many parents this behaviour and resulting diagnosis of ADHD comes as a shock and they do not understand where it originates from, how it manifests within each individual or how to manage these symptoms successfully. Attention Deficit Hyperactivity Disorder (ADHD) is a chronic, neuro-developmental disorder with no cure that can be identified according to the criteria laid out in the DSM-V (2013). Although no longer diagnosed as a learning disorder per se, ADHD is associated with several co-morbid conditions such as learning disabilities and psychological conditions that have a negative effect on learning (DSM-V, 2013:59).

The goal of this study was to explore and describe the effect of Gestalt group work on the behavioural aspects associated with ADHD among adolescents in a school setting. Gestalt play therapy and in particular Gestalt group work, was employed in order to assist the adolescent diagnosed with ADHD in managing these disruptive behaviours. The research was conducted with adolescents in a secondary school in Gauteng. These adolescents were diagnosed with ADHD and were often singled out as being disruptive within the classroom.

The population for this study was adolescents between the ages of 13 and 17 years, previously diagnosed with ADHD, who formed part of a specific school community. The researcher made use of non-probability sampling; specifically purposive and

volunteer sampling. Seven adolescents were selected to take part in the quantitative research study, over a period of eight sessions (Strydom & Delpont, 2011:392).

The study was exploratory in nature and the type of research was applied research. The research design that was appropriate was the single-system design, seeing that this design enhances the link between research and practice (Strydom, 2011a:160). A standardised check list, the 'Current ADHD symptoms scale self-report' was used to obtain information by means of a pretest, mid-point and posttest measurement. This is a standardised measuring instrument that has been developed and tested through empirical methods of instrument development (Adler, Spencer, Faraone, Kessler, Howes, Biederman & Secnik, 2006). The data collected for this study was analysed statistically, through the univariate method of analysis. Computerised worksheets in Excel enabled the researcher to structure findings and to make the most valid and objective recommendations through organised interpretation of data collected (Fouchè & Bartley, 2011). Findings were presented graphically and illustrated in figures. All relevant ethical considerations were considered, for example participants provided informed assent, while their parents provided informed consent for the research to be conducted.

Gestalt play provided for theme-based group sessions, assisting participants in recognising as well as mastering positive behaviour, as an alternative to the disruptive behavioural aspect of this condition. The research provided useful research data with regards to the use of both group work and Gestalt play techniques in assisting the adolescent with ADHD in addressing their disruptive behaviour.

Gestalt group work as method of intervention seemed to have a positive effect on disruptive behaviour related to ADHD. The group as a whole had improved their behaviour for both the characteristics of ADHD. Behavioural aspects characterised by inattention, as well as hyperactivity and impulsivity for the group of respondents, had improved through the application of Gestalt play techniques. The group of respondents therefore perceived that they had benefited in terms of the improvement of these behavioural aspects of ADHD.

It is recommended that educators, parents and caregivers be trained regarding ADHD in order to comprehend the nature of this disorder and the impact thereof on



M. Serfontein: 87166926

the learner and fellow learners in the classroom. Learners should become aware of their diagnosis, the symptoms and the disruptive element of their behaviour, the impact that this behaviour has in the classroom, as well as the resources available for the adolescent in addressing challenges.



M. Serfontein: 87166926

**Key words:**

Attention Deficit Hyperactivity Disorder (ADHD)

Adolescence

Gestalt play therapy

Group work

School setting

Social worker

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## CHAPTER 1

### GENERAL INTRODUCTION AND ORIENTATION TO THE STUDY

#### 1.1 INTRODUCTION

Children with behavioural problems become known to therapists and guardians alike through institutions such as the school setting. Within these systems, educators often verbalise their frustration with disruptive class behaviour caused by learners presenting with symptoms related to Attention Deficit Hyperactivity Disorder (ADHD). Several working definitions for Attention Deficit Hyperactivity Disorder exist. According to Wilkes, Cordier, Bruny, Docking and Munro (2011:231-240), one such definition of ADHD is that it is a common childhood neuro-behavioural disorder characterised by developmentally inappropriate levels of inattention, hyperactivity and impulsivity. Pennington (2009:154-166) is of the opinion that ADHD has been recognised as one of the most chronic disorders to come to the attention of specialists because of children's inability to adjust to the classroom setting. Tai, Gau, Gau and Chiu (2012:1-10) make the statement that ADHD has been recognised as a chronic disorder with high psychiatric co-morbidity, persistence of core systems and long-term impairment lasting into adolescence and adulthood. This behavioural disorder might thus even be recognised in early adulthood and be caused by external factors in the living environment and life of the individual.

Gestalt play therapy provides powerful opportunities for intervention within both individual and group settings. Blom (2006:18) describes the concepts 'Gestalt' and 'Gestalt therapy' in the following manner: "The gestalt concept can be considered an entity or whole of which the total is more than its component parts. Gestalt therapy is mostly concerned with individuals' functioning as an integrated, whole being." The researcher, being a school social worker and a psychometrist within a secondary education setting, was interested in the application of this theoretical approach within the naturalistic setting of a school and more particularly the classroom setting. The dual role of therapist and educator is viewed as an excellent learning opportunity with regards to the child presenting with symptoms related to ADHD. According to Drewes and Schaefer (2010:61), school counsellors play an important role in the school setting, seeing that learners are faced with problematic circumstances that

have a profound influence on their ability to respond satisfactory within the educational system. These issues often reflect on their behaviour in the classroom, leaving educators helpless. The school counsellor provides a safe and secure environment for learners to deal with every day difficulties. It was then within this frame of thinking, that the researcher aimed to engage in group work activities with learners diagnosed with ADHD.

According to Frost, Northam and Reifel (2012:393), group work is growing in popularity, as long as the groups are applicable to the needs of the individual. Thus, “the focus of the group is always the individual child” (Frost et al., 2012:394). The value of Gestalt group work is that each child learns from the other children in the group (Geldard & Geldard, 2010:251). According to Cattanach (2003:55), the role of the therapist is to “create the group, select the activities and within the group develop and maintain group goals and a treatment plan across group sessions.” An appropriate description of Gestalt play therapy in terms of the proposed research is “a psycho-therapeutic technique whereby the therapist attempts to give the child the opportunity to express his or her feelings verbally and non-verbally” (Blom, 2006:19).

Gestalt play therapy is a relatively young school of intervention, but play per se, is the universal language of all ages and cultures. “Play exists in every culture and in every population and is a place of connection for all living beings, without using any words. Play is the universal expression of children...” (Drewes & Schaefer, 2010:65). Play thus becomes the common language between the counsellor and the child as well as amongst the participants in the group. The lay person often queries the applicability of play for the older child or the adolescent. O’Conner (1991) as cited in Drewes and Schaefer (2010:65) however clearly states that “[p]lay therapy is also developmentally appropriate for children through high school ages.” In the context of this study, adolescence can be defined as “depending on biological and socio-cultural factors as well as individual differences, ...the age at which adolescence as a separate developmental stage begins, varies from 11 to 13 years, while the age in which it ends is between 17 and 21 years” (Louw & Louw, 2010:279)<sup>1</sup>. The authors also describe this age “as being characterised especially by conflict with parents and

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<sup>1</sup> In this study the concept ‘child’ and ‘adolescent’ will be used interchangeably as an adolescent can also be regarded as a child (Section 17 of the Children’s Act 38 of 2005).

other authority figures, moodiness and high risk behaviour” (Louw & Louw, 2010:291).

## 1.2 THEORETICAL FRAMEWORK

Historically the Gestalt theory was derived from early Gestalt thinkers disagreeing with the psychoanalytical way of thinking that the client was helpless and did not have much control over change. “Thus, Gestaltists perceived a need for an active dialogue between therapist and client and honoured the client as an agent of their own change” (Fall, Holden & Marquis, 2010:201).

The emphasis in Gestalt theory is on the present moment and the “here and now”. The ability of the individual to focus within the here and now is referred to as awareness. “According to the Gestalt theory, the most important areas of concern are the thoughts and feelings people experience at that moment” (Thompson & Rudolph, 2000 in Blom, 2006:3). The therapist’s effort in the therapeutic involvement thus has its focus on assisting the individual in increasing his/her awareness of the present moment and of the person as a whole, within this moment. As Henderson and Thompson (2011:224) explain, self-regulation requires awareness of one’s inner self and the environment.

The primary philosophical underpinning of Gestalt is the emphasis on a comprehensive phenomenological perspective of experience (Fall et al., 2010:203). “Gestalt is grounded on the assumption that the meaning is best derived and understood by considering the individual’s interpretation of immediate experiences” (Fall et al., 2010:203). Perls, seen as the father of the Gestalt asserted that the here and now, as well as the experience of the now is equal to awareness, which leads to reality (Fall et al., 2010:203). “In Gestalt, the counsellor’s respect for and understanding of each client’s unique perception of self, other and environment is the basis. The focus of the Gestalt is imbedded in the whole of the person’s experience” (Fall et al., 2010:208). According to Fall et al. (2010:205), from a Gestalt perspective, individuals and their environment are inextricably linked. This school of thinking has a direct implication for the functioning of the individual in the naturalistic school setting.

According to Fall et al. (2010:209), individuals take from their environment as much as needed to meet the ongoing search for balance by developing methods for



fulfilment. “Therefore, everyone’s needs sometimes go unmet and unmet needs constitute unfinished business with its accompanying discomfiting feeling of anxiety.” The focus on unfinished business refers to another core aspect with regards to the way the individual might function within his/her environment (Fall et al., 2010:209). In the individual’s search towards the fulfilment of unfinished business, they invent mechanisms to protect them from further harm, which is referred to as the contact boundary. “A way to conceptualize the contact boundary is as a kind of psychological ‘skin’ where the self meets the environment” (Fall et al., 2010:209). According to Blom (2006:20), a contact boundary disturbance is an imbalance between an individual and the environment. Where a contact boundary disturbance exists, individuals are unable to be fully aware and differentiate their own needs from that of their environment. The process of organismic self-regulation is therefore hindered (Oaklander, 1994 in Blom, 2006:22).

Perls devised five layers of neuroses, also referred to as the five layers of the personality, which he utilised to indicate how people fragment their lives, thus preventing them from growth and maturation (Blom, 2006:33). The layers referred to is known as the synthetic layer, phobic layer, impasse layer, implosive layer and finally the explosive layer. Each layer plays a central part in the individual’s ability to self-regulate and become aware of their needs. Moving through these layers thus implies the individual’s movement towards need fulfilment. They are ultimately able to identify their foreground and assess their current functioning and needs, and become aware of their existence in the here and now. “Gestalt theorists have a paradoxical view of change. They believe a person can change only when one is truly oneself; the more someone tries to be who one is not, the more stuck the person will become” (Fall et al., 2010:213).

The researcher focused on the Gestalt play therapy process within the Gestalt group work format. The focus of the research was not therapeutic intervention, but on the results gained from respondents participating in Gestalt group work, in affectively changing disruptive behavioural aspects that might have an impact on the educational environment. The group aspect should thus be understood as the progression of a Gestalt group work process and that each session was conducted according to themes associated with ADHD, with specific emphasis on coping skills within the school setting. According to Blom (2006:212), “[t]he here and now starts

with the current awareness, since prior events may be objects of present awareness. The focus of Gestalt play therapy is on the present. Although the influence of happenings in the past or predictions of the future cannot be denied, the only reality the child can work with, in order to achieve growth, is the present.” This aspect of Gestalt play therapy might assist the adolescents’ growth within the process of the group. No judgments on past behaviour are made and no assumptions on the possibility of positively influencing behaviour within a specific frame of thinking are made. The capacity to change lies in the adolescent’s ability to comprehend underlying, and often unfinished business of the past in order to move on to positive thinking in the present.

### **1.3 RATIONALE AND PROBLEM STATEMENT**

The researcher obtained knowledge and became aware of the influence of problematic behaviour in the classroom through her involvement with the adolescent within the school setting for the past ten years. It became clear through educator feedback that these challenging behaviours often have a profound influence on the educator’s ability to educate the rest of the class, while being confronted with the disruptive behaviour of certain individual learners. Educators are often frustrated and without adequate knowledge on dealing with ‘so called’ difficult learners, and have no means of adjusting the learning environment to suite these learners. Educators are also cautious not to adjust learning material as well as the functioning of the classroom because of the rest of the well-behaved learners in the classroom.

Within the school setting, behavioural disorders often call for disciplinary action towards the disruptive individual, which could reflect directly on the learner’s academic performance. Educators often lack the management strategies in the classroom to assist the learners affected by these behavioural symptoms. The researcher regularly communicated with other professionals who had validated experiences with regards to learners presenting with behavioural as well as academic problems. Amongst these learners were often those presenting with symptoms related to ADHD.

The researcher has access to staffroom forums where learner behaviour is discussed in a tutor format. The researcher made the observation during these forums that disruptive classroom behaviour was often singled out with regards to

certain individual learners who made education difficult in the school setting. Mention was also made that these learners might present with certain behavioural aspects associated with ADHD, which made coping in a 'normal' school setting close to impossible for both educator and the other learners in the classroom.

The researcher is currently involved with adolescent learners on several levels of their functioning within the school environment. The researcher is of the opinion that the Gestalt play process, implemented in a group format might facilitate addressing the negative behavioural aspects of ADHD.

This research study might create awareness amongst educators and counsellors alike, regarding the best way to assist these learners in adjusting to the educational environment. In support, Drewes and Schaefer (2010:79) state that "by gathering and researching data, professional school counsellors can use the results to increase awareness of their stakeholders and strengthen their programs." The researcher therefore aimed at creating awareness, as well as drawing attention to the power and potential value of theme driven Gestalt group work within the school setting.

#### **1.4 GOAL AND OBJECTIVES**

The research was prepared according to the following research goal and objectives:

##### **1.4.1 Research goal**

The goal of this study was to explore and describe the effect of Gestalt group work on behavioural aspects of ADHD among adolescents in a school setting.

##### **1.4.2 Research objectives**

In order to achieve this goal, the following objectives were set:

- To contextualise ADHD and the behavioural aspects of ADHD, as well as adolescence as a life stage.
- To determine through pretest, mid-point and posttest self-reporting, the extent to which the exposure to Gestalt group work addresses disruptive behavioural aspects of ADHD in the school setting.
- To determine the effectiveness of Gestalt group work in addressing behavioural aspects of ADHD based on the above measurements.

- To make recommendations to practitioners regarding the implementation of Gestalt group work in order to address behavioural aspects of ADHD amongst adolescents in a school setting.

## 1.5 OVERVIEW OF RESEARCH METHODOLOGY

The following hypothesis was formulated for the study: *Exposure to Gestalt group work will have a positive effect on behavioural aspects of ADHD among adolescents in a school setting.* Since the researcher sought to understand the influence of Gestalt group work on the behavioural aspects presented by the adolescent diagnosed with ADHD, she utilised a quantitative research approach. Within quantitative research, a single-system design could in short be described as a design aimed at finding factual evidence to support the hypothesis of the research. A single-system design is a practical design, utilising specific measuring instruments applied at multiple levels (Strydom, 2011a:161). In this study measurement took place at the pretest, mid-point and posttest level. Delpont and Roestenburg (2011a:172) are of the opinion that this type of measurement is one of the best means of creating objective scientific knowledge. This ultimately provided the researcher with a flow of evidence that could support the possibility of the hypothesis being authentic. This design was utilised in order to determine the effectiveness of Gestalt group work in addressing the problem statement.

The population in this study was adolescents between the ages of 13 and 17 years, previously diagnosed with ADHD, who formed part of a specific school community. The researcher made use of non-probability sampling as the odds of being selected as a participant were not known. Purposive and volunteer sampling was utilised (Strydom & Delpont, 2011:392).

The participants took part in eight structured, Gestalt group work sessions during a period of 12 weeks. The research data gathered during the pretest, mid-point and posttest measurement, using a standardised measuring instrument, the 'Current ADHD symptoms scale self-report' was interpreted and the data statistically quantified.

The researcher took great care in considering all ethical matters. She made use of a consent form signed by the parent or guardian of the participant, as well as an

assent form, signed by the participant himself/herself. All ethical principles applicable to this study were taken into consideration. These principles are discussed in chapter 4 of this research report. A detailed description of the research methodology which includes the research approach, design, and type of research, population, sampling techniques, data collection and analysis will be presented in Chapter 4.

## **1.6 LIMITATIONS OF THE STUDY**

The research took place on school premises and within school hours. This restricted time available for group sessions with the respondents during school hours. The learners, diagnosed with ADHD had to be constantly reminded of the group work sessions. This necessitated several administrative measures to ensure promptness and attendance by all respondents.

It could be regarded as a limitation that the research data was based on respondent self-scoring only. The researcher therefore relied on respondents' insight regarding their own behaviour as it relates to ADHD.

As this research was conducted with seven respondents at a specific school in Gauteng, the research findings can therefore not be generalised to the larger population.

## **1.7 CONTENT OF THE RESEARCH REPORT**

The research report is presented in five chapters. The outline of these chapters is as follows:

**Chapter 1:** This chapter comprises of the introduction, contextualisation of the study and definitions of key concepts being used; the theoretical framework of the study; the rationale and problem statement, the goal and objectives of the study; a brief overview of the research methodology and the limitations of the study.

**Chapter 2:** In chapter 2, the researcher will present an in-depth literature review on ADHD. Several aspects related to ADHD such as co-morbid learning disabilities related to ADHD; neurological brain profile and executive functioning; diagnosing ADHD; probable causes for ADHD; the general behavioural aspects of ADHD; the adolescent with ADHD and the challenges faced by the adolescent with ADHD, will be discussed.

**Chapter 3:** In chapter 3 the researcher will present general strategies for addressing ADHD; theoretical concepts of Gestalt play therapy; objectives of play therapy and play techniques used in the process of Gestalt group work.

**Chapter 4:** Chapter 4 comprises of the research methodology, the ethical principles that guided the study, as well as the results of the empirical study, which is integrated with the findings from the literature review.

**Chapter 5:** In chapter 5, the researcher presents the key findings, conclusions and the recommendations of the study. In this chapter, the researcher discusses the extent to which the goal and objectives of the study have been met.

## CHAPTER 2

### THE ADOLESCENT WITH ADHD WITHIN THE SCHOOL SETTING

#### 2.1 INTRODUCTION

Skirrow, McLoughlin, Kuntsi and Asherson (2009:489) believe: “Currently ADHD is perhaps one of the most controversial diagnoses, in part because its symptoms can so clearly be related to concepts of personality and temperament.” The authors state that: “Specifically, inattention, impulsivity and hyperactivity present as chronic and trait-like, rather than showing the symptomatic increases and declines commonly seen in other psychiatric disorders” (Skirrow et al., 2009:489). A diagnosis of ADHD therefore has a profound impact on the individual diagnosed with ADHD. Too often however an ADHD label is given without sufficient psychometric, psychological or medical information to back the diagnosis. When not handled with care and confidentiality the information might be observed by parties not involved with the individual’s intervention. Even educators and parents fall into the trap of referring to the very busy individual as being hyperactive, while this might not be the diagnosis for the specific individual (Skirrow et al., 2009:489).

The focus of this chapter is on defining the different components of ADHD, learning disabilities as co-morbid condition of ADHD, neurological brain profiles and executive functioning. This will be followed by a discussion of the diagnosis of ADHD, probable causes of ADHD and general behavioural aspects of ADHD. The chapter further describes the adolescent with ADHD’s general development within this life stage, behavioural manifestations of ADHD in adolescence, as well as challenges faced by the adolescent, diagnosed with ADHD.

#### 2.2 CONCEPTUALISING ADHD

The American Psychiatric Associations’ Diagnostic and Statistical Manual of Mental Disorders (DSM-V, 2013), is widely recognised as being the most reliable and appropriate diagnostic tool utilised by health care professionals for the diagnosis of ADHD. The chapter on Attention Deficit Hyperactivity Disorder clearly states that a mere definition of the disorder as a whole is not recommended and that defining ADHD also entails an understanding of the three characteristics of the disorder. The



DSM-V (2013:59) indicates that “[t]he essential feature of attention-deficit/hyperactivity disorder (ADHD) is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development.” The two categories for the disorder are created by the characteristics of each sub-definition. In combination with one another the characteristics are more sensible for creating a diagnosis of ADHD (DSM-V, 2013:59). A description of these features is provided below:

- **Inattention:** Inattention is a noticeable behavioural manifestation of ADHD and recognisable as “wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized and is not due to defiance or lack of comprehension” (DSM-V, 2013:59).
- **Hyperactivity:** Hyperactivity is noticeable as excessive motor activities that are present in the physical actions of the child and are recognisably inappropriate (such as a child running about) when it is not appropriate, or when he/she excessively “fidgets with or tap hands or feet or squirms in seat” (DSM-V, 2013:60). This characteristic is also noticeable in the adult with ADHD and manifests as “extreme restlessness or wearing others out with their activity” (DSM-V, 2013:60).
- **Impulsivity:** Impulsivity is characterised by hasty and little thought through actions in the spur of the moment and is potentially harming to the individual. The child might for example dart into the street without first looking out for cars. The rewards system that reflect the child’s “desire for immediate rewards or an inability to delay gratification” (DSM-V, 2013:59), forms an integrated part of this aspect. Impulsivity is recognised by behavioural manifestations with social intrusiveness, where the individual constantly and excessively interrupts others and/or makes “important decisions without consideration of the long-term consequences” (DSM-V, 2013:60).

Henderson (2008:1) defines ADHD in the following manner: “Attention Deficit Hyperactivity Disorder (ADHD) is a neurological condition that involves problems with inattention and hyperactivity-impulsivity that are developmentally inconsistent with the age of the child.” He furthermore states that Attention Deficit Hyperactivity Disorder (ADHD) has many different expressions and is one of the most debated and controversial themes in education (Henderson, 2008:1). ADHD is known as a



chronic condition with no cure. There has also been a continuous heated debate over medication as intervention strategy, the methods of establishing a diagnosis and additional treatment options for the children, adolescents and adults, to whom the management of the condition is of an essence in order to lead daily productive lives (Henderson, 2008:1).

As debated by Werner (1987) and Barkley (1990) (in Kadusen & Schaefer, 2006:101), ADHD is a chronic condition and the most commonly diagnosed behavioural disorder amongst children and adolescents. The specific mention of the adolescent is of significance in this research. ADHD is thus not only a childhood disorder, nor is it a condition that the child is able to outgrow in later life stages. This makes it even more important for the child who displays symptoms related to ADHD, to obtain the correct diagnosis and that the outcome is dealt with confidentially. This is of the essence, since many individuals suffer the consequences of misconceptions, often leading to the labelling of the individual displaying these disruptive behavioural aspects.

According to Pennington (2009:152), the syndrome involving hyperactivity and fidgeting displayed by the child was first noticed and described over 160 years ago. The German physician, Heinrich Hoffman (1845) wrote a humorous poem describing the antics of 'fidgety Phil who couldn't sit still'. This paved the way for numerous researchers attempting to describe these noticeable symptoms and the disruptive behaviour. Several descriptions have evolved over the years. Louw and Louw (2010:234) describe the disorder by referring to the child or individual who is consistently and repeatedly showing age-inappropriate behaviour, within the two general categories of ADHD, known as inattention and, hyperactivity and impulsivity (Louw & Louw, 2010:234). The findings of Barkley, 1996 (in Pennington, 2009:152), recognise "several characteristics of attention-deficit-disorder (ADHD) that have been validated by contemporary research" such as that it overlaps with conduct problems. Alcoholism is also pointed out as predominant with this disorder. Of significance is that there is a male predominance of about three to one, and that it may be caused by an earlier obtained brain injury. Pennington (2009:154) believes an estimate three to five percent of all school-aged children present with the symptoms related to ADHD. This amounts to about two children per average classroom (Du Paul & Stoner, 2003; Reddy & De Thomas, 2003 in Drewes &

Schaefer, 2010:307). This research confirmed that a family history increases the likelihood of a diagnosis of ADHD across socio-economic levels and cultures.

ADHD being a chronic disorder, results in it being present over the entire lifetime of the school going child and adolescent. These children and adolescents exhibit serious problematic symptoms also effecting their academic achievements (Du Paul & Stoner, 2003 in Drewes & Schaefer, 2010:307). Social, emotional and/or behavioural symptoms are further identified by Clark, Prior and Kinsella, 2002 (in Drewes & Schaefer, 2010:307). These authors state that the most prominent feature typical of ADHD is disruptive behaviour. It is this symptom in particular that leads to problematic classroom conduct. Further attention to learning disabilities as co-morbid condition to ADHD follows in the next section.

### **2.3 CO-MORBID CONDITIONS TO ADHD**

Several psychiatric conditions, which include conduct disorder (25-40%), mood disorders (10-30%), anxiety disorders (30%), and tic-disorders (6%), are co-morbid to the symptoms associated with ADHD (Barkley, 2005 in Drewes & Schaefer, 2010:308). Although mood instability is often associated with the symptoms of ADHD, Waxmonsky, Wymbs, Pariseau, Belin, Waschbusch, Babocsai, Fabiano, Akinnusi, Haak and Pelham (2014:527) suggest that emotional instability in a child diagnosed with ADHD does not necessary indicate that a co-morbid condition is present.

According to Macintyre (2010:108), coexisting conditions, such as dyslexia, anxiety or depression are experienced by two-thirds of children with ADHD. Tourette's syndrome is also a common syndrome that is diagnosed together with ADHD. The author is also of the opinion that these children have developmental delays and thus will be in need of parental/teacher support for far longer than their age-equivalent peers (Macintyre, 2010:108).

In the following section the researcher will focus on the neurological brain profile and executive functioning of the child with ADHD.

### **2.4 NEUROLOGICAL BRAIN PROFILE AND EXECUTIVE FUNCTIONING**

The researcher will now view ADHD as, not being a disorder of attention as assumed by researching more suitable origins for the dysfunctions, namely the role and

functions of the brain in the child developing ADHD. The focus falls on the function of developmental failure of the brain circuitry that monitors inhibition and self-control. This loss of self-regulation impairs other important brain functions crucial for maintaining attention, including the ability to defer immediate rewards for later gain (U.S. Department of Education, 2008:2). The research in neuro-psychology has shed light on the very intriguing world of the brain. “Neuro-imaging and brain injury research has shown overlapping brain structures and networks to be implicated in the regulation of behaviour and the regulation of emotions. Specifically, the role of the frontal lobe has been emphasized” (Skirrow et al., 2009:494). According to these authors, current researchers emphasise the behavioural and neurocognitive similarity between core ADHD symptoms and mood volatility throughout the entire life of the person diagnosed with the disorder and associated impairment (Skirrow et al., 2009:489-503).

It seems that both emotional and mood dysfunctional behaviours are associated with ADHD as ADHD is related to deficiency in a range of tasks (Skirrow et al., 2009:499). Researchers believe, with regards to the brain images of the person diagnosed with ADHD, the brain regions involved with emotional regulation and mood stability show structural and functional changes that deviate from the norm (Skirrow et al., 2009:499). Kadusen and Schaefer (2006:100) suggest that the symptoms associated with ADHD arise from a difficulty in executing executive functions. “Executive functions refer to a number of mental processes that are required to regulate, control, and manage daily tasks” (Kadusen & Schaefer, 2006:100).

It becomes clear that the next noticeable deviation in behaviour, after disruptiveness, is the inability of the individual to complete tasks. The managing of daily tasks through these mental processes is thus two of the most challenging objectives for the child diagnosed with ADHD. This impairment includes difficulty with organisational skills, time management, excessive procrastination, task processing, regulation of emotions and poor concentration. Even the ability to use both short and long-term memory is compromised (Kadusen & Schaefer, 2006:101).

Since impulsivity is regarded as one of the most recognisable symptoms of ADHD, it makes sense to assume that children with ADHD are not able to constrain their

impulsive responses (U.S. Department of Education, 2008:2). The behavioural aspects of ADHD are thus closely associated with impairments in very specific regions of the brain. Research conducted on brain images during the past decade indicated which brain areas may point to malfunctioning in patients with ADHD, and thus accounts for symptoms associated with this disorder. The research conducted by this institute is clear in its finding that, “at least two of the clusters of nerve cells known collectively as the basal ganglia are significantly smaller in children with ADHD” (U.S. Department of Education, 2008:2). It is not clear why these areas of the brain are smaller in some children, but researchers have suggested that mutation in several genes which are active in the prefrontal cortex and basal ganglia may play a significant role (U.S. Department of Education, 2008:3). Kadusen and Schaefer (2006:101) suggest that inattention as well as hyperactivity and impulsivity are caused by frontal lobe dysfunction and even that the cerebellum of the brain are implicated in behaviour associated with ADHD. It thus is imperative that the correct procedures and assessment material are used in reaching a conclusion with regards to ADHD diagnoses.

Kadusen and Schaefer (2006:101) believe, taken into consideration the rate of brain maturation and the increasing demand of executive control by the individual, impairments related to ADHD may not fully manifest themselves until adolescence or even early adulthood. It is once again clear that ADHD is not just a childhood disorder, but can also be noticed and diagnosed during adolescence and early adulthood. Diagnosing ADHD is often controversial. This important aspect will be discussed in the following section.

## **2.5 DIAGNOSING ADHD**

A diagnosis of ADHD often signals the beginning of the individual's life long struggle to fit in and concentrate. The child known as the individual with ADHD is often treated differently from the other learners in the classroom, since their behaviours are disruptive and not conducive to the normal learning environment (Kadusen & Schaefer, 2006:106). Parents of children diagnosed with ADHD often find themselves in a dilemma. These children need assistance with regards to their normal development on various levels, but often parents do not have the knowledge or resources to assist the child presenting with the symptoms associated with ADHD.

Even though learning disabilities are not co-morbid to ADHD, the child diagnosed with ADHD might, because of the behavioural aspects associated with ADHD, develop profound learning impairments and disabilities. In a desperate attempt to assist children, parents might even be under the impression that medication is their only resort and this is often seen as a quick-fix (Kadusen & Schaefer, 2006:106).

The U.S. Department of Education (2008:6) found that a diagnosis of ADHD has many facets and encompasses amongst others, behavioural, medical and educational data gathering. One component of the diagnosis includes an examination of the child's history through in-depth interviews with parents, teachers and health care professionals (U.S. Department of Education, 2008:6). According to Mash and Wolfe (2010:123), deficit in attention is one of the main characteristics of the child displaying symptoms of ADHD. The authors are of the opinion that "[t]he strong link between hyperactivity and impulsivity suggests that both are part of a fundamental deficit in regulating behaviour." It is then these behavioural manifestations that at first catch the eye of the educator or parent.

The child with ADHD experiences behavioural difficulties in various settings, for example at home, school and in the community (Kadusen & Schaefer, 2006:101). When monitoring incidences related to symptoms of ADHD, before diagnosing the child with the disorder, it is significant that at least a number of the symptoms be present prior to the age of seven years. In addition, all criteria and variations of the combinations of symptoms associated with ADHD has a six months' prevalence period before a final diagnosis of ADHD can be established (U.S. Department of Education, 2008:3). According to the DSM-V (2013:60), ADHD symptoms should be present in more than one setting (e.g. home and school). These settings should be disrupted with the specific symptoms of hyperactivity and impulsivity or inattention.

Skirrow et al. (2009:489) are of the opinion that with regards to a diagnosis with ADHD, "about 30% to 50% of people diagnosed in childhood continue to have symptoms into adulthood." This makes the life of the child functioning in the already difficult life stage of adolescence even more complex. According to Drewes and Schaefer (2010:64), "People with ADHD more often have difficulties with social skills, such as social interaction and forming and maintaining friendships." Researchers suggest that up to 50% of children and adolescents who had previously been

diagnosed with ADHD reportedly experience social isolation by their peers, in comparison to the 10% of non-ADHD children and adolescents who report the same rejection (Drewes & Schaefer, 2010:489). Hugely contributing to a diagnosis of ADHD is their tendency to disrupt the school setting. Fellow learners do not want to be associated with these activities, since it might result in them becoming unpopular. This would be a negative factor in the complicated life of especially the adolescent, who might be struggling with this life stage. These areas of interest represent the life of the individual diagnosed with the symptoms of ADHD and thus do not isolate the symptoms being present only in the school setting. It is also present in other normal life setting, for example within the family and amongst siblings and peers.

A diagnosis of ADHD is made according to specific criteria and procedures. These will be discussed in the following sub-sections.

### **2.5.1 Psychometric evaluations**

The testing and assessing of a child in order to establish a diagnosis of ADHD take place according to specific guidelines. Specified questionnaires and scales are implemented in order to establish and quantify the behavioural aspects of ADHD (U.S. Department of Education, 2008:3). Skuse, Bruce, Dowdney and Mrazek (2011:166) believe that there is a lack of accurate and objective instruments able to test for ADHD; subsequently there is a need for researchers to develop appropriate tests and scales. The chronological age of the individual who presents with symptoms of ADHD should also be considered. This should correspond with those individuals' ability levels during the testing with developmentally appropriate test material (U.S. Department of Education, 2008:3). Assessing a very young child is also not possible through the use of psychometric evaluation, since these tests require the respondent to be able to read and write.

A psychometric evaluation should be conducted in relation to the prescribed criteria for ADHD as stipulated within the DSM-V (2013:60). Only a specialised professional should conduct this evaluation. The current psychological assessment instrument (DSM-V, 2013), is under constant review and subjected to on-going research in psychological and psychiatric conditions. It is standardised in its categories and outcomes, and provides the defining criteria of which "six or more of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with



developmental level and that negatively impact directly on social and academic/occupational activities” (DSM-V, 2013:59), namely:

The child/adolescent:

- often fails to give close attention to details and makes careless mistakes,
- often has difficulty sustaining attention in tasks or play activities,
- often does not seem to listen when spoken to directly,
- often does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace,
- often has difficulty organising tasks and activities,
- often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort,
- often loses things necessary for tasks or activities,
- is often easily distracted by extraneous stimuli, and
- often is forgetful in daily activities (DSM-V, 2013:59).

### **2.5.2 Observational material**

As mentioned, the behavioural aspects of ADHD are often the first to be noticed by both educator and parents. It is important however to note that this might only be one of the symptoms of ADHD and that according to the U.S. Department of Education (2008:3), these behaviours must be displayed excessively in order to warrant identification as ADHD. Furthermore, with regards to the severity thereof, this questionable behaviour happens more frequently with the child diagnosed with ADHD, than with children of the same developmental and chronological age. Before diagnosing the child with ADHD, the observer should also take into account that the symptoms must have a negative impact on the child’s academic or social life, as well as being present in multiple settings.

Since educators spend large amounts of time with the child within a school classroom setting, they are often able to make the very important comparison between the child that presents with the behavioural symptoms of ADHD and other children in his/her classroom. The motive for recording this behaviour is to establish a record of the frequency and type of behaviour (U.S. Department of Education, 2008:8). It might however be difficult to predict the exact outcome of the diagnosis,

seeing that not all children with ADHD demonstrate both the categories of ADHD (Louw & Louw, 2010:235). Some children are primarily inattentive, while others are primarily hyperactive and impulsive, and yet another group of children display characteristics of both categories (Louw & Louw, 2010:235). According to Louw and Louw (2010:234) the child with hyperactive behaviour will also show impulsivity and “therefore hyperactivity-impulsivity is regarded as a single dimension of ADHD.”

Overly active behaviour takes on many forms. The most common complaints from parents and educators are that “the child does not or will not listen, cannot concentrate, does not follow instructions, is disorganised” (Louw & Louw, 2010:234). Complaints by both parents and educators of the child being easily distracted, being forgetful, daydreams, does not finish tasks, chores or assignments, and is quick to lose interest in boring activities, are noted (Louw & Louw, 2010:234).

### **2.5.3 Scales and questionnaires**

The psychometric measurement scale known as the ‘Current ADHD symptoms scale self-report’ has also been developed according to the criteria for ADHD, as categorised in the DSM-IV, and was standardised for diagnosing ADHD in the general population (Adler, Spencer, Faraone, Kessler, Howes, Biederman & Secnik, 2006:145-148). There are however several other scales to the disposal of researchers.

### **2.5.4 Medical and psychiatric evaluations**

A thorough medical evaluation is crucial in order to establish a diagnosis of ADHD. Within this examination, the neurological brain profile of the child that presents with behavioural symptoms is assessed. Mash and Wolfe (2010:139) are of the opinion that although there is substantial evidence of neurological and medical support for causal factors, ADHD remain far from being fully understood. It is suggested that an assessment of the symptoms presented by the child with ADHD should include those of the co-morbid conditions for example learning and language problems, aggression, disruptive behaviour, depression and mood disorders, as well as anxiety (U.S. Department of Education, 2008:9).

The DSM-V (2013:59) specifically notes that the diagnostic features of ADHD should be viewed in the light of the following definition: “The essential feature of attention-



deficit/hyperactivity disorder (ADHD) is a persistent pattern of attention and/or hyperactivity-impulsivity that interferes with functioning or development.” Although many people report only being evaluated in adolescence or early adulthood, the DSM-V (2013:59) makes it clear that ADHD begins in childhood. Diagnosing ADHD requires several of the behavioural symptoms to be noticed before the age of 12 years. This emphasises the necessity of adequate and specifically prominent symptoms being present during childhood. An earlier diagnosis is difficult to establish, since the precise childhood onset behavioural aspects are different from the behavioural aspects in middle childhood and adolescence (DSM-V, 2013:59). Symptoms are further-more re-classified in an order of mild, moderate and severe, which indicates the level of impairment that the disorder might present in the child being diagnosed with ADHD (DSM-V, 2013:61).

In the following section, the probable causes of ADHD will be addressed.

## **2.6 PROBABLE CAUSES OF ADHD**

It is unclear what the direct causes of ADHD are and there are many theories surrounding this disorder. Barkley (1998) as quoted by the U.S. Department of Education (2008:2) is of the opinion that ADHD has previously been viewed as experiencing difficulties related to attention, stemming from an inability of the brain to screen competing sensory inputs such as sight and sound. Researchers now claim that children with ADHD do not have difficulty in that area of brain functioning and that the current belief is that children with ADHD are unable to prevent their impulsive motor responses to such inputs (U.S. Department of Education, 2008:2).

According to Peate and Fearn (2006:38) no single factor causes challenging behaviour. There are thus various physical, biological, behavioural, environmental and psychological influences that have a combined impact on the behaviour and symptoms presented by the child diagnosed with ADHD. By definition, the physical element of ADHD will be determined by a medical diagnosis and reference is made to the neurological brain difference seen in the brain activity of the child diagnosed with ADHD. Combined with the external influence of behaviour, environmental and other social pressures may result in the child as seen within the home or educational setting. In the search for the cause of the disorder, many have refrained from diets with sugary content, allergies to amongst others preservatives, as well as the effect

of lead on the body. All of these findings in research have led to much controversy and yet, research has still to proof sufficient links between these external factors and ADHD (Mash & Wolfe, 2010:141). According to Zentall and Kuester (2011:28), it is a known fact that, apart from neurological diagnoses, these children also face constant social failure.

Although the symptoms related to ADHD are felt differently by each individual, there is substantial evidence of hereditary factors along with the diagnosis. According to the DSM-V (2013:61) genetic factors play a significant role in the child's probability to develop ADHD in that, "ADHD is elevated in the first-degree biological relatives of individuals with ADHD. The inheritability of ADHD is substantial." According to Kadusen and Schaefer (2006:110), there is evidence that a history of psychiatric difficulties in a family escalates the likelihood that the child with ADHD will be presenting with comparable or associated problems well into adulthood. Their research has revealed that in many families of children with ADHD, one of the parents presented with having this disorder, even mentioning families with multiple generations of individuals diagnosed with ADHD and that they tend to be difficult to treat in therapy (Kadusen & Schaefer, 2006:110).

As explained, a diagnosis of ADHD has several inter-dependant factors. It thus explains the opinion of Kadusen and Schaefer (2006:101) that, "[t]hese problems affect children's interaction within their own environment and result in an inability to meet situational demands in an age-appropriate manner." The significance thereof manifests in the extreme importance of realising that the parents of children with ADHD are simultaneously struggling with several ADHD related issues. As with several impairments and disabilities that children acquire, "they have to mourn the loss of the 'normal' childhood" (Kadusen & Schaefer, 2006:107). The fact that the child has been diagnosed with a disorder for which there is no cure and which will be chronically present in the life of the child might be daunting to the parents. Had it been a more noticeable disease or disability, the loss that the parents suffer might have been better understood.

Drewes and Schaefer (2010:308) make mention of the fact that ADHD should be viewed as a disorder within its own right. The co-existence of learning disabilities to ADHD is often noticed especially within the school setting. The learners' difficulty to

comprehend academic work might be the first indication of ADHD. Although a vast number of learners with ADHD present with learning disabilities, these inabilities should not be viewed within itself as being learning disabilities, but rather as symptomatic of ADHD.

According to Peate and Fearn (2006:39), disruptive behavioural aspects are not isolated to children diagnosed with ADHD; they state that: “Challenging behaviour is both relatively common and relatively persistent amongst people with learning disabilities.” While a diagnosis of ADHD is not a certain cause for developing a learning disability, the positive management of the behavioural aspects displayed by the child could guard him/her from developing a learning disability.

The next section will introduce general behavioural aspects related to ADHD.

## **2.7 GENERAL BEHAVIOURAL ASPECTS OF ADHD**

Several symptoms related to ADHD are known, of which disruptive behaviour is one of the trade marks for ADHD. As stated by Drewes and Schaefer (2010:64), “[t]he reasons for this may be due to an altered reward pathway in the brain of ADHD individuals.” The behavioural aspects of ADHD can therefore be seen through the display of symptoms related to the disorder and are often the most noticeable characteristics of the disorder. ADHD is also known for its manifestation in two predominant sub-types namely, hyperactivity and impulsivity, and secondly inattention.

The child with ADHD of the primarily hyperactive and impulsive type may present with aggressive behaviour, while the child diagnosed with the primarily inattentive type might act as if being more withdrawn or wondering (U.S. Department of Education, 2008:2). The last category of children often slip through the cracks and are not noticed, since their behaviour does not seem to be disruptive. This creates a huge shortfall in knowledge and awareness amongst parents and educators. These learners are as much in need of a thorough assessment, followed by suitable intervention.

ADHD is not as a rule accompanied by aggressive behaviour, but it might occur in the case of isolated individuals’ portrayal of disruptive behaviour. As noted by Kadusen and Schaefer (2006:109), “[o]ne of the single best predictors of antisocial

behaviour and poorly adjusted emotional status in adolescence is a history of aggressive behaviour in younger childhood.” Since the adolescent life stage poses several emotional, physical and social problems, destructive and aggressive behaviour could thus be a symptom of both ADHD and adolescence and not solely be associated with a diagnosis of ADHD.

Many parents and educators do not understand this disorder and for them, the disruptiveness as consequence of the symptoms related to ADHD is the only noticed symptom. The major challenging component of ADHD with regards to the inattention component is where this affects the child’s experience of the educational material. The child with ADHD has a tendency of not being able to sustain direction in attending to the detail of the learning material and struggles to sustain focus for the duration of the task. They also misplace needed items for example, books or stationary during the lesson time (U.S. Department of Education, 2008:1). It is clear in this explanation that this behaviour might not be accompanied by disruptiveness, and the child might suffer these symptoms in isolation from the hyperactive-impulsive category of ADHD. For the last category, noticeable behaviour occurs, such as the blurting out of answers in the classroom. The consequences of this type of behaviour are described in the following manner: “their inability to control their own behaviour may lead to social isolation...consequently; the children’s self-esteem may suffer” (Barkley, 1990 in U.S. Department of Education, 2008:2).

These behavioural aspects cause a great deal of frustration for both the learners diagnosed with ADHD and educators, since these children will finish schoolwork in a hurry, or the tasks given are not performed correctly and are incomplete; often not sufficient to comply to the total learning experience. Added to these aspects, the child with ADHD struggles to concentrate for an extended period of time; therefore they make unnecessary mistakes (U.S. Department of Education, 2008:2).

Many children who suffer from hyperactivity and impulsivity experience difficulty in reading, maths and written communication. They are moreover being diagnosed with a learning disability (U.S. Department of Education, 2008:2). There should be reiterated that this learning disability should be viewed as separate from a diagnosis of ADHD and dealt with accordingly. It is also noticeable that in both types of ADHD,

children may be less complaisant with others and less prepared to wait their turn or do things according to the rules.

The researcher will specifically discuss adolescence as life stage since this age group is characterised by problematic issues.

## **2.8 THE ADOLESCENT WITH ADHD**

*The Oxford Dictionary of Psychology* (2009:14) defines adolescence as the “period of development from the onset of puberty... through the teenage years up to the legal age of maturity in adulthood.” Adolescence as a life stage is recognised for its rebellious nature. Adolescent learners, who do not per se struggle with disruptive behaviour associated with ADHD, also tend to become oppositional and less disciplined. For the adolescent with ADHD, conforming to the demands of society becomes a struggle. In an effort to conform and in a desperate attempt to fit in with their peers, “adolescents and adults tend to develop coping skills which make up for some or all of their impairments” (Landreth, 1993; Drewes, Carey & Schaefer, 2001; Armstrong, Warren & Balkan, 2005 in U.S. Department of Education, 2008:2).

Adolescence also seems to be a surprisingly normal life stage and all humans have to endure the consequences thereof on their way to adulthood. It still seems as if adolescence has the reputation for being an age of rebelliousness and challenging behaviour. Louw and Louw (2010:281) quote Socrates (469-399 BC) on adolescents who stated that adolescents “contradict their parents, don’t respect their elderly. They are indolent, eat gluttonously and tyrannise their teachers.” Social scientists have often wondered what is to blame for these inappropriate forms of conduct and rebellion. Louw and Louw (2010:281) attempted to resolve this question by simply stating that it is to blame for changes within the anatomy of human bodies. Adolescence is known for the most rapid biological and extensive physical growth, including the development and release of gender related hormones (Louw & Louw, 2010:281). The authors are furthermore of the opinion that this life stage typically starts with biological influences and changes and ends in the adaptation into society as a whole (Louw & Louw, 2010:281).

### 2.8.1 The life stage

Louw and Louw (2010:279) made it clear that the adolescent life stage starts more or less at the same age for all children. Louw and Louw (2010:279) came to the conclusion that although it depends on the biological and socio-cultural factors in the development of this separate life stage, the average age of onset for the individual varies from 11 to 13 years and lasts until early adulthood. Early adulthood is usually reached by the age of 18 to 21 years, also depending on gender, since it is known that girls deal with the behaviours related to this life stage a year or two before boys. This also is not cast in stone, but also effected by general maturity. Adolescence therefore begins at puberty and is concluded as soon as the individual's body had reached sexual maturation. It furthermore concludes when the person meets the norms of society for the definition of adulthood (Louw & Louw, 2010:279). According to Louw and Louw (2010:279), adolescence should also be viewed as a developmental bridge between the two life stages, childhood and adulthood. It therefore carries the burden of the behavioural manifestations of this life stage.

A few behavioural aspects of adolescence are more recognisable as being typical of this life stage. According to Louw and Louw (2010:291), these behaviours are characterised as being in conflict with parents and authority figures. This might explain the disruptive behaviour within the school setting and the assumption of educators that they are being disrespected by the adolescent (Louw & Louw, 2010:279). As in all other life stages, the adolescent too should reach specific developmental milestones. Mash and Wolfe (2010:13) quotes Coatsworths' (1998) examples of developmental tasks to be reached by the adolescent in order to succeed in this life stage:

- “Successful transition to secondary schooling,
- Academic achievement (learning skills needed for higher education or work),
- Involvement in extracurricular activities (e.g. athletics, clubs),
- Forming of close friendships within and across gender,
- Forming a cohesive sense of self-identity.”

According to Mash and Wolfe (2010:14), the adolescent is also expected to follow rules set by his/her environment, without further direct supervision, but this aspect is questionable in settings where many adolescents gather together, as for example



within the school setting. The emotional, social and moral development of the adolescent will be discussed in the following sub-sections.

### **2.8.1.1 Emotional development**

Adolescence seems to not be that easily demarcated since the general characteristics of the adolescent are not readily defined (Louw & Louw, 2010:278). When in interaction with these children, it should be considered that adolescence should be viewed as a normal life stage with its own difficulties. Along with behavioural difficulties comes life style and social challenges as a normal process and as part of the life stage (Louw & Louw, 2010:282). Most individuals will report that adolescents do not experience any significant social adjustments, little behavioural issues or even insignificant emotional turmoil (Louw & Louw, 2010:282). However, since this life stage is strongly driven by biological developmental and the onset of sexual hormones, adolescents are often unpredictable with regards to emotional behaviour. Louw and Louw (2010:291) report that amongst these unpredictable behaviours are high risk behaviours, a tendency to be moody and unexpected emotional outbursts.

ADHD is a puzzling disorder, leaving the lives of youngsters suffering symptoms of ADHD in total contradiction and chaos (Mash & Wolfe, 2010:120). These authors emphasise feelings of frustration, of not fitting in and of feeling different from peers and siblings; even stating that these children feel hopeless (Mash & Wolfe, 2010:120). These adolescents try to survive within the pressure of the average, normal functioning child.

The adolescent referred for therapy is frequently confronted with complex problems that are further complicated by several social and non-social difficulties (Kadusen & Schaefer, 2006:106). The authors state that in addition, some of the behaviour symptoms associated with the hyperactivity and impulsivity of the disorder interfere with emotional development; the reason being the child's inability to tune into the cues of communication, both verbal and nonverbal. The power of corrective emotional expressing can mediate some behaviour problems because of the intense attention that the child gives to these experiences (Drewes & Schaefer, 2010:122). Not being able to develop emotional intelligence will have far reaching complications for the adult. It is also found in research by Skirrow et al. (2009:490) that a wide

range of mood instabilities appear to be quite constant in association with ADHD and seems to be relevant throughout the lifespan of the individual.

### **2.8.1.2 Social development**

Regarding the social and environmental stressors faced by the child, Peate and Fearn (2006:38) state that the labelling of the child demonstrating symptoms of ADHD becomes problematic in the successful management of disruptive behaviour. Children are judged by their peers, educators and even parents regarding the symptoms of ADHD. The child might even feel stigmatised and singled out as a result of a disorder over which he/she has no control. Furthermore, the individual enduring the symptoms of ADHD also has to endure the frustrations of the behavioural outcomes of the disorder. “No single theory can explain the many attention and self-control problems associated with ADHD” (Mash & Wolfe, 2010:137). It seems sensible to argue that the maintaining of healthy peer interaction is crucial to social acceptance and that the ability to acquire better social skills would lead to even better social interaction. “Children with ADHD typically experience behaviour difficulties at home, in school and within their community. Peer interaction, academic achievement and overall adjustment are affected” (Kadusen & Schaefer, 2006:101).

The child diagnosed with ADHD will probably encounter difficulty in maintaining social relationships. Society is often harsh and judgemental with regards to mental illness, learning disabilities and psychological abnormalities. Kadusen and Schaefer (2006:107) make the comparison between a child who is paralysed and require a wheelchair for mobility and a child with ADHD, whose physical appearance is normal, but a good deal of the child’s behaviour is not. Paralysed children require a wheel chair for mobility and are not expected to walk. The contrary is true about children with ADHD, who display a behavioural disorder and a conceptual “wheelchair” is mandatory to keep the brain from functioning in an abnormal fashion (Kadusen & Schaefer, 2006:107). Therefore, one cannot expect the child diagnosed with this disorder to behave within the norms of society.

### **2.8.1.3 Moral development**

Disruptive behaviour in the adolescent life stage does not relate to conduct disorder, but rather that the child with ADHD presents with a behavioural disorder (Mash &



Wolfe, 2010:160). These aspects as displayed by the adolescent are a continuation of behavioural symptoms that has progressed from early childhood (Mash & Wolfe, 2010:160).

According to Louw and Louw (2010:307), the adolescent is better at cognitive self-regulation than the child in younger life stages. This assists the adolescent in making plans and planning ahead. As with cognitive development it seems as if the adolescent thinks of himself/herself in a more abstract and complex manner (Louw & Louw, 2010:314).

Morality, regarded by Berk (2013:485) as rules for good conduct, has an emotional, a cognitive and a behavioural component. The emotional component allows the adolescent to empathise with the distress experienced by others or to feel guilty if the distress was caused by him/her. The cognitive component allows the adolescent to develop social understanding which allows him/her to make judgements about actions believed to be right or wrong. The behavioural component allows the adolescent to experience morally relevant thoughts and feelings, but does not guarantee that the adolescent will act accordingly. The cognitive component could also allow the adolescent to cognitively justify moral issues.

Berk (2013:516) points out that children who are able to delay gratification are in a position to interpret social cues accurately. This ability facilitates effective problem solving and positive peer relations. As indicated in the DSM-V (2013:60) the child with ADHD experiences a desire for immediate rewards and therefore an inability to delay gratification. The researcher is therefore of the view that this characteristic of ADHD could impact negatively on the moral development of the adolescent diagnosed with ADHD.

### **2.8.2 Behavioural manifestation of ADHD in adolescence**

As with adolescence, ADHD is characterised by behavioural aspects recognisable specifically during the adolescent life stage. Adolescents seem to think differently about themselves than children in younger life stages (Louw & Louw, 2010:307). According to Kadusen and Schaefer (2006:101) the disruptive behavioural aspects related to ADHD should be understood clearly as being the norm. The authors assume that all children present with inattention, impulsivity and seem to be too active. For children with ADHD these behaviours are the rule not the exception

(Kadusen & Schaefer, 2006:102). These behaviours are thus distinguishable from normal adolescent behaviours and even have an acute effect on how other adolescents relate to the child with ADHD. For this age group, peer interaction is very important, and most often this along with academic achievement and the overall ability to adjust are severely affected (Kadusen & Schaefer, 2006:101). Their excessive behavioural symptoms might be misleading to their peers who might lack a comprehensive understanding of their behaviour and who do not want to be associated with their behaviour. According to Kadusen and Schaefer (2006:102), even the social skills deficit of the individual has “resulted in years of suffering negative feedback and lack of positive reinforcement, as well as inability to meet the reasonable demands of family, friends and teachers.”

The adolescent learner, who according to Louw and Louw (2010:307), is now able to regulate better on a cognitive level, should be improving in terms of reasoning. Therefore they seem to be improving on their ability to perform academically and have managed to obtain better study skills. However, the hyperactive adolescent stands out amongst other children in the school setting because of being overly active. Classmates and educators might even refer to these learners as being naughty or disruptive, and they are often asked to leave the classroom so that the teaching of the rest of their classmates could commence.

Kadusen and Schaefer (2006:109) found certain studies suggesting an inverse relationship between the level of hyperactive behaviour in primary school and academic achievement in high school. The authors are of the opinion that the level of hyperactivity in the high school learner may be associated with poor levels of performance and achievement in the primary school child (Kadusen & Schaefer, 2006:109). The authors state that not all children who have been diagnosed with ADHD display disruptive, hyperactive behaviour and that this aspect is one of the three mutually exclusive elements of this disorder.

A disturbing opinion by Johnson (2004:4) with regards to the child/adolescent diagnosed with ADHD is that children diagnosed with ADHD are more at risk than their peers to show delinquent behaviours because they do not continuously demonstrate behaviour that evokes positive feedback. This should then also be reflected onto the background of not having the opportunity or intellectual capacity to

manage their disruptive behavioural aspects associated with ADHD. They tend to constantly receive negative feedback on their disruptiveness from both peers and adults. In their effort to fit in with the peer group, they may find acceptance with children/adolescents who also display symptoms associated with ADHD. Academically, these children are faced with the likelihood of three to seven times more than their peers to be retained, suspended or expelled (Zentall & Kuester, 2011:28). The school setting which requires sustained attention usually worsens these symptoms (Johnson, 2004:4).

As already clarified, the life of the adolescent is one characterised by challenges, as discussed below.

## **2.9 CHALLENGES FACED BY THE ADOLESCENT WITH ADHD**

ADHD in itself is a huge burden to the child. The process of being diagnosed usually has an exhausting and lifelong progression. As mentioned, the neurological brain profiling along with psychometric evaluations explain only part of the problem. Several external factors influence the way in which the child diagnosed with ADHD functions. The child being diagnosed does not always have control over the external factors, influencing his/her behaviour.

### **2.9.1 Parental issues**

The point of view held by parents has a remarkable influence on how the child with ADHD perceives this diagnosis and the best way of dealing with the symptoms. The parents of the child might find themselves struggling to understand the behavioural aspects associated with this condition. Parents should maintain a realistic attitude and stay open-minded to additional approaches of intervention for ADHD (Kadusen & Schaefer, 2006:107). Although parents might even be looking for a so called 'quick fix', Kadusen and Schaefer (2006:107) suggest that parents should be open to all possibilities in treating ADHD. These include medication, child and associated family therapy, and developing better communicational skills with their educators. They must even look for the answers within themselves. Kadusen and Schaefer (2006:108) encourage parents to "understand that feelings of guilt and inadequacy are natural. They must accept negative and ambivalent feelings and gain a better perspective of the child by avoiding perfection as a goal" (Kadusen & Schaefer, 2006:108).

The parental feelings of guilt and responsibility might leave the child feeling powerless. He/she might even want to change their behaviour in order to fit in with peers and family members. As soon as the child accepts responsibility for his/her experience of these symptoms and behavioural difficulties, parents should express faith in the child's ability to handle difficult situations and circumstances (Kadusen & Schaefer, 2006:108). Parents are thus encouraged to, for the sake of intervening with the behavioural difficulties of the child with ADHD, step back and let the child prove his/her ability to improve their behaviour.

Parents are also required to keep an open mind with regards to the behaviour of the child diagnosed with ADHD, since the child is not the diagnosis but an individual with ADHD being the source of distress. Parents should therefore focus on the child's experiences and provide emotional support. The parent should clearly communicate to the child that this disorder does not define him/her, but the disruptive behaviour causes misconceptions with regards to the child and the reason for his/her behaviour (Kadusen & Schaefer, 2006:109).

### **2.9.2 Socio-economic status**

Kadusen and Schaefer (2006:109) came to the conclusion that parents with a higher socio-economic status have a higher probability to afford professional help for their children. This statement makes it very clear that ADHD is not defined by income group or socio-economic level of functioning within the community. The disorder is diagnosed, irrespective of socio-economic status and is a strong equalling factor amongst children diagnosed with ADHD. Help is currently also more regularly available for the child who displays disruptive behaviour associated with ADHD. Many schools make use of the help of professionals like educational psychologists and school social workers, even if on an ad hoc basis. Research results mentioned by Pennington (2009:154) indicate ADHD as being evident and prevalent in all socio-economic strata and in different cultures. There can however be considerable differences in the occurrence of ADHD within cultures even if the cultures are quite similar.

### **2.9.3 Intelligence**

Adolescence, viewed in terms of a life stage, should also be viewed as a cognitive developmental stage with developmental outcomes or milestones typical of the age,

to be reached by the adolescent. The adolescent with ADHD who functions on higher levels of intelligence, should have a greater opportunity to overcome and compensate for the lack of self-control displayed. It might even assist the child in accomplishing tasks at a greater speed or finishing difficult tasks more regularly. Intelligence also plays a role in the adolescent's understanding of the disorder in order to acquire coping and compensating skills. The other side of the pole is then the constant struggle of the child deemed less intelligent, thus not coping with the disabling effect of ADHD on their academic progression (Kadusen & Schaefer, 2006:109).

#### **2.9.4 Social skills**

The lack of sufficient social skills is often followed by the inability to meet the reasonable burden placed on the child by family, friends and educators (Kadusen & Schaefer, 2006:102). In addition to the difficulties associated with being diagnosed with ADHD, many of these children display a number of other related behavioural problems. These problems often present in academic areas as learning difficulties and in social skills areas as interpersonal difficulties. These children furthermore struggle with emotional difficulties in the form of anxiety and depression (Louw & Louw, 2010:236). According to Louw and Louw (2010:234), the child who is inattentive finds it difficult to sustain mental effort acquired during work or play activities. According to Louw and Louw (2010:234), “[t]hey have a hard time keeping their minds on any one thing or following through on requests or instructions.” This might make them unpopular with teachers and peers, and lead to social isolation or rejection.

#### **2.9.5 Delay of gratification**

Delay of gratification refers to the ability of the individual to accept not being immediately rewarded for an accomplishment. The child diagnosed with ADHD might not know how to comprehend this aspect and may view it as a further frustration in his/her daily life (Kadusen & Schaefer, 2006:110). Since the adolescent with ADHD struggles with the symptoms of ADHD the delay of gratification does not make logical sense to him/her. They would typically react impulsively and reflect an urge for immediate rewards, and would display an inability to obtain gratification at a later

stage (DSM-V, 2013:59). The adolescent struggles with the concept of being rewarded in the future.

### **2.9.6 Challenges within the school setting**

Schools require from the learners to fall in with a rigid and well planned routine. For most learners this creates a place of safety and unity. However, for the child diagnosed with ADHD, it becomes problematic. The problem in managing the behavioural aspects of the child with ADHD almost always draws the attention of educators during the initial years of schooling. This is specifically related to the problems these behavioural aspects pose in managing the child with ADHD within the school setting. Amongst the identified behaviour is the child's frequent talking, his/her inability to remain seated, trouble in keeping hands to themselves and difficulties in finishing school work within a given time (Skuse, Bruce, Dowdney & Mrazek, 2011:158-159). "Fidgetiness, poor attention, day dreaming, impulsive response style, problems persisting with difficult tasks, rushing through work, and making careless mistakes are all behaviours in the clinical setting that are consistent with the diagnosis" (Skuse et al., 2011:169). Louw and Louw (2010:227) mention the same scenario of distracting behaviour displayed by their constant moving and inability to sit still through an entire lesson. Adolescents diagnosed with ADHD often fall behind in their school work. They find themselves in a vicious spiral of problems. Unlike the rest of their classmates, they do not enjoy the rigid pattern of events and actions. They struggle to contain themselves in order to conform to the events in and behaviours of the school setting.

Many elements are encompassed of the classroom setting. Some of these elements are easily observed and include the classroom climate, the ability of the learners to self-regulate, levels of paying sufficient attention, the child's attitude towards learning and eagerness towards academic achievement. The educator's personality should be filled with warmth and supportiveness, friendliness, expectations, the giving of direction and instruction. He/she should also have the ability to obtain feedback, since this too is an important characteristic of the educator. Even the way that the school classroom's furnishings are arranged, plays a definite role on the actions of the child with ADHD (Louw & Louw, 2010:227). It is within these structures that the assistance of the mental health professional is of importance, since it is seen to be



“their main task to challenge attitudes, behaviour, teaching methods, curricula and the physical environment in order to meet the needs of all learners” (Louw & Louw, 2010:239). The schooling system has also in recent years moved towards inclusive education. Louw and Louw (2010:239) are in doubt if this system is suitable for all learners. “The management of ADHD in school-aged children needs to consider the school setting. Therefore, training of teachers about the conditions and increased support in the classroom is important” (Skuse et al., 2011:158-159). As ADHD is commonly noticed in the school setting, the child often gets recognition from teachers and peers alike for the diagnosis, which has a huge influence on their willingness to change the challenging disruptive behaviour. In the words of Louw and Louw (2010: 235), “They find it hard to regard their behaviour.”

Learners within the school system, who have been tested for ADHD and who present with the symptoms, as well as the behavioural aspects typical of the diagnosis, usually show a profound lack of performance in their schoolwork. Skirrow et al. (2009:489) advise that the learner’s lack of attention in the classroom may result in poor scholastic achievement. They often do not find the classroom setting stimulating enough to keep their attention. Their lack of concentration presents as wondering minds and disruptive behaviour. This, in return results in poor school performance.

Since educators are often the first people to notice the unwillingness of a learner to cooperate and are constantly faced with managing the challenging behaviour and symptoms of learners with an ADHD diagnosis they are thus expected to attend to the behaviour of the child displaying these behaviours amongst the rest of the learners within the school setting. The other learners in the classroom are constantly aware of these behavioural symptoms displayed by the child diagnosed with ADHD. Making this even more difficult to handle within the classroom setting, is the fact that the inappropriate behaviour and mood instabilities displayed by these learners may fluctuate and change within a very small space of time (Louw & Louw, 2010:235),

The learners are often punished by being asked to leave the classroom and stand outside. These actions might hamper the learners’ ability to keep up with the rest of the class, often impacting on their overall cognitive development. The learner finds himself/herself in a daily struggle for concentration in a well-organised school setting

that provides very little room for moving around and excessive activity. The discomfort that the educators endure while struggling to teach learners their school work within a given time period, and who cannot allow any disruptive behaviour, must be acknowledged. Learners with the ability to concentrate and work within the school setting cannot be deprived of a learning opportunity to the detriment of the learner diagnosed with ADHD. They do not have an equal ability to comprehend information and actively participate during lessons or when doing school work (Louw & Louw, 2010:235).

The understanding is that the school represents society as a microcosm thereof. There is an understanding amongst mental health practitioners who are actively involved with children who experience interpersonal, emotional, and behavioural difficulties that these experiences might reflect within the learning environment. Learning difficulties might thus be brought about as a result of stressors in their lives (Wynne, 2008 in Drewes & Schaefer, 2010:64).

## **2.10 SUMMARY**

In the diagnosis of ADHD the American Psychiatric Association with reference to the DSM-V (2013:59-61) indicates that clinical judgement should be applied to assess whether symptoms are “inconsistent with developmental level” or whether “it applies the same symptoms to individuals of all ages.” It is furthermore known that adolescents often present with behavioural problems. These symptoms include hyperactive behavioural symptoms (Steinhausen et al., 2003 in Mash & Wolfe, 2010:125). It should also be remembered that ADHD in itself is not a learning disorder, but that it is often accompanied by the co-morbid conditions, such as learning disabilities.

Skirrow et al. (2009:491) reminds that ADHD is of chronic nature. In order to diagnose the existence of the disorder, the therapist should take any psychometric evaluated material, any observed note and evaluations, as well as a medical history and profile of the adolescent, into consideration. Research has proven various physical, biological, behavioural, environmental and psychological influences that have a combined impact on the behaviour and symptoms known to a diagnosis with ADHD. The person with ADHD should furthermore be evaluated on the ground of their developmental level, their emotional and social development, such as social





skills development, and their level of morality. Peer relationships are typically negatively influenced, since the individual diagnosed with ADHD, might display a lack of, or minimal level of social competences (Kadusen & Schaefer, 2006:296).

Literature on strategies to address ADHD, specifically Gestalt group work will be presented in chapter 3.

## CHAPTER 3

### GESTALT GROUP WORK WITH THE ADOLESCENT DIAGNOSED WITH ADHD

#### 3.1 INTRODUCTION

The question surrounding the value of play as tool in intervening in the life of the child could be answered by the explanation in Frost et al. (2012:3), namely that play has a purpose in contemporary child development. Play is known to be the universal language of the child, since all normal and active children play and fantasise. Therefore, play therapy is advisable during intervention with a child who is struggling to cope with his/her current circumstances, by creating an avenue for dealing with maladaptive experiences (Frost et al., 2012:3).

Frost et al. (2012:32) conclude that in most children play provides for a psychologically safe framework where what is desired can be attained through the world of fantasy play. This, applied according to the Gestalt principles and not just as a metaphor to therapy, has proven to benefit the child in need of intervention on several levels of his/her development. Since children are social beings, the use of group work specifically is recognised for its applicability within Gestalt play therapy.

#### 3.2 GENERAL STRATEGIES FOR ADDRESSING ADHD

Powerful intervention strategies, such as social skills training, medication, and family and group counselling might have a significant effect on reducing the appearance of the symptoms related to ADHD (Louw & Louw, 2010:236). The management of ADHD usually involves some combination of counselling, life skills training and medication. Professional assistance is thus often within the reach of the child (Landreth, 1993; Drewes, Carey & Schaefer, 2001; Ray Armstrong, Warren & Balkan, 2005 in Drewes & Schaefer, 2010:64).

Regardless of the known intervention strategies or the lack thereof, studies found that children often have difficulties in managing the symptoms of ADHD during adolescence (Louw & Louw, 2010:236). Even though these studies found that medication did offer significant improvement over time, “the long-term benefits of

medication were found to be no better than children who were treated with behavioural therapy” (Louw & Louw, 2010:236). A combination of treatment is suggested by Skuse et al. (2011:158). Various treatment strategies are discussed below.

### **3.2.1 Medication**

Before any medication is prescribed to a child, the parents and medical personnel should be clear in their understanding of the actual cause of the child’s symptoms (Mash & Wolfe, 2010:145). As mentioned by Mash and Wolfe (2010:143), the use of medication in the form of stimulants and other types of medication in the treatment of the symptoms of ADHD in children has been the subject of substantial debate. It is often seen as an instant solution or a quick fix to the behavioural symptoms of ADHD. The most popular medications are stimulants, but in recent years several other non-stimulant drugs have been developed. The views are that stimulants are safe and useful, if used correctly and with the necessary supervision. According to Mash and Wolfe (2010:144) the short-term benefits of medication are familiar, but follow-up studies question the long-term benefits of stimulants regarding the child’s later adjustments in life (Jensen et al., 2007 in Mash & Wolfe, 2010:144). The researcher finds mention made of addictions in adulthood because of the prolonged use of these medications, disturbing. Stimulants have the adverse effect of dependency, leading to the use of greater and stronger forms of stimulants (Mash & Wolfe, 2010:144).

Unfortunately, there have also been instances where a child was prescribed the medication for reasons other than ADHD. Controversy surrounding the possible misuse of medication has also come to light. Researchers in America found that during the 1910’s stimulants were wrongly prescribed and administered to children, which lead to legislation to protect the child (Mash & Wolfe, 2010:145). Mash and Wolfe (2010:145) mention that despite the limitations of stimulants, it remains to be the most effective treatment for managing symptoms of ADHD.

### **3.2.2 Social skills training**

Social skills training is an important intervention strategy during the adolescent’s struggle with behavioural aspects related to ADHD, since interacting with age-related others is imperative for normal social development. While treatment effects are

frequently striking in medication trials, the behavioural treatment during skills development training proves to be part of the total intervention strategy (Louw & Louw, 2010:236). Peer interaction often becomes problematic when adolescents do not want to be associated with the individual displaying unruly behaviour. “Peer problems in both boys and girls with ADHD are apparent at an early age and are quickly evident when the child enters a new social situation” (Mash & Wolfe, 2010:130). According to Blom (2006:70) questions often asked with regards to the social ability of such children are:

- “How is the child’s relationship with others in his or her life?”
- Does the child have friends?
- Does the child show signs of independent thoughts and actions?
- Does the child have environmental support for his or her needs?
- How does the child satisfy his or her needs?
- Does the child have age-related egocentricity?”

Mash and Wolfe (2010:130) are furthermore of the opinion that the social difficulties of children with ADHD often predict that they will be disliked and excluded by their peers; subsequently they have few friends. Schaefer (2003:305) mentions that the membership of a group, even a therapeutic group, provides the group members with several social learning opportunities. Seen in this light, the adolescent going through a difficult life stage, as well as not coping with the behavioural elements related to the symptoms of ADHD, would need all possible assistance in a social setting. Group therapy provides opportunity for social skills training.

### **3.2.3 Family and group counselling**

According to Mash and Wolfe (2010:130), “[f]amilies of children with ADHD experience many difficulties, including interactions characterized by negativity, child noncompliance, excessive parental control, and sibling conflict.” Families are in a desperate search for solutions and support. Support groups are often formed, where members share information and useful tools to assist the family of the child with ADHD (Mash & Wolfe, 2010:130, 148).

Researchers believe medication and other intervention strategies such as family and group management training should not be neglected. It should rather all be done in

conjunction in order to solve the common problem at hand; namely the behavioural aspects related to the symptoms of the child diagnosed with ADHD (Mash & Wolfe, 2010:145).

According to Geldard and Geldard (2010:251), group work provides good prospects for children to identify and argue on acceptable and unacceptable social behaviour, as these behaviours do occur in groups. Groups provide for a safe environment to practice newly acquired behaviours. It also enables the mastering of new behaviours. Thereafter, children/adolescents might find that their interaction with their peers and classmates has also improved and that they have become more popular amongst their friends (Kadusen & Schaefer, 2006:347). “Finally, the therapeutic factors in the group process such as universalization, cohesion, altruism, and vicarious learning are present to enhance the power of this intervention” (Yalom, 1985 in Kadusen & Schaefer, 2006:343).

In the following section, Gestalt play therapy as an intervention strategy will be focused on.

### **3.3 GESTALT PLAY THERAPY**

Gestalt play therapy is a young and very applicable approach in dealing with childhood problems and trauma. The core of Gestalt therapy is in the creation of awareness as well as making contact with the environment. The role of the therapist lies in being attentive to the individual’s current needs and being supportive of the process of change (Corey, 2013a:196). Parents and educators are however required to ensure that the correct diagnosis is made regarding the disruptive child, by using current and standardised psychological instruments (Senreich, 2013:56).

Blom (2006:19) believes that children should make a conscious decision to address their own negative and disruptive behaviour, and states that by focussing on the realisation of their own behaviour, they are “defining the significance of their life” (Blom, 2006:19). If not adequately addressed the child demonstrating the problem behaviour and symptoms of ADHD will fail to meet the situational demands of his/her environment in an age-appropriate manner (Kadusen & Schaefer, 2006:101).

### **3.3.1 Historical background of the Gestalt theory**

Gestalt therapy as method of intervention became popular during the late 1940's, early 1950's in reaction to a central tendency of psychoanalytic thinking, by the then popular classical psychoanalysts. The theory has evolved through strong inputs by ground breakers in the field of psychoanalysis, such as Frits Perls. This paved the way to the Gestalt therapy's applicability during intervention with children (Yontef, 1993 in Senreich, 2013:56).

Yontef, 1993 (in Senreich, 2013:56) states that "Gestalt therapy, with its emphasis on self-actualization, human creativity, and nonconformity, fits in well with the zeitgeist of the counterculture movement that emerged in the 1960s and became a popular form of psychotherapy during the decade." Senreich (2013:56) believes this theory emphasised the view that self-actualisation is a principal human drive. Gestalt therapy as intervention therefore was shaped and formed through several inputs and has often been referred to as "a phenomenological psychotherapy, as it focuses intensively on the subjective experience of the client" (Senreich, 2013:67).

Gestalt therapy places the focus on techniques that increase attention to feelings, thoughts, movement, behaviours and bodily sensations by providing the client with these experiences, to create increased awareness in the client (Crocker, 2005; Mann, 2010 in Senreich, 2013:67). In the decades to follow, a new generation of Gestalt therapists embraced and expanded on the original concept of Gestalt therapy (Machewn, 1997 in Senreich, 2013:55). The attention finally focused on the knowledgeable researcher, Violet Oaklander. According to Oaklander, "the philosophy, theory and practice of Gestalt therapy can also be used with slight adaptation in therapy with children" (Oaklander, 1992 in Blom, 2006:17). Blom refers to the statement by Oaklander that numerous theoretical concepts and principles have advanced through the underlying practice of Gestalt therapy (Blom, 2006:46). Oaklander is renowned for her contribution towards Gestalt play therapy with children, which includes the developmental life stage of adolescence (Senreich, 2013:58).

### **3.3.2 Gestalt as central approach**

Gestalt play therapy, which is a specialised field of involvement with regards to behavioural aspects of children, might be beneficial in addressing the behavioural

symptoms related to ADHD. Play therapy is commonly known in the counselling circles as the most developmentally appropriate method in meeting the counselling needs of children in the school setting (Landreth, 1993; Drewes, Carey & Schaefer, 2001; Armstrong, Warren & Balkan, 2005 in Drewes & Schaefer, 2010:64). Papalia (1985) as quoted by Blom (2006:18) defines the Gestalt concept as the “significant arrangement of the parts of a whole.” Oaklander (2001:45-55) states that Gestalt therapy is a vibrant, present-centred, humanistic, process-oriented therapeutic method that focuses responsiveness on the healthy integrative functioning of the being in totality, involving the senses, the body, the emotions and the intellect. Corey (2013a:194) refers to Gestalt therapy as being “an existential, phenomenological and process-based approach created on the premise that the individual must be understood in the context of their ongoing relationship with the environment.”

Within this context a person receives special attention to his/her existence as an individual, with the human capacity to grow, develop interpersonal contact and develop insight (Corey, 2013a:194). Yontef (1993), quoted in Blom (2006:18-19) furthermore reports that Gestalt therapy can be described by its three main principles, namely awareness, the existential dialog (I-Thou relationship) and the concept of holism. These principles, all present in the life of a child and especially when interwoven with play, create a vibrant form of intervention, since it is applicable on several levels of the child’s functioning and development.

According to Cattanach (2003:24), defining play therapy is mostly determined by the perspectives of the person involved with the process. The principles and values of social work place the emphasis on the importance of human relationships and dignity seen in conjunction with the worth of the person. The client’s immediate experience is considered to be a way in which to enhance his/her awareness of how that individual exists in his/her world (Senreich, 2013:55). Corey (2013a:196) is also of the view that the individual in Gestalt therapy possesses the capacity to self-regulate and that play therapy should create an environment conducive to change.

Blom (2006:21) is of the opinion that Gestalt play therapy tends to attract counsellors more inclined to an experiential approach and who are open to symbolism and fantasising. The play therapy assumption is that children will play out their struggles in a symbolic manner and will learn to know how to channel their individual emotions



more effectively. They will furthermore learn to engage in relationships of trust with other people and that devious behaviour will subsequently be normalised (Blom, 2006:29). The Gestalt play therapy context refers to all the activities and experiences that children and therapists engage in, within the therapeutic context (Oaklander, 2001:46).

This intervention strategy might shed light on the dimensions of the child presenting with the behavioural symptoms of ADHD's ability to adapt, in order to remain part of his/her environment, which includes the school setting. Adolescent children in schools might benefit hugely from Gestalt play therapy, when focusing on the needs of the individual in the school setting (Landreth, 1993; Drewes, Carey & Schaefer, 2001; Armstrong, Warren & Balkan, 2005 in Drewes & Schaefer, 2010:64).

Theoretical concepts relevant to Gestalt play therapy will be discussed in the following section.

### **3.4 THEORETICAL CONCEPTS OF GESTALT PLAY THERAPY**

Understanding the client's often strange or destructive behavioural manifestations requires from the Gestalt play therapist to correctly apply the theoretical concepts within Gestalt play therapy (Blom, 2006:22). Play therapy should be viewed as a collaborative inquiry into the world of the child, which is contained within a therapeutic relationship between play therapist, child and other role players (Cattanach, 2003:44).

The following theoretical concepts of Gestalt theory will briefly be discussed: holism, homeostasis, contact and contact boundary disturbances, polarities and structure of the personality.

#### **3.4.1 Holism**

Gestalt theory incorporates existential phenomenology as a part of a holistic approach, where the emphasis is on awareness of the client within the here and now and the interdependency that exists between the client and his/her environment (Blom, 2006:19). Blom also refers to the objectives of Gestalt therapy as readdressing intrinsic holistic harmony/balance within the individual (Carson & Machewn, 1994 in Blom, 2006:23). Healthy individuals expect and understand the different aspects that form the self. Blom (2006:22) makes the statement that the



Gestalt theory can be considered to be a whole of which the total is more than its individual elements. Corey (2013a:196) agrees with the statement that holism is one of the core principles of Gestalt and explains that “[t]he whole is greater than the sum of its parts.” Blom furthermore suggests that from a holistic viewpoint, the individual is not just more than the sum of his/her behavioural aspects, but also that within holism a dynamic force moves the individual towards a holistic entity (Blom, 2006:23).

### **3.4.2 Homeostasis / organismic self-regulation**

The word ‘homeostasis’ refers to balance and describes the process during which the organism maintains this balance under different circumstances (Blom 2006:23). Homeostasis should furthermore be viewed in conjunction with the concept of organismic self-regulation. This refers to the ability of the individual to experience his/her needs in a different formation such as physical, emotional, social, spiritual or intellectual needs (Blom, 2006:24).

The particular attempt of an individual to obtain a need/want which would be the best option for the individual within a particular situation is referred to as creative adjustment (Melnick & Nevis, 2005 in Senreich, 2013:56). The ability of the individual to self-regulate places the emphasis on the ability of the organism to react and take part spontaneously in order to fulfil the need in a natural, flowing manner (Fall et al., 2010:203). According to Corey (2013a:197), “[t]he figure-formation process is intertwined with the principle of organismic self-regulation, which describes how the individual organizes experiences from moment to moment.” Humans are naturally aware of their needs and fulfil them, which lead to balance. According to the Gestalt theory the immediate situation of the moment is referred to as the “figure” of that person, whereas the totality of all past experiences is referred to as the “ground” (Senreich, 2013:59). According to Skirrow et al. (2009:491), emotional regulation presents a more active adaptation or alteration of ongoing emotional responses. As soon as the individual meets his/her needs, or should those needs remain unmet, newly formed needs will take the foreground and the original needs will recede into the ground, ready to, at the next appropriate opportunity once again become figure (Fall et al., 2010:205).

The process of organismic self-regulation is also described by Blom (2006:26) as the process of Gestalt formation and destruction. According to Blom (2006:26), “[t]he process of gestalt formation and destruction or organismic self-regulation consists of a cycle of stages.” Researchers seem to differ with regards to the number of stages and mention that the focal points within those stages tend to overlap (Blom, 2006:26). These different stages are briefly discussed below.

- **Stage 1: Awareness/sensation**

Gestalt therapy is known for using techniques that increase consideration to feelings, thoughts, movements, behaviours, and body sensations experienced by the client, as a way to increase the client’s awareness (Crocker, 2005; Mann, 2010 in Senreich, 2013:67). Corey views the goal of Gestalt therapy as firstly to increase awareness, which is viewed as healing and restorative (Corey, 2013a:197). The author states that this requires self-knowledge from the individual and the ability to make responsible choices. Making contact with the environment followed by the immersion of current experience, self-acceptance and the capacity to become resourceful from within are all skills in the process of successful problem solving and in discovering the elements necessary in making change possible (Corey, 2013a:198).

- **Stage 2: Mobilisation/choice of relevant action**

Children should be directed towards becoming aware of their needs in a way that relates to their developmental stage (Blom, 2006:25). In order to satisfy a need, the individual becomes fully involved in the chosen action (Blom, 2006:29).

- **Stage 3: Final contact/action**

During this stage of involvement, the play therapist assists the child in becoming totally involved in the action that he/she has been following, so that his/her needs are satisfied. This does also imply that other needs and unresolved issues might still linger in the background, but for the moment, the completion of the self takes place in the here and now (Blom, 2006:27).

- **Stage 4: Post-contact**

The play therapist should assist the child in realising that, as soon as contact has been completed, he/she experiences homeostasis. The figure, which is the need, returns into the background and the Gestalt is ruined (Blom, 2006:27).

- **Stage 5: Withdrawal**

Children often re-live their traumas by blaming themselves and by taking responsibility for these traumas (Oaklander, 1992 in Blom, 2006:28). Children often present with physical manifestation of the trauma, such as headaches. They also may project their emotions onto significant others in their world, “so that emotions are expressed in the form of destructive behaviour such as uncontrolled outbursts of anger” (Blom, 2006:29).

### **3.4.3 Contact and contact boundary disturbances**

Fall et al. (2010:205) explain these concepts as being “the border between me and not-me, the point at which those entities make contact, is the contact boundary.” In addressing the needs of the individual, even within group work, contact boundary disturbances, or neurosis occurs as soon as the individual can no longer form a sound balance between himself/herself and their world (Blom, 2006:31). Children with contact boundary disturbances are incapable of being aware of their needs or the healthy contact with the environment. These children have included holistic performance of the senses, body, emotions and the intellect that has become fragmented, by using contact boundary disturbances. These aspects will negatively affect the natural process of organismic self-regulation (Blom, 2006:31).

During the process of self-regulation, each person continuously shapes and alters the permeability of the contact boundary between the environment and the self, in the hope of making it more permeable. Through the use of Gestalt play therapy, focus is placed on enhancing the child’s awareness of his/her own process. The analysis of why the individuals’ specific behaviour manifests, becomes less apparent (Blom, 2006:51). Fall et al. (2010:209) furthermore explain that the child’s needs might sometimes go unmet, and unmet needs often lead to unfinished business, accompanied by uneasy feelings of anxiety. When the individual chronically restricts needs fulfilment by restricting awareness, maladjustments tend to occur. This might

create a pattern of maladjustments and unmet needs, thus leading to contact boundary disturbances (Fall et al., 2010:209). Corey (2013a:199) names and explains the five contact boundary disturbances that are articulated in Gestalt therapy, namely introjection, projection, retroflexion, confluence and deflection, explaining that it might be either healthy or unhealthy to the functioning of the individual or groups' level of awareness.

#### **3.4.4 Polarities**

The individual's inclination to place objects and ideas in totally opposite positions from the self, may explain the term "polarities" best (Blom, 2006:28). The author is of the opinion that the personality is made up of these two contrasting entities and that the individual spends most of the day in solving the conflicts resulting because of the contradicting part of the self (Thompson & Rudolph, 1996 in Blom, 2006:39). Blom (2006:39) furthermore explains that the aim of Gestalt play therapy is to incorporate polarities, in order to allow the child to function more adequately and ensure that each part of the polarity finds its place as part of the well-integrated personality (Thompson & Rudolph, 1996 in Blom, 2006:41). It thus makes sense when Blom explains that polarities might lead to feelings of confusion in children and might contribute to the fragmented existence of the self (Blom, 2006:41).

#### **3.4.5 Structure of the personality**

Fall et al. (2010:2012) explain that within the Gestalt theoretical ideology, changes occur in the individual's ability to become aware, in particular when the individual becomes aware of his/her unmet needs. In the search for balance and the promotion of health and growth, the individual will experiment with different ways in which to meet these needs the best. From this thinking, Gestalt theorists developed a paradoxical view of change and a belief that the individual could only change once he/she is true to who they are, within the self. "The more someone tries to be who one is not, the more stuck the person will become" (Beisser, 1970 in Fall et al., 2010:212). The Gestalt theory thus refers to the "layers of neurosis", as the process of need fulfilment (Fall et al., 2010:212). The layers illustrate how people can fragment their lives and in doing so, they do not achieve success (Blom, 2006:42). Blom (2006:42) summarises the five layers, or structures of the personality, from a Gestalt perspective.

The *synthetic* or *false* layer is the “outermost layer of the personality” (Blom, 2006:43). This layer signifies the roles that the child plays in the process of being what he/she is not. The *phobic* layer is also referred to by Blom (2006:43) as the “layer of roles”. As the child becomes aware of the synthetic game, he/she becomes “aware of their fears that maintain the game” (Blom, 2006:43). Thomas and Rudolph (1996 in Blom, 2006:43) are of the opinion that this awareness within the child is often accompanied by anxiety. According to Aronstam (1989 in Blom, 2006:43) the most recognisable characteristic of the phobic layer is the person’s resistance to be what he/she can be. The child thus acts according to the role ordinary expected from him/her, for example being the class clown. The *impasse* layer describes the child’s inability to support himself/herself. This layer is characterised by feelings and emotions of confusion, being caught up and anxiety, and contributes to high levels of discomfort (Clarkson, 1989; Clarkson & Mackewn, 1994 in Blom, 2006:44). The child finds moving through this phase before being able to deal with it in the correct manner, as a painful experience. During the *implosive* layer the child becomes aware of confining himself/herself, but has no energy to break free from the impasse. Children thus become aware of own behaviour and emotions but lack the energy to take action. The final layer is the *explosive* layer, where the child feels relieved from the painful previous phase and is now ready to move forward (Blom, 2006:45).

The objectives of play therapy need to be considered, before proceeding with a discussion of the process of play therapy.

### **3.5 OBJECTIVES OF PLAY THERAPY**

Play therapy is viewed as the organised use of a theoretical model in order to establish an interpersonal process. This process is facilitated by a trained play therapist, using the therapeutic value of play in order to assist his/her clients in overcoming social and psychological difficulties. This leads to the ideal growth and development of the client (*Board of Directors of the Association for Play Therapy*, 1997 in Frost et al., 2012:380). Play is thus defined as the child’s natural medium of communication. It is also believed that play therapy as an approach may assist school counsellors in effectively assisting the child during normal developmental growth (Ray, Armstrong, Warren & Balkin, 2005 in Drewes & Schaefer, 2010:65). Therefore, Landreth, 1991 (in Drewes & Schaefer 2010:65) defines play as “a

dynamic interpersonal relationship between a child and a therapist trained in play therapy procedures to provide selected play materials and facilitate the development of a safe relationship for the child to fully express and explore the self (feelings, thoughts, experiences, and behaviours).”

According to Corey (2013b:301), the Gestalt therapist takes on an active role by employing a wide variety of interventions and experiments to help individuals and group members increase their awareness and experience of their internal and interpersonal conflicts. It is thus the obligation of the group therapist to create a positive, nurturing environment within the session or the group (Corey, 2013b:301).

The three main objectives of Gestalt play therapy, namely promoting self-supportive behaviour, awareness of one’s own process and integration (Blom, 2006:52-54) will briefly be discussed in the following section.

### **3.5.1 Promoting self-supportive behaviour**

Play has as early as Axline (1968), Ericson (1963) Freud (1964) and Klein (1995), been viewed as a “means by which children can take charge of their problems and find routes for mastery and wellness” (Frost et al., 2012:312). Oaklander (2001:45) states that children consider play to be serious, purposeful business and that it provides for an avenue to develop mentally, physically and socially.

Since play encourages the use of the imagination, it serves as a language for children to apply symbolism that substitutes for the lack of words and encourages the child towards expansion of the spirit and letting-go of inhibition (Oaklander, 2001:45). The success of this technique is in involving the child in the process, which provides for an opportunity to learning life management methods (Werner, 1987; Barkley, 1990 in Kadusen & Schaefer, 2006:101).

### **3.5.2 Promoting awareness of one’s own process**

Awareness is paramount to the process of enabling the child through activities such as “seeing, hearing, touching, tasting, and smelling.” It can facilitate these children in growing out of their faulty sense of self and enable them to make adequate contact with other people. Another objective is to teach the child to become self-supportive by reacting responsibly and as stated by Thompson and Rudolph, 1996 (in Blom, 2006:51), “to facilitate the achievement of personal integration.”

Blom (2006:52) regards awareness of own process as a primary objective of Gestalt play therapy as the child needs to know the environment, take responsibility for choices, “self-knowledge, self-acceptance and the ability to make contact – in other words, awareness on cognitive, sensory and affective levels.” Encouraging the child in becoming aware implies that the child is placed in contact with himself/herself on a cognitive functioning level as well as a sensory and affective level. This also involves being in contact with other people as well as with the environment. They come to accept themselves and realise that they are being kept responsible for the choices that they make. These aspects, placed within the Gestalt therapeutic context, have an influence on each other and should be taken into account during the Gestalt play therapy process (Blom, 2006:53).

### **3.5.3 Promoting integration**

According to Blom (2006:53) integration and maturity are ongoing processes that focus on the child’s ability to become aware of himself/herself in order to be able to exist in the here and now. Blom (2006:53) is also of the opinion that the aim of therapeutic play is to give the child the opportunity to express his/her feelings both verbally and non-verbal. Play is a natural activity for children and is seen as the universal unspoken language, often the most appropriate method chosen by the therapist. The goals and outcomes of play therapy place attention on interactive play between the therapist and the child.

The objectives of Gestalt play therapy are used as a guideline during the Gestalt play therapy process (Blom, 2006:49). This process will be discussed in the following section.

## **3.6 THE THERAPEUTIC PROCESS**

The therapeutic process is not rigid, as therapy often moves back and forth during this process (Blom, 2006:49). The following phases in the process will be discussed: Building a therapeutic relationship, sensory and bodily contact making, strengthening the sense of self, emotional expression and self-nurturing.

### **3.6.1 Building a therapeutic relationship**

The concept of the ‘I-Thou’ relationship, as understood by the existential philosophers, refers to an approach based on the following: “we human beings are



inherently relational ...we become fully human through relationships with others ...we have the capacity and urge to establish meaningful relations with others” (Machewn, 1997 in Senreich, 2013:60). There is thus a strong emphasis on the relationship between the helping professional and the child and the relationship is seen as a mutual experience (Hycner, 1995 in Senreich, 2013:60).

The emphasis on the ‘I-Thou’ relationship implies that the social worker is horizontally instead of vertically involved with the child (Mann, 2010; Yontef, 1993 in Senreich, 2013:61). Blom (2006:54, 56) holds a similar view when she states that the therapist and the child are considered on an equal level; irrespective of age and status. This equal status implies congruence, respect and a non-judgemental attitude on the part of the therapist. ‘An equal level’ also refers to becoming the child’s playmate when meeting with him/her.

Geldard, Geldard and Yin Foo (2013:7) emphasise the significance of the child-therapist relationship in influencing the effectiveness of therapy. These authors make the following statement: “we claim that this relationship is the single most important factor in achieving successful therapeutic outcomes” (Geldard et al., 2013:7). Blom (2006:57) regards the emotional maturity of the therapist, therefore a dimension of themselves as a prerequisite for making effective contact with children in order to achieve therapeutic outcomes.

### **3.6.2 Sensory and bodily contact making**

The child’s ability to develop sensory and bodily awareness is of specific value in the use of the Gestalt approach. Children naturally investigate their surroundings and these aspects afford them the ability to be in contact with their environment. What is of significance is that the traumatised child will desensitise themselves in order to protect the self from more harm (Blom, 2006:90).

Sensory functions include the use of all the senses as previously mentioned. Sensory awareness is crucial as it has a direct influence on the child’s contact-making with the environment. Making sensory contact with the environment enables the child to gain inner strength and build self-confidence (Blom, 2006:90).



### **3.6.3 Strengthening the sense of self**

According to the Gestalt perspective, the child and his/her environment must be seen as two separate aspects of the self. The child's self-esteem is therefore the totality of the real self, present within the child. Therefore the child with the strong sense of self does not protect the self from external harm by employing contact boundaries. "Assistance-rendering to children to develop a strong sense of self is considered a primary prerequisite in order to help them to express suppressed emotions" (Blom, 2006:103). The uplifting of the self is thus of essence in order for the child to benefit from any therapeutic intervention (Blom, 2006:103). Oaklander's (1997) model on the strengthening of the self includes the ability to define themselves as well as providing children with choices to master new experiences and feelings, in order to eventually become able to project their own thoughts and emotions (Blom, 2006:105).

### **3.6.4 Emotional expression**

Blom (2006:119) believes the child must have a strong sense of self before being able to successfully express his/her emotions. All activities used to gain this strong sense of self will also contribute to establishing the I-thou relationship (Blom, 2006:120).

Oaklander (2006:36, 37) explains that to facilitate emotional expression children must be assisted to unlock buried emotions and to learn healthy ways to express their emotions. She discusses a variety of creative, expressive and projective techniques that could assist in achieving emotional expression and makes the following statement: "You might say that we are giving back to children modes of expression that are inherently theirs" (Oaklander, 2006:37). Blom (2006) concurs when stating that different techniques and activities can be used to talk to the child about emotions. This leads to promotion of emotional vocabulary; providing reasons for emotions and recognising emotions in others (Blom, 2006:124, 125).

### **3.6.5 Self-nurturing**

According to Blom (2006:152, 156) the child must learn the value of self-love. It is however of importance to establish the child's inner strength before moving to self-nurturing.

The child that self-blames for the trauma experienced in his/her life might find these aspects becoming introjects (Blom, 2006:151). Oaklander (2006:43) expands on this when she says that children introject and assimilate many faulty messages about themselves from an early age. These faulty messages and introjects interfere with healthy growth. Admitting to bad feelings about the self will enable the child and adolescent to “embark on a self-nurturing journey” (Oaklander, 2006:145).

During self-nurturing, the therapist will assist the child in accepting the aspect within the self that he/she has difficulty to cope with. This would in return lead to the nurturing of the self (Blom, 2006:151). According to Oaklander (2006:162) breathing and relaxation exercises are important tools for self-nurturing. When the child learns these exercises he/she can use them when needed, once the child has “made them their own.” These techniques could thus be incorporated into the Gestalt play therapy and the child should be assisted in the mastering of this self-nurturing tool.

Various techniques are used in Gestalt play therapy. Reference will be made to some of these techniques in the following section.

### **3.7 THE USE OF TECHNIQUES IN GESTALT PLAY THERAPY**

Play as intervention activity, might have both rational and pre-rational meaning for participants. “When we reflect on play... we are making play into a rational activity” (Frost et al., 2012:3). For the child however, using his/her imagination and natural thinking, the right hemisphere is paramount in the process (Frost et al., 2012:3). Henderson and Thompson (2011:560) make the statement that play therapists choose play therapy techniques, referred to as the “therapeutic powers of play”, to help children to express what is troubling them when the expression of thoughts and feelings are difficult. Children are provided with skills and experiences to help overcome adjustment and behavioural difficulties, trauma, or difficulties with emotional or social skills. A sense of competence is built when allowing children to do for themselves and to make decisions while using play therapy techniques.

Various forms of play exist and include creative, expressive, projective and dramatised play, “...for instance clay-play, fantasies, story-telling, puppet-show, sand play, music, body movement and sensory contact-making exercise” (Blom, 2006:20). Geldard et al. (2013:174) describe the use of media or activities used to engage the child. These authors consider the suitability of media and activities based on the

child's age group, the various situations children find themselves in and the suitability of the medium or activity for achieving goals. Blom (2006:20) emphasises that various forms and techniques of play are used during the Gestalt play therapy process, which she describes in the following manner: "...by developing a therapeutic relationship and contact, and according to a specific process, children are given the opportunity to confirm their sense of self and non-verbally, to express their thoughts and to nurture themselves" (Blom, 2006:20). This emphasises the importance of the therapeutic process, discussed above.

Play techniques enable children to project, own and express thoughts and emotions (Blom, 2006:128). Henderson and Thompson (2011:547) point out that projection reveals how children feel about both themselves and significant persons and their respective relationships. Projective techniques are briefly discussed in the following section.

- **Projective techniques**

Gestalt play therapy makes use of several different projective techniques: body movement, drawing, fantasy, games, metaphors and music. "They may interest children, facilitate contact, and further help them explore negative self-image, increase self-acceptance, establish self-worth, and move towards self-nurturing" (Oaklander, 1978 in Drewes & Schaefer, 2010:246). Each technique should be carefully selected in order to facilitate the theme of the session or the group. The techniques should also be selected because of their applicability to the needs of the group as a whole and of the individual adolescent in the group.

Blom (2006:128) states that projection has various functions in children's lives. It provides them with the opportunity to sort out the challenges that they face and to suppress those aspects which they cannot cope with. Schoeman (1996:67,68) describes the positive use of projection during Gestalt play therapy specifically used in the child's here and now; therefore, supporting the child and dealing with problems in the present. Projection is used to stimulate self-growth by making use of self-statements, based on the projection. Projection is also used to solve unfinished business and to assist children to work through the traumas in their lives.

Oaklander (1999) as quoted by Blom (2006:129, 130) is of the view that children must be willing to do the projective technique, such as drawing and painting, playing with clay, puppets or sand, or story-telling. They must be willing to share how it felt to do the projection; they must also be willing to become part and identify with certain objects in the projection. The projection is then owned on a symbolic and personal level in that they find a connection to what they experience in their own lives. Blom (2006:108) states that if children are capable of projection they make statements about themselves and their process, which enable awareness of themselves and the way in which they satisfy their needs.

- **The role of fantasy in play techniques**

Geldard et al. (2013:40) describe the manner in which Oaklander (1988) has demonstrated the combination of Gestalt principles and practice with the use of media when she works with children. “She works therapeutically with children by encouraging them to use fantasy, and believes that usually the fantasy process will be the same as the life process in the child” (Oaklander in Geldard et al., 2013:40). In this manner Oaklander relies on a projective process by working in an indirect way to bring out what is hidden or avoided by the child. She makes the statement that children who are able to be imaginative, cope better and have an improved ability to learn.

Children enjoy fantasy since it creates an avenue for dealing with reality in their own pace and dealing with the aspects that are of most importance to them (Frost et al., 2012:32). Cattanach (2003:25) states that when children play inventively, they create a fictional world, which can be a way of making sense of their real world, despite the context of the play. In order for the child to create this safe world of mastery and achievement, imaginative play is of the utmost importance (Cattanach, 2003:31). “The language of this inquiry is predominantly symbolic, allowing the child to explore their life experiences through such symbolic communication” (Cattanach, 2003:55). Utilising the correct Gestalt play techniques in a group work setting might be challenging, since group work is recognised as a very specific field of intervention. The theme and the play technique must compliment the naturalistic setting that the group work takes place in. Gestalt group work is expanded on in the next section.

### **3.8 GESTALT GROUP WORK**

Frost et al. (2012:393) state that the use of group work as method is growing in popularity. These authors believe that group work as method of intervention will address the needs of the group and applies equally well to the needs of the individual child within the specific group (Frost et al., 2012:393). Within these groups, an average group size ranges between six and eight group members. Groups meet weekly for approximately 12 to 20 weeks and for 45 to 50 minutes at a time (Drewes & Schaefer, 2010:293).

Gestalt therapy is well suited to a group context as it encourages actions and direct experience and not simply 'talking'. The 'here-and-now' focus of the group makes the group livelier and helps members in exploring their fears and anxieties. This enhances increased awareness (Corey, 2013b:213, 214). Some group facilitators favour "homogeneous groupings (similar areas of dysfunctionality); others favour heterogeneous groupings (different personalities, different symptoms)" (Frost et al., 2012:394).

During the therapeutic group, the individual is allowed time to express their own feelings and thus have the opportunity to address and change their challenging behaviour. The therapeutic group therefore aims to bring about change through utilising group work as method (Geldard & Geldard, 2010:91). Therapy groups are an ideal avenue to allow the child greater emotional distance, even for those children with psychiatric disturbances and those who experience some difficulty in coping with the stressors produced by the challenges in life (Geldard & Geldard, 2010:92).

#### **3.8.1 Benefits of group work**

Kadusen and Schaefer (2006:304) depict group work as the best way for the child to learn social skills in a real-life setting with their peers and not as an individual child in psychotherapy with an adult therapist. Group work offers the child a place to develop new behaviours, parallel to behaviours in the outside world. The group creates a safe environment where therapeutic involvement has a place. Where a group leader has a number of child clients who have similar problems or who had similar experiences, it can be to the advantage of the child to work therapeutically within a group work setting (Geldard & Geldard, 2010:90). Including children who all resemble the same categories of problem behaviour, enables them to share insight

and learn from each other's experiences. This becomes useful inputs during the counselling sessions (Geldard & Geldard, 2010:90). Skuse et al. (2011:158) are of the opinion that "[s]ince adolescence is the life stage of amongst others, the acceptance by their peers, it does make sense that group intervention on the behavioural aspects related to the symptoms of ADHD could be addressed successfully in homogeneous groups."

Geldard and Geldard (2010:90) mention that utilising the group setting allows children to discover their similarities with other group members. They come to the realisation that they are not the only ones that have to deal with problems and difficulties and that there are even similarities in how they experience these problems. "This discovery can be very empowering in enabling the children to open up and talk freely with their peers in the group about their personal issues" (Geldard & Geldard, 2010:90). Since the learner diagnosed with ADHD often lacks social interactive skills and experience peer rejection, groups provide a social setting which helps children with social interaction within the safety of the group (Geldard & Geldard, 2010:90). They benefit especially from the feedback that they receive from the other group members. Geldard and Geldard (2010:92) feel that "the benefit of learning social skills through practising new behaviours within a group setting has considerable advantages." The major advantage of group therapy is that it provides a safe social setting for discovering and experimenting with new ways to interact with peers (Kadusen & Schaefer, 2006:304).

These interactions in the group can produce change quickly and more effectively than during individual therapeutic intervention (Geldard & Geldard, 2010:90). Group work can be particularly useful in addressing self-esteem issues, as poor self-esteem can often be the result of a child's inability to interact positively with peers (Geldard & Geldard, 2010:90).

The effectiveness of the group work method in contrast to individual play therapy has often been debated. Most children have not been exposed to group work and prefer individual counselling, but there are children who seem to benefit more from group work and the communal attendance to a particular problem. Group work provides them with an opportunity to learn from their peers, who are struggling with similar behavioural problems (Geldard & Geldard, 2010:89). The researcher is of the view



that, with regards to this research, the inclusiveness of group work might create a mutual understanding amongst adolescents and might shed light on their functioning within the classroom setting.

“When a group plays together in an atmosphere of ownership, bodies relax, and satisfaction, the natural birth right of play, occurs. We have returned to a state of increased wholeness, together” (Schaefer, 2003:308). Schaefer (2003:303) also noticed the value of group work as described by Yalom (1975) who stated that “groups can instil hope, promote a sense of belonging, impart information, cultivate altruism, correct dysfunctional primary family imprints, develop social skills, facilitate socialization, model relational skills, provide emotional support and catharsis, help people bond with each other, and address issues of life’s meaning and purpose.”

Principles and techniques of group work fit in with social work practice. Gestalt play therapy is currently being instituted in schools with rewarding results (Botha & Dunn, 2009 in Senreich, 2013:58). Group work follows specific stages in its progression. These stages are highlighted below.

### **3.8.2 Stages within group work**

According to O’Conner, Hughes, Turney, Wilson and Sutherland (2006:113) the stages in the group’s development are planning, beginning, middle and ending. These stages emphasise both the development of relationships within groups and the idea of being included in a group.

According to Oaklander (1978) in Drewes and Schaefer (2010:246), the development of group dynamics will determine the values for each individual session. “The session typically starts with a round - each member takes turns to share anything of concern since the previous session and ends with a closure activity” (Oaklander, 1978 in Drewes & Schaefer, 2010:246). The emphasis of these interactions is not the products, but children’s concerns or feelings being respected and safely processed (Drewes & Schaefer, 2010:247).

The group facilitator should conceptualise the way in which the group process proceeds, by understanding the different stages within this process. The leader should also be committed to work with the individual and the group, and both parties

should benefit equally from the process. Corey (2012:303) presents the stages in the group work process as the first, second and third stage.

- **First stage**

The first stage of the group is often characterised by uncertainty and restraint. Group members often feel uncertain and wonder about the expectations that they would have to meet. Group members assess each other as well as their position in the group (Toseland & Rivas, 2012:198) as they are dependent on the way in which they will be perceived and responded to by other group members. The group leader provides a climate of trust that will enhance the forming of connections between group members (Corey, 2012:303).

The key aspects of this phase are in the group member's identity with the goal and objectives set out for the group. This process is called identity formation. The group members should realise their dependence on the group work process and the dynamics within the group. The group leader should create a climate of trust, which would provide the group members with the safety to take risks. "Once members discover what they have in common with each other, the group is ready to work on differentiation" (Corey, 2012:303).

According to Corey (2013b:199) contact is made by "seeing, hearing, smelling, touching, and moving." One would thus refer to effective contact making as the process where the individual in the group interacts with the nature of other group members, without losing his/her individuality (Corey, 2013b:199). Growth, as perceived by the individual partaking in group work often ignites change for the group as a whole.

- **Second stage**

The key characteristics during the second stage of the group work process are firstly, the influence that the group work has on the group member, and secondly the counter dependence on the group and its members as developed by the individual within the group. "During this time of transition, the group grapples with issues of influence, authority and control" (Corey, 2012:303). The group leader has the task to assist the group in increasing differentiation, divergence and promoting the flexibility of roles within the group. The group leader takes on the role of group facilitator which



includes a heightened sense of awareness of the norms in the group, encouraging members to challenge norms and to be able to openly display frustration and differentiation (Corey, 2012:303). Corey (2013b:297) is of the opinion that through giving attention to the continuum of awareness which is staying with the moment-to-moment flow of experiencing, group members are discovering how they are functioning in the world. For the child with ADHD, this aspect may bring comfort based on the realisation of their similarities as group members. The group leader is no longer the authoritarian of the group work process, but takes on the role of a consultant to the group (Corey, 2013b:304).

- **Third stage**

Toseland and Rivas (2012:398) make the statement that the group's work is consolidated during the ending stage as consideration is given to how the results of the group work can be implemented successfully. Changes made by individual group members should be stabilised and plans made to maintain changes. In successful groups, mutual aid and support develop as relationships deepen (Toseland & Rivas, 2012:398).

Ending the group could thus have a significant impact on individual group members, and is characterised by elements of intimacy within the group and interdependency amongst group members (Corey, 2012:303). The group members should establish managing and problem solving skills used in the group work process in dealing with issues of influence, power and authority. They are prepared, because of the group work process for a deeper level of progress, individually and within the group. During this final stage, the high level of cohesiveness experienced by group members encourages them to take risks by experimenting with new learning (Corey, 2012:303).

### **3.9 SUMMARY**

The adolescent that displays symptoms related to ADHD as well as parents of these children, are often in desperate need of strategies to address their behaviours. Research has proven the learning of new behaviours through social skills training as successful. Although parents would prefer a quick fix as a solution, the taking of medication alone, does not seem to be sufficient and therapists often suggest a

combination of intervention strategies. During group intervention group members gain better self-awareness through experiencing who they are and what they want, during the phenomenological process orientated dynamics of group work (Drewes & Schaefer, 2010:246). Drewes and Schaefer (2010:244) explain that group work tends to be beneficial since the group provides for a safe place where children can practice newly acquired behaviours, while being advised by their fellow group members and group leaders (Sweeney & Homeyer, 1999; Yalom & Leszcz, 2005 in Drewes & Schaefer, 2010: 244).

In chapter 4 the researcher will discuss the research methodology that was utilised in this research study. The empirical findings, generated from research on the adolescent displaying disruptive behavioural symptoms of ADHD, will also be presented in this chapter.

## CHAPTER 4

### RESEARCH METHODOLOGY AND RESEARCH FINDINGS

#### 4.1 INTRODUCTION

The literature utilised in the previous chapters provides the context for the empirical study. In this chapter, the researcher will present the research methodology utilised in this study and a presentation and interpretation of the empirical findings.

The goal of this study was to explore and describe the effect of Gestalt group work on behavioural aspects of ADHD among adolescents in a school setting. To achieve this goal, the following objectives were set for the empirical study:

- To determine through pretest, mid-point and posttest self-reporting, the extent to which the exposure to Gestalt group work addresses disruptive behavioural aspects of ADHD in the school setting.
- To determine the effectiveness of Gestalt group work in addressing behavioural aspects of ADHD based on the above measurements.

The following hypothesis was formulated for the study: *Exposure to Gestalt group work will have a positive effect on behavioural aspects of ADHD among adolescents in a school setting.* Key findings and conclusions were employed in the testing of the hypothesis.

This chapter is divided into three main sections, namely the research methodology, Gestalt group work as intervention, the empirical findings and interpretation of the quantitative data. A presentation of the research methodology applied in this research is outlined in the following section.

#### 4.2 RESEARCH METHODOLOGY

The research methodology utilised in this study will be discussed by focussing on the research approach followed, the type of research, the research design, research methods and the ethical aspects that applied during the research process.

#### **4.2.1 Research approach**

In conducting quantitative research the researcher could determine the effect of Gestalt group work on behavioural aspects of ADHD among adolescents in a school setting. The effect was measured by using a quantitative data gathering instrument. Delport and Roestenburg (2011a:172) state that measuring is one of the best means of creating objective scientific knowledge. This objective knowledge, obtained by means of empirical evidence, was effective in reaching a specific and precise understanding of aspects of an already well defined social problem (Fouché & De Vos, 2011:91).

#### **4.2.2 Type of research**

As explained by Fouché and De Vos (2011:95) applied research aims at solving problems in practice and helping practitioners to accomplish specific tasks. The researcher therefore focused on the effect of Gestalt group work on the behavioural aspects associated with ADHD among adolescent learners. The utilisation of applied research could enable practitioners and social workers to develop insight into this phenomenon and could provide guidelines for addressing the disruptive behavioural aspects associated with ADHD among adolescent learners in a school setting (Jansen, 2016:9).

#### **4.2.3 Research design**

A single-system research design was implemented during the research to determine the effectiveness of Gestalt group work in addressing the disruptive behavioural aspects in a naturalistic setting, namely the school setting. The single-system design is an investigative method, intended to help researchers explore the effect of the intended intervention. This requires repeated measuring of a single respondent at regular intervals (Strydom, 2011a:169). In this study, the behaviour related to ADHD among adolescent learners in a classroom setting was measured by means of respondent self-reporting. Comparisons were made between the measurements as acquired before, during and after the intervention (Graziano & Raulin, 2000 in Strydom, 2011a:161).

The single-system design was implemented in three phases: the baseline control phase, the intervention and then a return to the baseline phase. The initial behaviour

was measured. This measurement served as a basis for comparison with the measurements taken during and after the intervention (Strydom, 2011a:162). The measurements were imperative in establishing a cause and effect relationship between variables (Strydom, 2011a:160). The single-system design was therefore appropriate in determining the effectiveness and the impact of Gestalt group work.

#### **4.2.4 Research methods**

In this section, the researcher provides details on how the study was undertaken. The specific methods and techniques implemented will be addressed. The study's population and sampling, data collection and analysis, will be discussed.

##### **4.2.4.1 The study population and sampling**

The research population for this study was adolescents in a specific school in Gauteng, who have previously been assessed by an educational psychologist and who present with symptoms and behavioural aspects associated with ADHD. The learners at this school represent all races, religions, cultures and genders. A government facility (the school buildings, specifically a classroom in this facility) were utilised for the purpose of this research.

The researcher is a school social worker at this facility and as part of the school based support team provides mainly psycho-social support. As opposed to this, the educational psychologist focuses on learners with ADHD, as well as learners with learning disabilities. In this school, the researcher was faced with the difficulty of singling out individuals presenting with behavioural symptoms associated with ADHD, for the purpose of participating in the Gestalt group work sessions. Therefore, the educational psychologist approached parents and guardians of learners diagnosed with ADHD, regarding possible participation in the study. Only after informed consent was provided by these parents and guardians, were the names of the learners made known to the researcher, who then approached the learners for obtaining informed assent. The process was followed until seven respondents were identified.

The researcher utilised non-probability sampling. According to Strydom and Delport (2011:391), in non-probability sampling the odds of selecting an individual or object

are not known, since the researcher does not know the population size or the members of the population.

As a “particular case is chosen because it illustrates some features or process that is of interest for a particular study”, the researcher utilised purposive sampling for the selection of the respondents (Strydom & Delpport, 2011:392). As suggested by Strydom and Delpport (2011:392), learners were selected according to specific criteria and also with a specific purpose in mind (Maree & Pietersen, 2016a:198). For the purpose of this study, the researcher selected seven adolescent learners between the ages of 14 and 17 years old, who took part in the research through attending Gestalt group work sessions. The selection took place with the assistance of the educational psychologist, as described above. All the respondents were previously assessed by the educational psychologist and diagnosed with ADHD.

The following criteria applied in terms of selection:

- Adolescent learners who display symptoms of ADHD and disruptive behaviour,
- Adolescent learners between the ages of 14 and 17 years,
- Adolescent learners who are either male or female and of any race, religion or culture and
- Adolescent learners who are able to converse in English.

Permission to conduct the research was granted by the Gauteng Department of Education (See appendix 1). Strict guidelines set out by the Gauteng Department of Education were followed in the gaining of informed consent and informed assent from the selected respondents and their parents. The department also granted the researcher permission to conduct the research at a school and informed the Headmaster that the research will be taking place at this school. The headmaster also granted written permission to conduct the research and to involve learners who had been diagnosed with ADHD, before the research took place (See appendix 2).

#### **4.2.4.2 Data collection**

In this study, data was collected by means of a self-report scale. According to Neuman, 2006 (in Delpport & Roestenburg, 2011b:207) a scale can be described as “a measure in which a researcher captures the intensity, direction, and level or

potency of a variable” (Neuman, 2006 in Delport & Roestenburg, 2011b:207). Maree and Pietersen (2016b:186) describes a scale as a common and useful way of measuring how respondents feel or think about a specific issue. The researcher made use of the ‘Current ADHD symptoms scale self-report’ before, during and after the implementation of Gestalt group work as method of intervention (See attached as appendix 3). This is a four-item Likert scale, based on a scale frequency ranging from ‘never or rarely’ to ‘very often’. The scale was developed in conjunction with the World Health Organisation and the Work Group on ADHD, which included experts from several universities. It also included experts and researchers in the field of ADHD from the New York University Medical School and the Harvard Medical School. This scale has also been developed according to the criteria for ADHD, as categorised in the DSM-IV. Furthermore, the scale was standardised for diagnosing ADHD in the general population (Adler et al., 2006:145-148).

Adolescent learners, who displayed behavioural aspects relating to ADHD and who were previously diagnosed with ADHD, took part in the study. The adolescent respondents completed the ‘Current ADHD symptoms scale self-report’, by recognising and rating their own symptoms and behavioural traits. The independent variable, the Gestalt group work was then implemented. A measurement was taken by the respondents during the intervention (after session four) and measured again by using the same scale, after termination of the intervention (session eight). The three sets of data were analysed and the outcomes compared, in order to establish any possible behavioural changes within the individual respondent, as noted by the respondents themselves (Graziano & Raulin, 2000 in Strydom, 2011a:161).

#### **4.2.4.3 Data analysis**

Respondents were engaged in a Gestalt group work process (independent variable) for the duration of eight sessions, within a 12-week period. The self-report scale enabled the researcher in collecting relevant data before, during and after the Gestalt group work sessions. Fouchè and Bartley (2011:249) indicate that “before analysing the data, one has to make sure of the measurement level of the data that were collected”, and therefore all quantitative data can be divided into two categories, namely categorical and numerical data. This indicates the way data was analysed through the application of statistical measures.



The data collected for this study was analysed statistically, through the univariate method of analysis. Computerised worksheets in Excel enabled the researcher to structure findings and to make the most valid and objective recommendations through organised interpretation of data collected (Fouchè & Bartley, 2011:248, 250, 251). The data will be presented graphically followed by an analysis of the data. Data is analysed to determine relationships between variables (Strydom, 2011a:162-164).

#### **4.2.4.4 Reliability and validity**

According to Delpont and Roestenburg (2011a:172), “validity refers to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration.” Pietersen and Maree (2016:239) concur by means of the following statement: “The validity of an instrument refers to the extent to which it measures what it is supposed to measure.” Validity is intertwined with synonyms such as truthfulness, accuracy, authenticity, genuineness and soundness. Delpont and Roestenburg (2011a:173) state that validity has two central and important aspects: firstly, that the measuring instrument measures the concepts in question and secondly that the concepts are measured accurately. It was thus of utmost importance that the researcher establishes that the measuring instrument used in this research, meets the requirements for validity.

Reliability, according to Delpont and Roestenburg (2011a:177), is used to establish the dependability, consistency, stability, trustworthiness, predictability and faithfulness of the data-collecting method. “Reliability occurs when an instrument measures the same thing more than once and results in the same outcomes” (Delpont & Roestenburg, 2011a:177).

According to Glesne (2006:442), “quantitative researchers view validity and reliability as the main means of establishing rigor in social science research.” Proving validity and reliability for the quantitative approach was established using standardised procedures, with measurability through data analysis, interpretation and presentation. Results could thus be verified and controlled (Fouchè & Delpont, 2011:73).

The standardised measuring instrument used in this research was developed and tested through empirical methods of instrument development. With this instrument, as with all standardised instruments, validity and reliability depends highly on the

assessment result of the “internal consistency of symptom scores” as assessed by Cronbach’s alpha (Adler et al., 2006:145-148). “Agreement of ration was established by intra-class correlation coefficients (ICCs) between scales” (Adler et al., 2006:145-148). In this scale, the Cronbach’s alpha indicated a high level of internal consistency with scores obtained being 0.88 and 0.89 respectively. “The ICC between scales for total scores was also high; 0.84” (Adler et al., 2006:145-148).

#### **4.2.5. Pilot study**

Even though the ‘Current ADHD symptoms scale self-report’ is a standardised instrument, there was a need to test the relevance and appropriateness of the instrument for this study. Two learners who present with the symptoms and disruptive behavioural aspects associated with ADHD, whose parents provided informed consent, were requested to complete the scale.

The data gathered during the pilot test was utilised to determine whether the data gathering instrument is adequate and appropriate for the gathering of data in the proposed study (Strydom, 2011b:237). The ‘Current ADHD symptoms scale self-report’ was found to be appropriate to use with a sample of adolescents diagnosed with ADHD as it seemed that they were able to score their own disruptive behaviour by means of this scale.

#### **4.2.6 Ethical considerations**

Ethical clearance to conduct the research was granted by the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (See ethical clearance attached as appendix 4). It was of utmost importance that the respondents, in this case, adolescents younger than 18 years, were treated appropriately and in an ethically correct manner. The ethical issues discussed below were identified as applicable to the study.

##### **4.2.6.1 Avoidance of harm**

According to Babbie, 2007 (in Strydom, 2011c:115), the primary rule of social research is that it should bring no harm to the respondents. Everything the researcher does, could have possibly harmed someone and the researcher should weigh the possible risks against the possible benefits of the study. Respondents might not be harmed in a physical manner; but in this study, emotional harm might

have been a concern. “Emotional harm to subjects is often more difficult to predict and to determine than physical discomfort, but often has more far-reaching consequences for respondents” (Strydom, 2011c:115). When conducting the research, the researcher was therefore ethically obligated to protect the respondents within reasonable limits (Strydom, 2011c:115). The researcher was vigilant for any signs of emotional harm and had an educational psychologist to the disposal of the respondents. No incidents of emotional harm however occurred during the study.

#### **4.2.6.2 Informed consent and assent**

The educational psychologist approached parents of learners diagnosed with ADHD regarding possible participation in the study. Only when informed consent had been provided by the parent or guardian of the learner (See appendix 5) were the names of the learners provided to the researcher, who approached them in order to obtain their informed assent (See appendix 6). Obtaining informed consent and informed assent implied that all adequate information regarding the study; the duration, involvement, procedures, advantages, disadvantages and dangers, were shared with respondents (Strydom, 2011c:117). Informed assent refers to the process where minors may agree to participate in research studies (Strydom, 2011c:117). Having them participate without their assent would have been an infringement on their right to self-determination (Strydom, 2011c:117).

#### **4.2.6.3 Voluntary participation**

According to Rubin and Babbie, 2005 (in Strydom, 2011c:116) participation should be voluntary. The researcher clearly explained this aspect to respondents. The respondents had the opportunity to withdraw their participation at any stage, should they no longer wish to take part. None of the respondents withdrew their participation from the study.

#### **4.2.6.4 Violation of privacy**

Every respondent had the right to privacy and it is his/her right to decide when, where, to whom and to what extent information will be revealed (Strydom, 2011c:119). The researcher ensured that this principle was not violated at any time. Confidentiality further implied that others’ access to private information should be limited. In this study, the researcher and the educational psychologist were the only

persons aware of any private information of respondents. The researcher made use of pseudonyms; a name that was assigned to a respondent for the purpose of the research and which differs from the learner's original name. Confidential information gained from these respondents was never made available to any other person. The researcher handled all information with care to ensure that the privacy of the respondent was not violated (Strydom, 2011c:119).

#### **4.2.6.5 Debriefing of respondents**

Debriefing refers to sessions in which respondents are given the opportunity, after the study, to work through experiences and have their questions answered (Strydom, 2011c:122). The researcher debriefed the respondents after the research by clarifying possible misconceptions. No respondent reported any misconception or discomfort.

#### **4.2.6.6 Publication of findings**

The findings of this research will be presented as a written document in a research report format and will contain reliable information which can be used by future researchers (Strydom, 2011c:126). Findings will be released in such a manner that it can be useful to others, keeping the ethical consideration of privacy in mind. The researcher will provide the results of the study to the Department of Social Work and Criminology at the University of Pretoria. The researcher will ensure that all relevant information is clear and understandable. A manuscript, co-authored by the supervisor will be submitted for possible publication.

#### **4.2.6.7 Denial of treatment**

The researcher was not conducting experimental research and did not make use of a control group. Denial of treatment was therefore not an ethical consideration in this study (Strydom, 2011c:121).

#### **4.2.6.8 Actions and competence of researcher**

According to Walliman, 2006 (in Strydom, 2011c:123) researchers are ethically obligated to ensure that they are competent, honest and skilled. "Research should be based on mutual trust, acceptance, cooperation, promises and all-accepted conventions and expectations between all parties involved in the research project"

(Strydom, 2011c:123). The researcher was constantly aware of the ethical considerations and conducted the study in a professional and ethical manner.

#### **4.2.6.9 Deception of respondents**

The researcher had no need to withhold information and did not mislead respondents. No deception arose during this research that the researcher was at any time aware of. The respondents were informed that the research was conducted as part of postgraduate studies and not on behalf of the school (Babbie, 2007 in Strydom, 2011c:119).

In the following section an overview of the Gestalt group work sessions will be presented.

### **4.3 GESTALT GROUP WORK AS INTERVENTION**

Seven adolescent learners, diagnosed with ADHD, representing both genders and of diverse backgrounds and cultures, were selected to attend eight Gestalt group work sessions. The researcher planned the themes for each group session in accordance with themes relating to disruptive behavioural aspects of ADHD.

Group sessions were structured in the following manner: The session started with an icebreaker. The main activity consisted of a Gestalt play technique, followed by a discussion. The session was concluded with music and a relaxation exercise. The content of the Gestalt group sessions is presented in Table 4.1.



**Table 4.1: Gestalt group work sessions**

<b>Session</b>	<b>Objective(s)</b>	<b>Activities</b>
<b>1</b>	<ul style="list-style-type: none"> <li>Facilitating introductions; clarifying goal and objectives; building trust and group cohesion</li> </ul>	<ul style="list-style-type: none"> <li>Icebreaker</li> <li>Introduction of group members</li> <li>Group members discuss goal and expectations of group work</li> <li>Discussion of content of structured group sessions</li> <li>Discuss group rules</li> <li>Music and relaxation exercise</li> </ul>
<b>2</b>	<ul style="list-style-type: none"> <li>Creating sensory awareness</li> </ul>	<ul style="list-style-type: none"> <li>Icebreaker</li> <li>Activities for creating awareness of the five senses: touch, smell, taste, hearing, vision</li> <li>Group discussion based on the above activities</li> <li>Music and relaxation exercise</li> </ul>
<b>3</b>	<ul style="list-style-type: none"> <li>Enhancing emotional awareness</li> </ul>	<ul style="list-style-type: none"> <li>Icebreaker</li> <li>Activity: playing music selected by each group member while drawing emotions</li> <li>Group discussion of emotions in general, based on the music and drawings by group members</li> <li>Music and relaxation exercise</li> </ul>
<b>4</b>	<ul style="list-style-type: none"> <li>Strengthening of sense of self</li> </ul>	<ul style="list-style-type: none"> <li>Icebreaker</li> <li>Activity: draw body outline</li> <li>Group discussion of the activity; discuss strong points and aspects that need improvement in terms of functioning. Facilitating I-statements and choices</li> <li>Music and relaxation exercise</li> </ul>
<b>5</b>	<ul style="list-style-type: none"> <li>Emotional expression: Exploring emotions related to the manifestation of disruptive behaviors</li> </ul>	<ul style="list-style-type: none"> <li>Icebreaker</li> <li>Activity: role-play</li> <li>Group discussion of different emotions identified during role-plays</li> <li>Music and relaxation exercise</li> </ul>
<b>6</b>	<ul style="list-style-type: none"> <li>Emotional expression: Being labeled as: 'A child with ADHD'</li> </ul>	<ul style="list-style-type: none"> <li>Icebreaker</li> <li>Activity: colour my heart</li> <li>Group discussion of frustrations, feelings of rejection, abandonment</li> </ul>



		<ul style="list-style-type: none"> <li>• Music and relaxation exercise</li> </ul>
7	<ul style="list-style-type: none"> <li>• Coping mechanisms and self-nurturing</li> </ul>	<ul style="list-style-type: none"> <li>• Icebreaker</li> <li>• Activity: listing coping strategies and messages of accepting the self</li> <li>• Group discussion of coping strategies and positive messages</li> <li>• Music and relaxation exercise</li> </ul>
8	<ul style="list-style-type: none"> <li>• Termination of group work</li> </ul>	<ul style="list-style-type: none"> <li>• Icebreaker</li> <li>• Termination: evaluation of the group work experience</li> <li>• Discussing the maintaining and generalising of changes in behaviour in the future; discussion of feelings regarding termination</li> <li>• Acknowledgement of participation: giving of certificates and a lunch pack</li> <li>• Music and relaxation exercise</li> </ul>

Empirical findings and interpretation of quantitative data are presented in the next section.

#### 4.4 EMPIRICAL FINDINGS AND INTERPRETATION OF QUANTITATIVE DATA

The empirical results of the data collected during this study are presented in two sub-sections, namely the biographical profile of respondents and empirical findings and interpretation.

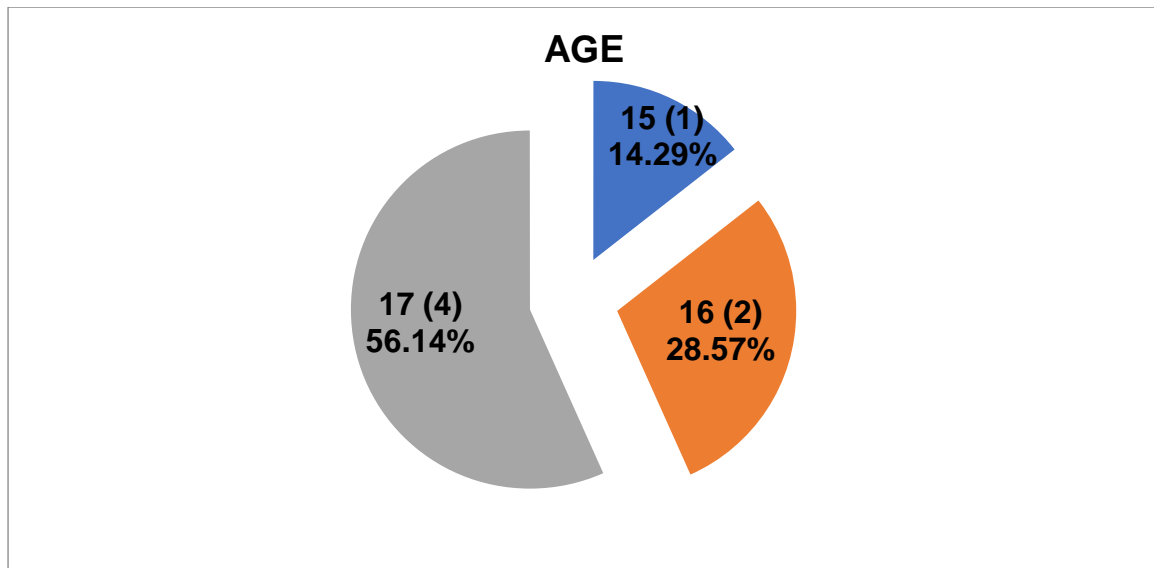
##### 4.4.1 Biographical profile of the respondents

The biographical profile of the respondents will be described according to age and gender of the respondents.

##### 4.4.1.1 Age of the respondents and developmental stage

The research respondents were all in the secondary school phase of their education. Their ages ranged from 15 to 17 years. They were also in the developmental life stage of adolescence. This life stage is characterised by rebelliousness. It is typically within this stage for the adolescent to be in conflict with people in authority positions, such as their parents or educators (Louw & Louw, 2010:281).





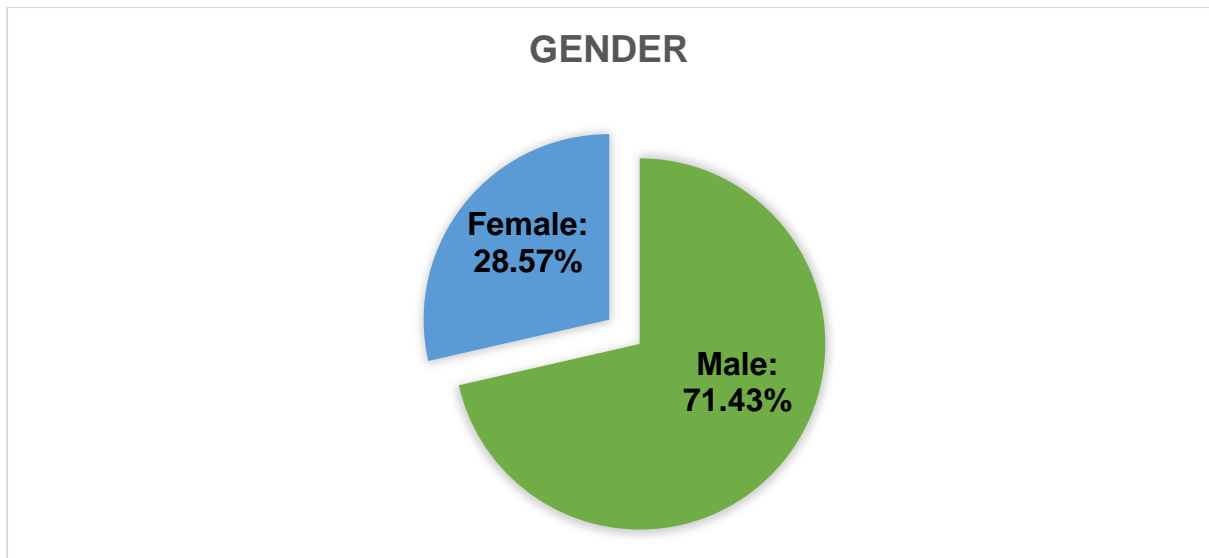
**Figure 4.1: Age composition of respondents**

Figure 4.1 above indicates the ages of the respondents. One respondent (14.29%) was 15 years old. The two 16-year-old respondents represented 28.57% of the respondent group, while four respondents (56.14%) were 17 years old.

Therefore, the group of 15 and 16 year olds represented a total of 42.86% of the respondents, while the 17-year-old respondents comprised 57.14% of the respondent group. The mean age of respondents was ( $\bar{x}=15.86$ ;  $SD=0.69$ ). The fact that all the respondents were in the same life stage, namely adolescence, made this a homogeneous group. An element of diversity was however included in the group as four of the group members were White, one group member was Coloured, while the remaining two group members were Black.

#### **4.4.1.2 Gender of respondents**

Both genders are represented within the school setting.



**Figure 4.2: Gender composition of respondents**

Both male and female respondents took part in the research. The majority of the respondents, namely five were male (71.43%), while only two of the respondents were female (28.57%). According to Louw and Louw (2010:28), ADHD is known to be diagnosed more frequently amongst males. Research studies by Louw and Louw (2010:28) have shown that the incidence of ADHD is as much as three times more prevalent amongst boys. This could therefore explain the higher percentage of boys in the research sample, as indicated in Figure 4.2 above.

#### **4.4.2. Empirical findings and interpretation of data**

Empirical data were collected by means of the 'Current ADHD symptoms scale self-report' (Adler et al., 2006:145-148). The scale was provided to each group member by the researcher and was completed individually in the absence of the rest of the group members. The goal of this study was to explore and describe the effect of Gestalt group work on the behavioural aspects associated with ADHD among adolescent learners in a school setting. In order to reach this goal, Gestalt groups were conducted for eight sessions over a period of 12 weeks, using Gestalt play techniques.

According to the DSM-V (2013:59-60), ADHD is characterised by two components, namely 'inattention' and 'hyperactivity and impulsivity'. These two components of ADHD form the basis of the 'Current ADHD symptoms scale self-report', as the 18

questions can clearly be divided into these two categories. The questions relevant to these categories are indicated below:

### **ADHD characterised by inattention**

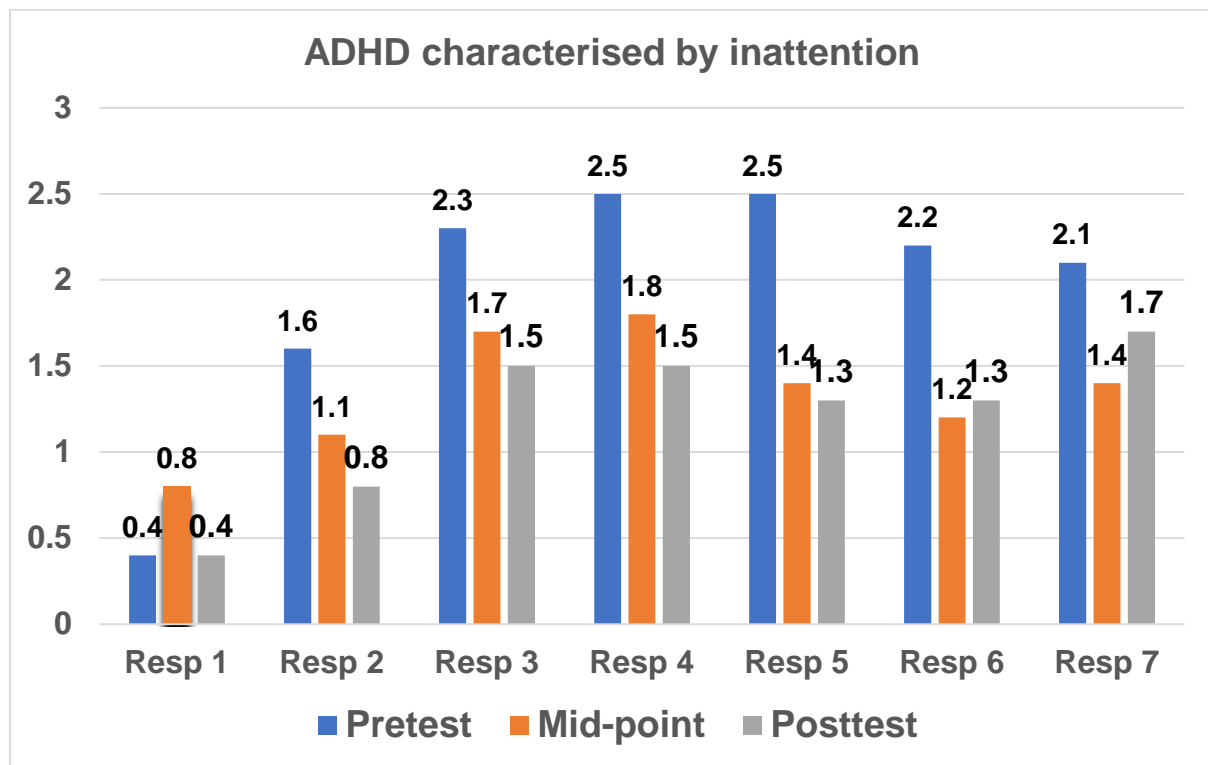
- Fail to give close attention to details or make careless mistakes in my work (Question 1)
- Difficulty sustaining my attention in tasks or fun activities (Question 3)
- Don't listen when spoken to directly (Question 5)
- Don't follow through on instructions and fail to finish work (Question 7)
- Having difficulty organizing tasks and activities (Question 9)
- Avoid, dislike or am reluctant to engage in work that requires sustained mental effort (Question 11)
- Lose things necessary for tasks or activities (Question 13)
- Easily distracted (Question 15)
- Forgetful in daily activities (Question 17).

### **ADHD characterised by hyperactivity and impulsivity**

- Fidget with hands or feet or squirm in seat (Question 2)
- Leave my seat in classroom or in other situations in which seating is expected (Question 4)
- Feel restless (Question 6)
- Have difficulty engaging in leisure activities or doing fun things quietly (Question 8)
- Feel "on the go" or "driven by motor" (Question 10)
- Talk excessively (Question 12)
- Blur out answers before questions have been completed (Question 14)
- Have difficulty awaiting turn (Question 16)
- Interrupt or intrude on others (Question 18).

The content of the questions was equally divided in terms of these two characteristics of ADHD, which indicated a balanced representation of the two main components of ADHD. The respondents' answers to the questions on this self-report scale were measured on a 4-point Likert scale, rated from '0' being 'never or rarely' to '3' being 'very often'. This rating from 0 to 3 applied to all the 18 questions.

ADHD as characterised by **inattention** will be presented in Figure 4.3.



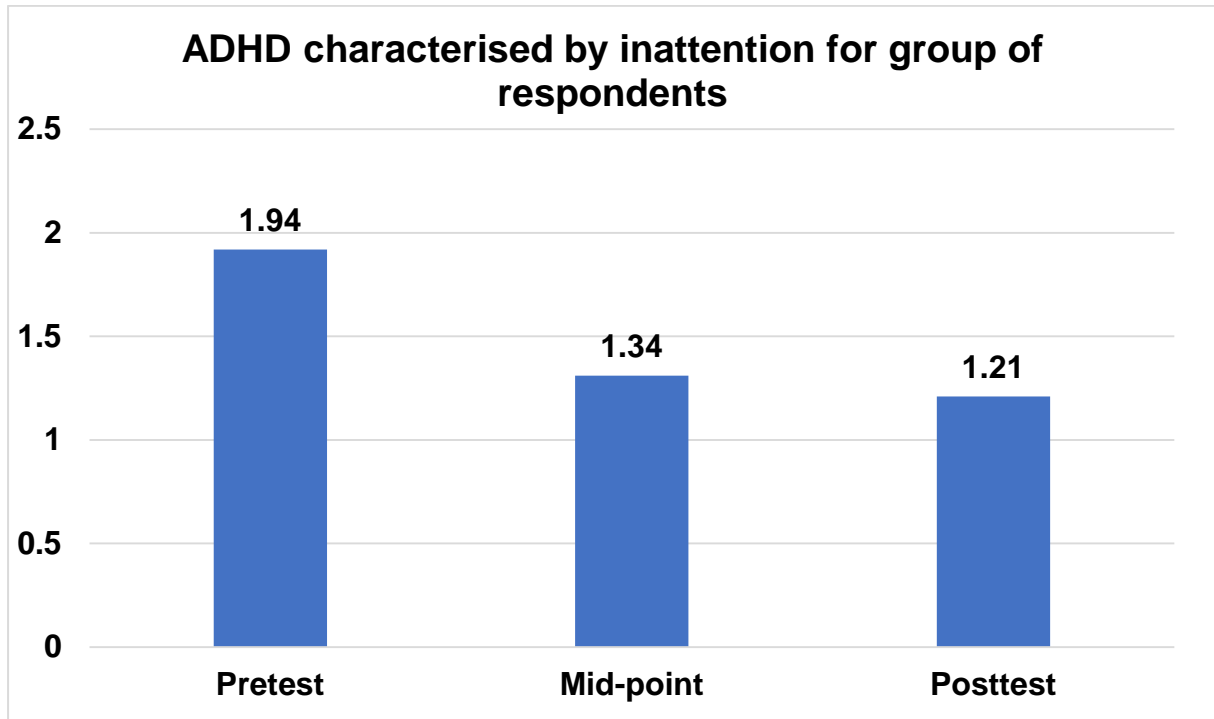
**Figure 4.3: ADHD characterised by inattention**

Figure 4.3 above indicates the responses of the seven respondents on the 4-point Likert scale for the nine questions on the ‘Current ADHD symptoms scale self-report’, that reflect the qualities of the construct ADHD characterised by inattention. Each respondent’s mean score is indicated for the pretest, mid-point and posttest.

Respondents 2, 3 and 4 perceived that their inattentive behaviour had improved during the course of the Gestalt group work process as their mean scores from the pretest to the posttest decreased respectively from 1.6 to 0.8 for respondent 2; from 2.3 to 1.5 for respondent 3 and from 2.5 to 1.5 for respondent 4. Respondents 5, 6 and 7 initially indicated a high acknowledgement of their inattentive behaviour. It appears that two of the three respondents, namely respondent 6 and 7 believed they could not sustain the change as the findings indicate a slight deterioration when measured from the mid-point to the posttest. Figure 4.3 however indicates an overall acknowledgement of inattention and an improvement in these three respondents’ disruptive behavioural symptoms categorised by inattention, as perceived by them. Respondent 1 scored inattention at 0.4 during the pre- and posttest, with a slight deterioration of attention at 0.8 during the mid-point self-scoring. Creating awareness

of ‘inattention’ during the pretest could have prompted the higher score during the mid-point.

It is of interest to this research to consider inattention as characteristic of ADHD for the group as a whole. The pretest, mid-point and posttest self-scoring of inattention for **the group as a whole** are therefore presented in Figure 4.4 below.

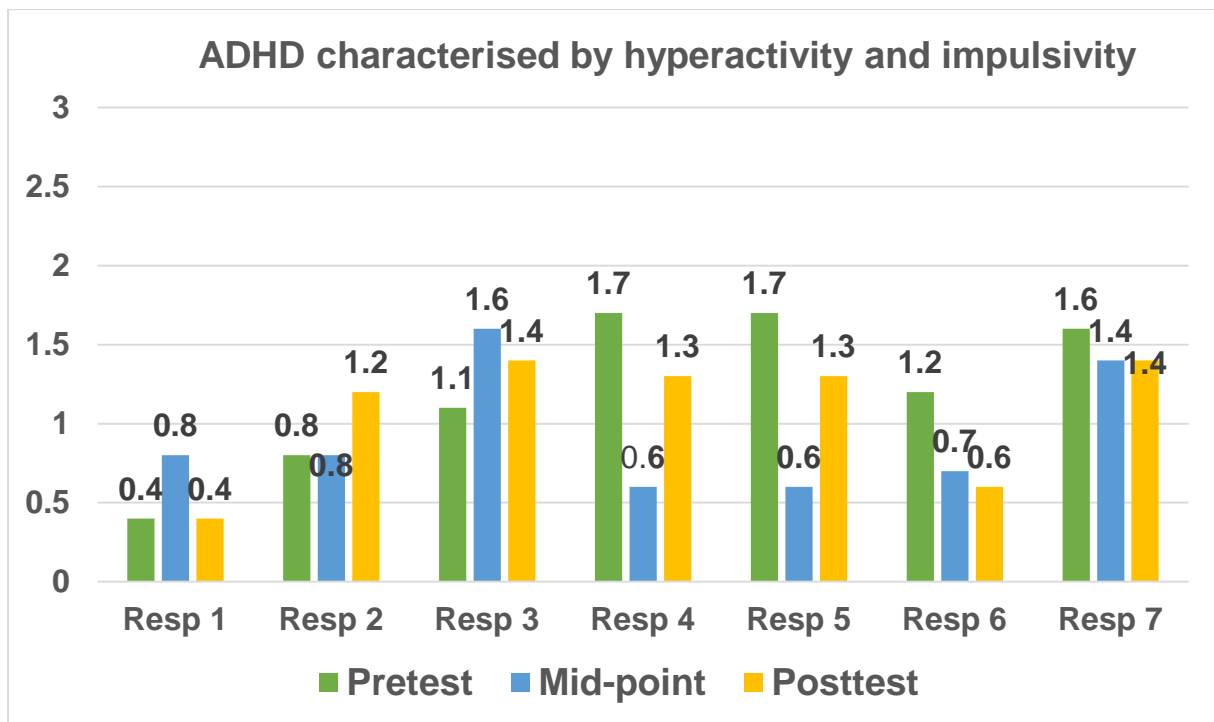


**Figure 4.4: ADHD characterised by inattention for the group of respondents**

During the pretest the ‘group of respondents’ indicated their recognition of inattention as a characteristic of ADHD with a mean score of ( $\bar{x}=1.94$ ;SD=0.75) on the 4-point Likert scale (see Figure 4.4 above). During the mid-point self-reporting, the respondents as a group scored an improvement in their inattention with a mean score of ( $\bar{x}=1.34$ ;SD=0.35) with regards to their perception of the influence of this specific characteristic of ADHD. The mid-point measurement took place after the first four Gestalt group work sessions were completed. During this measurement, the respondents perceived that their behaviour with regards to inattention had improved, as a much lower mean score was obtained. The final self-reporting took place after the completion and termination of the group work process. The score yet again indicated a slight improvement in inattentive behaviour with a mean score of ( $\bar{x}=1.21$ ;SD=0.46) for the group as a whole.

It is noteworthy that the respondents were able to observe their own inattention, since the generalisation is often made that ADHD is characterised by hyperactivity and impulsivity (Mash & Wolfe, 2010:120). The respondent with ADHD characterised by inattention would typically not interrupt the flow within the classroom by moving around and talking out loud. They would rather interrupt the theme of the lesson or not be able to sustain attention for the duration of the entire lesson (Mash & Wolfe, 2010:120). From the findings above it is evident that inattention as characteristic of ADHD measured lower after completion of the Gestalt group work, than before participating in the Gestalt group work sessions.

ADHD as characterised by **hyperactivity and impulsivity** will be discussed in the next section and findings will be presented in Figure 4.5



**Figure 4.5: ADHD characterised by hyperactivity and impulsivity**

Figure 4.5 above indicates the responses of the seven respondents respectively to the questions on the 'Current ADHD symptoms scale self-report', related to ADHD characterised by hyperactivity and impulsivity. Each respondent's mean score is indicated for the pretest, mid-point and the posttest.

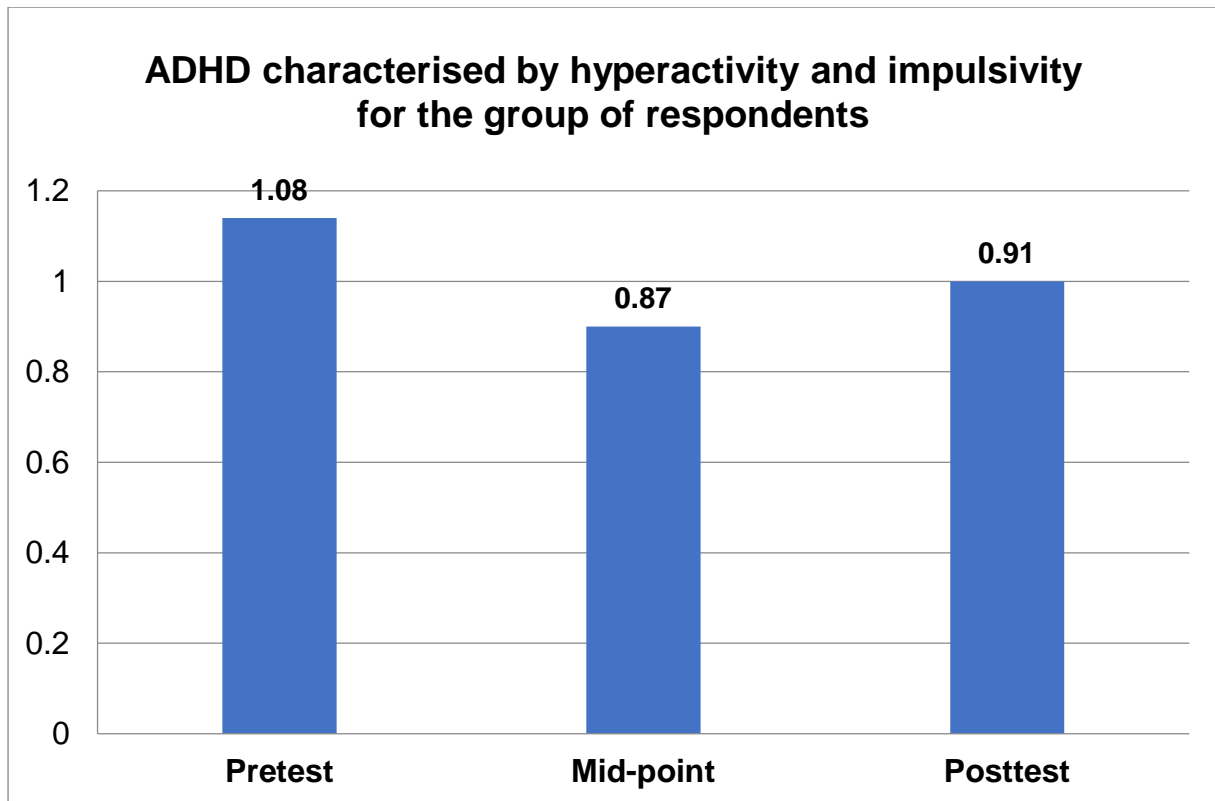
Respondents 4, 5, 6 and 7 perceived that their disruptive behaviour had improved during the Gestalt group work process, as their mean scores for the pretest and the

posttest decreased respectively from 1.7 to 1.3 (respondent 4); 1.7 to 1.3 (respondent 5); 1.2 to 0.6 (respondent 6) and 1.6 to 1.4 (respondent 7). Respondents 4, 5 and 7 initially indicated a high acknowledgement of their disruptive behaviour. It appears that two of the four respondents indicate deterioration in behaviour when measured from the mid-point to the posttest. Figure 4.5 however indicates an overall acknowledgement of hyperactivity and impulsivity, as well as an improvement in these four respondents' disruptive behavioural symptoms as perceived by them.

In contrast to the above, respondents 1, 2 and 3 reported a relatively low mean score for ADHD characterised by hyperactivity and impulsivity during the pretest, with respondent 1 scoring 0.4; respondent 2 scoring 0.8 and respondent 3 scoring 1.1. It appears that these three respondents were of the opinion that their disruptive behaviour, characterised by hyperactivity and impulsivity had either remained unchanged or had deteriorated when considering the mean scores at the pretest versus the mean scores at the posttest. Gestalt group work therefore seemed not to have been the most appropriate intervention strategy for all the respondents, since it did not have the desired effect on the disruptive behaviour of these three respondents.

The pretest, mid-point and posttest self-scoring of these characteristics for **the group as a whole** are presented in Figure 4.6 below.





**Figure 4.6: ADHD characterised by hyperactivity and impulsivity for the group of respondents**

During the pretest the group of respondents indicated their recognition of hyperactivity and impulsivity as a characteristic of ADHD with a mean score of ( $\bar{x}=1.08$ ;SD=0.35) on the 4-point Likert scale (see Figure 4.6 above). During the mid-point self-reporting, the respondents as a group scored an improvement in their hyperactivity and impulsivity with a mean score of ( $\bar{x}=0.87$ ;SD=0.35) with regards to their perception of the influence of this specific characteristic of ADHD. The final self-reporting took place after the completion and termination of the group work process. The score however indicated a slight deterioration in this characteristic of ADHD with a mean score of ( $\bar{x}=0.91$ ;SD=0.37) for the group as a whole.

Self-reporting by the group of respondents indicates an awareness of their disruptive behaviour, characterised by hyperactivity and impulsivity. From the findings above it is evident that hyperactivity and impulsivity as a characteristic of ADHD measured lower after completion of the Gestalt group work than before participating in the Gestalt group work sessions, when comparing the pretest and the posttest self-reporting by respondents as a group. It therefore seems as if the Gestalt groups had a positive impact on hyperactivity and impulsivity as behavioural aspects of ADHD. It

is also understandable from the nature of this characteristic, that change is challenging (Louw & Louw, 2010:235) and that it would take time to master alternative and less disruptive behaviour within the school setting, as presented in the discussion of the empirical findings.

#### **4.4.3 Discussion of empirical findings**

As stated in Louw and Louw (2010:281), adolescence is in itself a difficult life stage, recognised by challenging and even rebellious behaviour. Learners diagnosed with ADHD could thus benefit from Gestalt group work and social skills training, with the focus on understanding the symptoms of ADHD. The school setting seems not to be conducive to educating the adolescent diagnosed with ADHD, since teachers and fellow classmates cannot continuously accommodate disruptions. According to Drewes and Schaefer (2010:489), a huge contributor to a diagnosis of ADHD is the child's tendency to disrupt the school setting. The learner diagnosed with ADHD should thus be empowered to control these negative behavioural aspects in order to function appropriately within the classroom.

ADHD is characterised by two sub-categories, namely inattention, as well as hyperactivity and impulsivity. These sub-categories measured by respondents by means of the self-reporting scale, indicate a decline in disruptive behavioural aspects of ADHD. This was however scored, based on the perspectives of the respondents.

The DSM-V (2013:59) defines inattention as "wandering off task, lacking persistence, having difficulty sustaining focus, and being disorganized and is not due to defiance or lack of comprehension"; aspects important to modify within the school setting. Although characteristics of ADHD associated with hyperactivity and impulsivity are usually the first to be noticed, it is important that counsellors, educators and parents are made aware of the less noticeable characteristic namely inattention, since this may be the more disabling disruptive behavioural element that complicates the ability of the child to sustain attention within the school setting (Louw & Louw, 2010:234).

After attending the first four Gestalt group work sessions, inattention as characteristic of ADHD declined for all but one of the respondents. Session one and two dealt with being part of a group and becoming comfortable with the group work process, by focussing on introductions, clarifying the goal of the Gestalt group work and creating

sensory awareness. The focus of session 3 was on the enhancing of emotional awareness. The researcher considered that encouraging the adolescent to become aware implies that he/she is placed in contact with himself/herself on a cognitive functioning level as well as a sensory and affective level. This also involves being in contact with other group members as well as with the environment (Blom, 2006:53).

The theme for session 4 was strengthening of the sense of self, aimed at building a strong sense of self and an improved self-esteem (Blom, 2006:103). As indicated by Blom (2006:103) assisting children to develop a strong sense of self is considered a primary prerequisite in helping them to express suppressed emotions. Strengthening the sense of self enables the adolescent to make choices in order to master new experiences and feelings. This leads to the ability to project own thoughts and emotions (Blom, 2006:105).

After the mid-point scoring, session 5 focused on emotional expression, themed to complement the exploring of emotions related to the manifestation of disruptive behaviours. To facilitate emotional expression children must be assisted to unlock buried emotions and to learn healthy ways to express their emotions (Oaklander, 2006:36, 37). Session 6 built onto the theme and placed an emphasis on emotional expression with specific reference to the aspect of being labelled as a child diagnosed with ADHD, since this aspect continuously surface within the school setting. The theme for session 7 was related to coping mechanisms and self-nurturing. During this session, the adolescent was assisted to accept aspects of the self that are difficult to cope with. This could lead to the nurturing of the self (Blom, 2006:151). According to Oaklander (2006:162) breathing and relaxation exercises are important tools for self-nurturing. During session 8 the group work process was terminated. This session focused on an evaluation of the Gestalt group experience and ways to maintain changes, in order to adjust disruptive behaviour associated with the characteristics of ADHD. During the mid-point measurement, after session four the respondents perceived that their behaviour with regards to inattention had improved, as a much lower mean score was obtained. The final self-reporting took place after the completion and termination of the group work process. The score yet again indicated a slight improvement in inattentive behaviour for the group.

ADHD characterised by hyperactivity and impulsivity was also addressed by the Gestalt group work sessions. Four of the respondents scored lower on the 'Current ADHD symptoms scale self-report' after four Gestalt group work sessions and thus perceived their disruptive behaviour associated with the disorder as improved between sessions 1 and 4. Three respondents indicated that their behaviour characterised by hyperactivity and impulsivity did not improve during the Gestalt group work process. However, when considering the overall score for the respondents as a group, hyperactivity and impulsivity as characteristic of ADHD measured lower. This comparison could be made by considering the pretest and the posttest results as measured by the self-reporting scale, completed by respondents. Therefore, group sessions seemed to address negative disruptive behaviour and the consequences thereof within the classroom by creating an awareness of these aspects of ADHD amongst the respondents, indicating a decline in disruptive behaviour associated with the characteristics of hyperactivity and impulsivity. Gestalt group work sessions might not effectively address all behavioural symptoms of ADHD or all the needs of the individuals in the group. This is evident in the scores of three respondents not indicating improved behaviour. The researcher believes being part of a group gave the respondent the opportunity to recognise his/her behaviour through self-reporting and discussion with the rest of the group members. Geldard and Geldard (2010:90) emphasise that insight is developed when group members learn from each other's experiences.

The group discussions seemed to create awareness among group members that they could relate to each other and discuss common concerns addressed by the group themes. The group setting therefore allowed group members to discover their similarities with other group members. This discovery seemed to be empowering in allowing group members to open up and talk freely with their peers (Geldard & Geldard, 2010:90). The activities utilised during group sessions created awareness among the respondents of their frustrations, as well as unfinished business because of a diagnosis of ADHD. Respondents felt confident in engaging in the creative activities and the discussions that were generated by these activities. The group members were able to assist one another through the process of acknowledging and expressing their emotions (Blom, 2006:123). Grounding of the group as a whole was essential for the stabilising of emotions evoked during the group sessions. In the

researcher's view this was created using relaxation and music (Oaklander, 2006:162). Music to release tension created during the group sessions, was utilised after every Gestalt group work session (Blom, 2006:101, 102).

Gestalt group work created an opportunity for the seven respondents to associate with each other's struggles created through a diagnosis of ADHD. Group members could learn from their peers who are struggling with similar behavioural problems (Geldard & Geldard, 2010:89). The group sessions therefore assisted the respondents in acknowledging their similarities and differences, as well as assist each other in coping more effectively in their environments. The group experience created a mutual understanding among the respondents which could clarify their functioning in the classroom setting. It was the perception of respondents that their inattention, as well as hyperactivity and impulsiveness associated with ADHD improved during and after termination of the group work sessions.

#### **4.5 SUMMARY**

This chapter provided a presentation of research methodology used during the study, research findings as well as an analysis and interpretation of the empirical findings with regards to the adolescent diagnosed with ADHD and their response to Gestalt group work as method of intervention.

The research methodology entailed an overview of the research approach, type of research which was implemented, research methods and ethical considerations applied during this research study. The empirical findings were presented in two sections. The first section focused on the biographical profile of respondents, while the empirical findings were presented in the form of figures and graphs, followed by a discussion of the research findings.

The following chapter will provide the key findings and conclusions of the research, as well as recommendations for practitioners and for future research.

## CHAPTER 5

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 INTRODUCTION

In the previous chapter, the researcher presented the quantitative research findings. The purpose of this chapter is to conclude the research study. The researcher will indicate how the goal and objectives of the research were met. A presentation of the key findings of the study will be followed by conclusions and recommendations based on the research.

#### 5.2 ACCOMPLISHMENT OF THE RESEARCH GOAL AND OBJECTIVES

The accomplishment of the research goal and objectives are of importance to determine whether the research can be regarded as successful. The manner and extent, to which the goal and objectives were achieved, will be demonstrated in the following section.

##### 5.2.1 Goal of the study

The goal of this study was to explore and describe the effect of Gestalt group work on behavioural aspects of ADHD among adolescents in a school setting. The goal was successfully achieved through the implementation of appropriate research methodology. The researcher made use of applied research, a quantitative research approach and a single-system design. Within this design, pretest, mid-point and posttest measurements were recorded by means of a self-report scale. Data were statistically analysed and findings were graphically presented. The research goal was further accomplished by focussing on the objectives formulated for the study.

##### 5.2.2 Objectives of the study

The research objectives were obtained by means of a thorough review of appropriate literature and an in-depth analysis of empirical findings, demonstrated in chapters two and three, and in chapter four respectively. In the following discussion, the researcher will focus on the manner in which these objectives were achieved.

**Objective 1: To contextualise ADHD and the behavioural aspects of ADHD, as well as adolescence as a life stage**

This objective was achieved in chapter 2 by means of the contextualising of ADHD as a chronic disorder. The components that characterise ADHD were described in paragraph 2.2 and discussed as ‘inattention’ and ‘hyperactivity and impulsivity’. The prevalence and manifestation of ADHD were presented, as well as co-morbid conditions (paragraph 2.3). The various manners in which a diagnosis of ADHD is established (paragraph 2.5) and the probable causes of ADHD (paragraph 2.6) were presented in this chapter. General behavioural aspects of ADHD (paragraph 2.7), specifically behavioural manifestation of ADHD in adolescence (paragraph 2.8) formed a crucial aspect of the literature study. In terms of the research, establishing the challenges faced by the adolescent with ADHD was essential. This aspect was discussed in paragraph 2.9, with a specific focus on parental issues, the impact of socio-economic status, intelligence and social skills. Challenges within the school setting were specifically focused on.

In addition to the above, the researcher contextualised strategies for addressing ADHD in chapter 3. Medication, social skills training, family and group counselling, as well as Gestalt play therapy were briefly discussed (paragraphs 3.2 and 3.3). Gestalt play therapy was elaborated on by discussing theoretical concepts, the objectives of play therapy, the therapeutic process and the use of techniques in Gestalt play therapy (paragraphs 3.4 – 3.7). The contextualisation was concluded with a discussion of Gestalt group work in paragraph 3.8.

**Objective 2: To determine through pretest, mid-point and posttest self-reporting, the extent to which the exposure to Gestalt group work addresses disruptive behavioural aspects of ADHD in the school setting**

The extent to which the exposure to Gestalt group work addressed disruptive behavioural aspects of ADHD was determined through pretest, mid-point and posttest measurements. Disruptive behavioural aspects were measured by means of self-reporting using the ‘Current ADHD symptoms scale self-report’. Comparisons were made between the measurements as acquired before, during and again after the intervention. Research findings and interpretations were presented in Chapter 4 (paragraph 4.4). These findings reported on ADHD characterised by inattention for



the seven individual respondents and for the group of respondents. Findings were also presented for ADHD characterised by hyperactivity and impulsivity for the seven individual respondents, as well as for the group of respondents as a whole (paragraph 4.4.2).

**Objective 3: To determine the effectiveness of Gestalt group work in addressing behavioural aspects of ADHD based on the above measurements**

The effectiveness of Gestalt group work in addressing behavioural aspects of ADHD was determined through the above-mentioned measurements. Measurement was imperative in establishing a cause and effect relationship between variables. Three sets of data were analysed and the outcomes compared, to establish any possible behavioural changes within the individual respondent, as well as for the group. Changes in behavioural aspects of ADHD, as reported by the respondents themselves, could be ascribed to the impact of Gestalt group work (independent variable). These findings were presented in paragraph 4.4.2.

**Objective 4: To make recommendations for practitioners regarding the implementation of Gestalt group work in order to address behavioural aspects of ADHD amongst adolescents in a school setting**

Chapter 5, (paragraph 5.6) outlines the recommendations for practitioners regarding Gestalt group work as intervention in addressing behavioural aspects of ADHD amongst adolescent learners. These recommendations are based on the research findings and interpretations presented in Chapter 4. In the following sections the hypothesis and key findings of the study will be discussed.

### **5.3 HYPOTHESIS**

The following hypothesis was formulated for the study: *Exposure to Gestalt group work will have a positive effect on behavioural aspects of ADHD among adolescents in a school setting.* Key findings and conclusions were employed in the testing of the hypothesis. The key findings (presented in paragraph 5.4) and subsequent conclusions, derived from the empirical findings (presented in paragraph 5.5.2) confirm the hypothesis. As such, the hypothesis is accepted.

## 5.4 KEY FINDINGS

Key findings were presented in chapter 4 by distinguishing between self-scoring of behavioural aspects of ADHD characterised by ‘inattention’ and behavioural aspects of ADHD characterised by ‘hyperactivity and impulsivity’. As previously discussed, Gestalt group work was introduced as independent variable in addressing behaviour in group context.

### Key findings on ADHD characterised by inattention:

- Respondents 2, 3 and 4 (thus three respondents) portrayed in their self-scoring that their inattentive behaviour had improved as their mean scores from the pretest to the posttest decreased respectively from 1.6 to 0.8; from 2.3 to 1.5 and from 2.5 to 1.5.
- Respondents 5, 6 and 7 (thus three additional respondents) indicated a high acknowledgement of their inattentive behaviour during the pretest. Respondent 6 and 7 indicated that they could not sustain behaviour change as the findings indicate a slight deterioration when measured from the mid-point to the posttest; respectively from 1.2 to 1.3 and from 1.4 to 1.7. An overall improvement in these three respondents’ disruptive behavioural symptoms categorised by inattention and as perceived by them, was however indicated.
- Respondent 1 scored inattention at 0.4 during the pre- and posttest, with a slight deterioration of attention at 0.8 during the mid-point self-scoring. Awareness of ‘inattention’ during the mid-point could have prompted the higher score. Thus, for one respondent no improvement in behavioural symptoms categorised by inattention, was indicated as the pre- and posttest scores remained the same.
- Inattention for **group of respondents**: During the pretest the group of respondents indicated their awareness of inattention as a characteristic of ADHD with a mean score of 1.94 on the 4-point Likert scale. Mid-point scoring for the group showed an improvement with a mean score of 1.34. The posttest indicated a further improvement in inattentive behaviour with a mean score of 1.21.

### **Key findings on ADHD characterised by hyperactivity and impulsivity:**

- Respondents 4, 5, 6 and 7 (thus four respondents) revealed by means of self-scoring that their hyperactive and impulsive behaviour had improved as their mean scores from the pretest to the posttest decreased respectively from 1.7 to 1.3; 1.7 to 1.3; 1.2 to 0.6 and 1.6 to 1.4. Respondents 4, 5 and 7 initially indicated a high acknowledgement of their disruptive behaviour. Two of the four respondents indicated deterioration in behaviour when measured from the mid-point to the posttest (respondents 4 and 5).
- In contrast, respondents 1, 2 and 3 (thus three respondents) reported a relatively low mean score for ADHD characterised by hyperactivity and impulsivity during the pretest, with respondent 1 scoring 0.4; respondent 2 scoring 0.8 and respondent 3 scoring 1.1. The disruptive behaviour of these three respondents therefore had either remained unchanged or had deteriorated when considering the mean scores at the pretest versus the mean scores at the posttest.
- Hyperactivity and impulsivity for **group of respondents**: During the pretest the group of respondents indicated their awareness of hyperactivity and impulsivity as characteristics of ADHD with a mean score of 1.08 on the 4-point Likert scale. Mid-point scoring for the group showed an improvement with a mean score of 0.87. The post-test as the final self-reporting indicated a slight deterioration in terms of this specific characteristic of ADHD with a mean score of 0.91.

## **5.5 CONCLUSIONS**

Through the research study the researcher could explore and describe the effect of Gestalt group work on behavioural aspects of ADHD among adolescents in a school setting. Conclusions can be made based on the literature study and on the empirical study.

### **5.5.1 Literature review**

The conclusions derived from the literature review are outlined in the bullet points below:

- ADHD is a neurological brain disorder, which is a lifelong, chronic condition; there are no short cuts in the intervention of children diagnosed with this disorder.
- ADHD has a high co-morbidity to other diagnosable psychological abnormalities, such as mood disorders and anxiety disorders.
- Behavioural symptoms of ADHD are described in the DSM-V. ADHD is characterised by two components, namely 'inattention' and 'hyperactivity and impulsivity'.
- Behavioural symptoms of ADHD impact on the adolescent's social functioning. Peer interaction is often problematic; subsequently these adolescents are often rejected by the peer group.
- The adolescent with ADHD endures several challenges including parental issues, poor social skills, the inability to delay gratification and a school setting which is experienced as challenging.
- Medication as an intervention strategy is not a quick fix and should always be used in conjunction with other strategies. Family therapy is recommended since parents are often worn down by the process of assisting the adolescent living with this disorder.
- The therapeutic process starts off by building a therapeutic relationship, followed by the therapist assisting the child/adolescent in becoming sensory and bodily aware.
- Gestalt therapy is vibrant, present-centered, humanistic, process-orientated with a focus on involving the body, senses, emotions and the intellect.
- Group work as method of intervention is especially effective since it creates a platform for children and adolescents to discuss acceptable and unacceptable social behaviour with peers and fellow group members.

### **5.5.2 Empirical findings**

Conclusions based on the empirical research are outlined below:

- Gestalt play therapy provided the theoretical basis for group work with seven adolescents diagnosed with ADHD. Gestalt play created awareness among the respondents of their own behaviour which initiated a willingness to change.

- Group work as intervention created a positive environment in which respondents from different races and genders could feel sufficiently comfortable to express their feelings and frustrations.
- Group work empowered respondents to identify and discuss the issue of acceptable and unacceptable social behaviour with their peers as fellow group members.
- Research findings indicated that although each respondent had a different take on their personal behavioural symptoms, inattention, as well as hyperactivity and impulsivity played an equally determining role in the disruptiveness of the respondents' behaviour.
- Gestalt group work as method of intervention seemed to have a positive effect on disruptive behaviour related to ADHD. The group as a whole had improved their behaviour for both the characteristics of ADHD.
- Gestalt group work had a positive impact on awareness and improvement of inattention as behavioural aspect of ADHD for the group as a whole.
- Behavioural aspects characterised by hyperactivity and impulsivity for the group of respondents had improved through the application of Gestalt play techniques. The group of respondents therefore perceived that they had benefitted in terms of the improvement of this behavioral aspect of ADHD.

## 5.6 RECOMMENDATIONS

- It is recommended that educators are sufficiently trained regarding ADHD in order to comprehend the nature of this disorder and the impact thereof on the learner and fellow learners in the classroom. Such training will enable the educator in identifying and managing the disruptive behaviour of learners within the school setting more effectively.
- It is further recommended that the parents/caregivers of the child/adolescent with ADHD be advised regarding appropriate resources to assist the child diagnosed with ADHD and ensuring his/her improved ability to adapt within the classroom. The learner should become aware of his/her diagnosis, the symptoms and the disruptiveness of the behaviour, the impact that this behaviour has in the classroom and the resources available for the child in addressing challenges.

- School governing bodies should become aware of the negative influence that ADHD has on the child or adolescent's academic abilities and his/her social failure in the peer group. Learners should have access to the professional services of school social workers who are able to utilise group work as method of intervention in order to address disruptive behaviour displayed by children diagnosed with ADHD.
- Group work as method of intervention should be implemented by social workers within school settings in order to assist the child/adolescent with ADHD in managing these disruptive symptoms. Life skills training should be considered as a theme for these groups.
- During group work, social workers should enable the child/adolescent with ADHD to identify with the struggles of peers diagnosed with this condition to collaboratively learn how to cope with ADHD within the school setting.
- Groups for learners diagnosed with ADHD should run over a longer time period, exposing the child/adolescent to even more peer interaction, as well as a greater variety of life skills within the structured environment of themed Gestalt group work. The groups should function from a Gestalt framework in order to create a platform for positive interaction between the group leader, the individual participant as well as the group as a whole.
- A further in-depth study based on employing Gestalt group work as a method of intervention with the school-going child should be undertaken. The focus of this study could be to empower adolescent learners with coping skills to alter negative behaviour. The study could determine whether Gestalt group work as method of intervention plays a role in them coping in other areas of life, such as academically and socially.

## **5.7 CONCLUDING REMARKS**

The adolescent diagnosed with ADHD is characterised by the negative behavioural symptoms associated with this disorder. He/she also needs to cope with the challenges relating to adolescence as a life stage. It is thus clear that in order for the adolescent diagnosed with ADHD to cope within the school setting, some form of intervention or combination of interventions is advisable. Social skills training along with all other methods of intervention, such as group work, medication and family counselling are thus advised to address the disruptive behaviour displayed.



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Schools should accommodate a school social worker or counsellor with training in amongst others, play-based intervention in assisting the child or adolescent diagnosed with ADHD in their daily struggle towards academic and social success. This might positively contribute towards a smoother functioning classroom and make the learning experience more accommodating for teachers, learners with ADHD and the other learners in the classroom situation.



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## APPENDIX 1: PERMISSION BY GAUTENG DEPARTMENT OF EDUCATION



## GAUTENG PROVINCE

Department: Education  
REPUBLIC OF SOUTH AFRICA

For administrative use:  
Reference no: D2015 / 065

### GDE RESEARCH APPROVAL LETTER

Date:	14 May 2014
Validity of Research Approval:	14 May 2014 to 3 October 2014
Name of Researcher:	Serfontein M.
Address of Researcher:	P.O. Box 5396
	Rietvalleirand
	0174
Telephone Number:	012 771 2156; 083 259 1166
Fax Number:	012 807 0109
Email address:	mserfontein@willowridge.co.za
Research Topic:	The effect of "Gestalt" group work on behavioural aspects of ADHD among adolescents in a school setting
Number and type of schools:	ONE Secondary School
District/s/HO	Gauteng East

**Re: Approval in Respect of Request to Conduct Research**

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both Principal and SGB) and the District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted.

The following conditions apply to GDE research. The researcher may proceed with the above study subject to the conditions listed below being met. Approval may be withdrawn should any of the conditions listed below be flouted:

*Handwritten signature*  
2014/05/14

1

*Making education a societal priority*

**Office of the Director: Knowledge Management and Research**

9<sup>th</sup> Floor, 111 Commissioner Street, Johannesburg, 2001  
P.O. Box 7710, Johannesburg, 2000 Tel: (011) 355 0506  
Email: David.Makhado@gauteng.gov.za  
Website: www.education.gpg.gov.za





1. The District/Head Office Senior Manager/s concerned must be presented with a copy of this letter that would indicate that the said researcher/s has/have been granted permission from the Gauteng Department of Education to conduct the research study.
2. The District/Head Office Senior Manager/s must be approached separately, and in writing, for permission to involve District/Head Office Officials in the project.
3. A copy of this letter must be forwarded to the school principal and the chairperson of the School Governing Body (SGB) that would indicate that the researcher/s have been granted permission from the Gauteng Department of Education to conduct the research study.
4. A letter / document that outlines the purpose of the research and the anticipated outcomes of such research must be made available to the principals, SGBs and District/Head Office Senior Managers of the schools and districts/offices concerned, respectively.
5. The Researcher will make every effort obtain the goodwill and co-operation of all the GDE officials, principals, and chairpersons of the SGBs, teachers and learners involved. Persons who offer their co-operation will not receive additional remuneration from the Department while those that opt not to participate will not be penalised in any way.
6. Research may only be conducted after school hours so that the normal school programme is not interrupted. The Principal (if at a school) and/or Director (if at a district/head office) must be consulted about an appropriate time when the researcher/s may carry out their research at the sites that they manage.
7. Research may only commence from the second week of February and must be concluded before the beginning of the last quarter of the academic year. If incomplete, an amended Research Approval letter may be requested to conduct research in the following year.
8. Items 6 and 7 will not apply to any research effort being undertaken on behalf of the GDE. Such research will have been commissioned and be paid for by the Gauteng Department of Education.
9. It is the researcher's responsibility to obtain written parental consent of all learners that are expected to participate in the study.
10. The researcher is responsible for supplying and utilising his/her own research resources, such as stationery, photocopies, transport, faxes and telephones and should not depend on the goodwill of the institutions and/or the offices visited for supplying such resources.
11. The names of the GDE officials, schools, principals, parents, teachers and learners that participate in the study may not appear in the research report without the written consent of each of these individuals and/or organisations.
12. On completion of the study the researcher/s must supply the Director: Knowledge Management & Research with one Hard Cover bound and an electronic copy of the research.
13. The researcher may be expected to provide short presentations on the purpose, findings and recommendations of his/her research to both GDE officials and the schools concerned.
14. Should the researcher have been involved with research at a school and/or a district/head office level, the Director concerned must also be supplied with a brief summary of the purpose, findings and recommendations of the research study.

The Gauteng Department of Education wishes you well in this important undertaking and looks forward to examining the findings of your research study.

Kind regards

  
.....

Dr David Makhado

Director: Education Research and Knowledge Management

DATE: 2014/05/14  
.....

2

**Making education a societal priority**

**Office of the Director: Knowledge Management and Research**

9<sup>th</sup> Floor, 111 Commissioner Street, Johannesburg, 2001  
P.O. Box 7710, Johannesburg, 2000 Tel: (011) 355 0506  
Email: David.Makhado@gauteng.gov.za  
Website: www.education.gpg.gov.za

## APPENDIX 2: PERMISSION BY HEADMASTER OF SCHOOL IN PRETORIA



# WILLOWRIDGE HIGH SCHOOL

518 Verkenner Avenue • The Willows • Pretoria

Tel: (012) 807 3423  
Fax: (012) 807 0109  
e-mail: wrhs@icon.co.za



PO Box 72262  
LYNNWOOD RIDGE, 0040  
www.willowridge.co.za

8 August 2014

Dear Mrs. M. Serfontein,

**PERMISSION TO CONDUCT A STUDY ON THE EFFECT OF GESTAL GROUP WORK ON BEHAVIOURAL ASPECTS OF ADHD AMONG ADOLESCENTS IN A SCHOOL SETTING.**

Permission is hereby granted to Marianna Serfontein to have contact with the learners and their parents/guardians at Willowridge High School in order to conduct research for post graduate studies at the University of Pretoria.

The permission is granted with the understanding that all information gathered will be kept confidential at all times and that the research will be conducted in an ethical manner.

Yours truly

Mr. A. du Plessis

Headmaster

## APPENDIX 3: CURRENT ADHD SYMPTOMS SCALE SELF-REPORT

## CURRENT ADHD SYMPTOMS SCALE SELF-REPORT

Name \_\_\_\_\_ Date \_\_\_\_\_

### Instructions

Please circle the number next to each item that best describes your behavior

**DURING THE PAST 6 MONTHS.**

Items:	Never or Rarely 0	Some- times 1	Often 2	Very Often 3
1. Fail to give close attention to details or make careless mistakes in my work	0	1	2	3
2. Fidget with hands or feet or squirm in seat	0	1	2	3
3. Difficulty sustaining my attention in tasks or fun activities	0	1	2	3
4. Leave my seat in classroom or in other situations in which seating is expected	0	1	2	3
5. Don't listen when spoken to directly	0	1	2	3
6. Feel restless	0	1	2	3
7. Don't follow through on instructions and fail to finish work	0	1	2	3
8. Have difficulty engaging in leisure activities or doing fun things quietly	0	1	2	3
9. Having difficulty organizing tasks and activities	0	1	2	3
10. Feel "on the go" or "driven by a motor"	0	1	2	3
11. Avoid, dislike, or am reluctant to engage in work that requires sustained mental effort	0	1	2	3
12. Talk excessively	0	1	2	3
13. Lose things necessary for tasks or activities	0	1	2	3
14. Blur out answers before questions have been completed	0	1	2	3
15. Easily distracted	0	1	2	3
16. Have difficulty awaiting turn	0	1	2	3
17. Forgetful in daily activities	0	1	2	3
18. Interrupt or intrude on others	0	1	2	3

## APPENDIX 4: ETHICAL CLEARANCE BY FACULTY OF HUMANITIES



20 August 2014

Dear Prof Lombard

**Project:** The effect of Gestalt group work on behavioural aspects of ADHD among adolescents in a school setting  
**Researcher:** M Serfontein  
**Supervisor:** Dr H Hall  
**Department:** Social Work and Criminology  
**Reference numbers:** 87166926

Thank you for your response to the Committee's letter of 8 July 2014.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** at an *ad hoc* meeting on 20 August 2014. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

**Prof Karen Harris**  
**Acting Chair: Postgraduate Committee &**  
**Research Ethics Committee**  
**Faculty of Humanities**  
**UNIVERSITY OF PRETORIA**  
**e-mail:Karen.harris@up.ac.za**



## APPENDIX 5: INFORMED CONSENT FORM



**Researcher:** Ms Mariana Serfontein, University of Pretoria, Lynnwood Road, Pretoria  
MSW (Play Therapy)  
**Contact details:** Tel. 083 2591 166

## GUARDIAN'S INFORMED CONSENT

**Name of participant:** .....

**1. Title of Study**

The effect of Gestalt group work on behavioural aspects of ADHD among adolescents in a school setting.

**2. Purpose of the study**

The purpose of the study is to explore and describe the effect of Gestalt group work on behavioural aspects of ADHD among adolescents in a school setting.

**3. Procedures**

The adolescent (research respondent) will complete a self-report scale (Current ADHD symptom scale self-report). He/she will then participate in twelve Gestalt group work sessions. During the sessions, the adolescent will participate in theme based group work activities. After the twelve sessions, the adolescent will complete the Current ADHD symptom scale self-report again.

**4. Possible discomfort**

I understand that participating in the research study will mean talking about symptoms and behavioural experiences that relate to ADHD. I trust that the researcher will do her best to minimise emotional discomfort. If I feel at any point that the adolescent is not comfortable with the theme based activities in the Gestalt group work sessions, I can talk to the researcher. If needed, the researcher will refer the adolescent for counseling to the school's educational psychologist. These services will be provided free of charge.

**5. Benefits of the study**

I understand that there may not be any immediate benefits resulting from participating in the research. The research may however assist the adolescent in managing behavioural aspects of ADHD within the classroom setting.

**6. Right of participation**

I have the right to withdraw the adolescent from the study at any time. I understand that there will be no negative consequences resulting from such withdrawal. Ms Serfontein will respect my decision.

**7. Financial compensation**

I am aware that there is no financial compensation for the adolescent participating in the research study.

**8. Confidentiality**

Reports will be compiled to record the progress of the sessions. Ms Serfontein will be the only one to have direct access to these reports. In compiling documents, Ms Serfontein will not use real names. The research information will be stored in a safe place at the University of Pretoria for 15 years. The results of the study may be used for further studies.

9. If I have any questions I can contact Ms Serfontein on Tel 083 2591 166 at any time.

I understand my rights as the parent/guardian of a research participant and would like to help with this study. I understand what the study is about, why and how it is being done.

.....  
**SIGNATURE: PARENT/GUARDIAN**

.....  
**DATE**

.....  
**SIGNATURE: RESEARCHER**

.....  
**DATE**

## APPENDIX 6: INFORMED ASSENT FORM



**Researcher:** Ms Mariana Serfontein, University of Pretoria, Lynnwood Road, Pretoria

MSW (Play Therapy)

**Contact details:** Tel: 0832591166

**INFORMED ASSENT: PARTICIPANT**

**Name of the participant:** .....

**1. Title of Study**

The effect of Gestalt group work on behavioural aspects of ADHD among adolescents in a school setting.

**2. Purpose of the study**

The purpose of the study is to explore and describe the effect of Gestalt group work on behavioural aspects of ADHD among adolescents in a school setting.

**3. Procedures**

I will complete a self-report scale (Current ADHD symptoms scale self-report) regarding behavioural aspects and symptoms of ADHD. I will then participate in twelve Gestalt group work sessions with Ms Serfontein. In the sessions, I will participate in theme based activities. After the twelve group work sessions, I will complete the Current ADHD symptom scale self-report again.

**4. Possible discomfort**

I understand that participating in the research study will mean talking about symptoms and behavioural aspects of ADHD, which I have experienced within the classroom setting. If I feel at any point that I am not comfortable with the theme based activities in the group work sessions, I can talk to my parent/guardian. I can also tell Ms Serfontein and she will refer me to the educational psychologist for counseling.

**5. Benefits of the study**

I understand that I may learn more about my symptoms and about behavioural aspects of ADHD within the classroom setting.

**6. Right of participation**

If at any point I wish to stop participating in the Gestalt group work sessions, I have the right to tell Ms Serfontein that I do not want to continue. Ms Serfontein will respect my decision.

**7. Financial compensation**

I will not get any financial compensation for participating in the research study.

**8. Confidentiality**

Notes and reports will be compiled to record the progress of the sessions. Ms Serfontein will be the only one to have access to these documents. In compiling the reports, Ms Serfontein will not use my real name. The research information will be stored in a safe place at the University of Pretoria for 15 years. The results of the study may be used for further studies.

If I have any questions I can ask Ms Serfontein or have my parent/guardian contact her on Tel. 083 2591 166 at any time.

I understand my rights as a research participant and would like to help with this study. I understand what the study is about, why and how it is being done.

.....  
**SIGNATURE: PARTICIPANT**

.....  
**DATE**

.....  
**SIGNATURE: RESEARCHER**

.....  
**DATE**