Exploring how the Subjective Wellbeing of Young, Traumatized Children with Anxiety can be Supported

by

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DECLARATION OF OWNERSHIP

I, Ingrid du Plessis, declare that the study titled: Exploring how the subjective wellbeing of young, traumatized children with anxiety can be supported is my original work. All sources and literature citations have been acknowledged in-text and referenced in full.

Signature: .....

Date: .....

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ABSTRACT

The experience of childhood trauma and adversity is related to a wide range of negative outcomes that may potentially span into adulthood and over a lifetime. Childhood anxiety is often the outcome of traumatic experiences, with some estimates indicating high prevalence in the South African context. However, very few studies have been done on the lived experiences of young children at the intersection of trauma, anxiety, and optimal ways in which they can be supported to ensure wellbeing. The purpose of this study was to explore and explain how the subjective wellbeing of young, traumatized children with anxiety could be supported. The study adopted a qualitative interpretive phenomenological research design that included elements of both van Manen's method and the Innsbruck Vignette Research methodology, which was conducted during a comprehensive psychological support intervention. Theoretically, the study was guided by Bronfenbrenner's Ecological Systems Theory, in conjunction with fundamental tenets of Positive Psychology. The study was conducted at a primary school in Fairland, Gauteng. Participants included young children (n=5) with anxiety, as well as their parents and teachers. An integrative psychotherapeutic intervention process was conducted with the participants over an eight- to 10-week period. Data collection consisted of drawings, semi-structured questionnaires, observations, artifact collection, field notes, vignettes, voice recordings, and video recordings of each assessment and therapy session that took place. Data analysis was done by means of phenomenological theme analysis and a comprehensive set of vignettes. The findings from the study indicate that the subjective wellbeing of young, traumatized children with anxiety can be supported by (i) acknowledging the invisibility of anxiety at school, (ii) implementing an intuitive, integrative psycho-therapeutic approach, and (iii) mediating parental anxiety. The study was the first study to utilize the Innsbruck Vignette Research methodology with children with anxiety in a South African context. The study concludes with recommendations for practice, future research, and development as well as training suggestions.

Keywords: Traumatized children, children with anxiety, subjective wellbeing, intervention, vignette research.

EDITOR'S REPORT

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To whom it may concern

With this letter, I confirm that I have language edited the dissertation titled *Exploring how the Subjective Wellbeing of Young, Traumatized Children With Anxiety can be Supported* by Ms Ingrid du Plessis.

With a relevant degree and honours degree, I am fully qualified to undertake such editing.

Yours faithfully

Letitia Greenberg

CHAPTER 1

OVERVIEW AND RATIONALE

1.1 Introduction

This study attempts to address the question of how the subjective wellbeing of young, traumatized children with anxiety can be supported. This introduction will include the literature review, the study's context, and the research objective.

To work with traumatized children with anxiety is a heart-felt interest to me. The reason for this is my own life story. I was anxious throughout my childhood. I can remember how it felt to be anxious every day. Today as an educational psychologist, I have the privilege of helping young, traumatized children with anxiety. Therefore, in this study, I make it my priority to *Explore how the subjective wellbeing of young, traumatized children with anxiety can be supported*.

In light of the wide prevalence of childhood trauma and the complexities of the phenomena, research is needed into the fields of anxiety and subsequent states that call for interventions. This study aims to shed light on the importance of support for posttraumatic growth (e.g., self-worth, wellbeing, and resilience) (Kilmer, 2014; Shah & Mishra, 2021).

1.2 Rationale for the Study

Children with a history of trauma suffer from at least one anxiety, additional mood, or behaviour disorder (Brink & Wissing, 2012; DePierro et al., 2019). In addition, affected children frequently exhibit difficulties in self-regulation across various areas (e.g. emotional, behavioural, mental, intellectual, and relational). They display deficiencies in bonding, anxiety, mood, substance abuse difficulties, ability to focus, impulsivity, persistent medical issues, and academic achievement (Cook et al., 2005; Brink & Wissing, 2012; Spinazzola et al., 2018; DePierro et al., 2022).

Fernandes and Osório (2015) mention that childhood trauma and adversity are associated with numerous adverse outcomes which can persist throughout adulthood (e.g., poor physical health, low self-image, anxiousness, and an increased likelihood of co-morbid psychological symptoms). According to Fernandes and Osório (2015), childhood trauma can

have long-lasting outcomes on an individual. Typical examples of such traumatic events include physical, verbal, or sexual assault, abandonment, separation from caregivers, abusive behaviour, domestic violence, and general trauma. A traumatic experience and its emotional states might encourage and reinforce the child's negative and inadequate attitudes about themselves and their surroundings, leading them to experience more significant anxiety when confronted with new stresses. These factors increase the chance of developing anxiety disorders (AD), panic episodes, generalized anxiety, and social anxiety disorders (David et al., 1995; Jayasankar et al., 2020).

According to a study by Nemeroff (2004) and Dye (2018), childhood trauma may also increase the vulnerability to stress exposure by altering the regulation of the hypothalamus-pituitary (HPA) axis, thereby changing cognitive function and personal behaviour, and intensifying the risk of developing psychopathic personality disorders, especially those on the anxiety spectrum. Abraham et al. (2022) argue that the harmful influence of trauma experiences on the anxiety and disposition of children remains strong.

The widespread but false belief among professionals and the public in general that trauma and difficult circumstances do not affect young children is a formidable barrier to mobilizing trauma resources for young children (National Research Council and Institute of Medicine, 2012). More than a decade ago Lieberman et al. (2011) mentioned that graduate programs in psychology, social work, psychiatry, and other mental wellbeing fields do not systematically address the developmental psychopathology of childhood and infancy. Typically, providers of child mental health services receive training in individualized treatment approaches that exclude primary caregivers and are, therefore, inappropriate for children (Lieberman et al., 2011). The accessibility and capacity of the caregiver to assist and nurture during a traumatic event may be more influential in determining outcomes for mental health than the event itself. Prospective person-centered analyses of early childhood trauma exposure must incorporate parental somatic symptoms, family interaction, and relationships (Hagan et al., 2016).

According to Buss et al. (2015), early childhood development has been fast during the past 20 years. Practitioners and researchers working with young children continue to contribute to understanding trauma and early childhood mental health. However, the larger counsellor population seems less educated in childhood trauma, making referrals problematic for these exposed young children. For example, a counsellor may assist a victim of domestic violence who has young children. Due to the counsellor's constrained knowledge of childhood trauma, the counsellor might not consider support services for the children.

From a historical viewpoint, society and mental health counsellors do not recognize the difficulty that young children face during trauma exposure. However, advances in research and the counselling profession, such as the new American Counselling Association division, and the Association for Child and Adolescent Counselling, started to enhance counsellor knowledge and training in this area.

Research by Kaminer and Eagle (2010) mentions that South African trauma intervention models have been created; however, significant information gaps still exist. The focus must not only be on international studies additionally, but South African researchers must also continue to provide new perspectives on adult and child trauma, resilience and concomitant coping strategies.

According to Bunting et al. (2022), when examining the prevalence and risk factors of mood and anxiety disorders in children and adolescents in the United Kingdom, a comparison of 2017 data with that of past years revealed a slight rise in the overall prevalence of mental health disorders. However, a 2020 follow-up study focused on more general psychological functioning; 5- to 16-year-olds with a suspected psychological disorder rose from 11.4% in 2017 to 16.7% in 2020 (Vizard et al., 2020). Even though it is probable that such rises are ascribable to the Covid-19 pandemic (research indicates that the global epidemic has had a disproportionate impact on the psychological wellbeing of young individuals), these increases still cause concern (Shevlin et al., 2020). Since 2012, research with Irish adolescents undertaken before the pandemic has indicated rises of 7%

and 11% among those classified as having severe depression and anxiety (Dooley et al., 2020). International studies have documented comparable longitudinal significant increases in adolescent mental illness prevalence (Collishaw & Sellers, 2020).

There is limited epidemiological research on the prevalence and impact of mental health disorders among South African children and adolescents. However, according to Flisher et al. (2012), the estimated prevalence of anxiety disorders is 17%, with generalized anxiety disorder being the most prevalent. A correlation between exposure to violence and mental health issues like depression and anxiety has also been found (Flisher et al., 2012). Other traumatic events, such as abusive behaviour, loss, relationship difficulties, and psychological and social pressures, have also been linked to mental health issues in the South African population (Flisher et al., 2012). Due to exceptionally high levels of violence against women and children in South Africa and the prevalence of violent crime, South Africa has the disastrous dissimilarity of serving as a living laboratory for the research of traumatic stress (Kaminer & Eagle, 2010). However, interventions for South African adolescents and children are frequently underdeveloped or unreachable, despite increased levels of exposure to violence and accompanying issues with mental health. According to Babatunde et al. (2020), the existing Child and Mental Health (CAMH) service care system in the rural district is deficient, according to the findings of a study conducted in a rural region of South Africa. As a result, all of the health system's fundamental components must be strengthened. The situational analysis conducted to examine the current state of the child and adolescent healthcare system found that the district's provision of CAMH services is limited, uncoordinated, and not prioritized. A South African study by Gregorowski and Seedat (2013) propose different treatment guidelines for children and adolescents who are exposed to many kinds of trauma. The recommended guidelines include the following: safety, self-regulation, self-reflective information processing, integration of traumatic experience, re-engagement with relationships, and enhancement of positive outcomes. In general, there are two forms of trauma, i.e. chronic and developmental trauma. There are complex trauma interventions for persistent traumatization, including those founded by the NCTSN Complex Trauma Work Group (Ford & Cloitre, 2009).

Some interventions that promote wellbeing and prevent PTSD try to minimize persistent post-traumatic symptoms even in the presence of an ongoing threat, treating previous trauma without assuming current safety. Such solutions require additional research and are especially important for children exposed to ongoing, interminable violent conflicts (Bosqui & Marshoud, 2018). Research shows that there must be more psychosocial support for traumatized children because there are around 31 million displaced children in the globe today (Sunseri, 2019).

Although survivors of various traumas tend to report an increase in vulnerability and psychological discomfort (Tedeschi & Calhoun, 1996), reflecting the reality that they may have suffered in ways they were unable to control or prevent (Janoff-Bulman, 2010), they may also report (PTG) post-traumatic growth. This positive change materializes in several domains (Tedeschi & Calhoun, 1998; 2004). One domain is a greater sense of personal power and confidence in one's capabilities to survive. Survivors of trauma can also gain new perspectives on their relationships and see crucial positive and negative qualities in others. For instance, many reports discover true friends or those they can rely on. With these real friends, they feel safe and have the desire to talk about what has happened during and after the trauma. Many survivors find themselves developing greater comfort with intimacy. They may develop closer relationships with individuals who have endured similar circumstances and, as a result, develop a better capacity for empathy for individuals enduring life challenges. In addition, through cognitive processing, survivors may develop greater gratitude for the fragile nature of life, enhance their connections to their families and the impacted community, and recognize their courage in overcoming obstacles and restoring their lives (Riffle et al., 2020).

There are limited findings in this area to date, signifying possibilities for future child PTG research. The study of PTG in disaster mental health is a welcome departure from the traditional emphasis on psychopathology. In the face of adversity, children can not only survive but may also thrive and develop. There are, however, still many unanswered questions regarding PTG in children. Future research is required to understand the

potentially distinct process of PTG dependent on the type of trauma (Bernstein & Pfefferbaum, 2018).

More than a decade ago, views on positive psychology (Eloff et al., 2008) suggested limited studies on positive psychology in Africa. Positive psychology is fundamentally a strengths-based approach that may be difficult to develop in an environment with severely limited resources. Even though one of the main principles of positive psychology is that it takes an innovative approach to solve challenges, it may elicit an almost instinctive resistance because it may be perceived as too light-hearted (Eloff et al., 2008). Positive psychology in Southern Africa was undergoing several pioneering endeavors at the time. Globally, positive psychology is a growing movement within Psychology – regarding knowledge innovation and praxis (Wissing & van Eeden, 2002; Wissing, Wissing, Du Toit & Temane, 2006; Carr, 2004; Diener & Suh, 2000). Since then, numerous studies (Delle Fave et al., 2016; Maree & Ebersohn, 2007; Theron & Theron, 2010; Coetzee et al., 2010) have indicated the substantive nature of positive psychological research in Africa.

Savahl et al. (2015) did a study on the subjective wellbeing of a sample of children in South Africa. Their South African General Household survey aims to improve children's lives and wellbeing. Findings suggest that subjectively high levels of wellbeing are counter-instinctive to this agenda, as they may foster a false sense of accomplishment and negatively affect the motivation of policy measures and delivery of services. Subjective wellbeing research is still growing in South Africa, and it is difficult to chart a course forward for the intersection of wellbeing research, childhood trauma, and anxiety due to the paucity of empirical initiatives (Savahl et al., 2015).

This encouraged me to think about the extent of the subjective wellbeing of traumatized children with anxiety in South African schools. The most recent General Household Survey (GHS) results, as published by Statistics South Africa, show that there are 30.2% of preschool children in facilities, 97,4% of primary school learners in facilities, and 86.4% of learners in secondary school facilities in South Africa (Statistics South Africa, 2018). The latest result from the South African Depression and Anxiety Group (SADAG)

(2018) shows that 17% of children and adolescents suffer from anxiety that hinders their ability to live their lives, and 16.5% of South Africans did suffer from prevalent mental disorders such as depression and anxiety in the previous year. Mental disorders in children are common and occasionally severe. One-third of adolescents and children experience a mental disorder at some point during their lifetime. Anxiety disorders are the most prevalent mental illness among children. These include childhood overanxious disorder and separation anxiety disorder. Research conducted by Lockhat and van Niekerk (2000) at the University of the Western Cape reports various social, health, educational, and psychological factors of the wellbeing of South African children, both before and after the 1994 elections. As the nation's development and reconstruction program advances, the urgent need for psychological and social services for children continues to be a significant issue (Lockhat & van Niekerk, 2000).

According to research by Schmitt (2019), anxiety is on the rise among elementary school children, but indications are that they can overcome it with the right support. Support from other professionals is essential for empowering educators to maintain strong, supportive relationships with traumatized children and to manage their classroom behaviour. In the South African context, the question is how it can be supported optimally (Phasha, 2008). In their global study on children's wellbeing, Sadler et al. (2018) found that relatively low personal wellbeing is associated with neglect, feeling anxious at residences, being verbally abused, and feeling unsafe in neighborhoods. Recent research (Raws, 2016) has shown that the standard of living of children who have experienced interpersonal, physiological, or educational neglect is substantially lower compared to other children.

A study by McWhirter (2007) examined the impact of childhood disadvantage accumulation on adolescent and adult outcomes. The greater the number of disadvantages children suffer, the more challenging their future results will be. In another study, 13- to 14-year-olds with five or more family issues, such as caregiver mental illness, physical impairment, drug abuse, family violence, financial pressure, and substandard housing, were

36 times more likely to be dismissed from school than those without these challenges (Appleton & Sidebotham, 2017).

A recent survey by the National Organization of Head Teachers in the United Kingdom shows that one in every five children will suffer from a mental health issue before the age of 11, with anxiety being the most common (Cassidy, 2015). There are numerous reasons why children may struggle with anxiety. Some children struggle with separation anxiety and have difficulty adjusting to school away from their parents. Some are disturbed by domestic challenges, such as a divorce or a death in the family. However, for many, anxiety is triggered by school-related pressures. Academic achievement is increasingly emphasized at the expense of physical and mental health, social relationships, and communication skills (Cassidy, 2015).

The Covid-19 health crisis generated exceptional conditions that impacted billions of lives and triggered massive economic, social, and educational disruptions. Due to the multiple probable outcomes of Covid-19 on individuals and societies, the world is unlikely to return to its previous state (Bandyopadhyay, 2020). Sixteen percent of respondents in South Africa live alone and, according to research by SADAG (2018), loneliness and isolation are a constant theme among the hundreds of callers who contact SADAG's helplines every day. According to an online survey on Covid-19 and mental health in South Africa, loneliness could have mental health implications. “For many people, this is a worrying amount of alone time when they are forced to face themselves, their fears, and anxieties alone” (Korb, 2021, p. 1).

According to the child protection and Covid-19 report (Bandyopadhyay, 2020), lockdowns and shelter-in-place measures increase the likelihood that children will witness or experience violence and abuse. Children living in refugee and internally displaced person camps that are unsanitary and overcrowded are also at risk. Children's reliance on internet sites for distance education has increased their exposure to inappropriate material and online predators.

1.3 Problem Statement

The purpose of my study is to explore and explain how the subjective wellbeing of young, traumatized children with anxiety can be supported.

1.4 Research Questions

1.4.1 Primary Research Question

The purpose of my study is to explore and explain how the subjective wellbeing of young, traumatized children with anxiety can be supported.

1.4.2 Subsidiary Research Questions

- What do we currently know about children with anxiety in South Africa?
- What are the lived experiences of children with anxiety?
- How do experiences of subjective wellbeing, anxiety, and trauma manifest spatially, temporally, and relationally in an embodied way?
- How are traumatized children with anxiety currently supported?
- How can subjective wellbeing interventions be leveraged to support traumatized children with anxiety?

1.5 Background to the Study

The primary school where I conducted my study is a school with 1 200 learners and 71 teachers, situated in Fairland, Gauteng. Since 2013, I have been involved at this primary school as an educational psychologist with my own private practice. At the same school, I am also part of an organization run by the school's governing body. The group consisted of a psychologist, a speech therapist, and an occupational therapist. We work as a team with the teachers and remedial teachers to support underprivileged children.

Since I started working with children at the primary school, an annual increase in children with anxiety has occurred, especially during the Covid- 19 period. In my private practice, more than 80% of the presenting problems were anxiety related. These cases vary from Grade R to Grade 7. The children in this environment come from diverse religious, racial, and socio-economic backgrounds. They are exposed to chronic and developmental

traumas, such as divorce, death, domestic violence, and other forms of abuse. The significant increase in anxiety cases and the growing need for support fortified my inclination to study the subjective wellbeing of children with anxiety due to trauma.

There are several aspects of this research focus that intrigue me. For instance, what role does the science of positive psychology play in supporting a child with anxiety who has experienced trauma? How can positive psychology or wellbeing science bring about positive corrective change for an individual child? What are the minutiae of the lived experiences of traumatized children with anxiety – beyond the diagnosis? My preliminary review of the literature database on trauma, anxiety, and positive psychology led me to the conclusion that, while there are numerous South African studies focusing on how positive psychology can assist children experiencing adversity broadly, there are still limited in-depth studies that concentrate on traumatized children with anxiety, specifically in South Africa. I am of the view that we need research in positive psychology that reveals how to cultivate virtues such as creative thinking, future orientation, competence, personal morality, peace, laughter, and strength of character, as well as how to increase life satisfaction and happiness in the face of adversity.

Fortunately, the construction of such a science is underway. Numerous psychological theories are undergoing revisions to address the positive aspects of life, and researchers have begun to examine psychological strengths (Gillham & Seligman, 1999; Kizilhan & Wenzel, 2020). I aim to contribute to the existing body of knowledge regarding the nexus between subjective wellbeing, trauma, and anxiety in young children and the means of supporting them.

1.6 Research Methodology

1.6.1 Place of Research

I conducted this research in the South African province of Gauteng, in Fairland, at a purposively selected public primary school with approximately 1 200 learners and 71 teachers at the time of the study. The primary data collection took place in my therapy room at the school. The building was situated in a safe area. The therapy room was decorated

and furnished to accommodate all the participants. In the case of “lockdown” procedures, the study could be extended to an online environment. This would occur only in extreme circumstances. During the study, it was never necessary to commence online sessions with the participants. Alternative times were arranged to suit all the participant’s needs. Additional data was collected when I arranged one classroom observation session for each child participant. Those observation data sets were used to create classroom vignettes for each participant.

1.6.2 Participants

The primary participants comprised five children (boys=1, girls=4, parents=10, teachers=5). The boy was in Grade 2 and the girls in Grades 3, 4, 5, and 7. Their ages varied from 8 to 13 years. I have decided to work with only five learners because, during this study, I preferred to work in depth with each client and the amount of data was sufficient for a PhD study. The participants’ teachers used screening questionnaires to identify children with possible anxiety symptoms in their classrooms. These questionnaires were formulated by a group of professionals at the school consisting of psychologists, occupational therapists, remedial teachers, and speech therapists (Annexure A-1). The parents of the identified children were contacted to obtain their consent and confirm their children's willingness to participate in the study. Chapter 3 gives more detailed specifications of the identifying process of the child participants.

1.7 Interpretive Phenomenological Research Design Using Vignettes

1.7.1 Vignette Research

Vignette research is a phenomenologically oriented research methodology, with multiple formats. There are different methodologies in phenomenological research using vignettes. Van Manen’s methodology focuses on the recall of interviews and conversations as the Innsbruck Vignette Research (IVR) methodology does not emanate from recollection in interviews and conversations, but rather from co-experiencing the experience of others in the field (Westfall-Greiter & Schwarz, 2012). This research will include elements of both methodologies. The Innsbruck Vignette Research (IVR) paradigm was developed at the

University of Innsbruck's Department of Teacher Education and School Research (Meyer-Drawe, 2019). The main reason for using IVR is that it allows the researcher to go beyond their own psychological and professional experiences to those of the participant. When the researcher engages with empathy, he can document the lived experiences of the participants as authentically as possible. The elements of van Manen's methodology that I have included in my research are the way in which I used observation. When I observe, I depend upon detection, concentrating on psychological components such as bodily and facial gestures, voice tone, and quietness, which are documented in protocols as a flow of life experiences (van Manen, 2002).

A vignette is a type of literary short story that describes an emotional moment co-experienced by the person conducting the research study in various settings, which may include a therapy setting or a classroom. Eloff (2020) states that although IVR focuses on learning experiences, it can also capture various other occasions. The current study sets out to use vignettes to explore psychological experiences. This method is grounded on phenomenology, in which the research objectives are centered on the individual's experience. Transposing this thinking from a learning experience to a psychological experience in which intrapersonal processes are investigated means that the researcher goes beyond their own psychological and professional experiences to the experiences of another. It describes the effort to simultaneously encapsulate and liberate the experience of the other without the benefit of having experienced the personal experience of the other themselves. It is about engagement, "moving as close as possible to," empathy, and the attainment of psychological proximity within experiences. By co-experiencing classroom and therapeutic situations in and outside of the classroom or therapy room, researchers attempt to document learning or therapeutic observations as genuinely as possible, i.e., "*in statu nascendi"* (Schratz., 2014, p. 2). Every incident in a teaching or therapeutic setting is highly individual since each individual is assumed to be immersed in their own experience. When constructing a vignette, researchers seek to create a new rather than a reconstructed (restored) lived reality of individuals through language. Children, parents, teachers, and

therapists face daily instinctive and non-repetitive essences of situations and therapeutic experiences, respectively, as exemplified by the variety of experiences depicted in a vignette.

The writing process for vignettes cannot be standardized due to the subjective nature of writing. Yet vignettes are carefully crafted as phenomenological evidence. Once created, vignettes are the subject of phenomenologically oriented clarification, a process known as "vignette reading." A resource for professional development, vignettes can be used to support the development of a new awareness of individual classroom or therapy room experiences (Schratz, 2017).

An approach that "captures and records the voices of the lived experience that goes beyond mere fact and surface appearances; it presents details, context, emotion, and the interconnected webs of social relationships" is required to increase understanding of the complexities of what occurs in the classroom and the therapy room (Denzin, 1989, p. 83). Denzin's above-described definition of vignette writing correlates well with Schratz's explanation of experience-based data, the primary source used to describe an experience in phenomenological texts (Schratz et al., 2014). By the research goals and theoretical underpinnings of this type of study, researchers adopt a phenomenological standpoint wherein they set aside their presumptions, concepts, and beliefs and stay available to being influenced by someone else's experiences. Van Manen (1989) states that the anecdote or vignette is the most common device by which individuals talk about their experiences in everyday life. When teachers discuss their daily practice, they frequently use anecdotes or vignette-like descriptions to highlight their particular concerns regarding educating and living with children.

From the vignette interviews and observations during my study, I crafted raw vignettes. After completing each raw vignette, I made it available to other professionals and the children, parents, and my research supervisor to get the necessary feedback about their experiences while reading the vignettes. What feelings and emotions does it evoke while reading each vignette? I asked them to make changes if they wished to do so. The reason

for sharing the vignettes with the children was to capture authentic feedback from every child and to enrich the data by capturing the meaning and perspective of each child's mind during the research process. After the feedback, I refined or amended these vignettes.

1.8 Data Collection

I conducted an Interpretive Phenomenological research study using vignettes. Participants were requested to describe their lived experiences in any way. In phenomenological studies, in-depth interviews are the most common method for collecting data in order to contain participants' detailed descriptions of their lived experiences. Participants' written or verbal self-reports and artistic or narrative expressions of their expressive experience could also be evaluated (Moustakas, 1994). This study's initial data collection consisted of drawings and semi-structured and structured questionnaires administered to the children. Observing the children and collecting artifacts, field notes and video recordings of each assessment and therapy session. With the parents and teachers, I used guided or semi-structured interviews as well as casual interviews based primarily on open-ended questions. Examples of the interviews are given in Annexure A-3 and A-4.

Phenomenology does not explain but instead seeks to foster comprehension among the group of observers and observed (Bentz & Shapiro, 1998). Smith and Osborn (2015) assert that a phenomenology is a theoretical approach, first articulated by Husserl, that seeks to produce a record of personal experiences on their aspects instead of one given a prescription by conceptual frameworks. In this research study, hermeneutics interpreted participants' lifeworld experiences of the phenomena of interest in order to shed light on ways of being in the world via phenomenological processes. This shift to interpretive practice differentiates between phenomenological research that aims for rich lifeworld explanations and hermeneutic phenomenological study that seek to comprehend these worlds from the respondents' points of view (Smith & Osborn, 2015). In phenomenologically oriented research with children, using arts-based strategies such as drawing and photography within unstructured interview settings allows children to express their lived experiences in meaningful and imaginative ways on their terms (Finlay, 2008). A growing body of research

demonstrates an increasing interest in using visual methods with children (Veale, 2005). This approach acts as much as possible to prevent hermeneutics from being prematurely structured into pre-existing categories of thought. Another approach to protecting the data in their primitive state is to use a video and voice recorder, performing as minor formatting and censorship as possible and providing a concise psychological and lingual criticism of one's cognitive and perceptual biases (Bentz & Shapiro, 1998). The child's response to the semi-structured questionnaires of each drawing during the emotional assessments is also recorded to protect the data in their primitive state. After the evaluation, the data is analysed until saturation is reached.

1.8.1 Data Collection Process

The initial step was to identify the participants with possible symptoms of anxiety. The teachers used screening questionnaires. These screening questionnaires were formulated by a group of professionals at the school, consisting of psychologists, occupational therapists, remedial teachers and speech therapists. The reason for using screening questionnaires was to simplify the identification of possible anxiety symptoms in children. As previously mentioned, an example of a screening questionnaire can be viewed in (Annexure A-1). More details on the identification and selection process of the child participants are discussed in Chapter 3.

To select five participants, I had to do an emotional assessment to verify the most critical and urgent cases. Because an emotional assessment focuses on the wellbeing of the child participant, it assisted me to identify the most critical cases of anxiety. The procedure of an emotional assessment is discussed in more detail in Chapter 3. Before the assessment process commenced, a casual or semi-structured interview was held with parents and teachers to get the necessary background information.

The results of the emotional assessments were discussed with the board of therapists at the school for a second opinion and to make an informed decision, after which five participants were selected to participate in the study. The children not selected received

the same therapy and treatment as the selected participants, although they were not part of the study.

After the five participants were chosen, their registered teachers were required to provide written informed consent for them to participate in the study. The consent forms consisted of an explanation of the ethical considerations for the study. An example of such a consent form can be viewed in (Annexure B-5). After collecting all the consent forms, the intervention process commenced.

An integrative psychotherapeutic intervention process with the five children commenced once a week for approximately eight weeks. More details about the psychotherapeutic intervention process are discussed in Chapters 3 and 4. During the assessment and intervention processes, observations of the children included a collection of artifacts, field notes, video recordings of each assessment, and a therapy session. During the research process, two or three casual or semi-structured interviews were conducted with parents and teachers at convenient times that suited all parties. Classroom observations for all five child participants took place to collect the necessary data as part of the vignette research methodology. The vignette research process is discussed in Chapter 3.

1.9 Data Analysis

When the therapy process is completed, the data analysis process could begin. As part of the process, the crafting of the raw vignettes commenced. More detail about the vignette research process is discussed in Chapters 3 and 4. Throughout the research study, data analysis was conducted using interpretive phenomenological analysis and vignette research to comprehend the lived experience of a particular phenomenon among children, their teachers, and their parents.

Focus was placed on fully grasping and making sense of the phenomenon's description throughout the data analysis process, which began with the collection of the first source of data. The investigator must exclude "the self" and enter the perspective and experience of the other person to perceive the world through the lenses of others genuinely. In addition, phenomenology emphasizes the impact of the research experience on research

and the researcher's personal experience with the study (Creswell & Báez, 2020). To extract the essential meaning of each participant's experience on a common theme, it is crucial to employ the mythology of reduction and analysis of specific arguments and to manipulate overarching themes.

During the analysis process, I used induction to generate themes from the bottom up. This allowed me to search for the most important themes and predominant relevant data by transitioning from a large number of examples to identifying recurring themes engrained within the data. The inductive identification of themes separated recurring themes and categories from a seemingly disorganized collection of data. During this procedure, the progression of the complexity from topics to sub-topics and categories to sub-categories became evident to me. Throughout this data analysis, I never lost sight of the overall objective of this study.

The participants had to confirm that their opinions and views were not misunderstood. This could be achieved via an audit trail and member verification. Auditing is a record of the measures taken from the beginning of a study project to the creation and dissemination of its research results. These documents detail every step of an investigation (Eatough & Smith, 1017). Beyond content analysis, the interpretive phenomenological analysis provides a comprehensive understanding of the lived experience.

1.9.1 Member checking

Member checking is the process of providing participants with interview summaries or transcripts to correct any inaccuracies so that no participant can be identified; it is a critical aspect of vignette research. The use of pseudonyms is frequently required, as this allows individuals to respond in their own words while maintaining confidentiality. Through in-depth interviews, participants' feelings and attitudes about the phenomenon can be uncovered (Candela, 2019).

1.9.2 Ethics

Ethics clearance for my study was obtained by writing a research proposal, and completing and obtaining the following documents before submitting them to the Ethical Committee to be approved.

1. Ethics Application Form.
2. Permission Letter to the Department of Education.
3. Consent Letter to Parents.
4. Consent Letters to Teachers for Interviews.
5. Consent Letters to Principals and Teachers.
6. Interview Schedules.
7. Observation Questions.

After I completed the ethical clearance process and submitted my application with my research proposal, it was approved, and I received an ethical clearance nr: EDU 207/20.

I committed to the ethical conduct of the research as outlined in the Terre Blanche and Durrheim (1999) statement, which stipulates that moral concerns should be integrated into the planning and execution of research. The foremost principle in research is the best practice interest, which includes the participants' safety and well-being. To accomplish this, it is necessary to implement "best practice" principles throughout all phases of the research. Most participants in my study were between the ages of six and 13 and were asked to provide written informed assent. An example of an informed assent form for children can be viewed in Annexure B-4. The participants' parents and schoolteachers participating in the study also had to provide informed written consent. I provided the most complete and precise ethical consent forms, so they could make rational, consensual, and correct decisions about their potential participation. Aspects such as the research goals, the nature of the assessment and intervention, and my credentials as the researcher were explained to the children in a language at their level (McMillan & Schumacher, 2014). It was essential to be aware of the ethical challenges posed by the research because of the emotional and personal involvement in their study (Sanjari et al., 2014). I committed to upholding the

impartiality and autonomy of all participants. The voluntary nature of participation allowed participants to withdraw from the process at any point without penalty or repercussion (Bhumika Aggarwal & Gurnani, 2014). This was explained to each participant at their developmental level. In terms of the ethical agreement, they could also choose not to respond to any question or participate in any activity presented. They were aware of this throughout the entire process. The ethical responsibilities of confidentiality demanded that the identities of all people involved and any gathered information or data had to be sorted and compiled to preserve their anonymity and privacy. I advised the participants that their names, data, and findings would be disclosed in a manner that safeguarded their privacy and anonymity. The participants were selected in a fair and equitable way (Elias & Theron, 2012). During this selection process, diversity played a significant role. Every child, regardless of age, gender, language, race, context, or socio-economic status, was given a fair opportunity to receive the help they deserved. Parents who could not afford professional help received support from the NGO service at the primary school. Parents and sponsors in the school funded this organization.

All participants were thoroughly briefed on the research procedure and the objectives I hoped to accomplish. Throughout their participation, I kept all participants informed of the investigation's progress through constant communication. To adhere to this concept, participants were only asked to perform tasks within their skill level. The ethical consideration of confidentiality also became essential in the execution of this study. During the discussions, the participants and I gradually developed confidence in one another, and the extensive information-gathering period was not initiated for the sake of profit or advantage. I took great care to construct a study that could potentially benefit participants taking part, multiple researchers, and even the general public. I did my best to recommend and elaborate on material and topics that I believed could prove beneficial for potential parents and children in similar situations by incorporating the participants' experiences, varied viewpoints, and perspectives into the research findings. One other ethical

consideration I employed was that I disclosed the research findings as an accurate depiction of what transpired during the study.

I followed the same steps when recruiting teachers as participants (Cohen et al., 2000; de Vos et al., 2011; Denzin & Lincoln, 2008; Lichtman, 2012; Terre Blanche & Durrheim, 2002).

1.9.3 Delimitation of the Study

This was a qualitative study that, even though intertwined, was more psychological than educational in nature, as I focused more on psychological phenomena than educational phenomena. The study took place within a specific well-developed geographical context within South Africa.

1.10 Conceptual Framework

The theoretical approach for my study was derived from the perspective of Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner, 1979). This approach encompasses the child's larger ecological environment and acknowledges that the child is the core of their ecosystem (Shaffer & Kipp, 2013).

The Developmental Psychopathology Model links with ecological theory as, across some ecological domains, it intends to understand developmental changes to emphasize developmental processes and the importance and complexity of risk and protective factors.

Instead of any single factor, developmental psychopathology conceptualizes children's development as continuously influenced by various interacting factors within and over multiple domains (Kerig et al., 2012).

In addition, developmental psychopathology assumes a continuum between normal and abnormal development. The same fundamental developmental principles underlie every life course, whether healthy or maladaptive. To comprehend how development may go awry, it is crucial to have a clear understanding of adaptive development. The challenge is to understand why development takes one path rather than another. It is normal to encounter difficulties during the course of development. Developmental psychopathology is not viewed

as internal pathological conditions, but rather as significant deviations from a healthy developmental progression.

My study focused on the multifaceted perspective of the ecological systems in the development and maintenance factors of parental and contextual influences. The effectiveness of positive psychology treatment of anxiety in children is also discussed by incorporating all the systems into the treatment plan.

1.10.1 Ecological Systems Theory

According to Bronfenbrenner and Morris (1998), the child's living environment needs to be examined in order to comprehend the child. Bronfenbrenner's ecological system model (Bronfenbrenner, 1979; Steyn & van Rensburg, 2014) notes that the child is developing as part of a set of interrelated systems that affect the child's development once more. Bronfenbrenner allocated the child's environment into micro-, meso-, and macro-level ecosystems (Bronfenbrenner, 2005; Kail & Cavanaugh, 2010).

1.10.2 The Impact of Diverse Ecological Systems on the Growth and Treatment of Anxiety in Traumatized Children

1.10.2.1 Microsystem. One needs to acknowledge the child as the core of this system when considering the development of anxiety. According to Wenar and Kerig (2005), biological and individual risk factors for developing anxiety include neurological damage, inadequate nutrition, low self-esteem, and poor self-control. In a family context, the risk factors are insecure attachment, interparental conflict, abuse, neglect, and domestic violence, and in a social context, the risk factors are antisocial friends. Traumatic events and the associated emotional states can stimulate and reinforce one's negative and inadequate beliefs about oneself and the environment; the subject is predisposed to encounter higher anxiety levels when exposed to new stress factors, thereby increasing their future likelihood of acquiring ADs (Fernandes & Osório, 2015).

Trauma has been shown to impair neurodevelopment, cognitive development, acquiring knowledge, social progress, the capacity to form healthy attachments with others, and physical wellbeing (Moore et al., 1998). According to Bartlett and Smith (2019), children

who experienced trauma during their childhood or trauma-related incidents between birth and the age of six are especially notable because they occur during a time of intense brain development that is particularly susceptible to disruption by childhood trauma, which may raise the likelihood of severe mental and physical health issues in early age children later in life (De Bellis & Zisk, 2014; Shonkoff et al., 2009). Each child's response to trauma depends on the kind of trauma, the child's and family's characteristics, and the alignment of risk and protective factors in their life. Almost all children experience anxiety immediately following a traumatic event, but with parental and other caregiver support, the majority recover their normal functioning over time (Green & Mitchell, 2012). Early-life trauma takes various forms, is extreme and prevalent, and typically involves dangerous behaviour by primary caregivers like the parents and is associated with the most severe symptoms of post-traumatic stress disorder and negative child outcomes (Bartlett et al., 2016).

Wenar and Kerig (2005) also note that vulnerability intensifies the child's response to risk. A child with an anxious disposition will most likely be negatively affected by household disruptions. When examining the treatment and general upkeep of children with anxiety, it can be difficult for researchers to identify the "protective factors" that encourage or promote healthy development. Children who adjust well despite being at risk are often identified as resilient. Examples of protective factors in children may, for instance, be an easy-going temperament or competencies valued by themselves or others. Protective factors at home might include the presence of a nurturing family, a dependable parent, a style of parenting distinguished by a combination of warmth and structure, and social support from extended family members. Positive psychology interventions can facilitate all these protective factors (Wenar & Kerig, 2005).

1.10.2.2 Mesosystem. The mesosystem involves the interdependent connections between two or more systems (Christensen & Rudebusch, 2016). The school plays a significant role in treating traumatized children with anxiety. According to Bartlett et al. (2017), society has overlooked the impact of early childhood trauma due to the misunderstandings that toddlers do not fully comprehend traumatic experiences or that they

always "bounce back" from traumatic events. According to Bartlett et al. (2017, p. 5), “Children are more sensitive to trauma during their first few years of life than at any other point in their development.”

Landsberg et al. (2005) mention that at the mesosystem level, interactions between the family, school, and peer group adjust each system. For instance, a child from a non-supportive or destructive home environment may not receive the emotional comfort they need, putting them at risk of developing possible learning barriers. Within this system, the school can function as a protective factor because it can be an escape route for children with dysfunctional families. The child may have an accommodating and caring teacher who can provide a supportive environment that, over time, increases the child's self-esteem and sense of safety. Because a child spends the better part of the day at school among peers and teachers, the school impact on a child is second only to parental influence (Webb, 2018).

1.10.2.3 Macrosystem. This system refers to a particular society's principles, resources, and ethos (Bronfenbrenner, 1994). Attitudes, beliefs, and values in the system may impact either of the other systems (Landsberg et al., 2005). For example, community exposure to violence and being a latchkey child are both potential risks for developing child behaviour problems (Wenar & Kerig, 2005). Protective factors in the cultural context might include involvement with prosocial institutions, such as the church or a community center (Masten & Coatsworth, 1998).

1.11 Origins and History of Positive Psychology

Positive psychology is a subfield of psychology, not a separate science (Eloff, 2006). According to Lindley et al. (2006), positive psychology aims to address inequities and imbalances in psychological research and practice. The roots of positive psychology must be investigated in greater detail to comprehend positive psychology within the broader field of psychology. It then becomes evident that this phenomenon is not recent. Positive psychology developed from ground-breaking work done by Rogers (1961), Erikson (1963; 1982), and Maslow (1962). According to Rathunde (2001), Abraham Maslow, William,

James and John Dewey introduced "experimental turns" in American psychology. They researched the meaning of life and challenged the positivist paradigm in scientific research. Rathunde (2001) claims that to create a more integrated psychology of ideal human cognition, one must understand and value both the benefits and challenges of an experience-based view.

Within the framework of positive psychology, researchers' interest in the origins of individual resilience and psychological wellbeing grew significantly since 1995 (Werner, 1995; Wissing et al., 2020). Anlonovsky (1979) invented salutogenesis to refer to the research origins of health or wellbeing (Pretorius, 2004). Strümpfer (1993; 1995) introduced the idea of "fortigenesis" which relates to the origins of psychological strength. The fortigenic framework concentrates on the fundamental question of where power comes from (Pretorius, 2004). In this regard, Strümpfer (1999, p. 89) asserts: "two fundamental assumptions are that stressors and adversity are an essential part of the human condition and that there are sources of power through which this condition can be endured, even transformed, thereby producing a strengthening and hardening of the individual." In contrast to psychopathology, Wissing and van Eeden (2002) expand on the idea of fortigenesis and incorporate the sub-discipline "psychofortology," which focuses on the origins and expressions of psychological health.

Positive psychology, therefore, is not a new phenomenon, and is expanding as well as building momentum. The APA dedicated its 2000 issue to the expanding field of positive psychology (Seligman & Csikszentmihalyi, 2000). Several studies on positive psychology have appeared in scholarly journals (Carter, 2006; Eloff, 2006; Folkman & Moskowitz, 2003; Held, 2004; Lazarus, 2003; Schwarzer et al., 2003; Seligman & Csikszentmihalyi, 2000; Seligman et al., 2005).

1.12 Layout of Chapters

This thesis's chapters are organized as follows:

1.12.1 Chapter 1: Overview and Rationale

Chapter 1 provides the study's context. It includes an overall description of the study, an introduction, and the study's rationale. It describes the research problem, the research questions, and the study's context. In addition, it contains an introduction to the research design and methodology.

1.12.2 Chapter 2: Conceptual Framework

This chapter discusses the theoretical framework of the research and provides a comprehensive literature review and analysis.

1.12.3 Chapter 3: Research Design

This chapter provides a detailed description of the research design. The formal data gathering and analysis of data procedures, along with the research methodology, are examined in depth.

1.12.4 Chapter 4: Research Findings

The data and data format, as well as my data analysis and findings, are described in Chapter 4. This chapter summarizes the research findings and addresses the subsidiary research questions.

1.12.5 Chapter 5: Conclusion and Recommendations

The key findings of the study are presented in this chapter. The results are clarified and related to the conceptual framework and study questions of Chapter 1. This chapter also includes suggestions for future research in this field.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

Chapter 2 presents the ways in which the central constructs in the study connect conceptually. At first, the chapter offers a background to the phenomenon of subjective wellbeing. I comment on the potential matters, tensions, strengths, and weaknesses arising from subjective wellbeing relevant to this study (Wissing et al., 2022). In addition, I discuss the three elements of subjective wellbeing: high positive affect, life satisfaction and negative affect. I comment on the causes of subjective wellbeing and the different measuring scales of subjective wellbeing. I then examine contemporary criticisms of subjective wellbeing worldwide and in South Africa. During this literature review, I aim to explore what research has been done and what needs to be addressed to fill the gaps in subjective wellbeing. Secondly, I discuss the young, traumatized child with anxiety and what role interventions can play in bringing positive change.

2.2 Subjective Wellbeing of Young Children

In their introductory article to a special issue of the American Psychologist, Seligman and Csikszentmihalyi (2000, p. 5) define positive psychology as the study of "positive subjective experiences, positive individual traits, and positive institutions to improve quality of life and to prevent pathology" (Wissing et al., 2022, p.5). In earlier work, Diener (1984) supported the concept of subjective wellbeing and explained that happiness and wellbeing are characterized by frequent positive affect, life satisfaction and infrequent negative affect. Subjective wellbeing (SWB) research demonstrates that a subjective sense of life satisfaction and happiness is essential to an individual's and a society's functioning. Diener et al. (2018b) also found that SWB reflects a synthesis of how individuals evaluate the various facets of their lives. Consequently, it is a very useful indicator of the individual and societal quality of life.

Monitoring citizens' subjective happiness and life satisfaction is essential to enhance societal conditions and optimize human potential. This perspective formed the basis for

further research and practice on happiness and satisfaction with life (Diener et al., 2018). According to Ben-Arieh and Shimon (2014), SWB pertains to the way in which individuals assess their lives both generally and in specific living environment (leisure time, friends, family, etc.). This definition applies to both children and adults.

Regarding psychological distress, childhood trauma can negatively impact an individual's subjective wellbeing (SWB). Positive attitude, negative attitude, life satisfaction, and flourishing are the four components of SWB, which is the cognitive and emotional evaluation of an individual's life (Corcoran & McNulty, 2018). Oshio et al. (2013) discovered that childhood trauma was linked to decreased SWB in adulthood.

Researchers have also noted that in addition to experiencing adversity, adult attachment insecurity (i.e., avoidance or anxiety) is also linked to reduced SWB (Lavy & Littman-Ovadia, 2011). Given these two correlations, it is reasonable to believe that childhood trauma may result in reduced SWB due to insecure attachment. For instance, emotional abuse and neglect as a child may cause an adult to fear abandonment and seek closeness in response to signs of rejection. This hypervigilance may result in unpleasant or failed relationships, a lack of social support, and a diminished life evaluation (Corcoran & McNulty, 2018).

Given that the study of subjective wellbeing is in its early stage in South Africa, it is challenging to graph a course forward. Adaptation across cultures and the transcription of internationally validated instruments needs to be accelerated. Qualitative methods will improve accessibility to the definitions associated with subjective wellbeing, resulting in a more thorough knowledge of subjective wellbeing and quality of life (Savahl et al., 2015).

According to Diener et al. (2018), SWB consists of individuals' valuations and evaluations of their own lives. It contains all intellectual judgments, such as life satisfaction, and positive and pleasant emotional responses to ongoing life, as opposed to negative and unpleasant emotions. When individuals perceive their own lives, such as health and work, and make judgments on them, they do so in relation to their standards for a good life. Thus, rather than the researcher, respondents determine the factors contributing to life satisfaction. Accordingly,

when individuals experience positive emotions, they respond to favourable conditions and life experiences.

Busseri (2018), Diener et al. (2017), Diener et al. (2018) and Pavot and Diener (2013) agree that subjective wellbeing consists of three major components: (i) an overall positive evaluation of one's life; (ii) an increase in pleasant or positive emotional life experiences; and (iii) a decrease in unpleasant or harmful emotional experiences. We can express subjective wellbeing as a three-part formula: life satisfaction plus a high positive and low negative affect equal subjective wellbeing (Wissing et al., 2002).

2.2.1 Life Satisfaction

Pavot and Diener (2013) found that one's cognitive evaluations determine subjective wellbeing. When we create life satisfaction, we begin a process in which we evaluate the quality of our lives based on our criteria. A study by Raats et al. (2019) found a positive correlation between hope and life satisfaction among children in Cape Town. This finding agrees with the findings in literature by Gilman and Huebner (2006), Park and Peterson (2006), and Savahl et al. (2013), who recognise hope as a positive character trait, being positively connected with life satisfaction.

2.2.2 Positive and Negative Affect

According to Lee and Browne (2008), wellbeing is subject to interpretation, since it varies depending on an individual’s assessment of the quality of his or her life. Life satisfaction (subjective wellbeing) is commonly thought to consist of three parts: global satisfaction with life, positive emotions, and psychological distress (Land et al., 2007; Diener et al., 1999). In this conception, global life satisfaction refers to an individual's holistic evaluation of their life. Lee and Browne (2008) state that there is also an emotional component, which includes the positive and negative emotions individual associates with various experiences. In particular, it consists of consistent good feelings, such as joy and pride, and negative emotional states, such as grief and rage. According to Wissing et al. (2022), a Positive and Negative Affect Schedule (PANAS) is a generally recognized scale for assessing the emotional component of psychological happiness (Watson et al., 1988). The

scale is based on an affective component model that describes the beneficial impact as "high energy, full concentration, and pleasurable engagement" and the negative impact as "sadness and lethargy and includes emotions like anger, contempt, disgust, guilt, fear, and nervousness" (Watson et al., 1988, p. 1063). Greater subjective wellbeing would be associated with the absence of negative affect. Positive emotions are linked to vitality, eagerness, and excitement, whereas negative attitude indicates subjective distress and has been associated with anxiety and depression (Watson et al., 1988).

In recent decades, subjective wellbeing among adults has been the subject of extensive research, whereas it received less attention among children (Moore & Russ, 2008; Steptoe et al., 2015; Siedlecki et al., 2014; Yildirim & Arslan, 2022). After a series of analysing life satisfaction and both positive and negative impact measures, Huebner and team discovered the same three fundamental elements of psychological happiness (life satisfaction and positive and negative affect) in children (Huebner et al., 2006) and young teenagers (satisfaction with life, both positive and negative affect) (Huebner & Dew, 1996).

Benninger and Savahl (2016) indicate that self-esteem remains a lower priority on the child's wellbeing agenda. This review provides evidence that self-esteem is crucial in how children perceive their wellbeing. Due to the complexity of the self, no universal self-esteem intervention is suitable for all children. Instead, the intervention needs to be based on the children's perspectives in the intended context. This serves as a convincing argument for child wellbeing research to intensify children's opinions, mainly from underprivileged countries and communities, on challenges relating to their wellbeing.

Fredrickson (2001) maintains that the increased levels of subjective wellbeing are associated with the presence of more positive emotions than negative emotions. Positive emotions, such as love, contentment, and happiness, are essential to our wellbeing and can contribute to developing our psychological resources (Wissing et al., 2022). Does this mean you should strive to experience only positive emotions and avoid negative ones? Are positive emotions respectable and negative emotions destructive? The role of positive and negative emotions in our lives is complex. When you experience a high level of subjective

wellbeing, it does not imply that you only experience positive emotions, but rather that these two affective aspects coexist harmoniously (Fredrickson, 2013). While having more frequent positive emotions might be good for us, it might harm your wellbeing if the intensity of those positive emotions is too high. According to research, extremely high positive emotions are frequently associated with risky behaviour, such as extreme alcohol use or even manic episodes (Gruber & Johnson, 2009; Weiss et al., 2019). Fredrickson (2013, p. 224) states that “experiencing more positive emotions and fewer negative emotions is better for our wellbeing up to a point.” However, more research must establish precise positive and negative emotional experiences ratios. The context in which emotions are experienced is very critical. For example, experiencing negative emotions is more appropriate: in a dangerous situation, fear can assist us to be more alert and take actions to ensure safety; in confrontational situations, anger might be more beneficial, while happiness essential in collaborative contexts is (Kim et al., 2015).

2.2.3 Causes of Subjective Wellbeing

According to Diener et al. (2018), subjective wellbeing has internal and external causes of subjective wellbeing. Individuals have intrinsic causes, including temperaments, personality qualities, outlook on life, and resilience. External causes refer to the conditions we find ourselves in. These conditions include accessing social support and residing in a desirable society (Wissing et al., 2020).

SWLS is utilized globally in psychological research as a valid and reliable measure of life satisfaction, and it has already been applied in several South African studies involving a diversity of groups (Guse et al., 2021; Keyes et al., 2008; Kliewer et al., 2018; Patel et al., 2007).

2.3 Traumatized Children

According to the United Nations International Children’s Emergency Fund (UNICEF) in South Africa and its partners in child protection, children in South Africa are at a higher risk of abuse and violence because of the widespread outcomes of Covid-19. The warning was raised after Childline South Africa reported a 36.8% increase in calls for assistance in

August 2020 compared to August 2019. This information is consistent with reports from health facilities indicating an alarmingly consistent number of severe injuries among child abuse recommendations.

“Violence against children is unacceptable anytime,” said UNICEF South Africa Representative Christine Muhigana. “It is extremely concerning that at a time of national and global crisis, children are facing violence and abuse at such horrific levels,” added Muhigana (Reddy, 2020, p. 1). In South Africa, the Covid-19 lockdown measures have slowed the spread of the virus; however, they have, in some cases, further isolated susceptible children at home and disturbed response and prevention services. UNICEF’S recent global report titled "Protecting Children from Violence in the time of Covid-19" noted that children away from school and behind closed doors face a greater risk of abuse and violence. The economic consequences of the virus have added to the socioeconomic strain on already-struggling families. Muhigana stated that “Parents, families, and individuals are understandably facing extreme stress due to the Covid-19 impact, but children should not bear the brunt of this” (Reddy, 2020, p. 2).

Emergency measures aim to create a nurturing setting for children to equip them as they enter adulthood. This includes investments in prevention and early intervention services, psychological health, youth safety, youth engagement, and work opportunities. UNICEF calls on the government, the private industry, and all partner organizations to implement emergency measures to improve the mental and physical health of children and adolescents and, ultimately, to create a society that is more adaptable and productive (United Nations International Children’s Emergency Fund, 2020).

At least one mood, anxiety, or behavioural disorder exists in children with a trauma history (D’Andrea et al., 2012). In addition, impacted children frequently exhibit difficulties with their identity in different areas (e.g., emotional, behavioural, physical, intellectual, and social); they present deficits in affection, anxiety, attachment, drug abuse, and concentration, somatic symptoms, chronic medical issues, development, and educational performance (Cook et al., 2005; D’Andrea et al., 2012; Spinazzola et al., 2005).

As mentioned in Chapter 1, Fernandes and Osório (2015) suggest that childhood trauma is associated with various negative adult outcomes. These negative childhood experiences can have permanent outcomes on an individual's life. Such traumatic experiences typically involve physical, emotional, and sexual abuse, detachment from a primary caregiver, domestic violence, and widespread trauma. Traumatic events can promote and reinforce inadequate and negative self-beliefs. These experiences can result in higher anxiety levels in response to new stressors, increasing the likelihood of developing an anxiety disorder (AD), panic attacks, generalized anxiety, and social anxiety disorders.

Traumatic experiences are not limited to adults who are employed outside of the family or home; children (from newborns to teenagers) are typically susceptible to trauma as a result of exposure to a variety of harmful events. Children are frequently both direct and indirect victims of trauma, and witnesses to adult violence in their environment. Children may have various coping abilities to deal with severe stressors; however, because children's bodies, minds, and brains are not yet fully developed, they are often especially susceptible to trauma outcomes (Wenar & Kerig, 2005). Therefore, it is essential for children to invest in psychological resources for the mastery of normative developmental duties; attempts to cope with traumatic experiences may hinder this development and lead to significant stress. Numerous studies have demonstrated that trauma in the early stages of development can have lasting consequences on personality development, Behaviour, and mental health. For example, it is now well known that adult perpetrators are more likely to claim to have been abused as children than non-abusers (Fegert et al., 2020; Nelson et al., 2020; Reavis et al., 2013). In addition to several other conditions, a South African study found that traumatic experiences and childhood PTSD increased the probability that an individual would not graduate from high school. Consequently, a trauma in childhood can have both instant and long-term outcomes. Although children exhibit trauma responses similar to adults in many ways, their developmental phase and capabilities greatly influence their responses to traumatic events. Anyone evaluating or treating traumatized children must thoroughly understand normative developmental stages (Kaminer et al., 2008).

Given the difficulties in evaluating exposure and distress levels across situations and countries, it is challenging to determine what proportion of children are exposed to traumatic experiences and how many are disturbed. When preschool-aged children are exposed to trauma, outside authorities are unlikely to become aware of trauma exposure unless caregivers or parents report it on the child's behalf. The more violent and dysfunctional a society is, the greater the number of extraordinary life stressors children will be exposed to. A study that compared the levels of exposure to traumatic experiences among South African and Kenyan youngsters, it was found that 80 percent of these adolescents had encountered severe trauma, either as direct victims or as witnesses, at some stage in their lives (Karsberg & Elklit, 2012) and in a study conducted in Cape Town, South Africa, fifty-seven of the sixty children evaluated (30 school children from a region with a high incidence of violence and thirty from a foster home in Khayelitsha) had witnessed violence. In contrast, 34 had been abused (Ensink et al., 1997). According to Cook et al. (2022), a study was conducted to investigate children's exposure to violence and aggressive parenting and to explore their relationships with self-regulation in exposed preschool-age children from low-income communities in Cape Town, South Africa. The findings correlate with the literature on the high levels of violence faced by young children in low-income communities (Cuartas, 2021; Lokot et al., 2020; Shields et al., 2008; Shields et al., 2009), verifying what is known about the challenges of violence in low-income communities in South Africa, including in Cape Town (Stats SA, 2017; Western Cape Government, 2020). The increase in violence exposure that correlates with an increase in age shown in this study underlines the importance of addressing the risk of exposure to violence in these communities, given the harmful impact of adversity on early childhood development (Black et al., 2017). Further, this could suggest that the protection of young children from violence might reduce with the increasing of age, a pattern that needs further research. Even in a survey among youth attending private schools in Cape Town, the prevalence of trauma exposure was high, with 30% reporting a violent assault by a stranger and 48% reporting an assault by a known individual (Shields et al., 2008). In a second study performed in a high-violence area of Cape

Town, more than two-thirds (68.44%) of the sixth-grade students surveyed at five schools reported being victims or witnesses of violence (Distiller et al., 2007). Not only are urban children subjected to high levels of violence, but the research on 148 children in a Northern Province rural region found that 67% had directly or indirectly encountered a traumatic experience (Peltzer, 1999). This study indicates that roughly half of the South African children may have witnessed or been directly affected by a traumatic event by adolescence. Thus, it is crucial to understand the potential outcomes of such exposure and the scope for both preventative and secondary intervention. Although no group of children is excused from trauma exposure, the levels of exposure seem to vary according to demographic factors such as gender, racial group, socio-economic status, and sociopolitical and historical circumstances (Cluver et al., 2015).

When separated from their families due to significant conflicts, children experience traumatic stress and may be orphaned or displaced. Numerous regions of Africa are home to large populations of refugee children, some of whom are unaccompanied (Hecker et al., 2022). Thus, tragic experiences may have impacts beyond initial shock and traumatization, profoundly influencing the context in which a child continues to grow. It is difficult to do justice to the overall consequences of traumatic experiences within the diagnostic systems.

2.3.1 Children with anxiety

The DSM-IV-TR (2000, p. 476) specifies the following diagnostic criteria for 300.02 generalized anxiety disorder:

(a) Excessive anxiety and worry (apprehensive anticipation), occurring on most days for at least six months about various events or activities (such as work or school performance).

(b) The individual struggles to control their anxiety.

(c) The anxiety or worry is accompanied by at least three of the following symptoms: (with at least some symptoms present for more days than not for the past six months). Note: Only one item is necessary for children.

(i) Unease or a sense of being tense or on edge.

(ii) Being quickly exhausted.

(iii) Trouble concentrating and a blank mind.

(iv) Irritability.

(v) Muscle tension.

(d) Sleep disturbances (difficulty falling asleep or staying asleep or restlessness) are common.

(e) Anxiety and worry are not restricted to features of an Axis 1 disorder; for example, anxiety and worry are not about having a panic attack (as in panic disorder) or being embarrassed in public (as in social phobia).

(f) The anxiety, concern, or physical symptoms cause clinically significant impairment or distress in important social, occupational, or other areas of functioning.

(g) The disturbance is not caused by the direct health consequences of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism), nor is it unique to a mood disorder, psychotic disorder, or pervasive developmental disorder.

2.3.2 The psychology of children with anxiety

According to Sweeney and Pine (2004), anxiety is a psychological state frequently compared to fear. Anxiety includes thoughts (such as concern), behaviour (such as aversion), feelings (such as panic), physical reactions (such as an increased pace of breathing), and interpersonal aspects (Morris & March, 2004; Ollendick & March, 2004; Boer et al., 2001; Headley & Campbell, 2013). It is an instinctive reaction to a serious risk and might be motivated by safety concerns (e.g., supporting in exam preparation or discouraging pedestrians from crossing in front of moving vehicles). When a growing child is exposed to stimulation which they are unable to comprehended or regulate, these protective responses supports the child (Craske, 1997; Ollendick & King, 1991). Anxiousness during infancy is a natural developmental stage.

Typically, children outgrow feelings of anxiety as they become older (e.g., scared of storms or at night). Nonetheless, some children experience anxiety beyond the norms for

their age. Anxiety disorders are characterized by excessive stress, which is on a continuum with normal anxiety levels, which can be beneficial (Eysenck, 2014). When a young person experiences fear that is out of proportion to the threat level and when there is a fear response in the absence of a true threat, this is when excessive anxiety emerges (Lewis et al., 2022; Sweeney & Pine, 2004). Despite the fact that anxiety is a continuity, it is classified as a medical condition when a person exhibits serious anxiety indicators that last for a long time (lasting within one and six months, obviously reliant on the disorder), are inappropriate for their stage of development, and interfere with daily functioning in numerous ways, frequently leading to avoiding behaviours (American Psychiatric Association [APA], 2011; Lewis et al., 2022; Campbell, 2007).

It has been found that children with excessive anxiety have challenges with peer and familial relationships, general, social, and psychological impairments, and lower academic achievement (Ezpeleta et al., 2001; Grover et al., 2007; Woodward & Fergusson, 2001). Adverse outcomes of anxiety disorders, such as extreme school truancy (Calvete et al., 2018) and difficulties in peer relations (Headley & Campbell, 2013), can lead to poor long-term vocational adjustment and poor self-esteem (Etkin et al., 2022; Campbell, 2007).

Educators asserted—contrary to previous study—those externalizing behaviours like acting out, being violent, or being hostile could signify excessive stress. According to research, anxious youngsters exhibit more avoiding behaviours, whereas defiant children exhibit more confrontational behaviours (Lester et al., 2010).

As mentioned in Chapter 1, there is another significant concern that sifted into the lives of all individuals worldwide: the Covid-19 pandemic. It impacted the lives of billions of individuals worldwide and disrupted economic, social, and educational systems. After this disruption, the world will never be the same again. The Covid-19 report on child protection reported that many children witnessed or were victims of violence and abuse (United Nations Educational, Scientific and Cultural Organization, 2020).

In response to children's high levels of anxiety, and physical and emotional abuse during Covid-19, a high-level board of child protection and children's rights experts

assembled a virtual meeting of the "African Child Trauma Conference" on October 7 and 8, 2020. Jelly Beanz, UNICEF South Africa, End Child Prostitution and Trafficking (ECPAT) international, and the Teddy Bear Foundation hosted the conference. In the context of the pandemic, it aimed to identify revolutionary and ground-breaking solutions and strategies to promote child protection within the context of the pandemic. Other UN agencies, the South African government, the private sector, and academics attended to promote child protection. During the meeting, an "Emergency Action Plan" was created in response to the catastrophic consequences of violence and abuse on children. It also provided particular action points for government partners, United Nations agencies, the private sector, and civil society at the international, regional, and federal levels to generate actions for children at risk of being left behind, such as children with disabilities, children on the move, children impacted by violence, abuse, neglect, and exploitation, and children with mental health issues.

According to a recent survey conducted by the National Association of Head Teachers in the United Kingdom (Cassidy, 2015), one in five children will experience a mental health issue before the age of 11, with anxiety being the most prevalent. There are numerous reasons why children may experience anxiety. Some children struggle with separation anxiety and have difficulty adjusting to school away from their parents. Some are disturbed by domestic issues, such as a divorce or death. However, for many, anxiety is provoked by school-related pressures. Academic achievement is increasingly emphasized at the expense of physical and mental health, good social relationships, and effective communication (Cassidy, 2015).

Even so, little psychological education is provided to teachers as a requirement of their educational credentials (Gowers et al., 2004). According to reports from educators, this exclusion could leave them inadequate in identifying the needs of children at school and responding accordingly to children’s specific needs (Green et al., 1996; Rothi et al., 2008; Rothi et al., 2005). Cvinar (2010) agrees that the absence of formal training may also lead to incorrect recommendations and an inability to recognize and meet the needs of these

children. Future studies need to investigate into how educators describe anxiety in children and the point at which it becomes excessive.

According to Headley and Campbell (2013), teachers sometimes struggle to identify youngsters who have internalizing challenges since these children frequently behave good in class (Molins & Clopton, 2002) or because they accept that the child's internalizing disorders could very well improve with age (Green et al., 1996). Recent research has shown that although educators are capable of identifying psychological challenges, they are much more focused on externalizing challenges in children than internalizing challenges (Loades & Mastroyannopoulou, 2010; Papandrea & Winefield, 2011; Walter et al., 2006). These findings may indicate that educators have difficulty understanding internalizing disorders, their consequences, and how to recognize internalizing disorder symptoms given the widespread incidence of internal challenges, particularly anxiety disorders. It is difficult for educators to recognize the symptoms of internalizing challenges, especially anxiety disorders, due to their basic characteristics.

Wenar and Kerig (2005) mention that research demonstrated that anxiety disorders incline to run in families. Bandura's theory of social learning, which has received a lot of attention in this field of study, contends children may subjectively obtain avoidance or anxiety through their parents (Bandura, 2005). In addition, parental figures may verbally communicate their anxiety in the nearness of their child, either directly to the child, to another individual (such as a partner), or when speaking to themselves. When faced with an anxiety-inducing trigger, children may observe their parents' using avoidance as a coping mechanism (Fisak & Grills-Taquechel, 2007).

There are three potential processes by which parental anxiety might influence the child. These are avoidance as a coping strategy and imitating parental models, and the parent may become irritable with the inhibited child, worsening the child's anxiety (Wenar & Kerig, 2012). According to Fisak and Grills-Taquechel (2007), there are three risk factors for child anxiety development. The first risk factor that earned the most attention in studies on

how children acquire anxiety from their family context is parental modelling of avoidant or anxious behaviour.

Parents typically provide the most significant learning opportunities throughout a child's development. The extend to which primary care givers provide learning experiences connected to anxiety may significantly contribute to the onset of anxiety in children due to regular and extended interaction with parents (Fisak & Grills-Taquechel, 2007).

Fisak and Grills-Taquechel (2007) describe reinforcement of anxious and avoidant behaviours as a second risk factor or learning method connected to the etiology of anxiety challenges in children. It has been theorized that parental figures may encourage, facilitate, or praise anxious/avoidant behaviours in children (Rapee, 2002). As an example, a caregiver could eliminate a child from a fearful event (e.g., by taking a child home early on the day of a test from school), advocate and attain a child's prevention of anxious circumstances (e.g., by allowing a child to avoid school or a group event), to give a child special treatment in an effort to reduce their anxiety (e.g., by giving attention or incentives), or approve the exclusion of duties (e.g., by removing garbage for a child when there is a scary situation, such as a big dog outside). Under these conditions, parental behaviour may be troubling, as efforts to reassure or calm the child may be negatively and positively reinforcing. Children can keep participating in such behaviours to get positive reactions from their primary caregivers or avoid unpleasant situations.

Instructional learning or information transfer has been linked to the development of child anxiety as the third risk factor mechanism of learning. In other words, parents can communicate to their children about wellbeing, safety, and scenarios that can be prevented because of the possibility of injury. Despite the fact that messages are meant to defend the child, parents could exaggerate the danger in certain situations (Fisak & Grills-Taquechel, 2007). In addition, parents may be communicating dangerous messages more frequently or excessively. For example, when children are playing outside, parents of anxious children communicate more anxious messages (such as "be careful" and "do not climb too high") than parents of non-anxious children (Fisak & Taquechel, 2007, p. 9). These messages may

impact children's understanding and interpretations of these situations and heighten their level of anxiety. Because parents are typically the first, greatest essential, and most impactful source of guidance to their children, anxious parent–child interaction could have a disproportionate influence on how a child perceives different scenarios and stimulation (Fisak & Grills-Taquechel, 2007).

During 2016 to 2019, the Centers for Disease Control and Prevention (CDC) in the United States reported that 9.4% of children aged 3 to 17 (approximately 5.8 million) had been diagnosed with anxiety. Anxiety is becoming an increasingly prevalent issue among children today. Many believe that anxiety in children is grossly underdiagnosed and underrecognized. Johnstone et al. (2018) note that regardless of the widespread pervasiveness and detrimental outcomes of depression and anxiety, fewer than one-fourth of children receive treatment for these mental disorders (Korkodilos 2016; Lawrence et al., 2015; Merikangas et al., 2010). Moreover, many children seeking psychological treatment do not experience persistent benefits (Ginsburg et al., 2005; Weisz et al., 2018).

Mostert and Loxton (2007) report that the prevalence of anxiety symptoms among South African children is considerably higher than in other countries. An urgent need for efficient early anxiety intervention and prevention programs for South African children is needed. In South Africa, the prevalence of children with anxiety disorders is high. Perold (2001) state that the prevalence rate of childhood anxiety symptoms among 7- to 13-year-olds in the Western Cape was between 22% and 25.6%. Epidemiological studies indicate that phobia and anxiety disorders influence 2.2% to 9.5% of adolescents and children in community samples (Costello et al., 2003; Polanczyk et al., 2015). Furthermore, it has been found that the occurrence of these challenges is fairly high among South African children (Burkhardt et al., 2003; Muris et al., 2002, 2006; Howard et al., 2017). According to Chiu et al. (2016), anxiety disorders are the most prevalent mental illness among children and Adolescents. Such conditions include generalized and separation anxiety disorders (SADAG, 2018).

2.4 Interventions for Traumatized Children with Anxiety

As mentioned in Chapter 1, there have been concerns regarding the delay between initial referral and treatment. Most diagnosed children in the US child welfare system had not received treatment 12 months after their initial diagnosis (National Research Council and Institute of Medicine, 2012). According to Duffee (2021), recent developments in understanding the lifelong outcomes of early childhood adversities have simplified the need for a structured approach to identify and intervene with children, adolescents, and families at risk for maladaptive responses. The resulting pediatric healthcare delivery strategy fosters and restores resilience in children and adolescents, collaborates with families to promote relational health, and reduces secondary trauma among pediatric healthcare clinicians. The guidelines in this statement and the clinical report build on previous policies of the American Academy of Paediatrics that address the needs of children and adolescents in foster care or from low-income or homeless families.

According to Lieberman et al. (2011) in Chapter 1, developmental psychopathology of infancy and early childhood is not included in the curriculum for graduate studies in psychology and other mental health disciplines. In addition, Lieberman et al. (2011) explain that child mental health providers are typically trained in individual treatment approaches that exclude parents and are, therefore, inappropriate for young children. During a traumatic event, the support and nurturing of the primary caregiver are the greatest priority during a trauma situation. It can influence the mental health outcomes of children even more than the trauma itself. Hagan et al. (2016) focus on the necessity of parent-child relationships during investigations of trauma exposure in early childhood. In Chapter 1, Kaminer and Eagle (2010) state that there are still gaps in the knowledge of trauma intervention models in South Africa. We need to focus on new perceptions of trauma resilience and coping mechanisms in our country.

In Chapter 1, Gregorowski and Seedat (2013) mention different treatment strategies for two kinds of trauma. The Complex Trauma Group of the National Child Traumatic Stress

Network (NCTSN) developed complex trauma interventions for chronic traumatization. Child-parent psychotherapy and trauma systems therapy (TST) for developmental trauma exist.

Considering the wide prevalence of childhood trauma and the complexities of the phenomena, research is needed into the fields of trauma and the subsequent conditions that require interventions. This research aims to provide information on the need to facilitate posttraumatic growth support (e.g., self-esteem, wellbeing, and resilience) following trauma (Kilmer, 2014).

According to Headley and Campbell (2013), elementary school educators are a reliable provider of assistance. They can promote assistance by directing schoolchildren to psychological programs offered by the school or by local organizations (Rickwood et al., 2005). They usually provide parents with support and direction because they are frequently the first individuals outside the family to identify psychological challenges (Headley & Campbell, 2013).

Teachers are essential in identifying potential mental health challenges, but they are neither intended nor qualified to make any diagnosis on children. Educators may address a child's emotional or behavioural challenges internally after recognizing them (i.e., in the classroom itself) if they are convinced that they have the necessary skills to address matters or refer the child to the school psychologist for assessment and treatment or if deemed necessary, consider additional school support (Rickwood et al., 2005). Nevertheless, educators receive minimal to no training or education in psychological health as part of their training certification (Gowers et al., 2004). According to Shelemy et al. (2019), recent increases in the number of secondary school exclusions in the United Kingdom suggest that schools cannot address challenging classroom behaviour effectively. Consistent with educators' findings, this negligence may leave them unprepared to identify and successfully address the needs of the children in the class (Green et al., 1996; Rothi et al., 2008; Rothi et al., 2005). By leaving teachers unprepared to recognize and meet the requirements of these children, this lack of training could also lead to incorrect referrals (Cvinar, 2010).

According to a study in South Africa, Visagie et al. (2021) found that cognitive behaviour therapy (CBT) is a well-established, well-researched, and evidence-based

intervention for the treatment and prevention of anxiety (Silverman et al., 2008; Walkup et al., 2002). However, despite CBT's promising results, fewer than a quarter of children with anxiety disorders receive treatment (Korkodilos, 2016; Lawrence et al., 2015; Merikangas et al., 2010), many of those who begin treatment will discontinue it prematurely (Pina et al., 2003; Wergeland et al., 2015), fail to respond (Rey et al., 2011) or continue to experience recurrent difficulties after treatment (Last et al., 1998). A possible approach to overcoming these limitations and addressing the high prevalence of anxiety and its negative outcomes is to emphasize anxiety prevention (Johnstone et al., 2018).

Research done by Johnstone et al. (2018) demonstrates that existing anxiety and mood disorders intervention approaches may be beneficial in reducing depressive symptomatology during post-prevention and long-term follow-up. There was, nevertheless, no evidence that these programs reduce anxiety symptoms. All the programs used in this meta-analysis were based on CBT fundamentals, and while the findings suggest that all these programs produce some modest advantages, there is room for improvement. Therefore, future research could investigate using different therapeutic strategies or techniques to determine if they would yield better results.

In recent years, educational psychologists have strongly emphasized systemic assessments, despite admiring the change toward positive psychological testing of children and adolescents. They might collaborate with whole schools, grades, and school systems (Lowe et al., 2013) while evaluating capacity and strength (Ferreira & Ebersöhn, 2011).

As mentioned in Chapter 1, Bronfenbrenner and Morris's (1998) ecological systems theory was the focus of my research. They claimed that investigating a child's living environment is essential to comprehending the child. According to Guy-Evans (2020), the ecological systems theory of Bronfenbrenner views child development as a complex system of interactions influenced by multiple levels of the immediate environment, ranging from immediate family and school settings to broader cultural beliefs, laws, and customs. To investigate a child’s development, we need to consider the child and their immediate environment and their collaboration with the larger environment. Bronfenbrenner categorized

the child's environment into four distinct systems: the microsystem, mesosystem, macrosystem, and exo-system. I discuss Bronfenbrenner's ecological systems theory under the theoretical framework for this study.

2.5 Wellbeing Interventions for Children

Morris (2009) involves students in wellbeing education, in other words, the broad field of positive psychology. He explains multiple clinical processes consisting of recognition, intervention, and evaluation (reflect). In this methodology, merely requesting children to observe facets of themselves and their surroundings increases their wellbeing awareness. Therefore, children are required to apply the essential skill of wellbeing. Knowing when things are going well and when they are not enables them to modify their lives. In the second stage, the child takes steps to contribute to their flourishing and happiness. During the phase of assessment and reflection, children can evaluate the efficacy of the action plan steps. Morris (2009) differentiates between experiential and reflective techniques in positive psychology. Experiential techniques include participation in games, recreations, and assuming the role of a scientist carrying out experiments with interventions. Techniques for reflection may include journaling, sharing, discussing, developing scenarios, and implementing visual material (Eloff, 2013).

The conceptualization of coping is crucial for promoting subjective wellbeing. Coping involves individuals' efforts to survive in an immediate situation by effectively implementing methods to deal with expected, prevailing, or arising matters, difficulties, and any negative emotions associated with them (Aldwin et al., 2021). Aldwin’s definition of coping differs from that of Snyder and Pulvers (2001), as Snyder and Pulvers (2001) explain coping as involving one’s thoughts, emotions or trying to maintain a relaxed psychological state in the face of adversity. Time and context, including interpersonal, environmental, and cultural challenges, and with an individual's personality and subjective experiences, influence how individuals perceive and respond to stressful situations and challenges (Snyder & Pulvers, 2001).

This correlates with the internal and external causes of subjective wellbeing. Individual internal causes include temperament, personality traits, outlook on life, and even

resiliency. External causes refer to the conditions in which individuals find themselves, such as having access to social resources and residing in a desirable society (Wissing et al., 2020). According to Zeidner et al. (2016), two primary factors influence an individual's coping strategies. First, a person's coping style is determined by their assets, such as available resources, efficiency, commitment, beliefs, and values. Second, knowledge related to possible coping strategies and personal beliefs regarding the efficacy of the various options determines how individuals respond to challenges. In turn, coping effectiveness depends on a given situation's internal and external demands of a given situation. My research explores the subjective wellbeing and coping strategies of young, traumatized children with anxiety.

Measuring and monitoring initiatives or objective indicators have vastly improved in South Africa, mainly due to implementing laws aimed at enhancing the welfare of children (Savahl et al., 2017). A study by Eloff (2008) explored the ways in which young South African children perceive the concept of happiness. The findings indicated that participants constructed 'happiness' in terms of relationships, amusement, and on the obtainment of material possessions. Further studies in Africa and Southern Africa contexts are recommended to expand the diversity of insights needed to recognize how young South African children understand happiness (Eloff, 2008). Adaptation across cultures and the translation of internationally validated instruments can be expanded. Additional translation and cross-cultural testing of subjective wellbeing instruments are also recommended. Given the age differences in subjective wellbeing, it is suggested that further research be conducted across multiple age groups (Casas (2011). Noting the recommendations of Casas (2011), Eloff (2008) and Savahl et al. (2015), qualitative research initiatives that encourage a deeper understanding of children's subjective perceptions of wellbeing are recommended.

This positive change materializes in several domains (Tedeschi & Calhoun, 1998; 2004). These positive changes are an increased sense of personal confidence in one's capacity to survive. Trauma survivors can also gain new perspectives on their relationships by recognizing positive and negative characteristics in others. Due to their desire to disclose

their experiences during and after a traumatic experience, many individuals report learning who their true friends are or whom they can depend on. Many survivors find themselves developing greater comfort with intimacy. They may develop closer relationships with others who have endured similar circumstances and, as a result, develop a greater capacity for empathy for those experiencing life challenges. Only a few studies have examined posttraumatic growth (PTG) in children (Cryder, 2006), indicating possibilities for future child PTG research. Positive growth is connected to the theoretical foundations of positive psychology and other third-wave therapies. Intervention programs for children also need to be culturally relevant and appropriate (Rasmussen et al., 2011), as well as grounded in the knowledge and practice of overall child wellbeing, in addition to an experienced understanding of how trauma and stress manifest in children at different ages (Delaney-Black, 2002).

According to Savahl et al. (2015), South Africa is prepared to improve the lives and wellbeing of children, within the socio-political context. Further findings from Savahl et al. (2015) suggest that the high levels of subjective wellbeing are counterintuitive within the South African context and may create a false sense of accomplishment and negatively affect the motivation of policy programs and service delivery. As the above findings do not support the objective indicators of wellbeing, there is a risk that the focus on subjective wellbeing would be understated. In South Africa, subjective wellbeing research is still developing; the lack of empirical initiatives makes it difficult to chart a course forward for the relationship between wellbeing research, childhood trauma, and anxiety.

Deeper access to the meanings associated with subjective wellbeing and a more comprehensive understanding of subjective wellbeing and quality of life would be facilitated by qualitative techniques' that allowed for in-depth investigation (Savahl et al., 2015). Chiu (2016) opines that anxiety disorders are the most prevalent mental disorder among children and adolescents. These include childhood anxiety disorder and separation anxiety disorder (SADAG, 2018). Research done at the University of Western Cape reports on various social, educational, health, and psychological pointers of South African children's wellbeing before

and after the 1994 elections. As the country's reconstruction and development program progresses, the pressing need for social and psychological services for children remains a major concern (Lockhat & van Niekerk, 2000).

According to research by Schmitt (2019), the prevalence of anxiety among elementary school children in South Africa is rising, but they can overcome it with the right support. Support from other professionals is essential to empower teachers to sustain strong, supportive relationships with traumatized children and to maintain the children's classroom behaviour. In the South African context, the question is how it can be supported optimally (Phasha, 2008).

2.6 Trauma and Subjective Wellbeing

Vaillancourt-Morel et al. (2019) argue that sexual trauma in childhood is a breach of trust and boundaries between the child and the perpetrator. The perpetrator in this study can be a direct or extended family member, a familiar individual outside the family, or a stranger. In this way, sexual trauma in childhood can cause significant psychological distress in those affected. According to Lambie and Reil (2021), childhood abuse was found to be linked with negative life perceptions for both male and female participants. They also indicated that adult re-victimization is likely to occur for survivors of childhood abuse. In contrast, adults who had positive childhood experiences frequently report extremely high levels of life satisfaction, suggesting that those who experienced childhood trauma may have lower levels of subjective wellbeing (Hinnen et al., 2009). Hinnen et al. (2009) evaluated family context, parental behaviour, childhood adversities (such as divorce, neglect, and abuse), adult attachment style, and life satisfaction in their study. According to the regression analysis findings, childhood memories influence adult attachment, which anticipates overall subjective wellbeing (Hinnen et al., 2009).

Hinnen's et al.'s (2009) study of the consequences of childhood trauma and levels of subjective wellbeing correlates with Corcoran and McNulty (2017), in addition to psychological distress, childhood trauma can have a negative impact on an individual's subjective wellbeing (SWB). Positive affect, negative affect, life satisfaction, and flourishing

are the four components of SWB. SWB refers to an individual's cognitive and affective life evaluation.

Oshio et al. (2013) found that childhood abuse was related to decreased adult SWB. In addition to experiencing adversity, researchers noted that having insecure attachment in adulthood (i.e., fear or insecurity in relationships) is also associated with lower SWB, according to research by (Lavy & Littman-Ovadia, 2011). Given both associations, it is reasonable to think that childhood adversity may decrease SWB due to insecure attachment. For instance, emotional abuse and neglect as a child may cause an individual to fear rejection and seek closeness when rejection signals are perceived. This feeling of insecurity may result in unhealthy or failed relationships, a lack of social support, and a diminished life evaluation (Oshio et al. 2013).

2.7 Criticism of Subjective Wellbeing

Although the concept of subjective wellbeing includes both internal and external influences on our lives, the emphasis is on the individual and a subjective view of happiness. Arcidiacono and Di Martino (2016) criticize subjective wellbeing for being too dependent on personal resources. Contextual factors, such as living in a supportive society and having access to material resources, are only considered if they have a positive outcome on an individual's quality of life. Happiness is observed as the outcome of an individual's efforts and is measured by creating life satisfaction. According to Arcidiacono and Di Martino (2016), too much emphasis is placed on the individual's ability to choose and change the context, regardless of the objective qualities of the context and the resources it may or may not provide. Consequently, SWB fails to adequately account for context and the dynamic interaction between individual, interpersonal, and environmental phenomena in the experience of wellbeing. This is especially critical in the context of South Africa, where our society continues to remain one of the most unequal in the world.

Peterson (2009, p. 3) is of the view that positive psychology generally reframes how individuals view children. It is essential to encourage the world that "the kids are all right"; most are happy, healthy, and have close relationships with their parents. They value their

educators. Children are deeply committed to character development, doing the right thing, and making a difference (Peterson, 2009). Positive psychology is not excessively optimistic but acknowledges that assets and strengths exist with challenges. While Peterson's (2009) argument may be legitimate in a developed context, it is significantly more complicated in a developing context like South Africa. Many South African children strive to be happy and healthy, but they face daily obstacles. It is highly challenging for children to overcome the limitations of poverty, HIV/AIDS, and crime which present significant obstacles. In light of this, an interpretation of Peterson's (2009) reasoning may impose acknowledging the high prevalence of strengths and capacities in children while considering the coexistence of challenges and strengths. However, note that the *zeitgeist* in both professions and disciplines (education and psychology) has provoked a teaching/learning approach that promotes strengths and capacities and a constructive, positive attitude (Eloff, 2013).

2.8 The Interventions in this Study

2.8.1 Psychotherapeutic Techniques

The literature strongly supports the use of integrative approaches to psychotherapy (Stricker & Gold, 2011; Erskine & Moursund, 2019; Eubanks & Goldfried, 2019; Reinares et al., 2020). The integrative techniques for my research were based on the following psychotherapy interventions:

- Positive psychology interventions enable a child to improve their self-esteem, to know themselves better, and to accept themselves for who they are (Carr et al., 2021).
- Gestalt play therapy is a method for increasing a child's awareness and assisting them in getting in touch with their intense emotions (Blom, 2006).
- Sandplay therapy enables the child to deal with trauma and especially anxiety (Turner, 2017).
- Somatic experiencing play therapy techniques use the brain, memories, body, senses, and nervous system to help children with anxiety and trauma (Levine & Kline, 2006).

Before any intervention process could commence, it was essential to do an emotional assessment with all the participants to determine the central theme(s) of their presented problem. The assessment process was necessary for crucial rapport building between therapist and client. When the participant feels safe, trusted, and accepted, they will open and share, and corrective change (psychotherapy) will occur. The therapist gathers background information about the participant's presenting problem. The intuitive approach can begin when the therapist and the participant have established, a trusting relationship with each other.

2.8.1.1 Positive Psychology. Carl Rogers (1961, p. 22) describes change experience thus:

"The paradox that characterizes my experience is that the more I simply am willing to be, in the midst of all the complexity of life, and the more I am willing to understand and accept the reality in myself and in others, the more change occurs". In South Africa, a new focus is on health and wellbeing, and on what is right with an individual instead of only what is wrong with him/her (Wissing et al., 2020).

Positive psychology interventions (PPIs) are defined as interventions in which the goal of enhancing wellbeing was attained in ways consistent with positive psychology (Carr et al., 2021).

In his work in positive psychology, Seligman (2018) mentions constructs such as national psychological explanations of wellbeing, positive psychotherapy, the classification of strengths and qualities, comprehensive soldier fitness, and positive education as positive psychology claims. Beyond psychology, positive psychology has spread to neuroscience, health, psychiatry, theology, and the humanities. Seligman (2018) hopes that positive psychology and the promotion of wellbeing will become a pillar of morality, politics, and religion. Therefore, positive psychology is not a new 'trend', but rather it is expanding and advancing as a scientific field.

2.8.1.2 Gestalt Play Therapy. Blom (2006) asserts that gestalt therapy is a humanistic and process-oriented form of therapy. It incorporates concepts from other

theoretical perspectives, including psychoanalysis, gestalt psychology, and humanism. Additionally, it is an experiential approach emphasizing awareness of the present moment and immediate experience (Blom, 2006; Oaklander, 2018). Gestalt therapy integrates the cognitive and emotional totality of every individual, every moment, and every circumstance. This theory focuses on the right-hemisphere, nonlinear thought. It is defined by metaphors, fantasy, figurative language, body posture and movement, and the complete expression of emotion using the entire body in action (Clarkson, 2014).

According to Oaklander (2018), this psychotherapeutic technique aims to provide the child with opportunities to express their emotions verbally and nonverbally. This statement correlates with Clarkson (2014) who states that individuals express their emotions utterly by using the entire body, verbally, and nonverbally. Furthermore, the child is expected to play out their trauma symbolically and learn to control their emotions more effectively. The child will learn to establish a relationship of trust with another individual (Oaklander, 2018).

2.8.1.3 Sandplay Therapy. According to Turner (2017), sandplay therapy is a therapeutic technique that supports children with mental distress. The sandplay therapist encourages the client to create whatever they wish in the tray and observes the work in silence. The sandplay method permits the client to transcend the boundaries of their conscious state, thereby creating a space for the unconscious to guide and facilitate the healing and development of the psyche. Sandplay is based on the personality theory of Carl G. Jung, a world-famous Swiss psychiatrist, and psychotherapist who lived and practiced in the small suburb of Kusnacht, just outside of Zurich, on the shores of Lake Zurich. Jung's work emphasized the image-based, non-rational content that flows from the unconscious (Turner, 2017).

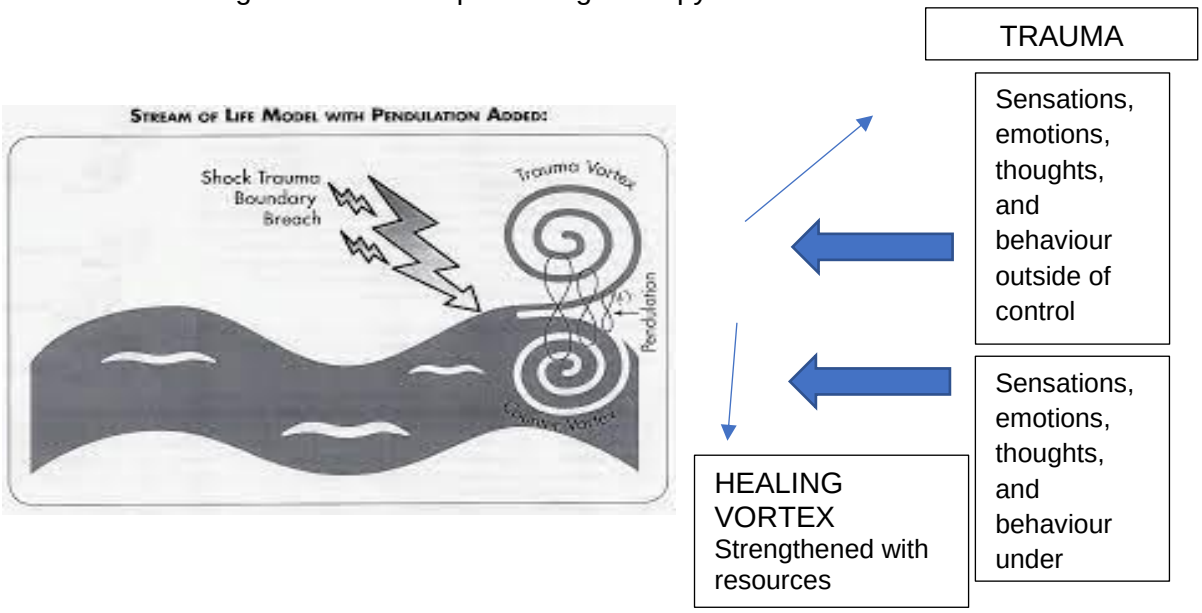
Sandplay therapy allows the child to tell their story through symbols within a defined space. The child can recreate past events and situations in the sand tray and in their imagination while telling their story. During this activity, corrective change takes place. It is essential for the therapist to allow the developing process to occur without interpretation or interference and to refrain from assuming the meaning of symbols or objects in the sand. It

is preferable to investigate the meaning the child assigns to their story. This increases the child's awareness of challenges and changes in the world (Geldard et al., 2017).

2.8.1.4 Somatic Experiencing Play Therapy. This therapeutic technique can be described using a metaphor, e.g., “River of life”. This metaphor describes our emotional life, which flows like a river within its banks. This river contains all the sensations, feelings, thoughts, and behaviours that are under our control. There are also stones and boulders in the riverbed that represent difficult situations we have faced in the past that may account for some of our personality quirks, but which are still under our control. When traumatic shocks are too overwhelming, they cause a break in the riverbank, which creates a rush of energy that is outside our control: a trauma vortex (Ross, 2010). Somatic experiencing therapy is a powerful technique to help children to reverse the spiral of the trauma vortex, engage in the healing vortex, and return their nervous systems, bodies, and brains to a sense of safety and wellbeing, as depicted in Figure 2.1.

Figure 2.1:

Visual Image of Somatic Experiencing Therapy



Riordan et al. (2017)

According to studies by Briggs-Gowan et al. (2010), children in the United States experience high rates of trauma, with one in four children experiencing or witnessing a traumatic event by age four. Cognitive Behavioural Intervention for Trauma in Schools is

currently used to treat trauma in school-based settings (CBITS). CBITS has effectively reduced post-traumatic stress disorder symptoms, according to a three-month follow-up after treatment (Stein et al., 2003). However, as Van der Kolk (2014, p. 176) states, “The imprints of traumatic experiences are organized not as coherent logical narratives but as fragmented sensory and emotional traces”. Therefore, a treatment that is not primarily focused on cognitive therapy (such as CBITS), but is an overall mind-body approach, may be an important addition to school-based trauma treatment.

Extensive research has been conducted on mind-body approaches to school-based treatment (Cozzolino et al., 2021; Garbers et al., 2021; Maykel & Bray, 2020). Somatic Experiencing (SE) is one therapeutic approach that schools could implement (Sultan, 2019). According to Hughes and Levine (2016), Peter Levine developed somatic experiencing almost fifty years ago. Levine's work is to some extent based on observations of animals in the wild and how they respond to threats differently than humans by discharging fight-or-flight energy through trembling and shaking. To Hughes and Levine (2015, p. 197) “trauma is a result of a biological response to threat, where the event is frozen in time”. Bottom-up procedures, in contrast to top-down approaches, emphasize the body and 'body memory’. In other words, these methods emphasize subcortical brain regions, such as the brain stem and limbic system. Beginning with these more primitive brain structures and their embodied responses, bottom-up approaches aim to modify how the body responds to traumatic experiences and work up to higher cortical systems (Levine, 1997; van der Kolk, 2014).

In a school-based setting, Sultan (2019) investigated the use of somatic experiencing to relieve the symptoms of trauma in adolescents aged 12 to 18. The findings indicated that somatic experiencing may benefit children in a school-based setting. According to Levine and Kline (2014), pain and trauma are unavoidable aspects of life, but so is the capacity for resilience, or the ability to bounce back. Levine and Kline (2014) discuss the SE intervention process of five different cases of child trauma and how somatic experiencing interventions were implemented in the healing process. The interventions focused on children from ages three to 12 years.

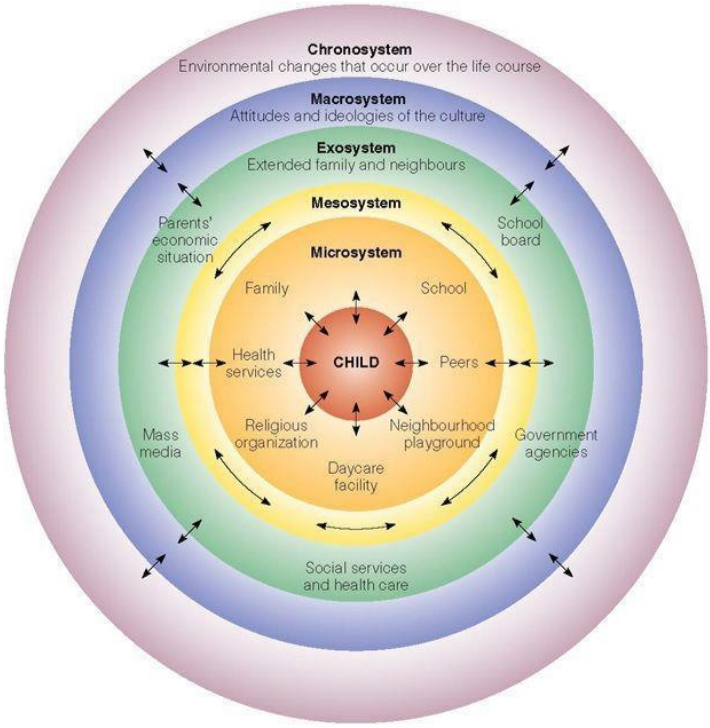
2.9 Theoretical Framework

Bronfenbrenner and Morris (1998) state that to comprehend the child, one must examine the child's living environment. According to Bronfenbrenner's ecological system model (Steyn & van Rensburg, 2014), the child's development is influenced by a set of interrelated systems.

Bronfenbrenner (2005) categorizes the child's environment into micro-, meso-, macro-, and ecosystem systems (Bronfenbrenner, 2005; Kail & Cavanaugh, 2010).

Figure 2.2

Theoretical Framework for this Study



Guy-Evans (2020)

2.9.1 Microsystem

The first level of Bronfenbrenner's theory is the microsystem, which consists of individuals who have direct contact with the child in their current environment, such as their parents, teachers, siblings, and peers. Relationships in a microsystem are bidirectional, which means that the child can influence and be influenced by the beliefs and actions of

others in their environment. Moreover, the child's responses to individuals in their microsystem can affect how they treat those individuals in return. The interactions within microsystems are highly personal and vital for promoting and supporting the child's development. A strong, nurturing, and caring relationship with their parents is said to have a positive influence on the child, whereas detached and emotionally distant parents will have a negative impact on the child (Guy-Evans, 2020).

As stated in Chapter 1, Wenar and Kerig (2005) discuss the family and school context risk factors for the development of anxiety. They include insecure attachment, interparental conflict, abuse, neglect, and domestic violence; antisocial friends are risk factors in a social or school context. Trauma can strengthen negative beliefs about oneself. The context can influence a child's anxiety levels when confronted with new stressors (Fernandes & Osório, 2015).

2.9.2 Mesosystem

According to Guy-Evans (2020), the mesosystem represents the interactions between the child's microsystems, such as between the child's parents and teachers or between the child's school peers and siblings. The mesosystem is where an individual's microsystems are interconnected and create influence over one another in a relationship (Christensen & Rudebusch, 2016). For example, if the parents of a child communicate with the child's teachers, this interaction may affect the child's development. A mesosystem is essentially a collection of microsystems. According to the ecological systems theory, if the parents and teachers of a child have a good relationship, this will have positive outcomes on the child's development, as opposed to adverse outcomes if the teachers and parents do not get along. Therefore, the school is essential in treating traumatized children with anxiety.

Landsberg et al. (2005) concur with Christensen and Rudebush (2016) that at this level, family, school, and peer groups interact, altering each system. When a child comes from a neglected or abusive family, the school can be a protective factor to boost the child's self-esteem and reduce the adverse circumstances at home. Since a child spends most of

his time at school, the school's impact on the child's development is second only to that of his parents (Webb, 2018).

2.9.3 Macrosystem

The macrosystem is a part of Bronfenbrenner's ecological systems theory. It concentrates on how established cultural factors such as socioeconomic status, wealth, poverty, ethnicity, and geographic location influence a child's development by impacting their beliefs and perceptions about occurring incidents. For instance, a child living in a third-world country would develop differently than a child living in a wealthy nation (Guy-Evans, 2020). A child exposed to community violence is more at risk of developing behavioural issues (Wenar & Kerig, 2005). On the other hand, the church and community center function as a protective factor in the child's cultural environment.

2.10 Conclusion

This chapter discussed the theoretical concepts that underpin this study. I first discussed what the subjective wellbeing of young children implies. Then I discussed and described empirical studies on traumatized children and children with anxiety. This discussion included definitions of anxiety, diagnostic information about anxiety, and many children with anxiety who remain undiagnosed. I then presented global and South African trauma statistics and the prevalence of trauma and anxiety. I then considered various wellbeing interventions for traumatized children with anxiety worldwide and in South Africa. I then addressed the interventions planned for this study. I concluded the chapter with the theoretical framework for this study. I describe and identify the methods and approaches I employed for my research and inquiry strategies in the chapter that follows.

CHAPTER 3:

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

In this chapter, I discuss my research methodology and data collection strategies and justify my preference for an interpretive phenomenological research study, using vignettes. I explain why I chose this specific research study and its participants. I describe the process, development and writing of the vignettes and collection of data, analysis of data, and methods of interpretation. A detailed session timetable indicates the intervention sessions that were completed during the research project. I then explain the intervention sessions at the individual participant level.

3.2 Integration of the Research Design for This Study

Table 3.2 offers an integrated view of the research design for the study. The table includes the primary research question, subsidiary research questions, and interpretive phenomenological research design.

Table 3.1

An Integrated View of the Research Design for the Study

<table>
<tr><td colspan="6">Primary Research Question
How can the subjective wellbeing of young, traumatized children with anxiety be supported?</td></tr>
<tr><td colspan="3">Subsidiary research questions</td><td colspan="3">Strategy</td></tr>
<tr><td colspan="3">What do we currently know about children with anxiety in South Africa?</td><td colspan="3" rowspan="2">Literature review</td></tr>
<tr><td colspan="3">How are traumatized children with anxiety currently supported?</td></tr>
<tr><td colspan="3">What are the lived experiences of children with anxiety?</td><td colspan="3" rowspan="2">Vignette research</td></tr>
<tr><td colspan="3">How do experiences of subjective wellbeing, anxiety and trauma articulate spatially, temporally, relationally, in an embodied way?</td></tr>
<tr><td colspan="3">How can subjective wellbeing interventions be leveraged to support traumatized children with anxiety?</td><td colspan="3">Interpretive phenomenological analysis</td></tr>
<tr><td>Research design</td><td colspan="5">Interpretive Phenomenological Research Study, Using Vignettes</td></tr>
<tr><td rowspan="2">Data collection methods</td><td colspan="2" rowspan="2">Observation</td><td rowspan="2">Psycho-emotional assessment to screen for anxiety and intervention sessions</td><td colspan="3">Interviews</td><td rowspan="2">Audiovisual materials</td></tr>
<tr><td>Child</td><td>Parent</td><td>Teacher</td></tr>
<tr><td>Data collection instruments</td><td>Field notes</td><td>Vignettes</td><td>Questionnaires for emotional assessment, artefacts</td><td colspan="3">• Semi-structured interviews
• Casual interviews</td><td>• Video recorder
• Voice recorder
• Photographs</td></tr>
</table>

Data source	Researcher, participant.	Researcher, participant	Child, parent, teacher	Researcher, Participant
Data collection period	March – September 2021	March-June 2021	March-September 2021	March-September 2021
Data analysis	Vignettes	Instrument scores, interviews with parents, teachers, and intervention observations.	IPA	Visual analysis
Data analysis period	September 2021 – February 2022	October 2021- March 2022	October 2021- March 2022	October 2021-March 2022
Conducted by	Researcher	Researcher	Researcher	Researcher
Verification: Trustworthiness and authenticity	Member checks with participants, Triangulation	Triangulation	Triangulation	Triangulation
Ethical considerations	• Informed consent from all participants • Anonymity • Confidentiality	• Documents can take on a confidential form, obtain permission to use • Anonymity	• Informed consent from all participants. • Anonymity • Confidentiality	• Informed consent from all participants. • Anonymity • Confidentiality

3.2.1 Vignette Research

As mentioned in Chapter 1, vignette research is built on a phenomenological research methodology. There are several methodologies of vignette research. Van Manen's methodology focuses on the recollection of interviews and conversations as the Innsbruck Vignette Research (IVR) methodology does not originate from recollection in interviews and conversations, but rather from co-experiencing the experience of others in the field (Westfall-Greiter & Schwarz, 2012). This research includes elements of both methodologies and is based on phenomenology because the study goals concentrate on the experience of the individual. Each occurrence in a specific situation is very personal, and every individual encounter synonyms for their own unique experience. When crafting a vignette, the main goal is to create rather than reconstruct the lived experience by using language as the technique of sharing. The method of writing a vignette cannot be consistent because it is an individual personal process. What is very important when writing a vignette is to always 'show and don't tell". In other words, always try not to interpret. In the classroom or the therapy room, vignettes can be used to encourage the development of a lived experience (Schratz, 2017).

To increase the understanding of the complexities that took place during a therapy session and what arose in the classroom, I crafted vignettes carefully for each participant. During this process, my goal was to describe the deeper meaning of each therapy and classroom session without any interpretation.

As a phenomenological researcher, it is important to not only observe, but to also rely on one's own sensing, and to concentrate on characteristics such as facial and body gestures, voice tone, and silences. This experiential information is the most crucial source for writing vignettes (Schratz et al., 2014).

As mentioned in Chapter 1, vignettes are simultaneously data collection and data analysis strategies. The process of vignette interviews and observations took place in the form of writing down as much information as possible and focusing on all the different senses of the participant during the session. In other words, what we as researchers and

participants, saw, heard, smelled, and touched. My objective was to incorporate the embodiment of the participants' lived experiences. I then started to craft the raw vignettes and present them to my supervisor for feedback. During the second presenting round, I made them available for feedback to all the parents and child participants.

For feedback from the other professionals, I made three appointments that suited all of them. Before these sessions, the various vignettes were sent to them to read beforehand and guided questions were provided to assist them in preparing for the upcoming discussions and to give the necessary feedback. The kind of feedback I expected was on the feelings they experienced when reading these vignettes. The reason for incorporating professional's opinions was to get each professional's objective perspective, which would enable me to decide how and if it was necessary to amend the vignettes.

Apart from following the Innsbruck Vignette Research process, another reason to share the vignettes with the participants was to capture genuine, authentic, and trustworthy feedback that would enhance the performance of data by including the meaning and perspective of each child and parent as they engage with the vignettes that portray their experiences. It was necessary to share the vignettes with every child participating in the research process because their experiences are being depicted. The process was by e-mailing the vignettes to the parents. A parent was assigned to read a vignette to the child, and the child was then allowed to discuss their feelings about the vignette. The parents were sent questions to assist them in presenting the vignettes to their children, and then they were asked to return their own and the children's feedback via email.

After the feedback, I refined or amended these vignettes. The research decisions, from design to fieldwork to analysis, were consistent with the postulated research question/s. The theme analysis on the comprehensive data set showed that, inadvertently, the vignettes aligned with the themes. As stated in Chapter 1, Schratz and Westfall-Greiter (2015) proclaim that the validity of phenomenological texts can be determined by their capacity to initiate resonance in their readers, who are then motivated to reflect on their own practice.

3.2.2 Intervention Research

According to Fraser and Galinsky (2010), intervention research is the creation and implementation of interventions; it is the systematic study of deliberate change strategies. Design is the specification of an intervention. It is defining the extent to which an intervention is defined by clear and specific practice, fundamentals, objectives, and activities. Geldard and Geldard (2017) state that the literature strongly supports the use of integrative approaches to psychotherapy, which integrate a philosophical, conceptual, and clinical orientation into the study and practice of psychotherapy. This perspective is characterized by an interest in fostering dialogue between therapists of all orientations and a willingness to comprehend the similarities and interactions of the vast array of sectarian psychotherapies. Psychotherapy inclusion is also characterized by a desire to gain knowledge from all therapeutic approaches and therapists, instead of pledging allegiance to a single psychotherapy school or model (Stricker & Gold, 2011). The integrative psychotherapeutic techniques for my research were based on the following psychotherapy approaches: gestalt play therapy, sandplay therapy, positive psychology interventions and somatic experiencing play therapy. These psychotherapy approaches were adopted based on my expertise as a therapist and on empirical studies that support the potential use of these approaches with traumatized children with anxiety. The intervention process was semi-structured and accommodating. It needed to be adaptable and responsive to the specific needs of the participants during the therapy session.

3.2.3 Interpretive Phenomenological Research

According to Danaher and Briod (2005), in phenomenological research, the researcher formulates a guiding question or concern considering interesting and potentially illuminating lived experiences that can help us better comprehend the experiencer's lifeworld. When investigating lived experience, preconceptions, assumptions, and beliefs are either abandoned or exposed. The essential themes or meanings of the experience are uncovered both passively and actively. A general narrative and descriptive framework of the experiential phenomenon is provided (Van Manen, 2016).

I conducted an interpretive phenomenological study using vignettes as a descriptive and narrative structure. Participants could describe their lived experiences in any way. The most shared method of data collection in phenomenological research is in-depth interviews with participants to collect a thorough description of their experience. Participants' written or verbal self-reports and artistic or narrative expressions can also be evaluated (Greening, 2019). During intervention sessions, drawings and semi-structured and structured questionnaires were administered to the children as part of the initial data collection for this study. Observation of the children and the collection of artifacts, field notes, and video recordings of each intervention session took place. An assessment of the identified children was conducted, using interpretive and descriptive hermeneutic phenomenological analyses (Van Manen, 2016) to identify in-depth insights into subjective wellbeing, trauma, and anxiety.

Phenomenology does not explain but instead aims to foster comprehension between the set of observers and the observed (McRobbie, 2021). Within this research study, hermeneutics assumes the interpretive task of comprehending participants' lifeworld life experience of the phenomenon of interest, which, through phenomenological procedures, can shed light on ways of being in the world. This shift to interpretive practice differentiates phenomenological research that seeks detailed lifeworld descriptions from the lifeworld and hermeneutic phenomenological research that seeks to comprehend these worlds from the participants’ perspectives (Simon & Goes, 2011). As mentioned in Chapter 1, visual methodologies in hermeneutics can be seen as visual art in drawings, paintings, and photos and are introduced during conversational dialogue. By using these forms, children express their lifeworld experiences on their own terms meaningfully and creatively (Finlay, 2012). A growing body of research demonstrates a growing interest in using visual methods with children in general (Peralta et al., 2022; O’Kane, 2008; Rose, 2016; Veale, 2005).

Using a recording device, performing as little editing or censorship as possible, and providing an explicit psychological and linguistic critique of one's perceptual and cognitive biases is another method for protecting data in its original state (McRobbie, 2021). In this

study, the child's reactions to the semi-structured questionnaires for each drawing were recorded during the emotional assessments to safeguard the data in their raw state. These semi-structured questionnaires are discussed in Chapter 1; for an example, see Annexure A-5 and A-6.

The questionnaires were administered during the emotional assessment of every participant. After the participant completed the drawings, the researcher-therapist administered a semi-structured questionnaire as part of the emotional assessment procedure. In other words, the child answered questions related to the drawings. The child's drawings were considered as part of the vignette writing process to give a purer, more profound, and undiluted meaning to their lived experience. After the assessment, the data were analysed until data saturation was reached.

3.3 Research Methodology/Intervention Research

3.3.1 Role as Educational Psychologist

Soon after I qualified as an educational psychologist in 2010, I accepted a position as a lecturer at the University of Johannesburg and started my private practice. In 2011, I started working at the primary school where I am conducting my research study. At this school, I am a member of a group run by the school governing body comprising a psychologist, a speech therapist, and an occupational therapist. We, the teachers, and the remedial teachers work as a team to support underprivileged children.

Since 2011, there has been an annual growth in the number of children in Grades R to Grade 7 with anxiety. The boys and girls come from diverse backgrounds, religions, races, and socio-economic situations. Those with anxiety are exposed to chronic and developmental traumas, for example, divorce, death, domestic violence, and different forms of abuse. In my practice, I focus substantively on trauma, anxiety, and bereavement therapy and educational and school readiness assessments. As an educational psychologist, I frequently conduct parent guidance sessions as a component of my practice. Because of the marked increase in anxiety cases in my practice and professional work, and the vast need

for support, I decided to pursue a doctoral study on the subjective wellbeing of children who present with anxiety due to trauma.

3.3.2 Role as Researcher

According to Topping and Lauchlan (2013), the final year of an educational psychologist's training should be devoted to developing research skills to ensure that the trainee EP is prepared to enter the field as a competent researcher-practitioner (Eodanable & Lauchlan, 2009). As educational psychologists, our final year of training focused on research skills. However, after completing our thesis as part of our master's degree, our role as educational psychologists did not include doing much research. Only when a psychologist decides to specialise in a specific field of psychology do they get approval to research in that field of practice. Time pressures in assessment, consultation, counselling, and in-service training have frequently resulted in educational psychologists in applied settings giving research a low priority (Stewart & Johnson, 1986).

In order to do research, an educational psychologist has to change lenses from an empathetic and interpretive lens to a researcher's, which is more analytic and objective. This included collaborating with participants to collect and analyse data based on their understanding (Maree, 2020). Accepting the responsibilities of the qualitative researcher meant being serious and professional in formulating and planning the research, as well as adaptable and considerate throughout the sessions with the individuals participating. I ultimately accepted my role as a data collector, reality constructor, and translator during my research study. I concurrently embraced and accepted my position as the primary data collector and analyser, while remaining a responsive observer throughout the research process (Lichtman., 2012). I knew I was collaborating with the participants to collect and analyse information for this research. During the research, I constantly kept in mind my primary objective: to comprehensively understand the phenomenon, I originally intended to comprehend fully (Maree & van der Westhuizen, in Maree & Ebersöhn, 2007). I accepted that my personal encounters, values, and viewpoints would affect how I ultimately understood this study because it was inevitable that I would filter all the data I gathered

using my preconceptions as a phenomenological researcher and human (Lichtman, 2010). As I attempted the initiative to comprehend, investigate, reassemble, and experience the beliefs, and perspectives of the participants, I endeavoured to maintain objectivity and set aside my values, perspectives, and presuppositions. As a researcher writing vignettes, I acknowledge the importance of writing from the child's perspective, not from my own. For the writer of a vignette, it is crucial to remember that experiential data is the primary source for describing the experience in a phenomenological text (Schratz et al., 2014). As a psychotherapist, it is natural to interpret what the client says or does.

3.3.3 Place of Research

As stated earlier, I conducted this study in Fairland, Gauteng, South Africa, at a public primary school with approximately 1 200 students and 71 teachers. The research study took place in my therapy room at the primary school and my private practice at my home in Honeydew. Both therapy settings are situated in safe areas and are furnished to accommodate all the participating participants.

3.3.4 Participants

As planned, the primary participants included five learners and their parents and teachers. The children were from different grades with ages 8, 9, 10, 11, and 14 years. No ‘disqualifying’ criteria prevented any child from participating in the study. With the collaboration of the teachers, children with possible symptoms of anxiety in their classrooms were identified, using a basic screening questionnaire formulated by a group of professionals at the school consisting of psychologists, occupational therapists, remedial teachers, and speech therapists (Annexure A-1).

The parents of the identified children were then contacted to obtain both their and their children's assent to participate in the study. After receiving both parties' written consent, I made appointments with the parents to conduct a background interview to obtain the necessary information before commencing the therapy sessions with the children. As soon as I finished a background interview with both parents, I made appointments with the parents to commence the emotional assessments with the child participants. The emotional

assessments were used to verify the most critical and urgent cases. In total, there were eight participants that took part in the emotional assessment. From the eight participants, only five were selected for the study. The results of the emotional assessments were discussed with the board of therapists at the school for a second opinion and to make an informed final decision; following this, five participants were chosen for the study. The three non-selected children received the same therapy and treatment as the selected children. Participants were selected fairly and equitably to give every child, regardless of age, gender, language, race, context, or socioeconomic status, a fair opportunity to receive the same assessment and intervention. The process for the final selection of the participants is discussed in the next section.

Each participant was given a false identity (pseudonym name) to protect their identity and guarantee their anonymity. These pseudonyms were used throughout the research process. Table 3.2 presents the pseudonyms of the participants in the study.

Table 3.2

Participant's Pseudonyms

Participant 1	Pieter
Participant 2	Lizette
Participant 3	Karné
Participant 4	Doné
Participant 5	Pam

3.4 Research Process

In February 2021, the teachers started to identify learners with symptoms of anxiety. The parents of three of the five participants identified their children with anxiety and reported it to their class teachers for support and to ask for referrals. When the teacher identified a child with a potential anxiety challenge or anxiety-specific need in completing the child's screening questionnaire, the form was given to the parents, whose responsibility it was to respond to the request from the teacher and to give their written consent for further intervention, which they did.

I then started the emotional assessment to identify the most critical cases. These assessments were discussed with the board of therapists to decide on the five most critical cases for the study. After the five participants were chosen, their registered teachers were required to provide written informed consent for them to participate in the study. The consent forms consisted of an explanation of the ethical considerations for the study. After collecting all the consent forms, the intervention process commenced.

After I had explained the ethical considerations to all the participants, I scheduled all interviews in advance, at convenient times for all parties involved. The assessment and intervention with the five children took place once a week for between 8–10 weeks. The two interview sessions with the parents consisted of an intake interview and the feedback session; I conducted open and semi-structured interviews with the parents. I also conducted open and semi-structured interviews with the teachers at the beginning and end of my sessions with the children. The emotional assessment took place within the first 4 to 5 weeks.

The intervention process occurred between weeks 6 to 10, involving the various positive psychological and psychotherapeutic techniques described earlier in Chapter 2. The complete intervention process was free of charge for all the participants throughout the study.

I then started to analyse the data by writing raw vignettes. I then made each completed vignette available to the other professionals on the team and the participating children, parents, teachers, and my research supervisor to get the necessary feedback about their experiences while reading these vignettes. I then set out to refine the vignettes.

3.4.1 Intervention Sessions

The session timetable below (Table 3.3) reflects the number of completed sessions during the intervention session period. The months in pink indicate those in which sessions were held. The number within each pink block represents the number of monthly sessions assigned.

Table 3.3

Session Timetable – Sessions at Home and School

Participant	March 2021	April 2021	May 2021	June 2021	July 2021	Aug 2021	Sept 2021	Total
1. Pieter	1	2	2		1	3	1	**10**
2. Lizette	3	1	3	1	1	2	1	**12**
3. Doné			3	3	1	3		**10**
4. Karné		2	2	2	1	3	1	**11**
5. Pam			2	2	1	3	2	**10**

I scheduled at least 10 sessions per participant, with an additional one or two sessions, depending on the child's specific needs. One or two sessions with participants 2 to 5 took place at my private practice at home; all the other sessions took place at school.

3.4.2 Summary of the Intervention Sessions

During the first three sessions, I conducted an emotional assessment with every participant to identify their primary needs and concerns. From sessions 4–10, 11, or 12, I addressed the specific needs of each participant using an intuitive approach to implement integrative psycho-therapeutic techniques for each participant. Every session had a format containing the details of each participant and their presenting problem, following the specific theme, goal, activity, specific materials, or instruments needed during the session. Annexure A-2 provides a detailed summary of data capturing during the intervention sessions.

3.5 Formal Data-Collection Strategies

The initial data collection during the intervention sessions consisted of drawings, semi-structured and structured questionnaires, observations of the children, artefacts, field notes, and video recordings of each assessment and therapy session. An emotional assessment of the identified children was administered to identify in-depth insights into their anxiety (Van Manen, 2016).

Phenomenological research includes visual methodologies like art in the form of drawings, creations out of clay, paintings, and photos within an unstructured interview context that permit children to articulate their lifeworld experiences in meaningful and original

ways. (Finlay, 2012). After the assessment and therapy process, the data were analysed. The data-gathering strategies were developed and implemented in the mother tongue language of the participants, which was Afrikaans.

3.5.1 Observations

I prepared for observation as a data-gathering technique by recalling that my goal for the entire research process was to connect with the participants, establish a relationship of trust with each individual and experience the world through their eyes in every way possible (Alasuutari, 2014). This required intense attention and an unwavering focus on the outcome I desired. My role was to co-experience teaching and therapeutic situations in and out of a classroom and therapy room. I thus tried to capture learning or therapeutic experiences as authentically as possible, describing one moment in time. It was about pausing, creating an atmosphere, creating a new awareness, sensitizing participants, making the invisible visible, and paying attention to time, space, and body language (Eloff, 2020).

I accompanied my therapy room observations with field notes and video recordings of every session. When I did classroom observations, I made voice recordings. I observed the participants transformation through their experiences of actual situations as they underwent therapy.

Vignette research grounded in a phenomenological framework offers the opportunity to regain the ‘magical’ dimensions of the child’s life world. For these purposes, vignette researchers refrain from observing childlike expressions from their anticipated perspective, as if waiting to fulfil their own expectations. The vignette researcher is instead called upon to share children’s experiences.

For vignette researchers the challenge is to understand children and, in a general sense, to understand others, to grasp their expressions, and to avoid playing the ‘fool’ in a mirror-cabinet, always reflecting one’s perceptions or views. We can overcome this dilemma only to the extent that we renounce trying to understand children or others entirely (Meyer-Drawe, 2019).

Researchers adopt a phenomenological stance when they seek to disregard presuppositions, theories, and understandings and rather allow themselves to be influenced by the experience of others. “This experiential data is the primary source for writing an experience in a phenomenological text.” This phenomenological text is called a “vignette” (Schratz et al., 2014, p. 126).

In this study, I had the privilege to go beyond observation into the participants’ life experiences by zooming into facial and bodily expressions, tone of voice, and silence. I had to focus holistically, not only on what the child communicated verbally but also on their non-verbal communication, and then put it into words from their perspective. To accomplish this, I also used video recordings to justify the co-experiences that occurred in the classroom and therapy room.

3.5.2 Interviews

“Qualitative interviewing can be considered a conversation with a purpose” (Lichtman, 2010, p. 139). I used interviews as an additional data-collection technique to gather as much data from the participants as possible, including their thoughts and feelings during a specific time and space.

Semi-structured interviews, as well as informal interviews, typically consisted of open-ended questions. Both types of interviews shifted the emphasis from me as the researcher to the participant’s interests and experiences (Roberts-Holmes., 2005). The duration of the semi-structured interviews ranged from 30 minutes to one hour. They were based on open-ended questions in my therapy room at school, in the classroom, or at my private practice at home. The children, their parents, and their teachers were interviewed. Each group had its own specific atmosphere; however, the semi-structured format of the interview was maintained. I could adapt the questions to the circumstances (Lichtman, 2010).

Before every interview and session, I arranged with the parents and teachers to negotiate the most convenient times for them. The primary objective of the interviews was to

gain a richer understanding of the phenomenon, not to obtain specific answers (Omizo & Omizo, 1990).

The semi-structured interview varied slightly for the three groups because the contexts and circumstances differed. I adapted the questions for each participant according to the circumstances. I also applied casual interviews when I spoke with participants about a topic related to this study (Lichtman, 2010); a participant would mention something or initiate an informal conversation, resulting in a casual interview. Casual interviews happened with all three groups of participants.

I held intake interviews with the parents before the assessment and therapeutic intervention process began. The interviews took place in my school therapy room or private practice at home. These semi-structured interviews sometimes turned into casual interviews, depending on the specific situation.

The questions for the parents were intimate and specific, focusing on the child. Typical questions concerned the child's intellectual, emotional, and physical development, for example: “Tell me more about the emotional wellbeing of (your child).” These intake interviews took between 60 and 80 minutes. The feedback sessions with parents usually turned into casual interviews and took between 40 and 60 minutes.

The questions for the teachers were based on their experiences of the child in the classroom context. These interviews were always individual. A question early in the interview would be: “Tell me more about (the specific participant) in your classroom.” The teacher would answer the question, which might trigger another topic or incident in the classroom that led to a casual interview. These interviews took between 10 and 15 minutes.

The questions for the children were based on their developmental level and personal context. For example, a topic about children with anxiety, or the possible causes of anxiety, was relevant to every child participant because it was part of their presenting problem. Depending on the child and their rapport with me, a semi-structured question could quickly become a casual interview with the child participants.

Annexures A-3 to A-4 present examples of the different interviews. I recorded and transcribed the teacher interviews afterward so that I could focus on my primary objective, active listening, during the interviews. Nonetheless, I frequently took notes during the interviews to document essential details and nuances of tone and emphasis (Creswell, 2009).

Using a variety of interview formats disclosed the impressions and experiences of the participants and clarified their significant responses. I felt prepared and at ease because interviewing is within my professional competence as a psychologist. By consistently applying these methods throughout the research process, I could gather a vast quantity of detailed and exhaustive information. The information in the interview allowed me to cultivate strong relationships with the participants and remain flexible during the data collection process (Mertens, 2019).

Unique to the intake interview was the likelihood that respondents would provide data and viewpoints they believed I wanted to hear rather than their genuine personal opinions and responses (Lichtman, 2010). Therefore, I frequently reminded the participants, particularly the children, that there were no correct or incorrect responses and that they had to share their thoughts, feelings, and experiences.

The interview format was also highly time-consuming, which was an additional challenge. When I could not finish an interview with a child in one session, I had to complete it during the next session. It was even more challenging with parents because they were busy and sometimes had to leave work to see me for an intake interview or a feedback session. In addition, recording, categorizing, analysing, and comparing all the data gathered during the intervention and research method requires tremendous effort (Mertens, 2019). Two methods for overcoming such obstacles are developing and clinging to a strict schedule and using specific analytic techniques.

3.5.3 Field notes

I made field notes on my preparation papers during all interviews, assessments, and therapy sessions to record my observations and impressions (Annexure A-5 and A-6). This

allowed me to record my immediate impressions of what I witnessed during these conversations with the individuals involved (Hatch, 2002). I used these notes in crafting the vignettes for each participant. Annexure A-5 and A-6 presents an example of a questionnaire paper on which I normally wrote the field notes I took during the research process.

3.5.4 Structured Activities and Instruments

Conservative observations and interviews would not have provided me with the scope and depth of knowledge necessary to answer the research questions satisfactorily. I employed various creative activities and therapeutic techniques to accommodate the mental, emotional, and developmental needs and interests of the individuals I worked with. These included various organised activities and therapeutic techniques designed to capture the participants interest and attention during the emotional assessment and therapy process. As an educational psychologist, it was my role to ensure that my conversations with the child participants were child focused by excluding my own religious views, perceptions, and professional language and instead engaging on the child's developmental level. This strategy resonated well with my role as a vignette researcher. These provisions allowed me to adhere to a high standard of qualitative research and keep the data collection process as child-focused as possible (Roberts-Holmes, 2005).

3.5.5 Audio-visual Materials

I used my cell phone to take photographs and record the interview sessions to add them to my audio-visual data collection. I also made video recordings with my cellular phone during each session with the child participants and during the intake interviews and feedback sessions with the parents. I made similar audio-recordings of the interviews with the teachers and the classroom visits and I also made voice recordings of the discussions with the professionals about the vignettes.

During structured activities with the children, I made a point of photographing the instruments and prompts so that I would have a record of how they appeared. Most of the resources created by the participants during the sessions were kept so that they could use

them to their benefit and as part of the healing intervention process. Additionally, the photographs assisted me in managing my data collection and structured processes. I included them in my thesis to give the reader a comprehensive understanding of the methods and tools we applied (Bogdan & Biklen, 2007). The video recordings of the therapy room at school and my private practice at home provided a densely patterned, insightful, rich, and layered overview of the physical and therapeutic space in which the participants were located. The photographs did not contain any images of the participants. I was able to respect and guarantee their anonymity in compliance with the ethical guidelines that guided this research. Before beginning each video session with the child participants, I obtained their permission to record everything we said and did.

I also did voice recordings of all the interviews with the teachers, all translated into English from my native language, Afrikaans, and transcribed for subsequent verification. Even though the translation was a laborious and time-consuming task, I chose to undertake it myself due to my familiarity with the individuals involved, the conditions under which the video and audio clips were made, and what the participants were referring to. It was also more cost-effective, not having to pay an external transcriber.

I used the transcriptions to familiarize myself with every facet of my interactions with the participants. During the final stages of the research, this placed me in the best position possible to conduct a comprehensive reflective analysis (Roberts-Holmes, 2005). Interacting intensively and intimately with the data ensured that I was connected with the research data from the beginning of the research study (Mertens, 2019). An example of transcript data is in Annexure A-7.

Table 3.4 below provides information about the data instruments and how the data collection took place.

Table 3.4

Data Instruments and Data Collection Methods

Vignettes (total)	**Vignettes sessions with professionals for feedback**	**Vignettes verbal reading and written feedback sessions with a supervisor for modification**
20 final vignettes, comprehensive set: • 4 raw vignettes for each participant (n=5), total 20 final vignettes	Three sessions (90 minutes each)	Three oral feedback sessions for modification (60 minutes) • Minimum of two written pieces of feedback on each raw vignette (20 raw vignettes x 2 pieces of feedback)
Vignette feedback from parents Vignette feedback from participants		
Interviews with teachers	**Interviews with parents**	**Intervention sessions with participants**
Two open-ended interviews lasted between 15 and 20 minutes with each educator (2 x 5 = 10 interviews)	Three approximately 60-minute- open-ended interviews with each parent (3 x 5 – 15 interviews)	Between 10 and 12 intervention sessions with each participant

3.6 Data Analysis

3.6.1 Vignettes

A vignette is a brief piece of literature that adds depth or comprehension to a story. The term “vignette” originates from the French word vigne, which means "small vine." A vignette can be a "little vine" of a story, like a photograph of words. A good vignette is concise, to the point, and crammed with emotions (Collins Dictionary, 2022).

According to Van Manen (1990, p. 8), “A vignette is a form of literary non-fiction that captures a poignant moment experienced by the researcher in a classroom.” This research approach is grounded in phenomenology, the philosophy of experience because the inquiry goals were focused on the experience of learners (Schratz et al., 2014).

The process I followed when writing a vignette for a specific session was to choose one of my three focus points, namely subjective wellbeing, trauma, and anxiety. I then allocated 10–15 minutes for writing observations, which I started writing after deciding on the setting and subsequently entering it. I included the time and place and what was seen, heard, smelled, and felt (atmosphere), as well as the tone of voice, silence, facial expressions, body language, and intonation. Based on the observations, I then wrote a raw vignette, bearing in mind the notion in vignette research that there must be congruence between the observations and the vignettes.

Another important aspect I always tried to keep in mind was to “show and not tell.” At first, I wrote the vignettes unthinkingly from the therapist’s perspective. After finishing three vignettes from the therapist’s perspective, I did more intensive reading about vignette writing, which steered me towards writing from the child’s perspective (Eloff, 2020; Schratz et al., 2014). In alignment with IVR, my supervisor also suggested that I write the vignettes from the child's perspective to emphasize the child's life rather than the therapist's.

The following extracts provide examples of vignettes written from the therapist's and child’s perspectives to illustrate the shift between the two perspectives.

3.6.1.1 Second Vignette Karné, Session 6, 5 June. Phenomenon Subjective Wellbeing, Therapist’s Perspective. In today's session, I invited Karné's mother

along to see how they get along with each other. Karné is still wearing her school clothes and is extremely excited by the way she smiles at me. Still, I notice a degree of uncertain anxiety in her eyes, as if she cannot believe her luck and, at the same time, does not want to disappoint her mother. I pack out some unstructured activities for them to do. The therapy room is nice and big, the blinds are open and there is enough light shining through the vents. It is a cold winter afternoon, and the heater is on to let in enough warmth to create a cosy atmosphere.

3.6.1.2 Second Vignette Karné, Session 6, 5 June Phenomenon Subjective Wellbeing, Child's Perspective. In today's session, Aunt Ingrid invited my mother along to watch the two of us get along. I'm still wearing my school clothes and am terribly excited because I cannot stop smiling. It's weird to have Mom in the session together today, but still, I'm terribly happy and a little anxious because I do not want to disappoint her. Aunt Ingrid unpacks various activities for us to do. The therapy room is nice and big. The blinds are open and there is enough light shining through the windows. It is a cold winter afternoon, and the heater is on, which creates a lovely cosy atmosphere.

3.6.1.3 First vignette, Session 4 of Lizette 6 April Phenomenon Anxiety, Therapist's Perspective. It's two o'clock on a late autumn afternoon, the school has just come out and Lizette is sitting quietly on her knees on a soft blanket on the carpet in the therapy room. She looks carefully at the camera. There is a nervousness in her eyes. The blinds in the therapy room are halfway closed for privacy as children are constantly walking by. There is still enough light coming through to see clearly. It's cloudy outside, so the room light is also on. Lizette's mind seems open, although she still sits very shy and cautious. She sits calmly, yet a little anxious, and listens attentively to her therapist.

3.6.1.4 First vignette, Session 4 of Lizette 6 April. Phenomenon Anxiety, Child's Perspective. It is a late autumn afternoon. It's two o'clock, the school has just come out and I am sitting quietly on my knees on a soft blanket in the therapy room. This is

my fourth session with Aunt Ingrid. I carefully look into the camera. I feel a little nervous and I think Aunt Ingrid can see it in my eyes. The blinds in the therapy room are halfway closed to have more privacy because children are constantly walking past. There is still enough light coming through to be able to see clearly. It's cloudy outside, so the room light is on too. I'm very excited about the session, even though I'm still very shy. I listen carefully to Aunt Ingrid.

A raw vignette might include observations that reflected my interpretation as a psychologist. In refining the vignette below, I deleted the underlined phrases as assumptions I made on the child's behalf without having grounds for them. This illustrates an important aspect of 'show and don't tell'.

Raw Vignette. The teacher says that he has to wrap his tooth in a piece of tissue and take it home so that the tooth mouse can come and visit. Sometimes I get so busy that it may seem to Aunt Ingrid that I do not listen, but when teacher instructs us to take out our reading cards and reading books, I do so immediately. The teacher is very proud of me and says that the class should clap their hands for me because I remembered them so beautifully. I smile proudly.

Refined Vignette. The teacher says that he has to wrap his tooth in a piece of tissue and take it home so that the tooth mouse can come and visit. When teacher instructs us to take out our reading cards and reading books, I do so immediately. Teacher says that the class should clap their hands for me because I remembered so beautifully. I smile proudly.

- I used Eloff's (2020) questions to guide me through the process of refining each vignette.
- Does the vignette convey a specific message? Does it show something in the particular?
- Who "tells the story" in my vignette? Does it remain consistent throughout the vignette? Is it intentional and does it make sense?
- What is the atmosphere that is created in my vignette? Vignettes are about creating an atmosphere.

- Does my vignette reduce the distance between the 'observer' and the main 'character' in the vignette? The purpose of vignettes is to reduce the distance between the researcher and the participant.
- After giving some thought to my vignette (a good night's sleep can do this), is there any way that I can strengthen my vignette?
- Do I need to shuffle the order of my sentences inside the vignette, in order to strengthen the 'golden thread' of the story?
- Does my vignette use sensory descriptions to enrich the story? (Visual, auditory, tactile, scents and perhaps taste or bodily experience?
- Does my vignette provide a clear description of the place, so that my reader can 'picture' where the vignette is situated?
- Have I checked the vignette for technical fluency and accuracy?
- Is there any redundant text in my vignette? Repetitions?
- Have I checked my text for sentences that may be too long? Mixing up short and long sentences works well.
- Can I condense my vignette in any way? Can I remove any details that are not central to my vignette?
- Have I checked my observation notes to see if there is anything that I can add or revise?
- When I finish reading my vignette, am I left with a particular feeling? Am I affected by reading the vignette?

After I had considered each question and done the necessary editing, I sent the vignette to my supervisor for comment and feedback. When she was satisfied with all the vignettes, I made appointments with the other professionals to present them via live vignette group meetings on Skype.

These interactions included resonance readings and discussions with the three educational psychologists, in each of which we discussed two vignettes per session of 90 minutes. Before the discussions I e-mailed the vignettes to the psychologists with the

following list of discussion points based on the questions I used myself in crafting the raw vignettes:

- When you read the vignette, what message did it convey to you?
- Did I use enough sensory descriptions to enrich the story? (Visual, auditory, tactile, scents, and perhaps taste or bodily experience?)
- Is there anything that you think could be added to enrich the vignette?
- When you read the vignette, what atmosphere did you sense?
- How did the reading of the vignette make you feel?
- Were the descriptions of the experiences clear enough to you, did they make sense?

Finally, I requested that they provide feedback that was open and honest. Before we started with the discussions, I read the vignettes out loud to them. Then they participated in a full feedback discussion. Each psychologist took turns to provide feedback.

Some of the comments from the psychologists at the resonance readings were as follows:

- Add more sensory experiences (embodiment) from the child's perspective, in other words, what happens in the body, body tension, facial expression, and breathing.
- Focus on the participant's facial expressions; include more emotional expressions from the child's perspective.
- Remember that the main focus is the child and not the therapist.
- When crafting these vignettes focus on the symbiosis between the child, their environment, and anxiety.
- Remember to be specific with descriptions of the therapy room in terms of what happens where in the room.
- Make use of metaphors to describe what the child feels, e.g., 'the emotion bottles up until it explodes like a volcano'.

After these discussions, I listened to the voice recordings of the resonance readings and made changes to the vignettes where I thought it was necessary. Most of the changes were based on sensory explanations during a session. Some of the vignettes needed more sensory details to enrich them. I also made some changes to the therapy room descriptions and to when we did what, for example, moved from one setting to another.

The next section presents extracts from three vignettes where I make changes in terms of embodiment and then gave a clearer description of the movement that took place in the therapy room during a session. The changes are underlined.

3.6.1.5 First Vignette of Doné, Session 2, May 19, Phenomenon, Trauma. Then my dad would pick me up and comfort me and then they would stop fighting. It was my way of getting them to stop fighting. It went on like this until I was 10 years old, then it stopped.

Now if they fight, I will get very annoyed and sit in a corner, and then they will try to calm me down. It was not so bad for me when I heard that my parents were breaking up. Suddenly my emotions feel like a volcano that has been building up in me for years and is about to explode! This was not the first time my father had an affair with another woman. It's hard to find the right words.

3.6.1.6 Vignette 4, Pam, Session 10, September 8, Phenomenon Subjective Wellbeing. I told Aunt Ingrid about my sneakers at the previous session and cannot wait to show it to her. She thinks it is "beautiful" and wants to buy it for her daughter as well. When I walked into the therapy room, I saw towels on the floor as well as a foot spa. There is a table with nail polish and foot cream. I wonder if it's going to be for our session. It looks like bold fun. It is cloudy outside and the blinds of the therapy room are open so that enough light can pass through. On the orange blanket where we first sit, Aunt Ingrid tells us what we are going to do today. Says that we will first plant a plant in my flowerpot that I painted at the previous sessions and that I have to choose one.

3.6.1.8 First vignette, Session 4 of Lizette 6 April Phenomenon Anxiety, Child's Perspective. It is a late autumn afternoon, it's two o'clock, school has just come out and I am sitting quietly on my knees on a soft blanket in the therapy room. This is my fourth session with Aunt Ingrid. I carefully look into the camera. I feel a little nervous and I think Aunt Ingrid can see it in my eyes. The blinds in the therapy room are halfway closed to have more privacy, because children are constantly walking past. There is still enough light coming through to be able to see clearly. It's cloudy outside, so the room light is on too. I'm very excited about the session. Even though I'm still very shy I listen carefully to Aunt Ingrid.

After I had made the necessary changes, I sent them to my supervisor for final comments. The final step was to send the vignettes to the parents and children for feedback.

3.6.2 Participants' Feedback

- "I did read a vignette to her, the one where you were in class, and she did the three pigs she reacted to the most. She agrees with your assessment on that, and she says that after her time with you, she thinks she could do something like that again without feeling so nervous and anxious." (Feedback from Pam).
- "I really enjoyed it, it was my favourite place and I really like the vignettes that Mum read to me, thank you." (Feedback from Pieter).
- "Thank you, Aunt Ingrid, for the beautiful vignettes that mom read to me. I was extremely excited about the final session with Aunt Ingrid. I was no longer so shy and afraid. I really liked to paint and the beautiful little white Pansy plant I planted was so appropriate for a spring day." (Feedback from Lizette).
- "After Doné read the vignette, she said that she could remember the orange blanket she used to sit on during her sessions with her therapist. Then while reading the vignette, she suddenly jumped up and said that this is her story! She felt very proud and then replied that she learned to verbalize her feelings and not to keep them inside". (Feedback from Doné).

- “While listening to the vignette, I recognize some of the things I said and did, and it made me smile because I could not believe that Aunt Ingrid remembered everything so well. I really enjoyed listening to all the things we did and sometimes it even made me laugh. Thank you, Aunt Ingrid”. (Feedback from Karné).

3.6.3 Parents’ Feedback

- “You have accurately portrayed Pam in each one and have shown the difficulties she faces in different situations. Your time with Pam has helped her tremendously in many aspects. She is now able to communicate her feelings and worries more effectively, and her anxiety is at a point now that it is actually manageable.” (Feedback from Pam’s mother).
- “I'm at a loss for words except to say that I believe you are aware of what is occurring behind the scenes. She definitely seeks reassurance from something or someone in new or strange situations. She is getting older and her communication skills are improving, thank you for everything.” (Feedback from Karné’s mother).
- “We just wanted to say a very BIG Thank You for sending these four vignettes through to us. It was so interesting to read, and wonderful to see the interaction that Pieter had with you in his sessions. It really was so special to see all the detail and extra efforts that you went to in order to help our boy with his anxiety. We absolutely loved all his responses within the various scenarios and found it so interesting to try and understand his thought process within the various situations.” (Feedback from Pieter’s mother).
- “Thank you very much for the positive contribution you had in Lizette’s life. I really enjoyed reading all the vignettes, it was so interesting. She tells me every day what happened at school, and I can tell that she stands her ground if necessary. She also really enjoys being a media leader at the school and helping children find books to read and working in the media.” (Feedback from Lizette’s mother).
- “Thank you very much for the vignettes, it was very informative, got a lump in the throat here and there. I could identify something of Doné in each of the four

vignettes as well. I could see that there were difficult days and topics but also that she learned to deal with them and process them. I can confirm that she is now also using it to help some of her friends in the High School. We really appreciate the time and attention you spent with her." (Feedback from Doné's mother).

3.6.4 Analysis of Interview Data

I chose two techniques to help analyse my interview data: involvement and familiarization. I immersed myself in the transcriptions of the teachers' and parents' interviews and feedback sessions and with my field notes, vignettes, and all video recordings. This familiarised me with the sense and atmosphere of the participants' world, identifying what was important to them in constructing their life worlds (Terre Blanche & Durrheim, 2002).

The study adopted Van Manen's (2016) six interactive approaches for interpretive phenomenological inquiry and data analysis. These included locating oneself to the phenomena of interest and elaborating presumptions and preconceived notions, investigating life experience as resided through informal discussions rather than as we truly understand it, trying to reflect and performing thematic analyses that define the phenomenon and analysing through dialogues, and explaining the occurrence through the procedure of repetitional writing (rethinking, reflecting, recognizing), to generate in-depth understanding (Leone et al., 2013).

According to Van Manen (2016, p. 1), phenomenology concerns "sober reflection" on the lived experience of human existence without theoretical, prejudicial, and hypothetical distractions."

Furthermore, phenomenology is motivated by an interest in meaning. These two observations indicate that phenomenological data analysis focuses on how individuals perceive and make sense of the world. In order to truly see the world through the eyes of others, it is also essential to set aside the 'self' and enter the other individual's perspective and experience. In this study, crafting vignettes demonstrated how to exclude the self and view the world through the participant's eyes. Beyond content analysis, phenomenological analysis provides a comprehensive understanding of lived experience (Nieuwenhuis, 2020).

In conclusion, the interpretation and verification techniques provided a written account of my observations of all the processes during the study. This required ensuring no procedure components were neglected or ignored and that irrelevant data elements were not overanalysed and misinterpreted. It was essential to consider my role as a researcher during the analysis and data collection phases (Terre Blanche & Durrheim, 2007).

3.7 Conclusion

This chapter examined the paradigm presumptions and epistemological concepts used in this study, such as interpretive phenomenological research employing vignettes. It included why I chose this research study and its specific focus. I described and clarified the participant selection, data collection and analysis, and interpretation procedures. The example of intervention sessions completed between March and September is supplemented with a full summary of the sessions in Annexure A-2. The chapter concluded with the process, development, and writing of vignettes.

CHAPTER 4

DATA ANALYSIS AND FINDINGS

4.1 Introduction

This chapter presents the study's findings. The analysis of the data obtained reflects the approach that was used to answer the primary question, in which interpretive phenomenological analysis in combination with vignette research revealed the lived experience of the subjective wellbeing of young, traumatized children with anxiety. In addition to the vignettes, I used the six interactive processes by Van Manen (1998) for interpretive phenomenological research and data analysis, which I previously mentioned in Chapter 3. This chapter recalls the data analysis methods I employed to thoroughly explain the research findings of this study, for which Chapter 3 provides a detailed explanation.

In this interpretive phenomenological research study, the intensive phase of data analysis was based on the interviews with the parents and teachers, the vignettes of the child participants, as well as my observations, photographs, and field notes. All of this data and its associated meanings were therefore brought to the fore and given coherence (Merriam, 1998). To interpret the data from a place of empathy, my constant objective when interpreting the data was to stay truthful to the information and true to what I understood it revealed. According to Holland (2014), the interpretive phenomenological analysis's purpose is to examine lived experience, focusing on the meaning-making processes involved in comprehending individual experiences within specific contexts, such as in this study, the lived experiences of young, traumatized children with anxiety in a primary school setting.

This has been made easier because I was the only individual involved during each data collection session and I gathered all the information personally. As part of the preparation process of the data analysis, I reviewed all the information transcripts to gain familiarity and immersion. This enabled me to classify the data using different colours and symbols. In the final phase of this procedure, I examined my interpretations and refined my initial categorization (Maree et al., 2020).

4.2 The Findings of the Study

This section presents the study's findings regarding the three major themes that emerged from it. I substantiate each finding using the following datasets: the teacher's interviews, the parental interviews, the comprehensive intervention sessions with each participant, artifacts from the therapy sessions, and visual data captured during the interventions. The sets of individualized vignettes developed around each participant's engagement with the intervention process are also presented dialogically with each of the key themes. Each theme discussion is embedded within the broader literature to interrogate, confirm and explain the findings.

The research findings recommend that the subjective wellbeing of young, traumatized children with anxiety can be supported by

- Acknowledging the invisibility of anxiety at school.
- Implementing an intuitive integrative psycho-therapeutic approach, and
- Mediating parental anxiety.

4.2.1 Participants

Table 4.1 below depicts the demographic variables for the participants. This is followed by background information about each child participant based on the intake interviews with their parents.

Table 4.1

Participants' Biographical Information

Participants	Chronological age	Grade	Sex	Home Language	Siblings	Parents	Presenting problem
1, Pieter	7 years and 8 months	2	Male	English/ Afrikaans	1 sister	Married	Anxiety
2. Lizette	9 years and 5 months	5	Female	Afrikaans	1 sister	Married	Anxiety
3. Done	13 years and 4 months	7	Female	Afrikaans	1 brother	Divorced	Anxiety and trauma

4. Karné	8 years and 7 months	3	Female	Afrikaans	1 brother	Married	Anxiety
5. Pam	9 years and 10 months	4	Female	English/ Afrikaans	1 sister	Living together	Anxiety

4.2.1.1 Participant 1 – Pieter. Pieter is the eldest child in his family. He has a younger sister of four years old. According to the mother, her pregnancy and Pieter's caesarean birth at 38 weeks were without complications. Pieter reached his developmental milestones within the normal range, but his mother describes him as having a poor appetite although he was a healthy baby.

At the age of five, he went for occupational therapy to improve his fine motor skills. His mother sees him as emotionally immature; he cries very easily, and she regards his four-year-old sister as 'much stronger' than him. She claims that he will have a meltdown if things do not go his way and that he despises change.

He started Grade 1 well, although he was very shy and insecure. According to the mother, this was a 'big year' for him. She mentioned his 'new uniform and everything' she said, 'He was fine, absolutely well, he did well'. However, at the beginning of March, even before lockdown, she started noticing that he would make unusual repetitive movements, like ticks. For example, he would make a quick in-and-out arm movement without even noticing it. He didn't like to be corrected or addressed when he did something wrong. She saw him as very insecure and very sensitive.

His mother says that 2020 was a disastrous year for him. His anxiety started near the beginning of Grade 1 and 'everything worsened' after the lockdown in 2020: "It was disastrous for Pieter". She said he hated the Zoom meetings because he was so shy; 'he would just sit there'. He did find a few friends, but according to his mother, under the Covid circumstances, when the school instituted school attendance on alternate days he did not build relationships because when his possible friends were at school he was at home.

When the children could return to attending school every day, his teacher was on maternal leave. The mother states that Pieter did not deal well with this. When the teacher returned, however, he became very settled; she believed he had a good ending to the year.

His mother said his second year had an exceptionally good start: he loved school and he loved his teacher. He seemed to have one or two friends, which his mother encouraged. During the intake interview, both parents mentioned that their main concern the previous year was that he would vomit in the mornings when he had tests and speeches at school. They thought it was pure anxiety and they did not want to go back to that this year.

4.2.1.2 Participant 2 – Lizette. Lizette is the eldest girl of two children in her family. She has a younger sister in Grade 3. According to the mother, her pregnancy and Lizette's caesarean birth at 39 weeks were without complications. Lizette reached her developmental stages within the average range, and she was a healthy infant with an excellent appetite. Lizette did not go to a nursery school but instead went to school for the first time in Grade R. The teacher was very strict, and Lizette had to stay in class during breaks if her work wasn't done. Lizette only told them about these incidents a year later, but according to the mother, it must have been a shock. The mother thought that was where the anxiety started.

The mother described Lizette as very sensitive and shy. Her social skills could improve, according to her mother, but she found it difficult to speak her mind in conflict situations. The mother said that Lizette was very anxious to do speeches in front of the class and preferred to do them at the teacher's desk. She said that Lizette did academically very well in school, but she did not take part in class conversations, and she spoke very softly. The mother thought that her self-esteem could improve.

The mother said she and her husband were experiencing problems in their marriage, and the tense conflict situations at home might enhance Lizette's anxiety. She says that they were currently in marriage counselling at their church. During an interview with both parents, they mentioned that their main concern was Lizette's anxiety levels and the fact that she struggled to stand up for herself. They requested help with her anxiety building her self-esteem and being less afraid to speak in front of other people.

4.2.1.3 Participant 3 – Doné. During the intake interview, the mother revealed that Doné was 13 years old and the eldest of two children. She had a younger brother who was 10 years old. According to the mother, her pregnancy was without any complications but there were complications during birth. Doné had the umbilical cord around her neck and was therefore under stress. Doné was born through an emergency caesarean section at 37 weeks and was in the intensive care unit (ICU) after birth for four days.

Doné reached her developmental milestones within normal limits and was a healthy child with a good appetite. The mother believed that Doné had been anxious from birth and she tended to be an emotional eater. An educational psychologist diagnosed Doné with ADHD (Attention-Deficit Hyperactivity Disorder) in Grade 1. The mother decided to take Doné to a homeopath for medication for concentration. The mother also mentioned that from a very young age, Doné had not been at all sociable. She didn't like communicating with people and had an almost agoraphobic fear of situations or places that might evoke a panic attack. She could not function in crowded spaces. She had anger outbursts or would get a panic attack. The mother's main concern was to help Doné with anxiety and anger management. Doné's trauma after her remedial teacher suddenly passed away when she was in Grade 4 was also a concern. Then in grade six she also lost a very dear adult friend who was diagnosed with covid. He was her biological grandfather's best friend; she saw him as a second grandfather, and they were very close. She did receive therapy for this loss after it happened but still struggled to move on.

4.2.1.4 Participant 4 – Karné. During the intake interview with the mother, the following information was shared: Karné was the youngest of two children. She has an older brother in grade five. According to the mother, there was a lot of sibling rivalry between them that the parents sometimes found difficult to handle. The mother said she had a very difficult pregnancy with Karné: at 20 weeks, she almost had a miscarriage because she went into labor and the doctors had to suppress the labor symptoms, after which she was in the hospital for a few days to get the birth contractions under control. She felt anxious during the whole pregnancy because she was afraid of having a miscarriage. When she went into labor at 37 weeks,

Karné had a significant fetal heart rate drop. As she was under stress, they had to perform a caesarean section birth.

According to the mother, Karné was a very needy baby after birth and today was still anxious and insecure. The mother said that Karné was very stubborn and would not take no for an answer. When things did not go her way, she would get meltdowns that lasted very long. This influenced the relationship between her and her daughter. Because the mother also struggled with anxiety, she found it difficult to handle Karné's emotional state. The mother believed that Karné reacted in anger as a coping mechanism. She thought Karné needed help with her anxiety and anger management skills. The mother described Karné as very sensitive, intellectual and needy.

4.2.1.5 Participant 5 – Pam. During the initial interview, Pam's mother revealed that she was the eldest of two children. She had a Grade 1 younger sister. The mother said that after she'd divorced Pam's father, her partner had been Pam's stepfather from birth. The mother said she had a complicated pregnancy with Pam. She went into labor at 32 weeks and was hospitalized for a few days to stabilize the birth contractions. Then at 36 weeks, Pam was born through caesarean section. The mother struggled with depression and was on medication. She mentioned that Pam had had anxiety since Grade 1 and had gone to therapy to work on her anxiety levels and to improve her self-confidence. She struggled with separation anxiety in Grade 2. The mother said Pam was very sensitive: if the teachers raised their voices or confronted her, she started to cry.

The mother said that the lockdown period was very difficult for Pam because both the mother and her partner felt sick with Covid and Pam had to look after them at home. This was very stressful for Pam as she was afraid, she was going to lose her mother and her stepfather. She also acted out with anger outbursts during the lockdown.

According to the mother, when school started again, Pam's emotional wellbeing improved for a short while. The mother said that Pam was very shy. She did not want to attend school in the mornings and would sometimes cry until her mother was called by her teachers to fetch her.

According to the interview with the teacher, Pam had a lot of school absences, and that influenced her academic achievement. The mother felt that Pam needed support with anxiety, insecurities and the skills she needed to verbalise her feelings.

4.2.2 Theme 1 – The Invisibility of Anxiety at School

The invisibility of anxiety at school was presented as the most prominent theme in this study. Evidence of it emerged across the datasets, prominently in all the teachers' interviews and some parental interviews, as illustrated in extracts from their interviews.

This theme is also present in relevant vignettes that were developed during the course of the study. In the first section, it is clear from the teacher's interviews that the anxiety the parents referred to is not "visible" to the teachers.

4.2.2.1 Teachers' Interviews

- "There are no actual signs of anxiety that I notice in him." (Interview 1, Pieter's teacher, line 11)
- "Not at all, no anxiety. He speaks comfortably in front of the class. He plays with all the mates." (Interview 1, Pieter's teacher, line 17)
- "Then he can tell me exactly what to do without any signs of anxiety." (Interview 1, Pieter's teacher, line 44)
- "I have never even experienced her nearly aggressively or anxious. Not at all, I cannot see it in her either." (Interview 2, Doné's teacher, line 39)
- "I'm Pieter's remedial teacher. He comes to me twice a week for extra help with schoolwork. I do not experience that he is anxious with me. He acts spontaneously and shows confidence when he does the work." (Interview 3, Pieter's remedial teacher, line 1)
- "I was shocked when the mom told me they were struggling with anxiety at home with Karné." (Interview 3, Karné's teacher, line 2)
- "So, when the mother told me there had problems with her at home, I could not believe it." (Interview 4, Karné's teacher, line 14)

- “Well, if she's anxious, she's hiding it well. She stands… she speaks… she speaks a little softly, but most girls speak a little softly. She talks nicely, she holds her speech cards nicely. She actually looks comfortable. Sometimes with the girls, I see they are a bit tense, because they are holding their dresses.” (Interview 1, Karné’s teacher, lines 36-40)
- “His attention can sometimes wander a bit and sometimes he struggles to organize his table, but emotionally he is doing very well, not that it has ever been a problem in class with him.” (Interview 3, Pieter’s teacher, line 5)

The parents confirmed that the teachers did not observe visible symptoms of anxiety in their children. This is illustrated in the following extracts from the data.

4.2.2.2 Parents’ Interviews

- “But his teacher also tells me that he functions very well in class. He gets his work done. He talks with his friends in class.” (Interview 1, Pieters mother, line 156)
- “In other words, when he experiences stress, he can handle it well. You do mention that he will ‘vomit’ at home, but when he comes to school, he handles it very well. His teacher does not notice anything. Really!! Are you serious? I cannot believe it!” (Interview 2, Pieters mother, line 225)
- “Was he anxious in the class when he had to do his speech? Not at all!” (Interview 2, Pieters mother, line 460)
- “Behavioural problems at home yes. Not at school at all. People think I'm crazy when I'm struggling with her at home. The previous therapist said that there is an underlying fear.” (Interview 1, Karné’s mother, line 119)
- “It feels to me like people think I'm totally cuckoo. No one sees this stuff except us at home. She does everything at school one hundred percent.” (Interview 1, Karné’s mother, line 665)

- “No not at school, the teacher has not yet mentioned anything about anxiety or anger outbursts at school. She’s just struggling with her schoolwork. At home, yes, a lot. She was very aggressive until my dad put a punching bag on for her so she could vent her emotions on it.” (Interview 1, Doné’s mother, line 327)

4.2.2.3 Vignettes. The invisibility of anxiety at school is also illustrated in the following three vignettes, which were developed on the basis of observational data during class visits. The vignettes confirm the absence of visible signs of anxiety in the school context.

> Third Vignette, Pieter, May 28, 2021, session 5, Phenomenon of subjective wellbeing. It's a winter morning at my school. The morning sun peeks through the classroom window while we just came to sit down after the break. I get the smell of sandwiches still hanging in the air. I hear the noise of tables as the children sit down at their seats. The friends are still talking about the excitement of the break and then my teacher says that we should sit in our seats and calm down because in a minute or two she will start listening to our speeches. I try to whisper one last word to my friend before it suddenly becomes very quiet in class. We each now get busy with our work while the children give their speeches, and we sit quietly and listen. Some of us are learning spelling for the next day and others are sitting and reading. Then the teacher calls my name to do my speech. I get up very excited from my chair and with my furry dinosaur mask on my face I step forward and stand in front. I peek in Aunt Ingrid's direction just to make sure she's watching and listening too. She is. Then I smile and look down with a shy laugh before I start. The teacher says that the friends who speak can take off their masks so that she can hear us clearly. I pull my mask up to my chin and tell the class about my pet puppy “Snoekie”. While talking lovingly about my puppy, I quickly peek in the direction of Aunt Ingrid again. She smiles kindly at me because she can see that I enjoy every moment. I end my speech by showing pictures of my puppy, and each child responds with an aah or oee or so cute! It makes me happy when my friends react like that. I think Aunt Ingrid and my teacher

can see the happiness on my face! When I finish, my teacher compliments me on my beautiful speech and here and there a child also agrees. While the rest of the children continue their speeches, I take out my books and quietly write down my spelling words and learn them. Every now and then I look up, nod my head as I listen to the speeches and then I get busy with my ruler. After the last child has spoken, one of my friends walks up to Teacher's table and says that he has just pulled his tooth. The teacher says that he has to wrap his tooth in a piece of tissue and take it home so the tooth mouse can come and visit. When Teacher instructs us to take out our reading cards and reading books, I do so immediately. I suddenly rub my eyes and quickly stretch my one arm in and out. Then Teacher says we should open our workbooks and write the date. She starts by asking what type of farm animals one finds on a farm. We each call out a different kind of animal. The class becomes restless and a boy shouts from behind, "Shoot!" Teacher says, "Guys, listen to me now, quickly put down everything in your hands for me. Where should your eyes be"? We shout, "On the board!" Teacher says she is doing revision to help us because we are now going to have to write sentences. Then she asks, "What do you call a male horse and a female horse"? The children answer excitedly: "A stallion and a mare!" When she asks what one calls a female chicken, I raise my hand and reply, "A hen, Teacher." Teacher is impressed with my quick answer and says, "Mooi, Pieter!" We all sound cheerful and it's really fun in our class! Lastly, teacher asks what you call a baby horse. Then she asks if I know the answer, and I answer, "A filly!" Teacher says that the class should clap their hands for me because I remembered so beautifully. I smile proudly.

Vignettes present an experience from the perspective of the other. The vignette above presents an experience of excitement, spontaneity and contentment. It is evident that Pieter enjoys every moment while performing his speech. After the speeches, he also participates in the class discussion about farm animals. Even though this vignette presents

an interpreted version of his classroom experience, the invisibility of anxiety reported by the study's teachers is confirmed in the depiction of his behaviour.

Third Vignette, Karné, 26 Augustus 2021, class visit. Phenomenon: Subjective wellbeing

> It's a cold Thursday morning and Aunt Ingrid walks into our class right after break. She's coming for a class visit today. The kids in the class are also excited to see her, and everyone greets her kindly. My teacher is also very kind to her and introduce her to the class. The friends cannot wait to recite their poems in front of the class. As this is my first time performing in front of Aunt Ingrid, I am a little anxious. I step in and immediately sit down at my table. I take my books out of my suitcase and then keep a close eye on Aunt Ingrid. Every now and then she looks in my direction and then winks at me. I feel a bit shy and then rather look down. Every child now sits at his place, and it becomes quiet. Then the teacher starts calling children forward to recite their English poems. Some children bring props, and some do not. I also did not bring anything with me. I do not think it is necessary because I know my poem well enough. Some children know the words fluently and others struggle and then my teacher helps them. We laugh because some children brought nice props. While listening I play with my fingers on the table. I rather do not look at my teacher or Aunt Ingrid, because I know it's almost my turn to stand in front. Every now and then I peek at Aunt Ingrid and then look away. Suddenly the teacher calls me forward. I get up quickly and step forward. I stand against the class board with my hands behind my back. I look straight ahead and start speaking expressionlessly. Fortunately, I know my words well. I do not look left or right. I say my poem and walk back to my desk. As I walk back, the class claps hands and Aunt Ingrid and my teacher complimented me on a good effort. I quickly look in their direction and give a slightly shy laugh before I sit down. I focus intently on the work in my book. I feel Aunt Ingrid's eyes on me. I look up again and she points a thumbs-up in my direction. After everyone has spoken, Aunt Ingrid congratulates us on our performances and says

that we were very sweet. When she gets up to walk out, one of the girls in the class comes up to her and gives her a bright pink shiny beaded necklace that she used as a "prop" in her poem. Aunt Ingrid looks surprised and thanks her for the gift. I'm glad Aunt Ingrid came to visit and especially listened to my poem!

When reading the above vignette, the reader can sense Karné's slight nervousness. However, it can be argued that it is normal to feel a bit exposed and nervous when performing in front of the class and that the experience does not depict anxiety. The vignette also presents a sense of excitement in the air. Interview 1 with Karné's teacher (lines 36-40) which underpins the vignette, also shows that the teacher and I could not observe any severe feelings of anxiety during Karné's performance.

Fourth Vignette, Doné, 16 September 2021. Phenomenon: Subjective Wellbeing

Today Aunt Ingrid comes to visit the class. I feel a little nervous, because I do not know what to expect. When she walks in, she greets the class kindly and sits down at the table right next to mine. My teacher suggested it because she says then Aunt Ingrid can keep a good eye on the class, and on me of course. I greet her kindly behind my mask and sit down immediately. I take out my books and the teacher says that we must open our books because she wants to see if we have done our homework. My work is done neatly. Aunt Ingrid glances quickly at my book and smiles. I smile back. The teacher walks through and stops for a moment when she comes to me, looks at my work and then nods her head as a sign that she is satisfied. The class goes on quietly as if no one is visiting us. We are now wearing our summer clothes again. I am neatly dressed with a tight ponytail on my head, rounded off with a black mask. My appearance looks as neat as my book. As we mark the work, the teacher asks the children to read their answers aloud. I know she's going to ask me soon because Aunt Ingrid is sitting here. My mind is not yet cold from the thought, and she asks me. Luckily, I know my answer is correct and I read it with confidence. The teacher says thank you and continues. Aunt Ingrid smiled quickly in my direction. It feels quite nice, and I smile back. After marking the

language work, we begin to discuss the poems and mark the work we also got for homework. The teacher works quickly and is sometimes a little impatient if the children do not give their answers soon enough. Then she simply answers on their behalf. It makes me a little nervous. “Oh no! She’s asking me!". I give my answer, but it's not right. She asks the question in a different way. While I am still hesitating, she calls out the answer. I feel a little embarrassed because Aunt Ingrid's eyes are on me now. She smiles reassuringly. It's not nice. Next time I will have to answer right. Luckily, the air conditioning in the class is on which cools me down a bit as I can feel the heat rising against my neck. When the teacher asks me the last question, I am ready and answer with certainty. Teacher answers: “Very good answer Doné!” I blush a little, but now I feel better! When the bell rings for the second Afrikaans period, Aunt Ingrid stands up and says that we are a very well-mannered class that works very well together. She smiles at me and then greets the class and walks out. It is nice that she came to visit!

From the above vignette, it is evident that Doné composed herself very well when the teacher asked her the first question and she could answer it correctly and with confidence in her voice. When Doné answered the second question incorrectly, she stayed calm until she answered the last question correctly.

As illustrated, the theme of “Invisibility of anxiety at school” is substantiated across the datasets of the current study. It can be deduced that this invisibility makes it very difficult for teachers in a classroom context to identify children with anxiety.

In spite of educators not being able to recognize and respond to these children' requirements, a lack of mental health awareness and knowledge may lead to potentially inappropriate referrals (Cvinar, 2010). Therefore, it is crucial to examine how educators describe anxiety and to raise awareness of the symptomatology of children with excessive anxiety. The teachers did not identify the anxiety of three out of the five participants in this study. This may be because anxiety symptoms are not always recognizable, but it may also be related to how children present in class.

According to Headley and Campbell (2013), because children with internalizing challenges are typically well-behaved, researchers have discovered that teachers frequently overlook these learners. Splett et al. (2019) discuss the unmet needs and discrepancies in service that have prompted multiple calls for effective practices, such as teacher training in children's psychological challenges, global psychological screening, and the continued integration of evidence-based practices are imperative (Weist et al., 2018). Since poor mental health is associated with significantly lower academic achievement, addictions, violent behaviour, compromised health and decreased satisfaction with life, it is crucial to identify children with mental health challenges and connect them with the best interventions (Gilman & Huebner, 2006; Patel et al., 2007). Early intervention in mental health is necessary to maximize positive outcomes for children; nevertheless, a challenge needs to be identified before making a referral. Teachers play a crucial role in determining children with mental health challenges. Reinke et al. (2011) mention that 75% of teachers who responded to a survey about their contribution, expertise, and training and development needs for supporting children's mental health in schools had worked with or referred children with mental health difficulties the previous year. Stiffman et al. (2010) refer to teachers as "gateway providers" when discussing the factors affecting access to mental healthcare for children with mental health challenges. Teachers are individuals who are not mental health professionals but who direct or initiate treatment access. Despite their critical role in facilitating children's access to psychological care, teachers frequently admit their need to identify and understand children's challenges with mental health difficulties as one of the top three training areas (Reinke et al., 2011).

Training teachers to identify psychological health concerns within the classroom may be particularly important for children with internalizing behaviour difficulties. Anxiety and depression are prevalent internalizing disorders that affect approximately 32% and 14% of adolescents, including both (Merikangas et al., 2010). Due to the absence of prominent or noticeable symptomatology, such as school disruption and rule violations, these prevalent disorders are frequently undiagnosed. Children with externalizing behaviour difficulties are 20% more likely to receive mental health services than children with internalizing behaviour

challenges (Bradshaw et al., 2008). This phenomenon has been labeled the "squeaky wheel" because children who disturb the learning environment due to more obvious academic and behavioural challenges are more inclined to receive treatment than children with less apparent or disruptive difficulties (Bradshaw et al., 2008, p. 3). In addition, studies have demonstrated that teachers have trouble recognizing children with internalizing behaviour difficulties (Cunningham & Suldo, 2014; Neil & Smith, 2017); however, they are much more inclined to refer and are more concerned about children with externalizing behaviour difficulties than with children with internalizing behaviour difficulties (Chang & Sue, 2003; Loades & Mastroyannopoulou, 2010).

Numerous teacher education programs in South Africa contain traces of mental health education, but the role of teachers in this domain is frequently underemphasized. As exemplars, early childhood education programs bear some consideration. For instance, the early childhood education training for undergraduate students at the University of Pretoria does include modules during the first two years of study that acquaint students with mental health challenges in young children:

- Education, where childhood development and developmental psychopathology are introduced to the students
- Life skills, where students learn more about emotional growth in the child
- Life orientation, where students learn more about emotional difficulties during early childhood, and
- The Learning Support module educates students on learning barriers and the internal and external factors contributing to learning difficulties.

Although these modules introduce teachers to children's mental health concerns, they do not necessarily emphasize the informal identification of children who suffer from mental health challenges and how to support them (University of Pretoria, 2022). In their third and fourth year of Early Childhood Education training at the University of Stellenbosch, teachers receive information on child mental disorders. The module title is "Development

and Learning of the young child and the mind of the young child." Unfortunately, it does not include skills on how to identify children with anxiety informally or how to refer them for support (Stellenbosch University, 2022). Foundation Phase early childhood education for teachers at the University of Potchefstroom (NWU) does not include modules on young children with mental health challenges. Teachers in the senior phase get training on mental health challenges in a module called, Learning Support but not about identifying and supporting young learners with anxiety (Northwest University, 2022). At the University of Johannesburg, Early Childhood Education training for teachers includes information about child mental health challenges during their first and second years of training. These modules are Life Skills and Education, where childhood development and developmental psychopathology are introduced to the students. In the life skills module, students learn about emotional growth in the child and in Life Orientation, they learn about the emotional difficulties during early childhood. Although these modules introduce teachers to children's mental health challenges, they do not address the informal identification and support of children who suffer from mental health difficulties (University of Johannesburg, 2022).

Despite the widespread occurrence of internalizing challenges like anxiety disorders, there are indications that teachers may struggle to comprehend what internalizing disorders are, their consequences, and how to recognize their symptoms. Internalizing challenges distinctive characteristics, in particular, anxiety disorders, makes it difficult for educators to recognize their symptoms. This might be why the teachers did not identify three out of the five participants in my study. They struggled with internalizing anxiety and, therefore could not be easily identified by the teachers. Internalizing disorders are more hidden and therefore often more challenging to detect and assess (Wilmshurst, 2005). While teachers cannot make formal diagnoses, they play pivotal roles during initial identification and first-order support.

When children internalize their feelings of anxiety, it is significantly more challenging to identify them. The most prominent signs of internalized anxiety are:

- Struggling to socialize.

- Low academic achievement.
- Poor self-esteem.
- Struggling with peer and parental relationships.
- Absenteeism.
- Restlessness (misdiagnosed as ADHD).
- Easily fatigued.
- Muscle tension.
- Sleep disturbance.

These symptoms are not easily identified in a classroom crowded with children. Teachers today find it difficult to handle various classroom challenges (Wilmshurst, 2005).

4.2.3 Theme 2 – Intuitive Integrative Psycho-Therapeutic Approach

The second theme that emerged from the findings was an intuitive, integrative psychotherapeutic approach. An intuitive approach was integrated into the intervention research process. In other words, no specific intervention program was formulated before the intervention period started other than some selected psychotherapeutic techniques. The intervention process was semi-structured and accommodating, as it needed to be open and flexible due to the different forms of anxiety presented in this study and differences in the participant's specific needs during the therapy session.

The integrative psychotherapeutic techniques included positive psychology, gestalt play therapy, sandplay therapy and somatic experiencing therapy, in which I had received further training. Both the literature review on the appropriateness of these psychotherapeutic approaches on children with anxiety and trauma and my experience in implementing these therapies convinced me of their potential efficacy in this study (Blom, 2006; Bohlmeijer & Hulsbergen, 2018; Struwig & van der Spuy, 2021; Wenar & Kerig, 2005).

Before the intervention process could begin, it was essential to do an emotional assessment with the participants to determine the background and nature of their presented problem and, crucially, establish rapport. When they felt safe, trusted and accepted, they would

open up and share, and only then could corrective change (psychotherapy) occur. A trusting relationship with my participants would enable successful intervention.

Table 4.2 presents the different psychotherapeutic techniques used during this study. Table 4.3 presents extracts of the therapeutic techniques and the therapy process followed by each participant. The healing process was unique to each participant (Ross, 2010).

Table 4.2

Intuitive Approach of Integrative Psychotherapeutic Techniques for this Study

Participants – 60 minutes per session	Positive psychology interventions	Gestalt play therapy	Sandplay therapy	Somatic experiencing
Pieter 10 sessions	4, 5, 6, 7, 8, 9, 10	8, 9, 10	6, 8	5, 7, 10
Karné 12 sessions	4, 5, 6, 8, 9, 12	6, 7, 9, 11, 12	8, 10, 11	5, 12
Lizelle 11 sessions	5, 6, 7, 8, 9, 10,	6, 7, 9, 10, 11,	5, 11	6, 8, 11,
Doné 11 sessions	3, 5, 6, 7, 8, 10, 11	3, 6, 7, 8, 9,10, 11	4,7,8	4, 8, 9, 10
Pam 10 sessions	2, 3, 4, 5, 6, 7, 8, 10	3, 5, 6, 7, 8, 9, 10	2,4,5,7,9	6, 7, 8, 9, 10

Table 4.3

Structured Activities for the Intuitive Approach of Integrative Psychotherapeutic Techniques for This Study

	Positive Psychology	Gestalt Play Therapy	Sandplay Therapy	Somatic Experiencing
Pieter:				
Session 10	Dream chart 	Flowerpot 		Chocolate coconut balls 
Lizette:	Dream chart	Perfect Bowl of light		Play dough with vanilla
Session 9				

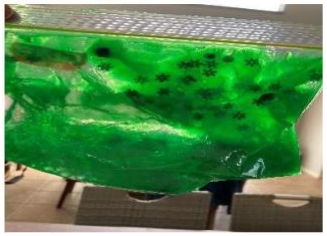
Karné:

Session 8

Dream chart

BiblioTherapy

Squishy bag



Doné:

Session 5

Dream chart

Perfect Bowl of light

Blow bubbles, down regulate

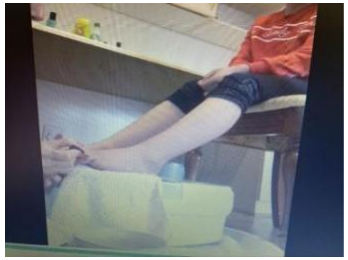
Pam:

Session 10

You are very special

Flowerpot

Pedicure with emotions



4.2.3.1 Teachers' and Parents' interviews

Data extracts from the interviews with teachers and parents confirm the efficacy of the intuitive, integrative psychotherapeutic approach used in the study. Although the teachers and parents were not directly privy to the therapeutic sessions' content, they received feedback and observed the participants in various school contexts.

Extracts from teachers' interviews:

- "Yes, a huge improvement from the first term and even more so from the second term. She asks questions. She crawled out of her shell and asked more questions. Furthermore, she is just as cute to me. I could not have believed it when you told me that her parents were struggling with her." (Interview 2, Karné's teacher, line 1).
- "Don't you think it helped a lot that you gave Mom a little guidance? I think they also just had to put their foot down a little bit." (Interview 2, Karné's teacher, line 49).
- "She is definitely much better than at the beginning of the year. She is much more relaxed; there is a huge, huge difference. I do not know if it is you, but I can see a clear difference in her. I do not know if it is the same with the other classes, but definitely with me. She says her say." (Interview 2, Lizette's teacher, line 4).
- "Yes, her marks also improved, she got deep in the 80's and her average was now 92% for Afrikaans." (Interview 2, Lizette's teacher, line 29).
- "She definitely became more spontaneous and started participating more in class.
- Her homework was always done. She's still very quiet, but I can see her talking more to children in class than before. They gave speeches in class last week. She prepared well and spoke well. She got a good mark." (Interview 2, Doné's teacher, line 3).

Extracts from parents' interviews

- "Emotionally, she is much stronger. This year has done a lot for her. She is no longer so shy and withdrawn. She is much more involved in the class. She sends messages to the class to remind them to learn for a class test. It had not been my child. There'sa very big change in the emotional development." (Interview 3, Doné's mother, line 5).
- "What I can tell you is that the bowl of light, she showed it to me and explained it. She said the pebbles were about how she felt scared. She changes the sizes of the pebbles depending on how she feels. It helped her verbalize which I think is good because she could not say what she was feeling. She just screamed. She can now identify more what she is feeling. She can identify and verbalize what she is feeling. This is something I have noticed a lot. One can reason with her." (Interview 3, Karné's mother, line 231).
- "He does this sandpit, but he is so sharp! I did a sandplay therapy with the previous child. She took my container of beads and then poured all of the beads into her sandpit. A thousand little beads! I then sat for a long time to get the beads out of the sand. Pieter was then next. He then saw that there were still some beads in the sand. While he builds, he puts all the beads in a hole in the sand. Now I'm watching him. Then I asked him if I should take the beads away. No, he says, these are 'dinosaur' bones. Then I thought, now I've heard everything. Then he took the crocodile and said that the crocodile was going to eat all the dino bones. So, he works it into his story. So creative! When he finished, he said, 'If aunty is looking for it, it's in the crocodile.' He then said that if the crocodile eats all the bones, he will become big and strong." (Interview 3, Pieter's parents, line 444).
- "Then I also did a lot of breathing exercises with him that he can apply if he feels anxious. This is an example of a somatic integration technique. I took a cup with a dish, soap and water and then he blew bubbles in the cup. It's a really fun activity

and they relax without actually realizing it. The key is to inhale in through the nose and exhale through the mouth while blowing bubbles." (Interview 3, Pieter's parents, line 286).

- "It is also important that she can talk about things that make her happy and unhappy. During our last session, I did a 'mood pedicure' with her. She chose different colours of nail polish. Each colour indicates an emotion. Then she got the opportunity to talk about each emotion. It is crucial that she has the chance to communicate her emotions. When you do this, you teach her the skills to do it too." (Interview 3, Pam's parents, line 479).
- "Definitely there has been a massive change in Pieter in his anxiety. He gets his days, but overall he is so much better. If things don't go his way, he will not burst out in tears, he can handle things so much more maturely." (Interview 2, Pieter's mother, line 6).
- "The anxiety from the beginning of the year where he wants to get nauseous in the car before school is gone." (Interview 2, Pieter's father, line 17).
- "I think the sessions helped a lot. A few times before a session with you she was…almost depressed. Then she will be with you and then she will walk out feeling happy. I would ask, how was it, did you talk a lot, how are you feeling now? Then she would say, I feel much better now. Tannie Ingrid told me this and told me how to do that … She is also a lot more expressive with her emotions as well. She is able to identify what she is feeling a lot better." (Interview 3, Pam's mother, line 52).
- "I think she is stronger and has more confidence. She stands up more for herself." (Interview 3, Lizette's mother, line 10).
- "Thank you very much. It is very beautiful! I also want to thank you for the plant, hoisting in her room. It's in her windowsill, she painted it so beautifully, it's beautiful!" (Interview 3, Lizette's mother, line 102).

4.2.3.2 Vignettes. Because vignettes form a substantial part of the data collection and analysis, five vignettes are included that depict the phenomenon of the subjective wellbeing of the participants. Reading these vignettes allows one to zoom into the participants' lived experiences and the changes that took place as the intervention process takes its course. The progress of the participants is tangible. Reading the vignettes also reveals the intuitive process during these sessions.

Second Vignette, Doné, 24 May 2021, session 3. The phenomenon, Subjective Wellbeing

> Today is the 24th of May. I have a session with Aunt Ingrid at her house today. I sit on her orange blanket in the study where we usually have our session when it's not at school. The blinds of the study are open and a lovely winter sun shines through the windows of the room. There is a coolness in the air, although I do not get cold quickly. I still think winter is around the corner. Aunt Ingrid also wears winter clothes with black boots. She mentions that she does not like winter because she does not like getting cold. I'm wearing my grey sweatpants, a maroon t-shirt with blue patches on. I sit with crossed legs on the blanket because then I am comfortable. Aunt Ingrid and I small-talk and it creates a calm atmosphere before we start the session. Then she asks me to draw a tree today that represents me. In other words, the tree is actually me. Before I start, she asks a few questions about the tree to help me get a better picture in my mind of what this tree might look like. As she speaks, I shake my head as a sign that I understand and then look up slightly skewed in the air to get an idea in my head of what my tree will look like. As she explains, my imagination starts to draw pictures. It's quite nice. Then I take the writing board and put it on my lap. It's more comfortable and then I start drawing. While I am drawing there is a dead silence. Aunt Ingrid takes notes and gives me a chance to take my time. When I finish, I start telling her about my tree. The tree stands in the middle of a forest. It is summer, which is also my favourite season. Actually, the change from spring to summer, this is also my birthday month of September of course! The tree is self-

sustaining because it has deep roots. There are various animals in the tree such as squirrels and birds. The tree does not stand alone; other trees stand at a distance around it. Lastly, this tree bears pink blossoms with green leaves. The trunk of the tree represents my immediate family. It is like in my whole family because we are a very close family. The leaves are the most important people in my life. It's my adopted grandfather, Jeff, who passed away, my two nephews and my best friend Liam. The flowers are all my talents like my dance and drama which I enjoy thoroughly and in which I am good. Being able to draw and describe this tree today has forced me to just realize again who the important people in my life are and how important relationships with family and friends are. I am so grateful because I have a big family and close friends whom I love and who love me!

The phenomenon of subjective wellbeing is visible when Doné changes her body posture to be comfortable. She feels at ease and takes part in a small-talk conversation. While drawing she uses her imagination without any anxiety. Towards the end of the session, she shares her feelings about her family and friends openly. Because I knew from previous sessions that Doné's friends and family play a vital role in her life, the above therapeutic techniques and activities were intuitively introduced.

Fourth Vignette, Pieter, 2 September 2021, session 10. The phenomenon, Subjective Wellbeing

Today is my last session with Aunt Ingrid. I feel a little sad because this is our last recording of the sessions and I will miss it. Luckily, I continue with therapy because I enjoy it too much. Winter is almost over and it's nice and warm today. The window blinds are open so that the sun can shine brightly while we work. Before we start the session, Aunt Ingrid reminds me that she had to bring a Tinky sweetie piece of paper so I could stick it on my dream card. That's all I needed to finish my dream card completely. I carefully cut it a little smaller so it can fit on my poster card. Perfect! I paste it up and am very proud of the dream card I made! Then we continue to finish painting my flowerpot. Each plank on my flowerpot represents a therapy session and

the colour I choose to paint also shows how I felt at that point. So, I start with a colour that shows how I felt during the first therapy session. I felt very scared then. The last session is my best, nicest colour because that's how I feel today. Much better! After I finish painting, we put the flowerpot aside to dry. Now, Aunt Ingrid says we are going to mix and roll our delicious chocolate cookies. It smells like chocolate in the room, and I just lick my lips! She throws the ingredients together and I have to mix them with a spoon. It's a bit difficult and then I just use my fingers to do it. It's a nice sticky mess and every now and then I lick my fingers. The brown sugar we use looks so delicious and I ask Aunt Ingrid if I can eat some sugar when we are done with the cookies. After I have rolled the last cookie in coconut and put it in my cup, we store it in the fridge to cool down a bit. It looks and smells so delicious! Aunt Ingrid asks what I want to do next, and I choose to play ‘My world’ out in the sandpit today. When she puts the sandpit down in front of me, my imagination starts running away with me as usual! The person who worked before me in the sandpit played with colourful beads in the sand. Some of the beads remain in the sand. And this is where my imagination starts. The beads suddenly become dino bones, which the crocodile starts eating in the sand. As he eats the dino bones he becomes bigger and stronger until he turns into a Chrystal Rex. I live myself out in the sandpit and enjoy every moment! I can see that Aunt Ingrid enjoys it with me and it makes it even more fun! We laugh and make jokes while I play in the sand. When I'm done, we end by planting a plant in my flowerpot. I choose the plant myself and we plant it together. As I scoop out the plant with the soil, my nose catches the smell of soil and then I dig with my fingers into the wet soil while Aunt Ingrid and I transplant my plant. I choose a yellow pansy. It looks so pretty, and I cannot wait to show it to mom! Today was the most enjoyable session ever!

The subjective wellbeing phenomenon becomes visible when Pieter uses his favourite colour to paint his flowerpot and says he feels much better. When he makes the chocolate cookies, his body language shows that he enjoys every minute because he would

lick his lips and then clean his fingers by licking them. Another indication of subjective wellbeing is after he planted his ‘pansy’ flower into the flowerpot. He smiles proudly and says he cannot wait to show it to his mother.

> Fourth Vignette, Pam, September 8, session 10. Phenomenon Subjective Wellbeing
>
> This is my last session with Aunt Ingrid today and I am so excited because I'm wearing my new pink sneakers I got yesterday and a red sweater. I told Aunt Ingrid about my sneakers at the previous session and cannot wait to show them to her. She thinks they are beautiful and wants to buy them for her daughter as well. When I walk into the therapy room, I see towels on the floor as well as a foot spa. There is a table with nail polish and foot cream. I smile and wonder if it's going to be for our session. It looks like a lot of fun. It is cloudy outside and the blinds of the therapy room are open so that enough light can pass through. On the orange blanket where we first sit, Aunt Ingrid tells us what we are going to do today. She explains that we will first plant a plant in my flowerpot that I painted at the previous sessions and that I have to choose one. I then chose a white flower plant and carefully planted it in my flowerpot. As I plant it, I inhale the smell of soil between my fingers. When I finish planting the flower, I feel so proud of myself because it looks extremely beautiful! When Aunt Ingrid goes out to pour water into the foot spa, I cannot help to touch the white flowers. It's so beautiful to me! When she returns, she explains that she is going to give me a pedicure with a variety of nail polishes. I excitedly take off my shoes and socks and then sit down at the foot spa. Then I put my feet in the warm foam water. It smells like flowers while she is washing my feet. After wiping my feet with a soft towel, she asks me what was the most enjoyable of all we have done during all the sessions. Immediately I say that this was when I made the perfect bowl of light from clay and also the bracelet with beads that reminds me that when I feel scared, everything will be 'ok'. Then she explains that each colour of nail polish represents an emotion and that I have to choose a colour for happy, sad, angry and scared. I first look carefully at each colour and then choose light pink for happy, blue for scared,

red for angry and dark pink for sadness. As she paints the colours, I tell her what makes me feel like every emotion. Every now and then her eye makes contact, and I can see in her eyes that she is listening as she paints my toes. It makes me feel very special. When we are done, I sit down on the blanket again and wait for the nail polish to dry. Then Aunt Ingrid opens a storybook and says that I should sit quietly and listen while she tells the story. When she's done, I can tell what message I get from the story. The story's name is "I'm special". I listen to the story, all eyes and ears. When she's done, she asks what the message is from the story. I then say that you should be content with yourself because you are special because Jesus made you. With that, we then end the session. I feel happy and satisfied with colourful toes!

The phenomenon subjective wellbeing becomes prominent when Pam felt excited to show her new pink sneakers, which she shared during the previous session. When she saw the foot spa, she smiled, and her curiosity showed. After she planted the flower in the flowerpot, she looks satisfied with herself. Her embodied experience of the warm foamy water that smells like flowers and the soft towel on her skin illustrates subjective wellbeing in this instance.

Second Vignette, Karné,15 June 2021, Session 6. Phenomenon Subjective Wellbeing,

In today's session, Aunt Ingrid invites my mother along to watch the two of us get along. I'm still wearing my school clothes and am very excited because I cannot stop smiling. It's weird to have my mom in the session together today, but still, I'm extremely happy and a little anxious because I do not want to disappoint her. Mom is more quiet than usual; I think it might be because she also feels anxious because it is her first therapy session with Aunt Ingrid today. Aunt Ingrid unpacks various activities for us to do. The therapy room is nice and big, the blinds are open and there is enough light shining through the windows. It is a cold winter afternoon, and the heater is on which creates a lovely warm atmosphere. A dough, drawing and puzzle table are unpacked. On the floor are rainbow soft pillows and a soft orange blanket

with some story books to read. Mom and I can decide for ourselves what we are going to do for the next 20 minutes. We decide together to sit at the dough table first. My mother gives some ideas what to make, and I agree very enthusiastically and give a hysterical laugh to express my delight of the moment and then each one forms her own picture with coloured dough on a page. Now and then I peek at what Mom does and then I do the same. When Mom's picture looks more interesting than mine, I then go and stand by her to help her finish the dough picture. We end the family picture by putting a red heart of dough on the page each. Then I say to Mom: "It was really nice!" Mom answers: "We love each other", and I say, "That's very true." Our love for each other makes the room even cosier. Then I ask mom what she wants to do next. We decide together to play 'snap' with emotion cards and while we shout excitedly 'snap', we share our emotions with each other in an honest and loving way. Last, we sit at the drawing table while I draw a picture of my favourite puppy “Bolt” and Mom colours a flower picture. Every now and then I get up curious to see how her colouring picture is progressing. Being close to Mom makes me feel safe and happy, and from time to time I give a satisfied laugh. With break time we sit on the blanket and enjoy chocolate and vanilla decorated cookies and apple juice. After mom pours in the cool drink, we 'cheers' I feel so happy that I cannot keep my eyes off Mom. Mom seems more relaxed now because she smiles and talks more than earlier. The moment is so special to me! The smell of chocolate and vanilla icing hangs in the air and then I decide to eat one last cookie. The last 20 minutes of the session Aunt Ingrid gives a specific assignment to do together. This time we have to make a collage of our upcoming sea vacation. I get so excited that I keep talking to Mom. I think Aunt Ingrid can hear the excitement in my voice and also see in my body because I cannot sit still. Mom and I chat like two bumblebees around a honeycomb.

Mom is patient with all my suggestions. We cut out both pictures. Mom packs the pictures on the page, and I paste them. The collage is a colourful, creative team

effort! The phenomenon subjective wellbeing becomes visible when Karné feels excited and cannot stop smiling. She and her mom decide together to sit at the dough table. Then she gives a hysterical laugh to express her delight. Then Karné would stand by her mom to help her finish the dough picture. They end the family picture by putting a red heart of dough on the page. Then she says to her mom: "It was really nice!" Mother and daughter share their emotions with each other in an honest and loving way. Karné gives a satisfied laugh to express her feelings of joy. She expresses her subjective wellbeing spatially, temporally and relationally. Subjective wellbeing is prominent in the excitement of her voice and in her body language. She cannot seem to sit still, thereby presenting an embodied experience of subjective wellbeing. Her mom is also patient with all her suggestions.

Fourth Vignette, Lizette,1 September 2021, session 11. Phenomenon Subjective Wellbeing

Today is spring day and I enter the therapy room with a big smile and a pink flower wreath on my head. This is my last session with Aunt Ingrid and I know we're going to have a lot of fun. I sit on my knees and am terribly excited. I know I'm going to finish painting my flowerpot today, so I also brought my own special paintbrush to finish my bowl nicely. When I started with the flowerpot last week, Aunt Ingrid said I should choose colours that would suit my emotions for the different sessions I had until today. Last week, I carefully chose my colours that depict the emotions from the beginning to today. Today I feel so excited and happy and that's why I choose my favourite colour, namely marble pink, purple! Before we start, Aunt Ingrid wants to know what happened to my and my friend's friendship. I told her at the previous session that I was going to talk to her and that we were not going to be friends anymore. I decided to open my mouth and say how I felt. I'm not going to let her tell me what to do anymore. As Aunt Ingrid mixes the colours I am going to use next, I smile broadly at the camera I have always been so afraid of. After I paint my flower bowl, Aunt Ingrid asks me to describe the colour I last painted in a feeling. The colour

I chose suits me, the fact that I no longer feel so ashamed and scared. Then I choose the flower that will come in my flowerpot. I decide on a white face. As Aunt Ingrid puts it in the flowerpot, I turn my head contently. I smile because it looks extremely beautiful.

The phenomenon of subjective wellbeing is prominent when Lizette enters the session with a smile and a pink flower wreath on her head. She brought her own paintbrush to finish her flowerpot today. She chose her favourite colour for the last session today and the colour she chose is pink-purple marble. She states that she has decided to open her mouth and express her feelings. Then she smiles broadly at the camera for the first time because she does not feel so scared and shy anymore.

The vignettes presented here depict the varied lived experiences of children with anxiety in the South African context. It also shows how subjective wellbeing interventions can potentially be leveraged to support children with anxiety, even in instances of trauma. It also shows how an intuitive approach to integrative psychotherapeutic techniques can support these participants subjective wellbeing.

The data in this chapter illustrate an intuitive integrative psychotherapeutic approach. The literature that follows positions these findings in the broader literature.

4.2.3.3 Intuitive Approach. Some therapists can rationally deny following hunches, having sudden intuitions, deciding on a course of action without knowing why, or experiencing mysterious feelings that are crucial for therapy. However, according to Sadler-Smith (2007), everyone has intuition. It is one of the hallmarks of how human beings think and behave. Under the right circumstances, intuition can have life-altering and life-saving outcomes. Clinical intuition can be a feature of expertise – the accumulation of knowledge, skills and experience (Anderson et al., 2019). In this study, intuition guided me to search for solutions, but experience, skills, and knowledge in the field play a very significant role when making decisions before interventions. Intuitive expert knowledge occurs when an expert uses their experience to recognize signals in a situation that allow them to recognize patterns and construct a narrative about that situation (Whittaker, 2018).

As Laughlin (2016) puts it, “Comparatively little knowledge is derived initially from conscious reasoning. Indeed, the nature of our brain and its modes of producing our world of meaningful experience are inherently intuitive” (Welling, 2005, p. 1). Although intuition is a commonly acknowledged experience, its role in psychotherapy has been the subject of remarkably little research and publication. It has proven difficult for authors who have written extensively on intuition (Grant & Langan-Fox, 2014; Mälkki & Raami, 2019; Sadler-Smith & Shefy, 2004) to move beyond a descriptive method to this phenomenon in terms of explaining the existence of intuition and suggesting mechanisms for its functioning.

According to Welling (2005), a significant publication was Hadamard's (1945) *The Psychology of Invention in the Mathematical Field*, in which he reviewed the findings of interviews with various scientists. Hadamard provided numerous examples of how intuition is a significant factor in advancing (mathematical) sciences. The most frequently reported phenomenon among scientists is the significance of intuition as a guiding principle for solving scientific problems. The scientist's intuition indicates which directions are promising, where to find a solution, and which pathways are dead ends. Listening to and relying on one's emotions rather than one's intellect became synonymous with intuition (Welling, 2005).

An intuitive approach was carefully integrated into the intervention research process of this study. In other words, no specific intervention program was formulated before the intervention period started. According to Fraser and Galinsky (2010), intervention research is the systematic study of change strategies with specific intent. It involves both the design and development of interventions. Design is the process of specifying an intervention. This involves determining the degree to which specific practices, principles, objectives, and activities define an intervention. I followed a semi-structured, accommodating intervention procedure. Depending on the participant’s specific needs during the therapy session, it needed to be flexible. Bowlby described the best therapist as someone who is naturally intuitive. Someone who can use their subjective implicit experience guided by the appropriate theory (Rass & Bowlby, 2017). To incorporate an intuitive approach into my study, the following crucial ingredients of this approach were knowledge, skills, and

experience (Anderson et al., 2019). Without those ingredients, this approach would not have been possible.

4.2.3.4 Integrative Psychotherapy. As stated in Chapter 3, Geldard and Geldard (2017) assert that the literature strongly supports integrative psychotherapy approaches. Psychotherapy integration encompasses a philosophical, theoretical, and clinical orientation to the study and practice of psychotherapy. This perspective is characterized by an interest in fostering dialogue between therapists of all orientations and an openness to recognizing the combinations and unities of the vast array of religious psychotherapies. Psychotherapy integration is a desire to learn from all therapies and therapists instead of declaring exclusive allegiance to one psychotherapy school or model (Stricker & Gold, 2011). The integrative psychotherapeutic techniques for my research were based on the following psychotherapy approaches:

- Positive psychology interventions. These interventions focus on positive emotions and other characteristics, including creativity, optimism, resiliency, empathy, compassion, humour, and life satisfaction. It helps enable a child to improve their self-esteem and know themselves better, and accept themselves for who they are (Carr et al., 2021).
- The benefits of Gestalt play therapy for raising a child's awareness and helping him or she get in touch with intense emotions are numerous (Blom, 2006).
- Sandplay therapy helps the child deal with trauma, especially anxiety (Turner, 2017).
- Somatic experiencing play therapy techniques use the brain, memories, body, senses, and nervous system to help children with anxiety and trauma (Levine & Kline, 2006).

4.2.3.4.1 Positive Psychology. Today, positive psychology aids as a catch-all for various positive psychology interventions. A 2011 systematic review identified 53 published definitions of positive psychology encompassing six core domains: (i) virtues and character

strengths, (ii) happiness, (iii) growth, fulfillment of capacities, development of the highest self, (iv) good life, (v) thriving and flourishing, and (vi) positive functioning under conditions of stress (Schrank et al., 2014). In my study, positive psychology intervention activities included the creation of dream charts and reading uplifting stories to boost children's self-esteem (section 4.2.2.5). In South Africa (and globally) there is a renewed focus on health and wellbeing in psychology, and on what is right with an individual instead of only what is wrong with them (Wissing et al., 2020). Positive psychology has also received some criticism. There was concern that the rhetoric of positive psychology was opposing and created a false contrast between a new 'positive' and an old 'negative' or 'usual' psychology. In actuality, the vast majority of academic work in psychology is neither positive nor negative but relatively neutral. In clinical practice, a particular focus on the positive has been condemned for fostering a "tyranny of positive attitude" that prevents individuals from expressing negative emotions and aids them in avoiding complex but necessary therapeutic processes (Schrank et al., 2014, p. 96).

In my study, positive psychology interventions worked well with children with anxiety, as we focused on their strengths and their need to experience joy and pleasure. It shifted feelings of anxiety to wellbeing and, at the same time, boosted self-confidence. Examples of subjective wellbeing during the interventions are available in five vignettes in section 4.2.2.6. Some examples of transcripts where we implemented positive psychology and the effectiveness of specific activities are the following.

4.2.3.4.1.1 Parents' interviews

- We played anger games. We played a card game where I read different situations and then she has to say how she would handle certain situations. Here I found out that she has the head knowledge about what to do, she must implement and practice it. Then we did self-esteem work where she had to make a 'dream card'. The dream card tells me more about Done, what she likes, what she wants to do one day, where she sees herself in 10 years, etc. Looking at it, I see Done. It

helped her to introspect, who am I, what do I like? (Interview 3, Doné's mother, Line 138-155).

- For positive psychology, she made an advertising card where she had to advertise herself. She had to mention all her positive points. Sold herself to me. She had to convince me of all her positive points. How did she do it, did she present herself as an artist? (Interview 3, Lizette's mother, Lines 173-174).
- She had to tell me what she is good at, what she likes, and why I had to hire her for a job. She had to convince me. This was also an example of self-esteem work. It's very cute. Her self-esteem has improved a lot. (Interview 3, Lizette's mother, Line 169-180).
- Then she had to make an advertisement of herself. She had to think of all her positive qualities and present them to me. She had to 'brag' about herself. It helps her to think about all her positive points and discover herself. One calls it self-projection. She had to convince me to appoint her for the position. At first, she was very shy, but it forces her to get out of her shell. I thought it was one of the less successful sessions because Pam was very shy about talking about herself. Mother… "It helped a lot. She knows who she is, and she is happy with herself. She is no longer what she used to be; if she tried something and didn't get it right, it was a mess. Then she would give up. She was always very hard on herself. She isn't like that anymore. (Interview 3, Pam's mother, Line 298-324).

4.2.3.4.2 Gestalt Play Therapy. This psychotherapeutic technique allows the child to verbally and nonverbally express their emotions. It is presumed that the child will learn to channel their emotions more effectively by symbolically acting out their challenges. Additionally, Gestalt play therapy is highly effective for increasing a child's awareness and assisting the child in gaining emotional insight. Section 4.2.2.5 (Interview 3, Karné's mother, line 231) is an example where gestalt therapy facilitates the child's emotional expression. According to Ashbolt (2018), play, like creative expression, is not merely entertaining; it

enables the possibility of inspirational presence and genuine connection between therapist and client in psychotherapy (Gomez & Smart, 2008; Marks-Tarlow, 2012). “Therapists draw from the creativity that inheres in play to animate the intersubjective space between patient and therapist” (Marks-Tarlow, 2012, p. 354). An eagerness and motivation to play introduce a potent tool for co-creation in the therapeutic space and enable the emergence of something new (Marks-Tarlow, 2012; Ayers, 2016). Creativity and play are not measured as thoroughly as other aspects of life within the science and technology frameworks in contemporary Western culture. Insufficient empirical evidence supports the effectiveness of gestalt therapy, a creative and playful modality (Ashbolt, 2018). The reason to implement gestalt play therapy in my study was that Gestalt therapy is more than just creativity and fun. Much of it consists of carefully examining the contact made in the therapeutic session and the resistances that emerge at the contact boundary to protect the individual from anxiety. Rather than direct behaviour modification, Gestalt therapy is an investigation akin to "peeling the onion." The intentions are not to solve clients’ challenges directly but to help them discover that choice comes through heightening their awareness (Corcoran & McNulty, 2018). Examples of gestalt therapy activities can be viewed in section 4.2.2.4. More examples of the effectiveness of this therapy technique are apparent in the following transcript extracts during the parent interviews.

4.2.3.4.2.1 Parents’ interviews

- It is also important that she can talk about things that make her happy and unhappy. During our last session, I did a ‘mood pedicure’ with her. While doing the pedicure, she had to choose different colours of nail polish. Each colour indicates an emotion. Then she got the opportunity to talk about each emotion. It is crucial that she have the chance to express her emotions. When you as parents talk about your emotions, you teach her the skills to do the same. Mother…Now that Pam has learned to express her feelings better, she and her sisters fight a lot less than before. They are getting along a lot better now. (Interview 3, Pam’s parents, Line 479-494).

- I also want to thank you for the plant; it is in her room. It's on her windowsill. She painted it so beautifully, it's beautiful! She was picky with the colours she chose to paint the flowerpot with. Choosing the colours helped her to reflect on the session we had together. Yes, it fits so nicely in her room. She took each panel on the pot and chose a colour that matched her. The emotion from the time she started until the last session. Mother… It's so cheerful, she looks after it so well! (Interview 3, Lizette's mother, Line 102-116).

4.2.3.4.3 Sandplay Therapy. According to Turner (2017), the child can use symbols within a distinct space to tell their story during sandplay therapy. While telling their story, the child reconstructs past events and situations in the sand tray and in their imagination. This is where corrective change takes place. It is essential for the therapist to refrain from interpreting or interfering with the developing process and to refrain from assuming the meanings of symbols or objects in the sand. It is better to explore the meaning that the child gives the symbol. In this way, the child's awareness of situations and developments in their story is raised. An example of a sandplay session can be found in section 4.2.2.5, (Interview 3, Pieter's parents, line 444) where the child gave his own meaning to a symbol. It was crucial for the therapist not to make assumptions about the meanings of symbols, but rather to inquire about their significance.

4.2.3.4.3.1 Parents' Interview

- "He does this sandpit, but so sharp! I did a sandpit with the previous child. She took my container of beads and then poured all of it into her sandpit. A thousand little beads! I then sat for a long time to get the beads out of the sand. Pieter was then next. He then saw that there were still some beads in the sand. As he builds, he buries all the beads in a hole in the sand. Now I'm watching him. Then ask if I should take it away. No, he says, these are dinosaur bones. Then he took the crocodile and said that the crocodile was going to eat all the dino bones. So, he works it into his story. So creative! When he finished, he said, 'If aunty is looking

for the beads, all of them are in the crocodile's stomach.' He then said that if the crocodile eats all the bones, he will become big and strong". (Interview 3, Pieters' mother, line 444-469). The sense of safety and acceptance that the client experience while creating images during the Sandplay process allows the client to feel silent and respectfully accepted (Zhou, 2009). I included Sandplay therapy in my study because of the positive changes I have witnessed in my private practice over the past 11 years using Sandplay therapy. I had intensive training by Dr Barbara Turner from America, the writer of many Sandplay therapy books. I also extensively read Sandplay therapy and its effectiveness with young children with trauma and anxiety (Matta & Ramos, 2021; Roesler, 2019; Zhou, 2009).

4.2.3.4.4 Somatic Experiencing Therapy. In Somatic experiencing therapy the brain, the memories, the body, the senses and the nervous system are incorporated into the therapy process to help children with anxiety and trauma. There is a "trauma vortex" and a "healing vortex" during trauma. The trauma vortex (Ross, 2010) is a metaphor for the whirlpool of chaos that follows trauma. Also known as the "black hole" of trauma, this downward spiral traps traumatized individuals. They lose control over their sensations, images, emotions, thoughts, and actions. The healing vortex refers to the intrinsic resilience of humans and their ability to overcome adversity and heal themselves. This vortex needs awareness and resources to re-engage it when it gets stuck. Somatic experiencing therapy is a powerful technique to help children reverse the trauma vortex spiral, engage in the healing vortex, and return their nervous systems, bodies, and brains to a sense of safety and wellbeing. An example of a somatic experiencing technique is a 'mood pedicure', seen in section 4.2.2.5 (Interview 3, Pam's parents, line 479). Another example of somatic experiencing is during an interview with Pieters' parents.

4.2.3.4.4.1 Parents' interview

- Working with the hands, kinesthetically is therapeutic for anxiety or trauma. So, when you, as a mother at home, notice that he is feeling a little anxious, let him bake n brew. Let him work with his hands. He can help you cook, mix and stir. He

made a ''slime bag'' that he can also play with. Mother … The slime bag that he made with you, he loved it! (Interview 3, Pieters' parents, Line 201-210).

During somatic experiencing, I used resources to strengthen and remind the nervous system of its ability to self-regulate and cope. Another technique that I have used was to blow bubbles in order to down-regulate the nervous system. See section 4.2.2.5 (Interview 3, Pieter's parents, line 283). This study included somatic experiencing due to the necessity of engaging the whole body and mind when working with children. The more senses you employ the more effective the outcomes. When an individual is traumatized, the trauma gets stuck in the body. Somatic experiencing therapy helps to track where the trauma in the body is and how to discharge it. Implementing playful activities with a specific purpose allows children to discharge their anxiety and trauma through play (Levine, 2012).

4.2.4 Theme 3

4.2.4.1 Mediating Parental Anxiety. The interviews with the parents suggested that pre-existing risk factors might have influenced their children's anxiety. The current study focused on anxiety in the child participants and did not assess for parental anxiety. Nonetheless, the study revealed several indications of parental anxiety, such that the mediation of parental anxiety emerged as a key finding for the child participants. In this regard, parental simulation, information transfer of anxious and avoidant behaviour and reinforcement are possible risk factors that may provoke anxiety in children.

Section 4.2.3 contains interviews with the parents where they admit that they struggled with anxiety.

4.2.4.1.1 Parental Anxiety in the parents' interviews

4.2.4.1.1.1 Parents' interviews

- "I am quite an anxious person." (Interview 1, Pieter's mother, line 201)
- "The father is not; he is the most chilled person. He doesn't worry about tomorrow or anything. I am quite an anxious person, and I am also a very shy person. I think

that Pieter picked that up from me, to be honest." (Interview 1, Pieter's mother, line 203)

- "The mother laughed again, I was scared, I did not know what to do. Should she go to an Afrikaans or English school? And am… I made it a matter of prayer. I enrolled her at both schools. Then I said dear Jesus, decide for me, I do not know. Then I said the first school that contacted me, is the right school. And it had been this school. I had not regretted one day." Interview Doné's mother, line 104)
- "I hid all the trauma, anger and fear from them and kept it inside of me. I never realized that she was watching him like that with me. She said to me a while back, "I knew everything". (Interview 2, Doné's mother, line 312)
- "I have always been the one who wants to cover and hide everything, but they have to see that it does not always work that way. This is just how it is now. This is what happened, we need to deal with it and get over it." (Interview 2, Doné's mother, line 444)
- "I do not know; I'm just moving everything to the side at the moment. I cringe with anxiety and heartbreak. I just focus on the kids and my work." (Interview 3, Doné's mother, line 249)

A study by Aktar and Bögels (2017) indicates that observational learning from parents' earlier expressions of anxiety in modelling situations may have direct and lasting consequences on a child's anxious/avoidant behaviours in infancy. The following data extract from an interview is a possible example of where parental modelling might have taken place. The child will have a meltdown situation. After the 'time out' discipline from the parent, the child comes out, and then the parent will provoke a situation where the child still observes anger from the parent. The parent sends the child back to her room and the process repeats.

4.2.4.1.1.2 Parents' interview

- “When we ask her to do something that she is not willing to do, then the response is dramatic. She cries, and if you ask her to stop, then she starts screaming at you. We have tried many kinds of discipline methods. We haven't found what works yet. So, she will get a hiding, which makes it worse. She just keeps screaming. We will send her to her room for 'time out'. Potentially, we did set 'time out' for too long, I think. Then, I would say, if you want to cry, go cry in your room. If you want to cry for three hours, cry for three hours. Don’t do it here in front of me, it drives me crazy. Then she continues to scream in the room.” (Interview 1, Karné’s mother, lines 169-186).

Instructional learning or information transfer is a second potential risk factor instrument of learning connected with the development of child anxiety. This occurs when parents communicate with their children about wellbeing and safety, and events to avoid because they may be dangerous. Despite the fact that the communication is intended to protect the child, parents might exaggerate the danger involved in these circumstances (Fisak et al., 2007). Additionally, experimental studies reveal that information transfer is pertinent to transmitting anxiety (Murray et al., 2009). The following interview with a parent is a possible example of a similar situation. Again, these examples are self-reported data and not based on clinical assessment of parental anxiety.

4.2.4.1.1.3 Parent’s interview

- “My mother says I make the kids anxious. I’m very strict about them locking the security gate. We have to close the doors. It’s not my intention to scare them, it’s unfortunately the reality. So, there are a lot of electrical wires and safety mechanisms in place and Dad always says our dogs are our protection as well.” (Interview 1, Karné’s mother, line 451)

4.2.4.2 Teachers’ interviews. The following interview with a teacher is a possible example of reinforcement of anxious and/or avoidant behaviours.

- “She was absent six times in May. It is a lot of absences. She will come to school and then start crying and then go to the office. Then they contact her parents, and they will come to pick her up. Or she just will not come to school if she is too anxious.” (Interview 1, Pam’s teacher, line 44)

The influence of parental anxiety in the participants’ lives is dealt with in the broader literature. Consistent with their hypotheses of Burstein and Ginsburg (2010), children reported higher anxiety levels, anxious cognitions, and the desire to avoid the testing situation when their parents modeled anxious versus non-anxious behaviour and cognitions. In addition, when parents confide in someone else about their anxiety (e.g., their life partner) or verbally to themselves in the presence of their child, their anxiety is communicated directly to the child. When confronted with an anxiety-inducing stimulus, children may also observe their parents employing avoidance as a coping mechanism (Fisak & Grills-Taquechel, 2007). A possible example is presented in section 4.2.3 (Interview 1, Pieter’s mother, line 203).

The reinforcement of anxious and/or avoidant behaviours have been identified as a second risk factor or learning mechanism in relation to the etiology of child anxiety. For example, a parent may take a child out of an anxious environment (e.g., by picking up a pupil from school earlier on the day of the test), encourage and motivate young people to stay away from situations that makes them anxious (e.g., by enabling a child not to attend a social gathering or school); try to lessen a child's distress by providing special incentives (e.g., by providing attention or special treatment), or allow avoiding obligations (such as putting the garbage outside for a child while a vicious dog is nearby). Parental actions may be problematic in these situations since attempting to reassure the child or relieve their anxieties may serve to reinforce both positive and negative behaviours. Children might keep engaging in these behaviours, as a result, to get their parents to reassure them or to get out of uncomfortable situations. A possible example of such a risk factor can be seen in section 4.2.3 (Interview 1, Pam’s teacher, line 44).

According to Wenar and Kerig (2005), it is highly probable that parents of anxious children are anxious themselves. There are three potential processes by which parental anxiety might influence the child. These are, imitating the models of parents, avoidance as a coping strategy and becoming irritable with the inhibited child, with the unfortunate outcomes of worsening the child's anxiety (Wenar & Kerig, 2005). According to Beato et al. (2018), parents who cited their own anxiety and negative parenting behaviours (such as overprotection) as possible reasons for their child's anxiety tended to bear responsibility for their child's distress and the management of their child's challenges (Apetroia et al., 2015; Lester et al., 2010; Reeves et al., 2010; Salkovskis et al., 2000). Another possible example of imitating the model of a parent is in section 4.2.3 (Interview 1, Karné's mother, lines 169-186).

To mediate the possible occurrence of parental anxiety is to shed light on the need for additional research on this topic in order to verify the possible learning risk factors that have been linked to the development of child anxiety. In the following extracts of two vignettes, parent anxiety is noticeable. See the underlined phrases.

Second Vignette, Karné,15 June 2021, Session 6, Phenomenon Subjective Wellbeing,

> In today's session, Aunt Ingrid invited my mother along to watch the two of us get along. I'm still wearing my school clothes and am very excited because I cannot stop smiling. It's weird to have Mom in the session together today, but still, I'm extremely happy and a little anxious because I do not want to disappoint her. Mom is more quiet than usual; I think it might be because she also feels anxious because it is her first therapy session with Aunt Ingrid today. Aunt Ingrid unpacks various activities for us to do. After mom pours in the cool drink, we 'cheers'. I feel so happy that I cannot keep my eyes off Mom. Mom seems more relaxed now because she smiles and talks more than earlier. The moment is so special to me!

First Vignette, Doné, Session 2, 19 Mei, Phenomenon, Trauma

My mother was afraid of losing him and forgave him for the third time. Then it started again last August. I knew all the women. These were my friends' single mothers. Everything got worse after my birthday last November. Although my mother was afraid of losing him, this time she had enough and finally broke up. This was the 4th time in two years that he had done this to us. Mom is done with him!

4.3 Answering the Subsidiary Questions

In accordance with the study's explanatory, exploratory, and interpretive phenomenological design, the following section addresses the subsidiary research questions proposed at the beginning of this study.

4.3.1 What do we Currently Know About Children with Anxiety in South Africa?

All five participants in this study can be diagnosed with generalized anxiety disorder. All of them exhibited anxiety symptoms lasting between one and six months, which is developmentally inappropriate and impaired their ability to function in multiple areas of daily life. Other symptoms that were also present that define anxiety are, struggling to socialize, low academic achievement, poor self-esteem, struggle with peer and parental relationships, absenteeism, and anger.

Table 4.4 outlines the different symptoms of anxiety. The check marks that appear indicate the symptoms of each participant.

Table 4.4

Different Symptoms of Anxiety Persistent in Each Participant

Symptoms of Anxiety	Participant 1 PIETER	Participant 2 LIZETTE	Participant 3 DONÉ	Participant 4 KARNÉ	Participant 5 PAM
Parental/Peer relationship problems		✓		✓	

Low academic achievement			✓		✓
Separation anxiety	✓			✓	✓
Aggression			✓	✓	✓
Poor self-esteem/ insecure	✓	✓	✓	✓	✓
Worries interfere with school		✓			✓
Trouble sleeping	✓			✓	
Persistent more month	✓	✓	✓	✓	✓

Because there is such a wide variety of symptoms, and children tend to keep these worries to themselves or internalize them, they become invisible, and the child might stay undiagnosed.

Evidence of the invisibility of anxiety at school emerged across the datasets, and pertinently in all the interviews with the teachers and in some of the parental interviews. Evidence of the invisibility of anxiety in school is also illustrated in Pieter's, Karné's and Doné's vignettes in section 4.2.1.3.

The invisibility of anxiety within the school context makes it very difficult for teachers to identify children with anxiety. This phenomenon is explored in the broader literature (Cvinar, 2010; Headley & Campbell, 2013; Reinke et al., 2011).

According to May et al. (2020), Covid-19 has increased an entire generation's mental health and wellbeing risk. Many young individuals are fearful, enraged, and anxious about the future due to disrupting their daily routines, education, leisure activities, family income, and health. The Children's Institute at the University of Cape Town releases The South

African Child Gauge every year, with support from UNICEF and other partners, to examine the realization of children's rights in South Africa. At the African Child Trauma Conference, Christine Muhigana, a representative of UNICEF South Africa, delivered pressing statistics to an audience composed of academia, civil society, government, and media (UNICEF South Africa et al., 2020). More than 13% of 10–19-year-old adolescents are projected to have a diagnosable mental disorder. This signifies 86 million adolescents aged 15 to 19 and 80 million youths aged 10 to 14, respectively. Approximately forty percent of these diagnosed mental disorders are anxiety and depression; the remainder includes attention-deficit/hyperactivity disorder, conduct disorder, intellectual disability, bipolar disorder, eating disorders, autism, schizophrenia, and a group of personality disorders. Furthermore, suicide is one of the top five causes of death for adolescents, accounting for nearly 46,000 deaths annually.

The prevalence of anxiety disorders was stated at the onset of the current study. According to epidemiological studies, between 2.2% to 9.5% of children and adolescents in community samples have phobias and anxiety disorders (Costello et al., 2003; Polanczyk et al., 2015).

The literature does not provide a clear definition of anxiety, although its descriptive characteristics are well defined and easily identifiable. The American Psychiatric Association (2000) defines anxiety as the expectation of a future threat or negative event, led by dysphoria or physical symptoms of tension. The elements revealed to risk may originate from both the internal and external environments. Similarly, the Italian Treaty of Psychiatry defines anxiety as an unpleasant emotional state associated with alarm and fear that arises in the absence of real danger and is uneven to any triggering stimuli (Perrotta, 2019). The symptoms of fear or anxiety include thoughts (such as stress), behaviours (such as avoiding), feelings (such as fear), physical responses (such as a raised heartbeat), and relational components (Byrne et al., 2018). Children frequently outgrow their anxiety as they mature (e.g., fear of the dark, strangers and storms). Childhood anxiety is a normal component of development. Excessive anxiety symptoms that are extreme but do not meet

diagnostic criteria are also prevalent and account for many primary care visits (Safer et al., 2015). The adverse outcomes of excessive anxiety symptoms and anxiety disorders on child functioning are well documented and are related to a wide range of academic, social, and familial impairments (Drake et al., 2015). Anxiety is a recognized disorder, despite being a continuum, when an individual exhibits extreme distress symptoms that persist for an extended period of time (depending on the condition, lasting one to six months), are developmentally unsuitable, and interfere with daily life functioning in multiple areas, frequently leading to avoidance behaviours (Cooper, 2018). As mentioned in Chapter 2, peer and parental relationship difficulties, as well as challenges with social functioning and poor academic achievements, are often the consequences of children who struggle with excessive anxiety (Ezpeleta et al., 2001; Headley & Campbell, 2013; Nayak et al., 2018).

Educators state that current research suggests that externalizing behaviours like aggression, violence, and acting out may be symptoms of excessive anxiety (Wilmshurst et al., 2005). Lester et al. (2010) found that anxious children frequently exhibit patterns of avoidant behaviour, whereas defiant children often exhibit aggressive behaviour patterns as a response. In both situations, it is possible that a child exhibiting externalizing behaviours is experiencing covert anxiety difficulties (Headley & Campbell, 2013). This assumption correlates with this study where, according to the parents, three out of five participants showed aggressive behaviour (See Table 4.4).

An anxiety disorder may be diagnosed when children do not outgrow the distinctive fears and worries of young children, or when they have so many fears and worries that they interfere with school, home, or play activities. Various types of anxiety disorders include the following (DSM-IV-TR).

- Exhibiting extreme anxiety when away from parents (separation anxiety).
- Extreme fear of a particular thing or situation, such as dogs, insects, or the doctor's office (phobias).

- Being extremely terrified of school and other places with people (social anxiety).
- Being extremely concerned about the future and bad events (general anxiety).
- Repeated episodes of sudden, intense fear that are accompanied by symptoms such as a pounding heart, difficulty breathing, or feeling dizzy, shaky, or sweaty (panic disorder).

Anxiety can manifest in children as fear or worry, as well as irritability and anger. Insomnia and physical symptoms such as fatigue, headaches, and stomach aches can also be symptoms of anxiety. Some children with anxiety keep their concerns to themselves, in which case the symptoms go undiagnosed.

There are strong indications that childhood anxiety is high and may be rising, yet little is known about their lived, subjective experiences – particularly regarding promoting health. Current research indicates that due to various anxiety symptoms, children sometimes tend to keep these worries to themselves or internalize them; they become invisible, and the child might stay undiagnosed (Headley & Campbell, 2013; Molins & Clopton, 2002). See the different symptoms of anxiety in Table 4.4. Examples of the lived experiences of children with anxiety that go unnoticed in school can be seen in the vignettes in section 4.2.1.3. The vignettes confirm the absence of visible signs of anxiety in the school context for participants in this study.

To alleviate parental anxiety, further research is required to confirm the learning risks related to the onset of child anxiety. Examples of extracts from Karné and Doné's vignettes, where parent anxiety is noticeable, can be seen in section 4.2.3.

4.3.2 How are Traumatized Children with Anxiety Currently Supported?

This study was conducted in a school located in a high socio-economic area, where the support for children with trauma and anxiety is above average. This school has a very effective support system in which the teachers identify children with emotional and scholastic challenges using screening questionnaires formulated by a group of professionals at the

school consisting of psychologists, occupational therapists, remedial teachers and speech therapists. After identifying a child with a specific challenge, the teachers contact the parents and guide them to various professionals for support. Despite this assistance for children with challenges, teachers are not trained or equipped to recognize and support children with mental health issues. According to Titi et al. (2022), violence is a prevalent method in South Africa for resolving problems in daily life. Children are especially susceptible in their families and neighborhoods due to strict parental standards, detrimental social expectations around parenting, the child's place in the family unit, and the substantial prevalence of drug and alcohol abuse.

To encourage children's growth and development and safeguard them from injury, South Africa has enacted a number of innovative policies and legislation. However, the implementation of these laws remains weak and ineffective. Particularly in underprivileged districts where police force services are underfunded, many crimes go unpunished.

According to research by (Titi et al., 2022) only 12% of cases reported in the Eastern Cape and KwaZulu-Natal concluded in guilt decisions, and very few children obtained access to therapeutic support. The rights of children to social services and safeguards from abuse and neglect are implemented under the Children's Act. The National Child Care and Protection Policy, a secondary policy of the Act, provides various care, from primary early intervention and prevention programs to services for child protection, substitute care alternatives, rehabilitation programs, and family reconsolidation programs. In theory, the Act supports multidisciplinary teamwork and provides for intersectoral collaboration.

Nevertheless, the policies that regulate the juvenile criminal system, educational programs, and child mental health facilities are governed by mainly independent and separate program frameworks. A comprehensive reaction is necessary due to the high levels of trauma and involvement with violence. Despite assertions to the contrary in the National Strategic Plan (NSP) on Gender-Based Violence and Femicide (NSP), an in-depth analysis indicates that children are merely a secondary concern. Along with those deficiencies, lacking human and financial resources has always impeded service delivery.

As resources were re-evaluated and numerous child protective services were relocated to give emergency assistance during the Covid-19 outbreak, the problem worsened. Considering the substantial amount of support for the NSP, inadequate funding has been set aside to enhance services, and there are not enough social service providers to help with even the most basic aspects of the Children's Act's implementation. Although most criminal justice professionals lack specialized training and Thuthuzela Care Center's clients consists of children, the facilities are not suitable for children and provide insufficient counselling. Children who need long-term psychological treatment must wait months before they receive any treatment. Support for children and women who have encountered or observed violence is inadequate or non-existent in rural communities. Early detection is needed to recognize susceptible families and promote good parenting and the development of children. Programs for early childhood development may be essential in this process (Titi et al., 2022).

School-based interventions are necessary to decrease the dangers of violence and trauma for children in schools, homes, and communities. In order to address intergenerational trauma and support parents in promoting the healing of children, integrated programs for children and women are necessary. For children and families to recover from trauma, trauma-informed approaches to services in various settings, such as the system of criminal justice (police and courts), social facilities, education, and health are all essential. Because of the ongoing violence that women and children witness every day in South Africa, the truth is that there is no clear-cut solution or quick fix to preventing violence and treating adversity on child and adolescent psychological health. Multi-integral therapies informed by trauma at multiple levels of the social ecosystem are the answer. We need to allocate money to evidence-grounded initiatives that support children's healing and strengthen families' ability to protect their children and help them achieve their full potential (Titi et al., 2022).

According to Skeen et al. (2022), early Childhood Education (ECE) is an element of a broader set of early childhood development (ECD) programs in South Africa that aim to support children's intellectual, social, emotional, and physical growth from infancy to age nine. Before April 2022, the Department of Basic Education (DBE; administering Grades 1 through 3) and the Department of Social Development (DSD; regulating preschool to Grade

R) shared responsibility for ECE. Preschool development programs, especially Grade R, are now managed by DBE as opposed to DSD. Young children may experience the initial stages of anxiety, depression, hyperactivity/attention-deficit disorder, behaviour, and psychological challenges. Early exposure to challenges and obstacles like abuse, violence, domestic stress or trauma, impoverishment, and malnutrition are risk factors. Protective components can have a favourable, lasting impact on children's wellbeing and health, including early diagnosis of psychological challenges as well as accessibility to psychological treatment.

ECE centers can promote early childhood mental health by:

- Curriculum, educational approach, and school environment that foster child functioning and wellbeing.
- Serving as a focal point for the screening of behavioural or developmental challenges.
- Establishing a connection between young people at risk with psychological challenges (such as those exhibiting early signs of behaviour challenges) to regional DSD or Department of Health (DoH) practitioners for additional care, and
- As needed, provide caregivers with knowledge and skills, and connect them to services and support networks.

According to Skeen et al. (2022), the DBE is responsible for primary school education. It begins in Grade 1, when the child is seven years old, and continues through Grade 7. Most children attend public schools without paying tuition, with elementary schools having the greatest enrollment percentages. The most frequently reported mental health challenges in primary school include behaviour, attention deficit/hyperactivity disorders, conduct disorders, anxiety, depression, post-traumatic stress disorder, and aggression.

According to Skeen et al. (2022), critical paperwork including the National School Safety Framework (NSSF), the Integrated School Health Policy (ISHP), and the Care and Support for Teaching and Learning (CSTL) Program lay out a structure of services that are essential during elementary and secondary schooling in South Africa. These policies are consistent with the Child and Adolescent Mental Health Policy Framework and the South

African Mental Health Care Act. Health education is a fundamental component of the ISHP and is offered through Life Orientation in the classroom. The objective of life orientation is to assist children in gaining knowledge, expertise, and values concerning themselves, their surroundings, responsibilities as citizens, living a healthy and fulfilling life, social involvement, getting enough sleep and physical activity, careers, and making career decisions. The material presented in elementary schools lay foundations for the subjects that are provided in the higher levels. The ISHP is being implemented inadequately and ineffectively in practice. Health and education officials fail to collaborate effectively enough, and there are not enough specialized healthcare personnel. Clarifying the role of educators in implementing the ISHP, providing training, introducing baseline standards for schools implementing the ISHP, and ensuring a stronger commitment to intersectoral collaboration all contribute to more effective implementation of the ISHP. Initiatives that promote school collaboration (such as a sense of belonging, school commitment, and a positive school atmosphere) and offer essential components, such as teacher support, have also been found to promote mental health during childhood (Skeen et al., 2022).

According to Titi et al. (2022), focusing on relationships is crucial in searching for effective interventions. Service providers need to meet families where they are in life. Existing systems do not always acknowledge the circumstances between families and children, particularly in cases where these circumstances have changed rapidly. In addition to altering the environment, these support structures need to transform how communities function. Some are provided at home, while others are provided in centers. Some concentrate on children individually or in groups, while others primarily work with parents. Numerous services have been created to meet the needs of young children whose possibilities are threatened by social, and economic difficulties, family disruptions, and diagnosed disabilities. They all believe that early childhood development is susceptible to environmental circumstances and that public investments in young children can improve developmental outcomes. These premises are supported by scientific evidence (National Research Council and Institute of Medicine, 2012).

According to Lieberman et al. (2011), the common ground between poverty and health challenges begins in early childhood, with increased exposure to chronic physical and emotional risk factors facilitating the relationship. Some risk factors include low-income housing, lack of resources such as adequate child care, and the absence of safe, rejuvenating neighborhoods. Child neglect and abuse, parental substance misuse, and domestic and community violence are additional crucial risk factors. The pervasiveness of risk factors and the lack of protective factors create toxic ecological systems for children from impoverished and powerless families, thereby generating a supra-clinical challenge that includes but replaces the mental health field (Lieberman et al., 2011). South Africa has a comprehensive policy response to meet the needs of learners, but there are distinctive obstacles affecting implementation at each stage and some areas that require further attention. At elementary school level, these areas are, the policy provides screening, psychosocial support, and links to primary healthcare facilities. Curriculums for health education include topics about mental health. Long-term investments could concentrate on educating health professionals and educators to implement school health policy. It is also essential to prevent bullying and encourage school integration. Educators in South Africa experience high-stress levels at work and frequently feel unprepared to deal with challenges (Skeen et al., 2022).

A concern about schools and support structures for children with mental health difficulties demonstrates the need for further research to examine how teachers define anxiety and to raise awareness of situations in which anxiety becomes extreme in children. Although teachers play a crucial role in identifying possible psychological challenges in children, they are not required to make a diagnosis. Teachers have the option to manage emotional or behavioural challenges in children within the learning environment if they think they have the expertise to do so, to refer the child to the guidance counselor for evaluation and intervention, or to use alternative support if they believe it is necessary (Rickwood et al., 2005). Numerous teacher education programs in South Africa contain traces of mental health education, but the role of teachers in this domain is frequently underemphasized.

Although these modules expose teachers to children's mental health challenges, they do not necessarily emphasize the informal identification of children with mental health challenges and how to support them.

According to a study in Australia by Armstrong et al. (2015), the expectation that educators will recognize and respond appropriately to mental health challenges reveals the need for specific, structured mental health training as a distinct, core knowledge base of teacher education. Furthermore, being unable to identify and meet the needs of these children, inadequate training may possibly lead to inaccurate recommendations (Cvinar, 2010).

The course content for graduate studies in psychology, psychiatry, social work, and other mental health disciplines does not methodically include developmental psychopathology of infancy and early childhood; child mental health providers are typically trained in individual treatment methods that do not involve parents and are therefore unsuitable for young children (Lieberman et al., 2011). Since 2011 some progress has been made regarding graduate education for mental health professionals. Due to the overwhelming evidence connecting trauma to human suffering and a variety of social skills, service providers must be well-experienced in trauma-informed care (TIC). In this regard, social workers are not alone, as many professions are required to serve traumatized individuals, groups, and communities. Although knowledge of trauma has expanded across various service sectors, there are still concerns that trauma-informed care is frequently misunderstood and inconsistently applied (Donisch et al., 2016).

Cognitive behaviour therapy (CBT) is a well-established, highly researched, evidence-based therapy for the treatment and prevention of anxiety, according to Visagie et al. (2021) in South Africa (Silverman et al., 2008; Walkup et al., 2008). However, despite CBT's promising results, fewer than a quarter of children with anxiety disorders receive treatment (Korkodilos 2016; Lawrence et al., 2015; Merikangas et al., 2010), many of those who begin treatment will discontinue it prematurely (Pina et al., 2003; Wergeland et al., 2015). A promising strategy for overcoming these limitations and addressing the high prevalence of anxiety and its detrimental effects is emphasizing anxiety prevention.

Prevention strategies aim to decrease the incidence or onset of mental health disorders by reducing risk factors and developing protective factors (Johnstone et al., 2018).

Johnstone et al. (2018) found that current anxiety and depression prevention programs may be beneficial in reducing depression symptoms post-prevention and during long-term follow-up. However, no evidence suggests that these programs reduce anxiety symptoms. All the programs included in this meta-analysis were based on cognitive behavioural therapy (CBT) principles. While the findings indicate that these programs generate minor benefits, there is still room for improvement. Therefore, future research could investigate alternative therapeutic techniques or strategies to determine if these would produce better results.

Future person-centered inquiries on trauma exposure in early childhood will need to include parental symptomatology and parent-child relationship measures (Hagan et al., 2016).

I did not incorporate cognitive behaviour therapy (CBT) as one of the psychotherapy techniques in this study because it is not one of my fields of expertise. As a therapist, I prefer techniques that focus on indirective play therapy. Implementing therapies in which I have substantial training and experience ensures that the study's findings accurately reflect the participant’s responses to the applied therapeutic techniques.

Mental health services in South Africa receive inadequate focus. There is an immediate need to restore the equilibrium between "curative" and promotional/preventive interventions. Petersen et al. (2009) reviewed child and adolescent risk, protective factors, and evidence for promotion and prevention interventions in low-resource environments. The nation demands strategies to improve the mental health of individuals, families, communities, and systems and to eliminate societal barriers (Patel et al., 2007). By applying these strategies, we will enhance the mental health of South African children and adolescents, contribute to the country's social and economic development, and enhance educational outcomes and adult social functioning.

This is ultimately a matter of social justice. Article 24 of the United Nations Convention on the Rights of the Child and Section 28 of the South African Constitution place a high value on the right of children and adolescents to healthcare and health services. According to Flisher et al. (2012), the vast majority's mental healthcare needs are not being met, which violates their Constitutional rights. Even though they were made available to the provinces, it is highly concerning that the CAMHS standards developed for the Department of Health in 2005 still need to be implemented. In addition, basic costing has been performed. On both the national and provincial levels, it is necessary to provide the necessary finances, infrastructure, and human resources to guarantee a minimum level of service to children and adolescents in each province. Managers of district and provincial health services are required to receive training. To address mental health promotion and prevention needs from infancy to adulthood, establishing provincial cross-sectoral structures must accompany this change for child and adolescent mental health (Flisher et al., 2012).

When comparing the study's context to the broader context of Flisher et al. (2015) work, provincial and national levels must implement the necessary finances, infrastructure, and human resources to guarantee a minimum level of service to children and adolescents in every province. District and provincial health service managers need to receive training in using these standards as a planning tool for CAMHS. This development needs to be accompanied by the establishment of provincial cross-sectoral structures for child and adolescent mental health to address mental health support and prevention needs from infancy to adulthood.

4.3.3 What are the Lived Experiences of Children with Anxiety?

There are many ways of researching the meaning of lived experiences, including vignette, narrative, ethnographic, biographic and critical incident research methods. In this study, I applied vignette analysis to describe the lived experiences of children with anxiety. The therapeutic and classroom vignettes for each participant capture the essence and more profound significance of their various life experiences. To enhance the comprehension of the intricacy of what occurs in the classroom and therapy room, a method is needed that

describes and records the voices of the lived experience that goes beyond mere facts and surface appearances. According to van Manen and van Manen (2021), Langeveld used observations, interactions, and insights from the literature on child development to investigate the phenomenological significance of things in children's lives, as in the reproduced current study. The manner in which things present themselves in the child's world is influenced by the child's particular situation, physical fitness, adult care, and the qualities of space and time that shape the child's world (van Manen & van Manen, 2021).

In accordance with the research objectives and theoretical-philosophical underpinnings of this study, I adopted a phenomenological stance in which I linked assumptions, theories, and understandings and remained open to being influenced by the participants' lived experiences. The goal was to go beyond observation and depend on my own sensing, focusing on pathic elements such as bodily and facial expressions, tone of voice, and silence, which were recorded in procedures as a stream of experiential data (van Manen, 2020). This experiential data served as the primary source for writing the experience in a phenomenological text, i.e. the vignettes in the present study (Schratz et al., 2014).

To respond to the research question, I present one vignette for each participant. These vignettes provide glimpses into the lived experiences of children with anxiety. In contrast to quantitative results, the vignettes aim to convey lived experiences in spatial, temporal, and relational dimensions. Each vignette is followed by a description of the phenomenon the vignette is portraying.

First Vignette, Pieter, 8 April 2021, Session 2, Phenomenon Anxiety.

The school has just come out and I am sitting in front of my therapist on an orange blanket on the carpet. The sunlight shines brightly through the room window. Most children have already gone home and it is quiet outside. The only other sound I hear is the person next door who is busy with piano lessons. I sit on my knees and am very excited for the session. I struggle to get my seat and then change my position. Now I sit with crossed legs in front of my therapist. While drawing my “Person in the Rain" drawing, I tell my therapist about Bob in my Person Drawing and tell her, “He

likes donuts a lot!" I'm saying donuts are Bob's whole life! Aunt Ingrid pulls the window blinds halfway for more privacy because there are now children outside laughing and talking. As I draw, I warn her that the clouds in my drawing will be big. Then I get carried away in my drawing and make all kinds of noises while I am busy. Occasionally I smell the Koki, and then say that it draws nicely. The clucking of chickens outside is very loud in the room. Then I mention that the man in my "Person in the rain" drawing is Tom and say that Tom and Bob are friends in my Person Drawing. Then I get carried away again and add that Tom has a lightning tracker on his phone and can see when lightning is coming. When Aunt Ingrid asks me what I enjoy most about school, I immediately reply without thinking, "Tinkies, of course!" Then I say: "Too much schoolwork is not fun!" and then say, "Tom's favourite food at school is Tinkies! He is a Tinky guy and smiles broadly!" Then I say that Tom's attitude is going to change a little, and then I say to Aunt Ingrid: "She will see!" As I speak, Aunt Ingrid gets a glimpse of my world and how I experience it. Then I start with the following description. There's a tornado! It's the rainiest and most dangerous place on earth! A volcano explodes! It's not a very good idea to be there now, I say. Behind the Tornado is a deadly beach that has the most tsunamis. It washes over everything! Only lava can stop it! The lava spews out of the mountain and blocks the Tsunami. The mountain is then covered with lava. Then it starts to rain. The rain stops the lava. Now a meteor falls out of space, forming a large hole that also stops the water. The big hole turns into a big pond with water that absorbs the lava. Bad news! There is a lot of lava, more than the dam can take, but Tom will be okay! The umbrella protects him from the rain and lightning. There is acid rain, but the umbrella is reinforced to protect me from the acid rain. As I tell everything, I draw it on paper so Aunt Ingrid can understand it better. A visual image of my imaginary world. Today, Aunt Ingrid gets a glimpse into the world of my life and how I sometimes experience it.

The vignette presents a singular lived experience of this participant. The anxiety Pieter experiences are tangible. Although he experiences a lot of anxiety, internally, the symbolic description of natural phenomena that consistently prevent disastrous outcomes in various scenarios are evident (see lines 18-27, underlined script). The lava blocks a tsunami, a big hole absorbs the lava and an umbrella provides protection from rain and lightning. “Tom will be okay!” he declares. The vignette shows the lived experience of his ability to cope very well with his anxiety. This lived experience is echoed elsewhere too: he copes well at school, and when he gets home, he feels safe to share his feelings with his parents. See Section 4.2.1, Pieter’s teacher interview 1, lines 11, 17, 44).

> First Vignette, Karné, 8 April 2021, Session 1, Phenomenon Anxiety
>
> Today is my first visit with Aunt Ingrid. After I sit down on the carpet, she tells me what we are going to do. She is very friendly, and it makes me feel welcome. As she speaks, I sit with Princess, my toy dog, on my lap and play. I feel a little scared because this is my first visit here and I do not really know if it will be fun for me. With Princess here with me, I feel less scared. Aunt Ingrid says that I can put Princess on the carpet next to me. I do it and we start! As she talks, I watch and listen with big eyes to what I have to do. I struggle a little to get my seat, and then decide to sit with crossed legs. Oh dear! It's not nice either. Then I sit again with my legs folded back on either side, so yes, it’s comfortable! Then I notice the camera and peek quickly into the camera, then I rather look away because it makes me feel a little uncomfortable. Then Aunt Ingrid asks me to draw my family. When she asks if I know what a family is, I start playing with my sandals on my feet, telling her about my family, and that it included my puppies. Then I say, “The quiet one is Jane, the less quiet one is Ticky and the very restless one is Bolt.” As I tell her about my puppies, I smile broadly and think, Aunt Ingrid does not know it yet, but my puppies are my life, I love them so much! As she unpacks the different coloured crayons and Koki’s in front of me, I become very interested in the different colours out there. As I excitedly draw my picture, I occasionally look at what Aunt Ingrid is doing. I see that she writes

down everything I do. It does not really bother me. Then I discover Koki's that smell good. The specific one I'm working with is red and smells like strawberries. Suddenly I hear the noise of voices outside. I turn around to look out the window and see the afternoon sun's rays peeking through the blinds but see no sign of a person outside. Aunt Ingrid hears this too and gets up to silence the people outside. I choose my colours very nicely before I draw. Aunt Ingrid says that I draw very beautifully. I think so too. Now I sit with my legs crossed again because I feel calmer and enjoy what I am doing. Suddenly I hear the sound of a piano playing very nice music. I stop for a moment while I'm busy, then look at the sandpit figures next to me and then at my fragrant Koki in my hand, while listening to the beautiful music before continuing with my picture. While drawing my family, I suddenly wonder what colour my brother's eyes are. Then Aunt Ingrid says, she wonders if he does not also have such beautiful big brown eyes like me. No, I say, "I think he has green eyes." While drawing, I am again aware of the interesting pictures on the Koki's, and I ask Aunt Ingrid why it looks like this. She says that each Koki represents a kind of fruit that also smells good. The different colours and smells interest me terribly! While working with the delicious Koki's, I smile because I enjoy myself. Last, I draw my puppies because they are also part of my family. As I draw, I tell Aunt Ingrid in the finest detail what each puppy looks like. Then she also asks questions about my family. I do my best to provide an honest answer. If I do not feel like answering a question, I just say: 'I do not know'. Aunt Ingrid then accepts it with a friendly smile and nods her head. I do not think I am ready or willing today to answer some of the difficult questions. Then we come to the last drawing for the session. Aunt Ingrid asks me to draw a 'Person standing in the rain'. I decided to draw myself in the rain. After carefully choosing my colours again, I accidentally draw my mouth happily. I actually wanted to draw it 'sad'. I still do not feel ready to tell her why I want to draw my mouth 'sad' instead. Then I add an umbrella to make myself happy. I again choose different bright colours for my umbrella and then draw beautiful fruit on my umbrella. I draw soft rain and

then tell the chickens out there to keep quiet! Then I just add the message to my picture. After I draw my picture, we talk about it. I think we had a great time today and I'm sure Princess really enjoyed it too! I cannot wait to tell Mom everything we did!

When reading this vignette, one senses Karné's anxiety in the beginning, when she brought her toy puppy to soothe her and to make her feel safe. It shows slightly in the fact that she struggled to find her seat and kept on fidgeting until she felt comfortable. It also showed when she quickly peeked into the camera and felt seemingly exposed and anxious. As soon as she started to talk about her dogs though (something she loved), she became more relaxed and a shift in her lived experience presented. Then when she touched the colourful Koki's and smelled them, downregulation continued. The sensory dimensions of her lived experience became apparent: the different smells amused her and then when she heard the piano playing next door, it seemed to soothe her even more. A sign of anxiety returned when she had to draw a 'Person in the rain". A glimpse of sadness came through when she admits that she actually wanted to draw a sad mouth instead of a happy one. But she wasn't ready to talk about it. She ended the session with the colourful umbrella she drew and again explored the different sensory smells and colours that down-regulate her.

First vignette, Lizette, 6 April 2021, Session 4, Phenomenon Anxiety.

It is a late autumn afternoon, it is two o'clock, the school has just come out and I am sitting quietly on my knees on a soft blanket in the therapy room. This is my fourth session with Aunt Ingrid, I carefully look into the camera. I feel a little nervous and I think Aunt Ingrid can see it in my eyes. The blinds in the therapy room are halfway closed to have more privacy, because children are constantly walking past. There is still enough light coming through to be able to see clearly. It's cloudy outside, so the room light is on too. I'm very excited about the session. Even though I'm still very shy I listen carefully to Aunt Ingrid. In the room, next door a piano plays soothing music. It makes me feel more relaxed. Then Aunt Ingrid asks me about Easter weekend that's just gone, and what we did. Now I feel a bit anxious because I do not really know what to say. After an awkward silence, Aunt Ingrid asks if we had an easter egg hunt.

When I hear the word “Easter egg hunt”, I immediately say we do not believe in the Easter bunny. Aunt Ingrid agrees and reassures me that they do not believe in the Easter bunny. “For us, Easter weekend is about Jesus”. Then I relax and I nod my head contentedly. The therapy session begins with me expressing my feelings using dough on a drawn heart. I carefully choose the colour that suits my specific emotion and pinch with my fingers the amount of dough that reflects my feelings. As I play with the dough, the sweet smell of vanilla essence thrown into the dough hangs in the air. I know exactly what I want and imprint my personal stamp on the drawn heart. Before I discuss each emotion, I look down, then turn my head and then there is a silence before I answer. Some emotions are harder to express than others. But I try.

The details, context and emotion in Lizette’s lived experience come through prominently in this vignette. At the beginning of the session, the anxiety in Lizette eyes and posture are very apparent. Then when she hears the piano music next door, downregulation is obvious. Although she is very shy and quiet, her body posture seems to be more relaxed. But when she hears the word “Easter egg hunt” she immediately becomes a nervous bundle. She makes it very clear that they do not believe in the Easter Bunny. After reassuring her that we are on the same page, she calms down.

As soon as I incorporate the sensory system by playing with vanilla fragrance dough, downregulation occurs, and she enjoys playing with the dough. When we start talking about emotion, I sense a feeling of nervousness in her. See lines 17-18, underlined script, in the above vignette. It was difficult for her to talk about her feelings. She would look down and turn her head awkwardly and then there would be silence before she answered, but she tried very hard.

Third Vignette, Doné, June 14, 2021, Session 5, Trauma, Subjective Wellbeing.

It is 12 o’clock on an early winter’s day at my School. I wear my school tracksuit and sit in front of my therapist on the carpet with crossed legs. I don’t feel in the mood for a session today. I look down and do not really make eye contact. I try to look

interested and smile a little when the therapist asks if I have played the “anger game” before. I just nod with a ‘jip’ reaction. Then the therapist discusses what she has planned for the session and mentions that I must make a “dream card”. When I hear the word ‘dream card’, I frown slightly and ask “Do I really have to do this now? And what on earth is a dream card?” While my therapist explains what a ‘dream card’ is, it interests me a little more, and I then give a quick smile, turn my head to one side and swing my ponytail through the air. I feel uncomfortable as I quickly look into the camera’s lens. Then I look down and listen intently. As the therapist shows me a ‘dream card’ as an example, I start feeling excited. I look in the direction of the example occasionally and then give my therapist a half smile. We first start with the ‘anger’ card game we have played before. Then the therapist asks if I saw my dad over the weekend. Suddenly I start pounding my fists against each other before getting my first words in. It is as if there is still anger in me that I am struggling to control. I talk about the time we spent together and that we also had a very nice meal. My therapist and I take turns asking each other the questions on the cards. Each card outlines a scenario of situations that can provoke anger and then I have to respond to it by voicing my opinion on possible solutions to dealing with anger. Then I mention that a method that helps me express my aggression is my punching bag. In the same breath, I add that I use it regularly if my brother irritates me. As the questions progressed, I realize I know how to handle anger situations well, but my self-control is still lacking. The last part of the session is devoted to making my “dream card”. I choose my pictures carefully one by one. While I am busy, the therapist suddenly asks how my time with my dad was over the weekend. Before I answer, I frown and then answer, “Fine”. I immediately mention with confidence and pride that we are still sending each other WhatsApp messages. Then I say: “The funniest thing is…”. There is silence and then I say: “I do not cry easily, nor can I show my feelings. So, my mother will say something sad, and I will not cry”. When the therapist asks why I say that I usually had to be the strongest person in the

family, because “In the family when something bad happens, my father is not always there”. Then I stop for a moment, look away, and say that sometimes my father has to work late. Then frown again as if only I know what I meant by those words. The session ends when I mention that since my dad left us, I have decided not to keep quiet anymore. I also mention that my father always said: “Just push it in and leave it,” but not anymore! I no longer want to be the quiet withdrawn girl I used to be. I think the therapist can read the determination on my face. I smile complacently when my therapist praises me for the positive turnaround I am making.

Doné’s vignette, conveys a mixture of trauma, anger and anxiety. She expresses her feelings with her body posture and facial expressions. Her way of dealing with her trauma and anxiety is with anger. Although she has the knowledge of how to deal with anger, she still finds it difficult to control her angry feelings. The session ends on a positive note when she decides not to follow her dad’s advice to internalize her feelings but instead to verbalize them.

First Vignette, Pam, 12 May 2021, Session 1, Phenomenon Anxiety.

It is a late autumn afternoon. It’s after school and I am with my therapist for my first therapy session. I’m wearing my favourite black t-shirt and short yellow shorts. I greet my therapist very softly and then sit on a soft orange blanket on the carpet. As I sit cross-legged, I play nervously with the mask in my hand and tell my therapist why I think I came to visit her. As I tell her, I look around the room wide-eyed and make quick eye contact every now and then while I talk to her. I say the reason I am here is that “Aunt Ingrid can help me to be less anxious when I go to school.” I think she can see the anxiety in my eyes and notice that my shoulders seem discouraged. I feel anxious and my eyes constantly jump around from one place to another. Then she reassures me by explaining why I am with her and that she will try her best to help me be less afraid. As she speaks, I shake my head now and then as I become more interested in what she is saying. After she explained nicely what we will do during the session, I carefully move closer, put down my mask and then start drawing my family

for her. It is very quiet, and the absolute silence is almost disturbing. As I do the drawings and answer the questions my therapist asks, I feel a little uneasy. It's like I cannot get my seat. Without actually noticing, I constantly press my hands into the waving of my legs while talking to my therapist, it is as if it calms me down. When the drawings are done, we play a card game and then I smile broadly because I love card games. I enjoy every moment! As we take turns asking questions from the cards, I smile and answer excitedly without thinking. We end the session with a final drawing where I must draw a 'Person in the rain'. I draw quickly and when I am done, I sit with my hands in the waving of my legs again; it makes me feel safe. With my shoulders slightly raised, we discuss the last drawing. It's been a long day and I'm emotionally exhausted.

Reading Pam's vignette, we see that her anxiety is noticeable in her eyes and posture. She struggles to find her seat. Putting her hands in the waving of her legs seems to make her feel safe and less anxious. The moment she starts doing something that she loves her face brightens and she becomes more spontaneous. Towards the end of the session, a positive change in Pam presents when she smiles, and her body posture becomes less tense. In spite of it all, in this lived experience Pam looks emotionally drained after a long day.

Observing each participant's body language and facial expressions brought to life the various emotions they felt. Some children used their different senses, for example, smell, to recall what they saw and heard to reveal their emotions at that specific moment. Children sometimes speak what they feel without any inhibitions. Patience and intense observation are crucially resonating with a participant's lived experience. Completing these vignettes gave me more insight into what it means to give meaning to a participant's lived experience, to feel what that person feels without interpreting it, and then to put it into the right words.

A vignette is a creative method for exploring the significance of life experiences. It introduces the concept of resonance with readers intentionally, by asking what kind of experience emerges and what the atmosphere feels like within that experience. Crafting and

reading these vignettes assisted me to explore specific dimensions of the phenomenon that may have been inaccessible otherwise. It also gave me more insight into the participants' lived experiences and helped me to resonate with their experiences and what they felt during the session. What was very challenging was to resist interpreting the experience with a psychotherapist's explanation of what took place during the session, but rather explain what I saw as a researcher, describing the bodily experience of the participant, in order to explain the phenomenon in terms of what is experienced at that moment.

4.3.4 How do Experiences of Subjective Wellbeing, Anxiety and Trauma Articulate Spatially, Temporally and Relationally, in an Embodied Way?

The following four vignettes illustrate how experiences of subjective wellbeing, anxiety and trauma articulate themselves spatially, temporally, and relationally in an embodied way for the participants in the study.

Because subjective wellbeing interventions were implemented to support the participants with anxiety, panic, and trauma, they also form part of the vignettes. It is significant to see how the lived experiences of these participants were transformed during the intuitive, integrative psychotherapeutic intervention process.

Second Vignette, Pieter, 20 May 2021, Session 4, Phenomenon Subjective Wellbeing

> Aunt Ingrid sits in front of me on an orange blanket. She smiles and says she is very happy to see me. I smile shyly and look down at the orange blanket. Then she asks me about my teacher who is not at school. I told her that she had an operation and should not use her shoulder. My new teacher is also friendly, but I like my first teacher more. First Aunt Ingrid tells me what we will do today, and then asks me to draw a tree. She says that it is not just any tree, but that the tree is actually Pieter. This is the first time I've ever had to draw a picture like this, so I smile awkwardly! Then I ask if I should give the tree a face because it's Pieter. While Aunt Ingrid gives ideas of what this tree might look like, I look down as my imagination runs with me. I start drawing with my fingers on the carpet as they itch, to begin with, the drawing!

Every now and then I smile at the adventure that awaits me. Aunt Ingrid then asks: “I wonder where this tree stands”? Then I feel silly and answer: ‘Is he standing in the sea, or inside a house?’ Now I laugh to myself, and Aunt Ingrid laughs with me! After she and I list all the possibilities of what the tree might look like. I cannot wait to get started. Before I start, my mind runs away with me, I try to put it into words, but it sounds confusing. Then I start drawing and saying that it has rained a lot and that there is a lot of mud. This tree has just been planted and is already big. The place where he was, is too dangerous for him because a tsunami is on the way. My tree has very wide roots. It is autumn now and I am drawing lots of red, yellow, and orange leaves on my tree. Now I draw carrots in the ground. I hope a rabbit sees these carrots; I will make bunnies now that can eat the carrots. A chicken suddenly chirps outside, and I stop to listen. The afternoon sun smiles through the window, and it shines down on the carpet where we work. As I draw a picture, I tell the story of my drawing. As I draw the bunnies I smile broadly because bunnies are my favourite animal. After drawing a bunny hanging upside down from my tree, I see what Aunt Ingrid’s reaction to my picture is. She laughs along because she can see the happiness on my face. Then I ask her if anyone has drawn my idea. Aunt Ingrid answers: "Never!" She laughs and says she likes my fresh, new ideas; I laugh along because I like them too!

One of the psychotherapeutic techniques implemented in this session was a projective positive psychology intervention where Pieter was asked to draw himself as a tree.

The vignette conveys how this technique activated positive emotions in Pieter. It also captured his imagination, creativity, and love for bunnies. Feelings of wellbeing are visible from the beginning of the session. Pieter smiles, the tone of his voice, and his creative drawings are all examples of happiness. Amid this happy atmosphere, he constantly explains what he is busy doing. The in-between laughs are contagious, and he laughs with

the therapist. This vignette exemplifies wellbeing as it articulates through body language, tone of voice, and facial expressions.

> First Vignette, Doné, May 19, 2021, Session 2, Phenomenon, Trauma, Anxiety. I sit quietly with my legs crossed on the carpet while my therapist gets her stuff together for our session. It's a Monday afternoon. I've had a long busy day, yet I'm looking forward to our session. We start with me having to do a "Person in the rain" drawing for her. I put the drawing board on my lap because it is comfortable. The sun is shining from behind through the window and I can clearly see what I am doing. When I'm done, we talk about the drawing. I feel calm and at ease with her. Now and then I peek quickly at the camera. As the session progresses, I am more comfortable in front of the camera and then looking into the lens for a few seconds. It's not that bad at all. We start by drawing different emotional faces and then talking about them. As we talk about each emotion, it takes me a while to bring my thoughts and feelings together before I can put them into words, especially when I have to talk about what makes me sad. I then start talking about my "kind of" Grandfather Jeff. He was one of my real grandfather's friends. He was like a grandfather to me and that is why I also called him grandfather. He died from covid during lockdown last year. We were very 'close', and it makes me feel uncomfortable because I cannot easily show and tell when I am sad. As I speak, I play with my shirt sleeves and close one eye slightly, so I do not have to make eye contact. It is quite weird. I could only feel slightly sad because I have to be strong for my brother, otherwise, he will 'freak out' if I start crying. My grandfather Jeff and I often played new board games and laughed together when we tried to figure out how it works. My main emotion is that I get angry quickly. My family thinks I have anger issues. I hurt myself when I get so angry. I pinch myself until it starts to bleed. But I found ways to deal with it, like playing with my dogs. It calms me down somehow. I suddenly sit up straight because it's so nice to talk about my dogs. When I think of them, I just smile! Then the conversation shifts back to my father who made me so angry that I kicked my door down three years

ago. Then I say, “It’s childish or funny, but if my mom and dad fought and cursed at each other when I was three, I would start crying to get their attention.” Then my dad would pick me up and comfort me and then they would stop fighting. It was my way of getting them to stop fighting. It went on like this until I was 10 years old, then it stopped. Now if they fight, I will get very annoyed and sit in a corner, and then they will try to calm me down. It was not so bad for me when I heard my parents were breaking up. Suddenly my emotions feel like a volcano that has been building up in me for years and is about to explode! This was not the first time my father had an affair with another woman. It is difficult to find the right words. This is the fourth time in two years that he has done this. I watched him. Now I prefer not to make eye contact with my therapist at all. It’s bad to talk about these things, it upsets me terribly, but it has to come out! He will go to work very early in the morning until 1 o’clock in the afternoon. Then go to the woman and be there until 11 o’clock in the evening and only then come home. At first, he would only visit her once a month and then it changed to every single day! I would call my father’s boss. We are very ‘close’ and then he would say that my father finished work early. I confronted him one night when he came home late. He started crying and then it stopped for one year. My mother was afraid of losing him and forgave him for the third time. Then it started again last August. I knew all the women. These were my friends’ single mothers. Everything got worse after my birthday in November last year. Three days before Christmas, he said he had to go overseas for work. He did not spend Christmas with us. Now I can feel the heat rising up in my face because I am angry with my father. He started neglecting me because we were like one person. We are still like one person. Then he started pushing me away somehow. As I speak, my hands ‘speak’ together, and I laugh because I explain everything with my hands. He started blocking and deleting me on his phone. Then I got angry somehow. As I speak, I feel my lips get a little dry because it upsets me to think about it. He said bad things to my nephew at his 21st birthday party. My nephew and I are very close and that made me

very angry. My nephew started crying and cries like never, except when he gets hurt a lot. I knew my father was cheating on us because he started crying when my nephew said he had the best family. When my father cried, I knew he was cheating on us. After that, he neglected us more and more. He left for two weeks. When he returned, his clothes smelled like a woman's perfume. He would no longer say to my mother, "I love you". He stopped loving my mother. Wow, now my words ran out, he 'pushes' us away. Then in March, he would leave for three days and not come home. Then I became very curious again. I confronted him again. He then admitted that he had a relationship again. This time my mom had had enough and they finally broke up. Although my mother was afraid of losing him, this time she had enough. It was the fourth time in two years that he did this to us. Mom's done with him!

The vignette shows how she describes her own actions and experiences. At the same time, it also shows how she experiences the actions of significant others in her life, for example, her nephew, her mother, a substitute grandfather figure, and her father. The vignette foregrounds her keen observational skills, and it also shows how she navigates the contours of her own anxiety within turbulent familial experiences.

Third Vignette, Pam, 26 August 2021, Class visit, Phenomenon: Anxiety

It's Thursday morning and Aunt Ingrid comes to visit the class as she told me. I'm quite nervous because this is the first time, she has come to visit me in class. The children are still walking around the class after break and struggling to get to their seats. Our class is nice and warm, and the sun shines between the purple blinds. Now it becomes calmer, and the children sit at their places but are very excited to perform their acts. We are divided into groups and have to prepare stories that we have to present to the class. Our group has little time to practice, but we will try our best. We must perform The Three Little Pigs. We have brought clothes and wear a pig snout on our nose. I think we look very cute. My class teacher is very friendly and introduces Aunt Ingrid to the class. The children are surprised to see her. We first sit and watch other groups perform. Everyone puts in a lot of effort and my teacher and

aunt Ingrid clap their hands and laugh heartily at each performance. I sit on the front bench with big eyes and watch because it's almost our turn. As I watch I move my feet around and play with the cardboard snout I am just about to put on my face. It gives my hands something to do, and I feel a little calmer. I prefer to look in front of me because I'm too shy and nervous to look at Aunt Ingrid. I can feel her eyes on me. The group just in front of us performs Snow White. It is damn cute. When they are done, Teacher and Aunt Ingrid clap their hands and my teacher shouts Bravo! Now it's our turn. I feel very scared, I am wearing a big black jersey and I get up quickly and walk forward with my group. As we stand, we look at each other and speak carefully not to make a mistake. When it's my turn to say my sentence, I speak softly, and I feel very self-conscious. I do not look at my teacher or Aunt Ingrid at all. After finishing my sentence, I stand with big eyes and arms folded and listen to the others. I wonder what Aunt Ingrid thinks of our performance. I see her smile at me, and it makes me feel good about myself. When we were done, everyone claps hands and I nod my head to say thank you. When I sit down, I put my hands under my legs while my feet swing back and forth. I feel relieved; it's over!

From this vignette, feelings of anxiety are very noticeable in Pam's body language and in her eyes. At first, she fidgets and struggles to find her seat. When she puts her hands underneath her legs, it seems to comfort her in a way. While she performs, she speaks very softly, and she looks self-conscious. After her performance, she looks calmer and more relieved and then gives a quick smile to her teacher.

4.3.5 How can Subjective Wellbeing Interventions be Leveraged to Support Traumatized Children with Anxiety?

The subjective wellbeing interventions used in the current study to support traumatized children with anxiety are presented in Table 4.3 below. In addition, two vignettes are included to illustrate how these interventions support the subjective wellbeing of children with anxiety.

An intuitive approach was carefully integrated into the intervention process. In other words, no specific intervention program was formulated before the intervention period started. Each session was planned a week in advance, with explicit practice principles, objectives, and activities outlined. The intervention procedure was semi-structured and accommodating because it had to be adaptable to the participant's particular needs during the therapy session.

Due to each child being a unique and complex individual, I focus on the child's specific needs. Interventions implemented in this study were sandplay therapy, somatic experiencing therapy, gestalt play therapy, and positive psychology interventions. After 12 years of experience in private practice, I have found that combining these techniques is very effective when working with traumatized young children with anxiety. I have used these therapies integratively, depending on the specific challenge or need of the child. During the therapy session, I engage with the child on their developmental and emotional intelligence level. The participants enjoy working in the sand. It creates an environment where they feel safe to enter their inner psyche without feeling exposed, and self-healing occurs.

I use Gestalt play therapy and methods like drawing, painting, fantasy, clay, puppets, and storytelling when working with traumatized, anxious, or aggressive children. The most crucial ingredient during the intervention process is to build report with the child. The flow of intuition comes with knowledge and experience as a therapist. The more you engage with the child during a session, the more you realize what to do next. When the child feels safe and accepted by the therapist, the healing process can begin.

The reason I think it is beneficial to use subjective wellbeing interventions is that when a child focuses on the positive in an activity it makes them feel accepted, and they tend to relax more, which enhances a feeling of safety and belonging. When a child feels safe enough, they will open up and share more intimate feelings that provoke anxiety or trauma. Effective psychotherapy is more likely to occur when a child connects with the therapist in a safe and calm environment.

Figure 4.1

Visual Summary of Subjective Wellbeing Interventions

SUBJECTIVE WELLBEING INTERVENTIONS

Positive Psychology	**Gestalt Therapy**	**Sandtray Therapy**	**Somatic Integration**
Positive Psychology interventions enable a child to improve their self-esteem, know themselves better, and accept themselves for who they are. In positive psychology, we focus on what is right in an individual instead of only what is wrong with them. Implementation: Dream chart, storytelling, painting a flowerpot, advertisement of the participant.	Gestalt play therapy is very useful for raising a child's awareness and helping the child to get in touch with strong emotions. The therapist attempts to allow the child to verbally and nonverbally express their emotions. The child will lay out their problems symbolically (Blom, 2006). Implementation: a	Sand play therapy assists the child in coping with trauma, particularly anxiety. It allows the child to use symbols within a defined space to tell their story or to play it out in the sand. It is a self-healing process. Implementation: I ask the child to build their world in the sand for me. They can use as many figurines as they want and do	Somatic/ Integration therapy techniques use the brain, memories, body, senses, and nervous system to help children with anxiety and trauma. With this therapy, we track the trauma and anxiety in the body and help the child to discharge (Levine & Kline, 2006). Implementation: make chocolate cookies, plant a flower in a pot,

	perfect bowl of light, flowerpot, making chocolate cookies.	whatever they want in the sand, non-directive.	make a bubble blower, blow up balloons and play with them, mood pedicure.

Theme 2

INTUITIVE APPROACH OF INTEGRATIVE PSYCHOTHERAPEUTIC TECHNIQUES

I used a variety of the above techniques depending on the child's specific needs. The most important ingredient during the intervention process is to build rapport with the child. Intuition occurs only when you know your client and have built a relationship. The more you engage with your client during a session, the more you realize what to do next. Examples of interventions are in section 4.2.2.3.

The following two vignettes supplement the intervention descriptions by illustrating how subjective wellbeing interventions can support the subjective wellbeing of children with anxiety at the personal level, as in the current study. Data for the vignettes were captured during the different subjective wellbeing interventions in the therapy process. The vignettes depict the positive and corrective change that can take place during an intervention.

Fourth Vignette, Karné, 26 August 2021, Session 10, Phenomenon Subjective Wellbeing

> It's a Thursday afternoon after school. I'm sitting for my second last session with Aunt Ingrid today. I am excited because I have finished painting my "perfect bowl of light" and I have already chosen the pebbles that I will put in my bowl at the previous session. Now, Aunt Ingrid asks me to talk about every pebble I have chosen. The first stone I choose is light green, and it's my scary stone! Aunt Ingrid mentions that I can always change pebbles if my feelings no longer fit the specific one. I want to change the green stone to a smaller one. I scratch with my fingers in the bowl, looking for the perfect pebble. As I scratch around and search, I play with the various pebbles in my hand. The big green stone now becomes the feeling when one of my dogs gets hurt, which has already happened. Then I choose a light blue round pebble for fear. Aunt Ingrid says that she notices that the pebble has become smaller for fear, and I agree with satisfaction. Then I say that I have already saved ninety rands for all the times I have slept in my own bed. I slept in my own room for a whole week. Aunt Ingrid adds that she is terribly proud of me. Then I suddenly look down, probably because I feel ashamed, and then say that I went to bed with my mum last night. Bolt my dog woke me up and then I did not want to be alone. Then Aunt Ingrid reassures me and says that it's ok if I'm scared to sleep in my own bed some nights. It makes me feel a little better. I tell Aunt Ingrid that I'm saving for a doll. My birthday is tomorrow, and I would like to have a doll from my parents. I love dolls! Aunt Ingrid says that she can see that I can no longer wait for my birthday. Then I wrap my arms around my body, give a quick laugh and then say: "Yes, I cannot wait!" In the same breath, I also say that

my aunt will bake me a puppy cake for my birthday! I'm so excited and then give myself another quick hug of excitement! Aunt Ingrid finds out I did not bring my two play dogs today, Princess and Rocky. I then say that they fell asleep in my suitcase and then we laugh about it! We start today with a fishing game; Aunt Ingrid explains that there are questions on every card that I must answer. We make packets of three cards with the same fish. The one with the most packs wins the game. There are different questions about how to deal with anger. As we play, I answer the questions, we talk about it, and it helps me deal with my feelings of anger. After a while, we stop the game because Aunt Ingrid says it's clear I won today! Then Aunt Ingrid puts a very interesting flowerpot in front of me. My first reaction is, What? She says it's a flower bowl I'm going to paint. It consists of different wooden planks. I must choose a colour that best describes my feeling about each session, from the first session until today. I then say: "In other words from my unfavourite colour to my very favourite colour? She nods a yes. The colour I choose first is black because the first session was the worst for me, I felt very scared and confused.! While I paint, I pick up the paint pallet carefully so as not to spill paint on my fingers. I smell the strong fragrance of paint and enjoy every moment!

The art of positive change in Karné presents in this vignette. The integrative interventions implemented were gestalt play therapy when she made the "Perfect Bowl of Light" and when she had to choose the different stones for each feeling she felt. Then she decides to change her anxiety stone for a smaller one. Therapeutically, this may suggest decreasing feelings of anxiety. The activity is linked to a story with a significant metaphor. Karné used to bring her toy puppy to every session. It comforted her. But on this day (session 10), it was the first session she left it at home. Progression occurred regarding self-esteem and security because she felt safe enough to leave her toy at home.

Playing the 'anger' fish game is a positive psychology game where we focus on positive ways to handle anger and there is always a winner. In this vignette, feelings of excitement are noticeable in Karné's body language and on her face when she smiles. She

scratches with her fingers in the bowl with colourful stones looking for the perfect stone that resembles her feelings. Suddenly, she looks down at the carpet without making any eye contact, then confesses that she slept in her parent's room the previous night. After confessing, there is a sudden relief in her voice tone when she starts to talk about her upcoming birthday. She gets so excited that she wraps her arms around her own body and gives herself a hug and a quick smile, and then says that she cannot wait. When playing the anger game, it helps her to deal with anger issues and she answers the questions with confidence.

Second Vignette, Lizette, May 11, 2021, Session 5, Phenomenon, Subjective Wellbeing

I am visiting my therapist again today. I'm excited to see her because we saw each other four weeks ago. While we are sitting on the carpet, the children are shouting outside, it is annoying, and my therapist decides to silence them. Then there is also the piano playing next door, but it is soothing music, and it does not really bother me. I already feel comfortable with my therapist and am no longer ashamed to keep my work open when I draw. As I draw a tree for her, I tell her about my vacation with my grandparents in Marloth Park near the Kruger National Park. We saw the big five and fed the kudus in the camp. Then my therapist asks how my friends are doing at school. I answer her by saying it is going very well and that we sorted out all our differences. I draw my tree with a lot of detail because it's fun to draw. I still only use a pencil and rub here and there with my finger over the work to form the effect of a shadow. My therapist compliments me on my hair with the tight bun my mom made on my head this morning. I also think it looks beautiful. While drawing I occasionally hear the chickens clucking. I am so used to the chickens at school. The heater is on, and it warms the room, and it creates a cosy atmosphere. While I work, I do not look up, I focus on what I do, and when I have finished drawing, I look up and tell my therapist I am done. We talk about my tree, and I explain to her exactly what I drew and give a reason for everything I drew. The roots of the tree represent my family

and I tell with so much pride about my grandparents in Marloth Park whom I truly love. This tree of mine stands in my yard, it is summer, and the sun is rising between the mountains. My tree has a very thick trunk with deep roots. On my tree hangs a swing on which children often come to swing. My tree is also the house of birds and squirrels. I draw a bird flying to the nest with a worm in its mouth on its way to feed its chicks. Finally, I draw light pink blossom flowers and red cherries on the tree. Next to the tree, I draw a bench on which I constantly sit when I want to be alone. The bird bowl next to the tree has water so the birds can bathe in it and drink some of the water. On one of the branches hangs a food bowl with bird seeds in it. My therapist says that I am very creative, and I am very proud of my drawing. My tree is a place where all animals can live and eat from. After I have told and explained everything, we discuss each section of my tree. The therapist says that each part of the tree has a specific meaning and then we talk about it. This is very new and interesting to me. I enjoy sharing everything about myself and my family and friends with her.

When reading this vignette, we glimpse Lizette's world and her lived experiences. The drawing of her tree is a gestalt play therapy projective technique. It is also a form of positive psychology because she can focus on the significant people in her life. Lizette is very creative and it is noticeable that she enjoyed every moment. When she reveals her work for the first time, her body language demonstrates increased self-assurance.

In the present research, subjective wellbeing interventions were leveraged to support traumatized children with anxiety by focusing on the positive, in other words, by implementing techniques to make the participants feel accepted. The therapeutic assumption was that when they relax, it tends to create a feeling of safety and belonging. In turn, when a child feels safe, they tend to open up to disclose more intimate feelings (negative feelings) that may have provoked anxiety or trauma. The study also assumed that psychotherapy is more likely when a child interacts with a therapist in a secure and tranquil environment. While implementing the different psychotherapy techniques. I followed the

notice, act, and reflect steps of the wellbeing process. The child was involved in this process holistically, and the child and therapist were able to connect on a deeper level.

In positioning the interventions from the current study in the broader literature, it can be noted that Morris (2009) involves students in the teaching wellbeing process (i.e., positive psychology). He explains a three-step clinical procedure of recognition (notice), intervention (act), and evaluation (reflect). In this strategy, the large effect of requesting children to simply notice aspects about themselves and their environment is an increased awareness of wellbeing, which, in turn, asks them to apply the primary skill of wellbeing: the ability to recognize when things are going well and when they are not in order to make adjustments in their lives.

In the second phase, the child takes actions that will contribute to their flourishing and happiness. During the assessment and reflective phase, children can assess the effectiveness of the action steps (Morris, 2009) and positive psychology differentiates between experiential and reflective techniques. Participating in games, re-enactments, and presuming the role of a scientist experimenting with interventions are examples of experiential techniques. Reflective techniques may include journal keeping, sharing, discussing, developing scenarios, and using visual stimuli (Eloff, 2013). In this study, I followed the positive psychology approach to well-being, as illustrated by the following two examples of positive psychology intervention sessions. For more intervention sessions, see Annexure A-2.

4.3.5.1 Example one, Pieter. The underlined text shows the positive psychology intervention. During this session, Pieter had to make his own ‘Dream chart”. Making use of A3 colour paper, Pritt glue, scissors, different magazines, colour Koki’s and crayons and stickers he created his own personal “Dream chart” that resembles his life goals, dreams and everything that reveals who he is. This activity went over two sessions. After completing it, he took it home and exhibited it in his room to look at it whenever he needs encouragement.

Figure 4.2

Pieter's "Dream chart"

Table 4.5

Example 1 of Positive Psychology Intervention

Session 7: 5 August 2021	
Theme/Goal/s	Somatic experiencing/Positive Psychology Emotions/ Who am I? My life goals and dreams.
Activities	Play traffic game Make a gel bag with glitter. Play "snap" with emotional cards. Make a Dream collage.
Instruments/Materials	Traffic game, small plastic bag, Green gel, Glitter, Emotional cards, A3 color paper, Pritt glue, Scissor, Different magazines, Colour crayons, Koki's, Stickers, and Video recorder.

4.3.5.2 Example 2, Lizette. The underlined text shows the positive psychology intervention. Lizette used vanilla-infused play dough to create her own symbol of strength that she can think of to help her to get through difficult times (Figure 4.3). It symbolizes her classroom with the chairs and her focus point on the board at the back of the classroom. The ball in front represents her standing and focusing on the red dot at the back of the classroom.

Figure 4.3

Symbol of Strength

Table 4.6

Example 2 of Positive Psychology Intervention

Session 6: 18 May 2021	
Theme	Who am I? Somatic Experience-Upregulation. Positive Psychology
Activities	Play “snap” with emotional picture cards. Make something out of the play dough that helps you to get through difficult times. Breathing exercises by using the palm of your hand. Blow bubbles Play the “Ungame”
Instrument/Materials	Colourful play dough with vanilla essence Polystyrene cup with straw and dishwasher soap “Ungame” board game Video recorder

A conceptualization of coping plays an important role in facilitating subjective wellbeing. Coping entails employing appropriate methods to deal with expected, prevailing, or arising problems and obstacles, together with the negative feelings associated with them (Aldwin, 2021).

According to (Savahl et al., 2017), monitoring and measuring projects of objective measures have improved dramatically in Southern Africa, mainly due to enacting laws intended to improve the welfare of children. In terms of what children perceive and feel about their subjective wellbeing and how they evaluate various aspects of their daily lives, however, there is a dearth of information on subjective happiness. Casas (2011) and Savahl et al. (2015) suggest that qualitative research efforts provide a deeper understanding of children's individual perception of wellbeing.

This study demonstrated that the subjective wellbeing of young, traumatized children with anxiety, as the participants in this study, can be supported by using an integrative intuitive approach to psychotherapy. Although the findings cannot be generalized, the study

does provide experiential glimpses into the lived experiences of children with anxiety, especially in a therapeutic context.

4.4 Findings and Conceptual Framework

In this study, we focused on the Ecological Systems Theory of Bronfenbrenner. This approach considers the child's more extensive ecological system and recognizes the child as the center of the ecosystem (Shaffer & Kipp, 2014). The following theoretical approach to consider is developmental psychopathology. It links with ecological theory as it emphasizes developmental processes and the importance and complexity of threat and protective variables. It conceptualizes children's development within and across multiple domains continuously influenced by various interacting factors (Kerig et al., 2012).

According to González-Carrasco (2017), the ecological approach proposed by Bronfenbrenner in 1981 had a significant impact on the field of child development studies. This conceptual structure categorizes the numerous settings where a child is rooted and can be based on their proximity to the child's regular life (between the macro-system and the exo-system, with the mesosystem in between). In this framework, it is essential to understand the reciprocal relationships among various settings in order to fully comprehend the psychological and developmental consequences of children. The significance of implementing an ecological method to research children's SWB has been defended by Lawler et al. (2017) and others. However, except for studies done by Oberle et al. (2011) and Bedin and Sarriera (2014), it has been applied infrequently to SWB research. A relationship-driven and ecological model of children's subjective wellbeing according to Lawler et al. (2017), acknowledges the multidirectional interactions among children, their home and family, life and neighborhood, and school and peer contexts. The child's safety is crucial in these contexts because these interactions define the child's life satisfaction, psychological health, and sense of self.

González-Carrasco et al. (2017) investigated the connection between a sample of young Catalan residents' (Spain) perceptions of security and safety and their wellbeing.

Researchers discovered that assessments of one's personal security and safety were positively correlated with an individual's general wellbeing and satisfaction with life. They claim that the relationship between individual security and subjective wellbeing must be understood in light of the specific contextual realities (González-Carrasco et al, 2017).

According to ecological systems theory, to comprehend a child, one needs to examine the child's living environment (Bronfenbrenner & Morris, 1998). Landsberg et al. (2016) note that a network of interconnected systems influences the child's development. According to Kerig et al. (2012), different ecological systems constantly influence the development and treatment of anxiety in traumatized children.

4.4.1 Microsystem

The microsystem – the parents, the family, and the individual – played an essential role in comprehending the subjective wellbeing of young, traumatized children with anxiety and the protective factors that can assist them, such as a relaxed temperament and capabilities valued by themselves or others. This may lead to good self-esteem. Protective factors at home might include a good supportive family, a dependable parent, a style of parenting defined by a combination of warmth and structure, and social support from extended family members. Children who make reasonable adjustments despite being at risk are termed resilient.

As mentioned in Chapter 2, when considering the development of anxiety among children, it is essential to place the child at the center of the microsystem. Kerig et al. (2012) mention that potential biological and individual risk factors for the onset of anxiety include neurological damage, inadequate nutrition, low self-esteem, and poor self-control. Possible risk factors in the family context are insecure attachment, interparental conflict, abuse, neglect, and domestic violence. In the social context, the risk factors are antisocial friends. Traumatic events and their emotional reactions can enhance and reinforce the individual's negative and inadequate beliefs about themselves and their surroundings (Fernandes & Osório, 2015). In this study, all participants had good protective factors within themselves

and protective factors in the family and extended family. I think that having good protective factors leads to a sense of wellbeing and belonging (Wenar & Kerig, 2005).

4.4.2 Mesosystem

Chapter 2 notes that the mesosystem comprises the connections between two or more systems (Christensen & Rudebusch, 2016). In the treatment of children with anxiety, the educational institution plays a considerably important part. Bartlett et al. (2017) argue that society underestimates the impact of early childhood trauma, mainly because of the misunderstanding that very young children can recover quickly from traumatic events.

The truth is that during the very early years of childhood, the child is more sensitive to trauma than at any other time in his or her life.

Throughout this research study, the therapist, teachers, and parents communicated continuously to provide the participant with the best possible support. Evidence of this can be seen in the interviews held with the parents and teachers throughout the research process, during which I, as therapist and researcher, sometimes functioned as a mediator between the child participants, the parents, and the teachers.

4.4.3 Macrosystem

As mentioned in Chapter 2, this system refers to the community or society that shapes the relationships and structures between systems, shaping the attitudes, beliefs, and values that can affect any of the other systems (Landsberg et al., 2016; Newman & Newman, 2020). In this study, the children come from more or less the same culture and society, where more or less the same attitudes, beliefs, and values are applicable. The context of this community is relatively safe and secure, and the socio-economic status of this particular community is average and above average.

4.5 Final Remarks

This chapter explored and explained this study's main three themes and findings using numerous datasets from the research process. The accumulated findings addressed the primary research question through three descriptive themes. I then responded to the study's five secondary research questions. In the subsequent chapter, the study's findings

and limitations are discussed, and recommendations are provided. It also contains the study's findings and contributions regarding its conceptual framework.

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This research attempted to address how the subjective wellbeing of young, traumatized children with anxiety can be supported. This chapter summarizes the study by providing a condensed explanation of the primary research question, examining the theoretical assumptions underlying this study, and situating the findings within the theoretical framework. After describing the findings and their implications, I discuss the study's contribution to prior understanding of the subject and its limitations. The chapter ends with several recommendations for future studies and practice on the subject at hand.

5.2 The Findings in Terms of the Three Themes

5.2.1 Theme 1: The Invisibility of Anxiety at School

According to the study's overall findings, the invisibility of anxiety was the most dominant theme. Evidence of this theme was presented consistently across all datasets in the study, namely the interviews with the parents and the teachers, the observation notes, and the subsequent classroom vignettes.

Evidence of these findings can be seen in section 4.2.1 where the teachers did not recognize the symptoms of anxiety in the participants and the parents confirmed that three of the teacher participants seemed to be totally unaware that these children were struggling with anxiety. The invisibility of anxiety at school is also evident in the discussion of three class visit vignettes in section 4.2.1.2.

It can be deduced that the invisibility of anxiety at school makes it very difficult for teachers in a classroom context to identify children with anxiety or to respond to their needs. It may also lead to inappropriate referrals (Cvinar, 2010). Therefore, it is crucial for future research to investigate how teachers define anxiety and to raise awareness when children's anxiety becomes excessive. The teachers did not identify three out of the five participants in this study. This may be because the symptoms of anxiety are not always recognizable or because of how children present in class.

In Chapter 4, it was mentioned that because these children are typically well behaved, researchers have discovered that teachers fail to recognize them as having internalizing challenges (Headley & Campbell, 2013). Splett (2019) discusses concerns about unmet needs and service disparities that have prompted multiple calls for effective practices, including teacher development in children's psychological challenges, global psychological health testing, and enhanced integration of substantial evidence practices. Recognizing children with psychological challenges and linking them to best practice is crucial because ineffective mental health is associated with a significant decline in educational attainment, drug abuse, violent behaviour, affected health, and decreased life satisfaction (Gilman & Huebner, 2006; Patel et al., 2007). Early mental health intervention and teacher training in children's psychological health is essential to maximize positive outcomes for children. Prior to making a referral, a challenge must first be identified. Teachers play a crucial role in identifying children with mental challenges. According to Reinke et al. (2011), 75% of teachers surveyed about their contribution, understanding, and mentoring necessities to promote children's psychological wellbeing in schools had worked with and referred children with mental health challenges within the past year. In their framework defining the variables that influence how children with psychological challenges obtain psychological care, Stiffman et al. (2010) identify these educators as entry point suppliers: non-mental health professionals who direct or initiate treatment access. Despite their crucial role in assisting children's rights to psychological support, classroom teachers rank recognizing and comprehending children's mental health challenges as among the top three areas for which they require training (Reinke et al., 2011). For children with internalizing behaviour challenges, the necessity for teachers to be equipped to identify psychological health challenges in the classroom may be especially pressing. According to Merikangas et al. (2010) in Chapter 4, anxiety and depression are prevalent internalizing disorders among learners. Due to the absence of explicit or apparent symptomatology, such as class disruption and disobedience to classroom rules, these disorders are frequently undiagnosed. In addition, studies have shown that educators struggle to recognize children with internalizing behaviour challenges (Cunningham & Suldo, 2014; Neil & Smith, 2017). However, they appear more inclined to refer to and be more worried about children with extrinsic

behaviours than those with internalizing challenges (Chang & Sue, 2003; Loades & Mastroyannopoulou, 2010).

As stated in Chapter 4, there have been developments in South Africa regarding early childhood development teacher education programs:

Early childhood development and the intermediate phase for undergraduate students at the University of Pretoria, for example, includes modules during the first two years of study that accommodate students about mental health challenges in young children (University of Pretoria, 2020).

At the University of Stellenbosch, early childhood education training and the intermediate phase for teachers include information about child mental challenges during their third and fourth years of training (University of Stellenbosch, 2020).

At the University of Potchefstroom (NWU), Early childhood education for teachers, does not include any modules concerning the young child with mental health challenges in the foundational stage of instruction. Teachers in the Senior Stage do get introduction training on mental health challenges (University of Potchefstroom, 2022).

At the University of Johannesburg, early childhood education and the intermediate phase training for teachers include information about child mental challenges during their first and second years of training. However, the mental health training these universities provide focuses not on identifying children with mental health challenges and how to support them, but rather on developing a broad knowledge base on mental health. Improving teachers' mental health literacy levels in the long term may thus potentially be beneficial at all the system's levels (University of Johannesburg, 2022).

Given the frequency of internalizing pathologies such as anxiety disorders, such findings may indicate that educators struggle to comprehend what internalizing pathologies are, their repercussions, and how to identify symptoms of an internalizing disorder. This might be why the teachers did not identify three of the five participants in my study. These participants struggled with internalizing anxiety and, therefore, could not be easily identified

by the teachers. Internalizing challenges are more covert and therefore, often more challenging to detect and assess (Wilmshurst, 2005).

The invisibility of anxiety in children at schools highlights the need for support services to be established at all district levels in South Africa. The Department of Education needs to select schools as resource centers where an educational psychologist can be trained. Then there needs to be a school school-based support team (SST) where educational psychologists and other professionals can provide support services to children, teachers, and parents. This team will act as a link with district support services. Personnel and the active solicitation of advice, workshops, and in-service training will be one method of accommodating all children with learning difficulties and psychological challenges (Donald et al., 2014).

The school where I did my research included me in a school-based support team that consisted of two educational psychologists, two occupational therapists, two speech therapists, and two remedial teachers. The schoolteachers have a vital role in identifying children with challenges by completing a screening form and presenting it to the SST for further investigation. The SST discusses the identified challenges and reaches out to the parents to make decisions about further referrals for professional help. This SST also offers workshops and in-service mentoring for teachers and parents on how to help children with mental health challenges and other challenges, such as speech, occupational, emotional, and academic difficulties.

5.2.2 Theme 2: Intuitive Approach of Integrative Psychotherapeutic Techniques

5.2.2.1 Intuitive Approach. The second theme revealed by the data was the value of an intuitive, integrative psychotherapeutic approach. No predetermined intervention program was formulated before the intervention period started. Instead, the psychotherapeutic intervention process was semi-structured and accommodating. It needed to be open and flexible to accommodate the different forms of anxiety presented in this study and each participant's needs during the therapy session. The integrative psychotherapeutic

techniques included positive psychology, gestalt play therapy, sandplay therapy, and somatic experiencing therapy.

As mentioned in Chapter 4, Sadler-Smith (2009) states that everyone has intuition. It is one of the trademarks of how individuals think and behave. Under the proper conditions, its outcomes can be life-altering and lifesaving. In this study, intuition guided me to search for solutions and interventions; experience, skills, and knowledge in the field also played a significant role. Whittacker (2017) explains that instinctive expertise occurs when a specialist draws on various experiences to recognize cues in a situation, allowing them to recognize patterns and construct a story about that situation.

5.2.2.2 Psychotherapeutic Techniques. According to Geldard and Geldard (2018), the literature strongly supports the use of integrative approaches in psychotherapy. The study and practice of psychotherapy integration involve a philosophical, theoretical, and clinical perspective. This viewpoint is characterized by a desire to promote conversation between practitioners of all viewpoints and an eagerness to comprehend the similarities and synergies of the vast array of sectarian psychotherapies. Psychotherapy inclusion is also characterized by a desire to gain knowledge from all therapeutic interventions and therapists instead of pledging allegiance to a single psychotherapy school or model (Stricker & Gold, 2011). The integrative psychotherapeutic techniques for my research were based on the following psychotherapy approaches:

- The numerous benefits of Gestalt play therapy for raising a child's awareness and helping the child get in touch with intense emotions. It is more than just creativity and fun. Much of the actual Gestalt therapy consists of carefully examining the contact made in the therapeutic session and the resistances that emerge at the contact boundary to protect the individual in the moment from their anxiety (Blom, 2006).
- Sandplay therapy helps the child to deal with trauma and especially anxiety. The Sandplay practitioner encourages individuals to create whatever they wish in the sandpit and observes the work in silence. The Sandplay technique enables the

individual to transcend the boundaries of the child's level of consciousness, thereby allowing the unconscious to direct and facilitate the recovery and development of the psyche. Sandplay therapy is a process of self-healing (Turner, 2017).

- Somatic experiencing play therapy techniques we use the brain, memories, body, senses, and nervous system to help children with anxiety and trauma. During my three years of somatic experiencing training, I realized the importance of engaging the whole body and mind when working with children. The more senses you engage the more influential the outcomes. When an individual is traumatized, the trauma gets stuck in the body. Somatic experiencing therapy helps to track where the trauma in the body is and how to discharge it (Levine & Kline, 2006).
- Positive psychology interventions. Today, positive psychology is an overarching concept for interventions focusing on positive feelings and other positive characteristics, such as creativity, optimism, resilience, empathy, compassion, humour, and life satisfaction. It helps a child improve their self-esteem, better understand themselves, and accept themselves for who they are. Positive psychology worked well with anxious children in this study as we focused on the child's assets and the need for the child to experience joy and pleasure. This shifted feelings of anxiety to wellbeing and, at the same time, boosting the child's self-confidence.

Before any intervention process could begin, it was essential to do an emotional assessment with all the participants to determine the central theme(s) of their presented challenge and build rapport between therapist and client. When the participant feels safe, trusted, and accepted, they will open up and share, and only then will corrective change (psychotherapy) occur. The emotional assessment provided good background and knowledge about the participant's presenting challenge. When the therapist and the participant establish a good, trusting relationship with each other, the intuitive approach can fall into place.

Table 4.3 depicts how the intuitive interventions for each participant were formulated. The table illustrates that an intuitive approach was followed. New sessions were developed

every week as the intervention process progressed. In section 4.2.2.4, the visual diagram illustrates an example of the different activities implemented during the intervention process.

The current study indicates that this intuitive, integrative approach was highly suitable as a support intervention for the participants, since they could be met “where they were” in their journeys with anxiety. The therapeutic sessions could be adjusted accordingly. Whether this finding would be similar with a selection of other psychotherapeutic strategies cannot be confirmed from this study’s findings; it can also not be generalized. The consistently positive therapeutic results for all participants in this study attest to the clinical validity of this study.

Five vignettes that illustrate the phenomenon of subjective wellbeing in this group of participants are included in section 4.4.4.6. The vignettes give an idea of the progress these individual participants made during the intuitive psychotherapeutic intervention process. It should be re-iterated that although this therapeutic approach worked with my participants within their specific context, it cannot be generalized to other contexts.

5.2.3 Theme 3: Mediating Parental Anxiety

A third theme from the parent interviews and data was the possibility that parental risk factors, such as parental modelling, reinforcement of anxiety, and information transfer of anxious and avoidant behaviour, may influence the children's anxiety. In section 4.2.3, data from parental interviews illustrate parents’ struggles with anxiety. However, the assessment of parental anxiety fell outside the scope of this study.

Research has shown that anxiety disorders frequently run in families (Wenar & Kerig, 2012). The parental modelling of anxious and avoidant behaviour has been the focus of most studies examining how children acquire anxiety from their family context (Kerig, 2012; Aktar et al. 2017; Fisak & Grills-Taquechel, 2007). Findings from a study by Aktar et al. (2017) mention that infants' anxious/avoidant behaviours may be influenced in the short- and long-term by their observational learning from their parents' earlier anxiety gestures in modelling situations. In this field of study, according to Bandura's theory of social learning, children may acquire avoidance or anxiety from their parental figures through observational

learning (Bandura, 2021). Fisak and Grills-Taquechel (2007) maintain that by verbally expressing their anxiety in the nearness of the child, parents interact their anxiety straightforward to the child, according to the argument. When parents are confronted with an anxiety-inducing stimulus, children may also observe their parents employing avoidance as a coping mechanism. In these instances, an observant child could imitate the parent's avoidant/anxious behaviours and display them themselves.

The challenge is that if a parent is so preoccupied with their anxiety, they may be unable to help the child with their anxiety. The consequences are that the child must deal with it on their own. As Freud stated, "The child is really not equipped to master psychically the large sums of excitation that reach him whether from without or from within" (Freud, 1926 [1979, p. 305]). Therefore, without their help in the form of calm and soothing parenting, the child is left battling on their own with their often unmanageable feelings. Anxiety can be a symptom resulting from an anxious, emotionally needy parent. In this situation, the child must learn to calm the anxious parent for his or her own emotional safety (Sunderland, 2020).

Throughout their children's development, parents typically provide the greatest number of learning opportunities. Due to children's regular and extended contact with their parents, the degree to which they provide anxiety-related experiential learning may be a significant contributor to the growth of anxiety (Fisak & Grills-Taquechel, 2007).

Reinforcement of anxious and/or avoidant behaviours is a second learning mechanism linked to the ethology of child anxiety. Theoretically, primary caregivers may encourage, facilitate, or recompense anxious/avoidant behaviours in children (Rapee, 2002). As examples, a parent may:

- Remove a child from an anxious situation, such as by picking the child up from school early on the day of a test.
- Encourage and support a child's avoidance of anxiety-inducing situations, such as by allowing him or her to skip school or a social event.
- Try to ease a child's distress by providing special treatment, such as attention or rewards; or

- Permit evasion of responsibilities, for instance by taking a child's refuse outside when a feared dog is present.

In such cases, parenting practices may cause concern, as attempts to reassure or calm the child may be negatively and positively reinforcing. Consequently, children may keep participating in these behaviours to elicit reassuring responses from their parental figures or to avoid unpleasant situations.

In this study, a parent of a participant would remove their child from an anxious scenario, such as by picking the child up from school early or leaving her at home if she did not want to attend school. See section 4.2.3.4.

The third learning process associated with child anxiety development is introductory learning or information transfer. Therefore, parents can speak with their children about safety, wellbeing, and situations that need to be avoided due to the risk of harm. Even though the messages are intended to safeguard the child, the parent could exaggerate the danger level. In addition, parents may be interacting danger more frequently or excessively. When their children were playing, parents of anxious children communicated more anxious messages ("be careful" and "don't climb too high") than did parents of non-anxious children (Beidel & Turner, 2007; Weijers et al., 2018).

These messages may impact children's understanding and heighten their apprehension of these situations. In addition, because anxious parents are frequently the first, most significant, and most influential source of knowledge for their children, anxious familial interaction may have an especially telling effect on how a child perceives various situations and sensory input (Fisak & Grills-Taquechel, 2007).

This study contains an example of a parent communicating messages to her children regarding safety. Although the message was intended to protect the child, the caregiver may exaggerate the actual danger posed by these circumstances. See section 4.2.3.5.

Therefore, I would recommend further studies on this theme to elucidate the interactions between parental and childhood anxiety manifestations. Based on the findings

of this study, I recommend that one way to support children is to mediate the possibility of parental anxiety in their lives.

5.3 The Findings in Terms of the Conceptual Framework

5.3.1 Theory of Ecological Systems

Bronfenbrenner's Ecological Systems Theory functioned as the theoretical foundation for this research study. As stated in Chapter 4, Shaffer and Kipp (2014) include an approach that acknowledges the child's larger ecological environment and recognizes that the child is central to their ecosystem. This study also adopted aspects of developmental psychopathology theory that link with ecological theory.

This theory emphasizes developmental processes and the importance and complexity of risk and protective factors. Chapter 4 notes that Kerig et al. (2012) state that instead of only one single factor, it conceptualizes children's development as continuously influenced by various interacting factors from within and over multiple domains. In Chapter 4, Gonzalez-Carrasco (2017) mentions Bronfenbrenner's (1981) ecological approach as one of the most influential conceptualizations of development studies from a theoretical standpoint. Based on this conceptual framework, the contextual factors in which a child is rooted can be categorized according to their proximity to the child's everyday life (from the micro-system to the macro-system, with the mesosystem and the exo-system in between the two). In this approach, the reversible interaction between the various contexts is essential to comprehending children's psychosocial and developmental outcomes. Lawler et al. (2017) defend the importance of adopting an ecological approach to research children's SWB.

When examining the subjective wellbeing of the child, it is necessary to examine the children's interactions with their family and home life contexts, as well as their neighborhood, school, and peers. The importance of the child's safety in each of these contexts stems from the fact that they provide diverse indicators of mental health, life satisfaction and self-perception. According to Wenar and Kerig (2012), different ecological systems continuously impact the development and treatment of anxiety in traumatized children.

5.3.1.1 Microsystem. In this study, the interpersonal relations between the participants and their families, school, and peers were satisfying. In some cases, there were slight differences in relationships between the individual, parents and siblings. These factors affected the child's emotional health and may have contributed to feelings of anxiety. Holistically, all participants had good protective factors within themselves as well as protective factors in the family and extended family, promoting their subjective wellbeing.

5.3.2.2 Mesosystem. In this study, the support system at school consists of a group of professionals (a psychologist, a speech therapist, two occupational therapists and several remedial teachers). By completing a screening questionnaire developed by the group of professionals, the teachers played a significant role in the identification of children with possible mental health challenges in their classrooms (Annexure A-1).

The following factors were present in the context of the study:

- A supportive classroom environment.
- Well-resourced support structures in the school.
- Supportive teachers.
- The availability of a psychotherapist and several other health professionals.
- An open communication system from the school to the families, and
- A safe school environment.

5.3.2.3 Macro system. In this study**,** the context of this community was relatively safe and secure, and the socio-economic status of this specific community was average and above average. This community also shared more or less the same beliefs, values and culture and, therefore, functioned as a protective factor for children with anxiety because the feeling of ubuntu could be experienced within this community. Although this study was conducted within a bounded system of relative privilege, the study also acknowledges the diversity of lived experiences of young children with anxiety who may be living in poverty. Within the macrosystem, these lived experiences may not always correspond with the educational goals and procedures developed in other, more privileged contexts.

5.3.2 Positive Psychology

In Chapter 4, it was indicated that Schrank et al. (2014) define positive psychology as an umbrella concept for positive psychological interventions. Positive psychology seeks to reorient psychological research and practice toward the positive aspects of one's experience, qualities, and assets. Examples of activities in positive psychology interventions in my study are making dream charts and reading positive stories to enhance the child's self-esteem (section 4.2.2.5). As mentioned in Chapter 4, in South Africa (and globally), there is a renewed focus on health and wellbeing in psychology and on what is right with an individual instead of only what is wrong with them. Wissing et al. (2020, p. 45) note that "positive psychology had been criticized for creating a false distinction between a new 'positive' and an old 'negative' or 'usual' psychology." "In clinical practice, the positive has been criticized for creating a "domination of positive outlook" that prevents people from communicating negative emotions and aids them in avoiding difficult, but necessary therapeutic processes." In my research on positive psychology interventions, I focused on the child's assets and the necessity to experience joy and pleasure. This shifted feelings of anxiety to wellbeing and at the same time boosted the child's self-confidence.

5.3.3 Developmental Psychopathology

As mentioned by Kerig et al. (2012) in Chapter 4, the developmental psychopathology model links with ecological theory across some ecological domains. Developmental psychopathology is concerned with the comprehension of developmental changes and the significance of protective and risk factors. The parents are one of the domains that continuously influence the child. This model, therefore, resonates with the third theme of the findings in this study, "Mediating parental anxiety."

As stated earlier in Chapter 4, the interviews with the parents revealed indications of possible parental anxiety in some of them. I recommend further in-depth studies on this theme to explore these dynamics. Nevertheless, the study recommends that one way in which young children with anxiety can be supported is to mediate the possible occurrence of parental anxiety in their lives.

The studies identify possible risk factors that might provoke anxiety in children. These were parental modelling, reinforcement, and the transfer of information regarding anxious and/or avoidant behaviour (section 4.2.3).

According to Aktar et al. (2017), observational learning from parents may have immediate and lasting outcomes on a child's anxious/avoidant behaviours during infancy. For instance, an example from this study shows that possible parental modelling of anxiety might have taken place: the child participant, Karné had a 'meltdown situation'. After the 'time out' discipline from the parent, the child came out of her room and then the parent aggravated the situation by saying: "If you want to cry for three hours, you can do so, but don't do it here in front of me, because it drives me crazy". The child observed anger in the parent when she came out of her room, and then the process repeated itself (section 4.2.3).

Fisak and Grills-Taquechel (2007), as mentioned in Chapter 4, describe the strengthening of anxious and/or avoidant behaviours in parent-child interactions. A parent may, for instance, start by removing a child from an anxiety-provoking situation (such as by fetching the child early from school on the test day) or encourage and support a child's avoidance of anxiety-provoking situations (e.g., by letting a child stay home from a social event or school).

According to Fisak and Grills-Taquechel (2007), instructional learning or information transfer is another probable factor mechanism of learning associated with the development of child anxiety. This occurs when parents talk to their children about safety, wellbeing, and situations to avoid due to the possibility of harm. Although the messages are meant to protect the child, the parent may be conversing a greater level of danger than is actually present. In section 4.2.3, interview with a parent, the possible example of a similar situation is unconfirmed because it falls outside the scope of my study.

5.4 Contributions in Terms of the Theoretical Framework

5.4.1 Ecological Systems Theory

This study applied the ecological systems approach to the micro and mesosystems of this model, whose structures play an important role in supporting young children with

anxiety. These systems include the collaboration between the teachers, children, parents, and the SST of the school. Based on the study's findings, I would prefer to recommend that because of the invisibility of anxiety at school, teachers might need more support in terms of more staff, in-service training, or workshops to support them in the initial identification of children with internalizing and externalizing symptoms of anxiety. My research did not include an evaluation of the teacher's ability to recognize children with mental health issues. The study did indicate the invisibility of anxiety in the classroom as a major theme – therefore this recommendation. Within the context of the present study, the school support team was well equipped to assist children with anxiety. The multidisciplinary team was supportive, and teachers, parents, and therapists communicated effectively. The parents of the participants were also willing to implement the parental guidance they received from the therapist. Theoretically, the study contributed to a deeper understanding of the lived experiences of young children with anxiety as it presents across various systems.

5.4.2 Positive Psychology

The study presents evidence of how various positive psychological intervention strategies can be used within an integrative, intuitive intervention programme with young children with anxiety. It included dream charts, storytelling, therapeutic painting activities and creating “advertisements” for the child-participants. As mentioned in Chapter 4, today, positive psychology serves as an overarching concept for interventions in positive psychology. Chapter 4 states that in South Africa (and globally) in psychology, there is a renewed emphasis on wellbeing and health and on what is right with an individual as opposed to only what is wrong with them (Wissing et al., 2022). During this research study, teacher and parent guidance took place continuously on how to support the subjective wellbeing of the participants. According to the examples of the feedback from the interviews, parents and teachers perceived the results of the intuitive Psychotherapeutic interventions positively. See sections 4.2.2.5 and 4.2.2.6.

5.4.3 Developmental Psychopathology

In addition, the study provided in-depth information and insight into the lived experiences of young children with anxiety about their developmental levels and psychopathology manifestations. The presence of anxiety in the children's experiences needs to be acknowledged despite the study implementing a positive psychological approach. Here developmental psychopathology theory is linked with ecological theory. Across some ecological domains, the understanding of ‘developmental’ changes: the emphasis on developmental processes, and the importance and complexity of protective and risk factors could be interrogated (Kerig et al., 2012).

The possible risk factors in this study were insecure attachment and interparental conflict in some participants. The possible protective factors were the fact that the family contexts of these participants were primarily positive and stable with competent adult role models. One of the most prominent factors that intensify anxiety is parental responses. This statement corresponds to the microsystem comprised of the family, the school, and the social circle, in which children engage in continuous face-to-face interactions. This system consists of trends of daily activities, roles, and relationship challenges that affect the child's development (Mavuso, 2020). In this study, the interpersonal relations between the individual participants and their families, school, and peers were satisfying.

In the theme concerning the invisibility of anxiety at school, possible risk factors could be the inability of the teachers to identify children with anxiety, possibly through a lack of knowledge to identify the symptoms of internal and external anxiety or the lack of support from assistant staff in the classrooms. Evidence of the invisibility of anxiety at school appeared across datasets in the teacher and parent interviews and the presented vignettes in sections 4.2.1.1 to 4.2.1.3.

The following protective factors at school could be identified: a supportive classroom environment, well resource support structures in the school, supportive teachers, the availability of psychotherapy and multiple health professionals including an occupational

therapist, speech therapists and remedial teachers, a system of open communication between the school and family members, as well as a safe school environment.

Concerning the second theme, mediating parental anxiety, the interviews with the parents revealed the possibility of previously existing risk factors that might have influenced their children's anxiety. The current study focused on anxiety in the child participants, however, and did not assess for parental anxiety. Although parental anxiety fell outside the scope of this study, the study did present several examples of the potential presence of parental anxiety, to the degree that the mediation of parental anxiety emerged as a key finding in this study. In this regard, parental modelling, information transfer of anxious and/or avoidant behaviour and reinforcement were potential risk factors that could induce anxiety in children.

5.5 Limitations of the Study

The primary limitations of this research are the role Covid-19 played in the manifestation of anxiety and the study's practical aspects. It included only qualitative data and the study was conducted within a socio-demographically specific context, within a specific school and area and therefore cannot be generalized to other contexts.

5.5.1 Covid-19 Limitations

During this study, Covid-19 may have contributed to the manifestation of anxiety in the participants. The lockdown period caused many changes within schools and households. Many children suddenly felt insecure and disorientated. Teachers, children, friends, parents and family members also fell ill with Covid-19 which caused intense heartache and anxiety in communities (Montserrat et al., 2021).

The new methods of school administration and organization may have substantially affected the emergence of child anxiety. The institution of health regulations may also have influenced the pragmatic aspects of the intervention process because numerous adjustments had to be made to accommodate the participants during the intervention process. During the study, the Covid-19 pandemic and subsequent lockdown regulations affected not only the children, but also the parents and teachers.

5.5.2 Lack of Quantitative Data

My intention with this study was to gather rich qualitative data. No quantitative data was collected. A disadvantage of this is that there is not a statistically representative form of data collection; the study relies instead solely on the experience of the researcher (Maree et al., 2020). Using a qualitative methodology allowed me to understand the individual experiences of young children with anxiety. Although quantitative data may have provided me with a different perspective on the lived experiences of young children with anxiety and permitted the results to be generalized to a larger population, the conditions of the study would have been different and in-depth insights may have been lost.

5.5.3 Relatively Small Sample and Specific Sociodemographic Context

The data in my study were collected from a relatively small sample of children with a particular educational and socioeconomic background. In addition to being located in a prestigious and affluent area, the participants' elementary school was also a popular, rapidly expanding institution. Therefore, the findings of this study cannot be generalized to participants' experiences in different socio-demographic circumstances. Instead, my intention during this study was to reach for depth to get in-depth insight instead of correlations and statistics.

5.5.4 My Role as a Researcher within the Scope of this Study

My roles as a researcher and a psychologist affected the study in various ways. Because of lockdown regulations, some of the intervention sessions needed to take place at my private practice at home and the scheduling of interviews with the parents and teachers presented some obstacles. Therefore, the process took longer than planned because of the lockdown restrictions.

The need to refrain from interpretation during the development of the vignettes also presented challenges. As a psychologist and psychotherapist, it is my natural inclination to interpret the dynamics, behaviours, expressions, atmosphere, tone and the cognitions during a therapeutic session. Predominantly, the observation data for the vignettes were collected during the therapy sessions, which made it quite challenging for me to "show, and not tell",

i.e. not to interpret. This was addressed through the various iterations of the vignettes, but some remnants of therapeutic interpretation do inadvertently remain in the text.

5.5.6 Use of Translated Data

The data collection process took place in Afrikaans, as it was the participants' mother tongue language. Some nuances may have been lost during the translation process; this should be taken into account when reading the transcripts in English. Each language develops its own idiom, which may or may not remain common usage. According to Taber (2018), each language has its own terms with subtle meanings (which are not entirely fixed, as word meanings are constantly in flux to some extent). Therefore, each language is a distinct resource for thought and communication. In the process of translating a speech work in one language into a speech work in another, the meaning of the original speech work needs to be preserved unchanged (Raxmonkulovna, 2021).

5.6 Contributions of the Study

5.6.1 Innsbruck Vignette Research

This study was the first to implement the Innsbruck vignette research methodology with children with anxiety in South Africa. I was privileged to attend some of the international vignette research conferences held online in 2020 by Michael Schratz and Johanna Schwarz, the co-developers of vignette research at Innsbruck University. What I gained from those conferences was the time they spent discussing each vignette. A whole conference will be devoted to the discussion of one vignette. The different perspectives and viewpoints of each participant were a fruitful learning experience.

My contribution to the science of psychology is that my research study is the first in South Africa to implement an interpretive phenomenological study using vignette research to give meaning to the lived experiences of young, traumatized children with anxiety. This method is necessary for capturing and documenting the voices of the lived experiences and for imbuing each vignette with details, context, and emotion. The purpose of creating these vignettes is to gain an appreciation and understanding of the complexities of classroom and

therapy settings. While reading the vignette, new phenomena are identified to give meaning and depth to it.

5.6.2 Extended Therapeutic Engagement

An extended therapeutic engagement with participants took place using an intuitive, integrative psychotherapeutic approach. As an educational psychologist, implementing this strategy was inherent to my identity. The advanced coaching and knowledge I received in these therapeutic techniques and twelve years of experience and knowledge helped me to implement them. The contribution that I aspired to make was in doing so with intuition. In other words, no intervention program was formulated before the study commenced.

This approach was intuitive in both the development and design of the therapeutic session: the research process developed flexibly depending on the participant's specific needs at each stage. In doing this, I had to rely on my instincts and intuition as a psychologist and to trust the process.

5.6.3 Combination of a Wide Variety of Qualitative Data Collection Methods

The numerous methods of qualitative data collection included in the study were as follows:

- Observation using field notes and vignettes.
- Psycho-emotional assessments to screen for anxiety.
- Intervention sessions using questionnaires and artifacts for emotional assessment.
- Child, parent and teacher interviews using semi-structured and casual interviews.
- Audiovisual materials using a video recorder, voice recorder and photographs.

5.6.4 Highlighting the Invisibility of Anxiety at School

The findings on the invisibility of anxiety in a school context might provide impetus to address the possibility of more support for teachers in terms of staff, in-service training, and workshops. I believe it is crucial for future research to examine how teachers define anxiety and to raise awareness in cases where children's anxiety becomes excessive. Three out of

the five participants in this study were not identified as anxious by the teachers. This may be because the symptoms of anxiety are not always recognizable, even more so if the anxiety is internalized, sometimes in a form of aggression as a fight response to anxiety, when it can be misdiagnosed as oppositional defiant disorder (ODD) (Struwig & van der Spuy, 2021).

5.6.5 Displaying the Potential of Intuitive Therapeutic Techniques with Traumatised Children with Anxiety

The study displays the potential of intuitive psychotherapeutic techniques with young, traumatized children with anxiety, incorporating the following techniques: gestalt play therapy, sandplay therapy, somatic experiencing play therapy and positive psychology interventions. In this study, intuition guided me to search for solutions, but experience, skills and knowledge in the field also play a significant role when making decisions before interventions. Psychotherapy integration is also characterized by an openness to learn from all therapeutic interventions and therapists, as opposed to pledging allegiance to a single psychotherapy school or model (Stricker & Gold, 2011).

5.6.6 Indicating the Need for a Broader Understanding of Parental and Child Anxiety Interactions

In the interpersonal context of this study, there was evidence that factors such as overprotection, modelling, reinforcement, and parental transfer played a crucial role in the preservation of anxiety in children. Although parental anxiety fell outside the scope of this study, the study did present several examples that suggest the potential presence of parental anxiety. The mediation of parental anxiety emerged as one of this study's most significant findings. Therefore, a deeper understanding of interactions between parent and child anxiety is a definite need.

5.7 Recommendations

This section contains recommendations for practice, future research, and development and training suggestions.

5.7.1 Recommendations for Future Research

The following studies can be considered for further research:

- Case studies on the visibility/invisibility of anxiety in the classroom.
- Vignette research on the manifestations of anxiety in school contexts.
- Mixed methods, e.g., quantitative and qualitative, studies on childhood anxiety in traumatized children in South Africa.
- Survey research on the occurrence of anxiety in South African children.
- Vignette research on parental anxiety and its effect on childhood anxiety.
- Intervention research that assesses various combinations of intuitive therapeutic approaches.
- Longitudinal research on the outcomes of childhood trauma and anxiety in adulthood.
- Vignette research on the perceptions of teachers about anxiety in children.
- Longitudinal studies on the long-term outcomes of parental anxiety on childhood anxiety.

To improve practice, action research will be conducted on the in-service training of teachers regarding the external and internal symptoms of anxiety in young children, and Intervention research to explore additional and/or alternative psychotherapeutic interventions in an integrative, intuitive way with young children with anxiety.

5.7.2 Recommendations for Practice

The following practice recommendations are made in light of the findings of this study:

- The training of psychologists and other professionals in intuitive psychotherapeutic interventions. In the current research, there is substantive information about CBT interventions and prevention programs for traumatized children with anxiety. The use of more intuitive, adaptable, flexible, and integrative approaches needs more exploration.
- Workshops for health and education professionals on wellbeing interventions for children.

- Workshops for parents in terms of preventing the parental transfer of anxiety, guidelines on how to support parents with anxiety and how parents can support their children with anxiety.

5.7.3 Recommendations for Future Training and Development

The study was conducted within a high-resource environment. In South Africa, however, anxiety is prevalent among vulnerable child populations and is influenced by poverty. As a result, we must also comprehend the lived experiences of young children with anxiety living in poverty, as they may not always correspond with the conventional educational goals and procedures developed in other, more privileged contexts. Unless we understand these challenges in the whole social context, we cannot effectively address them systemically. Recommendations for future training and development to take into consideration thus are:

- In-service training for community social workers on anxiety in young children and how to assist these children in their communities and at home.
- In-service training and workshops on mental health challenges in young children presented by educational psychologists to teachers regularly, as well as hands-on skills about how to support children and parents.
- Educational psychologists, with their practices, can reach out to low-resource communities and churches to present workshops on various mental health challenges in young children, especially children with anxiety. These workshops could be available to the broader community, social workers, parents, teachers, or any caregivers who need assistance.
- More specialized training on mental health challenges with young children, especially children with anxiety.
- Training at all universities in South Africa on how to support and refer children for specialized help.
- Mental health services at schools for families that need help, especially those that cannot afford expensive services in the private sector.

- The selection and funding of selected schools by the Department of Education as resource centers to facilitate training opportunities for teachers, social workers, psychologists and other professionals.
- More workshops on mental health challenges in children must be available to teachers to enhance their knowledge on how to identify and support children with internal and external mental health challenges.
- We need to engage the entirety of society in shifting the social norms that legitimize and normalize violence against children, combining this with a complete set of interventions across the life course to stop violence in children's homes, schools, and communities, and ensuring that children have access to the care, safety, and therapeutic support they require. To deal with the complex interaction of risk and protective factors at each level of the socioecological system, the response needs to be multisectoral and include a whole-society and whole-government perspective.
- Each school needs to delegate a principal health-care facility, and school health nurses should serve as the primary referring agents.

The need for school-based support teams consisting of qualified teachers, health authorities (full-time members of the school health team or lay health care workers based at amenities or part of primary healthcare (PHC) outreach teams), members of congress of the school governing body, and non-governmental organizations.

Networks for educational psychologists to implement training in the community are the South African Teachers Union (SAOU), Non-Profitable Teachers Organization (NAPTOSA) and National Representative Organization for Governing Bodies (FEDSAS).

5.8 Final Reflection

In light of the numerous challenges faced by parents, teachers, and young, traumatized children with anxiety, this study sought to shed light on considerations that needs to be made when working with young, traumatized children with anxiety. The need for

skills development for teachers on identifying and supporting children with anxiety is highlighted due to the invisibility of anxiety in classrooms. The value of an intuitive, integrative psychotherapeutic intervention to support young, traumatized children with anxiety and the need for parental guidance for parents is illustrated. The study also generated new knowledge about positive psychological intervention strategies with young children with anxiety, intuitive psychotherapeutic interventions for children with anxiety and knowledge about the need to mediate the potential parental transfer of anxiety.

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ANNEXURES

Annexures A: Documents Related to methodology and Strategy.

Annexure A-1

Siftingsvorm

Naam: _____ Gr. _____ Geboortedatum: _____

Onderwyser: _____ Datum: _____

Hierdie vraelys sal u help om duidelikheid te kry of die kind ‘n kandidaat is vir ‘n: Sielkundige evaluasie, Arbeidsterapie, Spraakterapie en/of Remediëring.

Merk toepaslike kolomme met kommentaar waar nodig.

Area van ontwikkeling	Ja	Nee	Soms	Kommentaar
ARBEIDSTERAPIE				
SENSORIESE PROSESSERING				
Raak oorweldig deur klanke prente.				
Hou nie van aanraking nie.				
Ondervind probleme om sy aandag en konsentrasie te hou.				
Soek beweging die hele tyd.				
Rusteloos.				
Raak vinnig angstig en vermy werk.				
POSTUUR EN GROOT-MOTORIES				
Lomp in uitvoering van groot-motoriese take.				
Onvoldoende sitpostuur by tafel en op mat.				
FYN-MOTORIES EN HANDFUNKSIE				
Dominansie nie vasgelê en wissel hande.				
Onvoldoende potloodgreep en skryf stadig.				
Swak inkleur, teken en skryfvaardighede.				
VISUELE PERSEPSIE				
Swak ruimtelike organisering van werk.				

Letter- en/of getalomkerings.				
Hulp nodig met legkaarte; kol tot kol prente.				
Sukkel om konsepte: prente; objekte te onthou.				
Kan nie verskille en ooreenkomste raaksien nie.				
Verloor plek en kan nie woorde of prente vind nie.				
Werk van Regs na Links; onder na bo.				
Verstaan nie bo; onder; voor; agter nie.				
SIELKUNDIGE EVALUASIE				
SKOLASTIES				
Die leerder toon ‘n agteruitgang in: skoolpunte of die kwaliteit van skoolwerk.				
Die leerder onder-presteer skolasties.				
Huiswerk en skooltake word nie ingehandig of voltooi nie.				
Werk impulsief, oorhaastig en maak onnodige foute.				
INTER-PERSOONLIK (GEDRAG EN SOSIALISERING)				
Die leerder is dikwels in die moeilikheid oor swak gedrag.				
Die leerder gee swak samewerking aan onderwysers en daar is ‘n onbereidwilligheid om instruksies te volg.				
Klasgedrag is ontwrigtend.				
Die leerder toon lae aktiwiteitsvlakke: passiewe klasdeelname of apatie.				
Die leerder ondervind probleme om onafhanklik te werk.				
Die leerder is huilerig, angstig of bang.				
Die leerder is skaam, teruggetrokke of inkenning.				
Die leerder is oormatig aktief of lawaaierig in die klas.				
Die leerder toon ‘n lae frustrasie toleransie of kry woedeuitbarstings.				
Die leerder word geterg of afgeknou of hy/sy terg en knou ander af.				
Die leerder ondervind probleme om sy/haar beurt af te wag of om mededeelsaam te wees (groepwerk is moeilik).				
Oneffektiewe sosialisering met portuurgroep word opgemerk.				

INTRA-PERSOONLIK				
'n Lae of swak selfbeeld en swak selfvertroue.				
Swak konsentrasie: aandag word maklik afgelei en die kind dagdroom.				
Senuweeagtigheid word waargeneem bv. naels kou.				
Leerder kom hartseer of terneergedruk voor.				
LEWENSOMSTANDIGHEDE				
Daar was onlangs 'n traumatiese ervaring bv. egskeiding, motorongeluk, misdaad, finansiële probleme ens.				
SPRAAKTERAPIE				
Artikulasie				
Ondervind probleme om klanke reg uit te spreek, soos: (r) of (s) en ruil klanke om (kat word tak)				
Taal				
Eenvoudige woordeskat, kort sinne, ruil woorde in sinne om, gebruik verkeerde voorsetsel en voornaamwoorde, verstaan nie moeilike vrae nie.				
Gebruik meestal Engels om te kommunikeer.				
Ouditiewe prosessering				
Kan nie in geraas funksioneer nie.				
Los klanke uit as hy/sy woorde skryf (klas word kas).				
Kan nie klanke saamvoeg of opbreek nie.				
Los woorde uit in sinne as hy/sy skryf.				
Kan nie 1ste /middel /laaste klank identifiseer nie.				
Opdragte moet altyd herhaal word.				
Sukkel met luistertoetse, diktee en begripstoetse.				
Hakkel				
Herhaal klanke, woorde of frases op 'n onnatuurlike manier.				
REMEDIËRING				
Taal				
Swak klankherkenning en/of verwarring van klanke.				
Woord- en sinsbou verg aandag.				
Probleme met spelling.				

Kan nie spelreëls toepas nie.				
Probleme meet lees.				
Swak leesbegrip.				
Woordherkenning is swak.				
Wiskunde				
Getalbegrip nie vasgelê nie.				
Ondervind probleme met basiese bewerkings en konsepte.				
Ondervind probleme met getalpatrone en getalkombinasies.				
Ondervind probleme met Woordprobleme.				

Enige ander belangrike inligting:

AANBEVELING:

Annexure A-2

Example of Assessment and Intervention sessions

Participant 1 Pieter	
Age **Gender and race** **Presenting problem**	8 years Male, white Anxious at home and every morning before school starts.
Session 1: 3 March 2021	Emotional Assessment
Theme/Goal/s	Emotional assessment- Who am I?
Activities	KFD (Family Drawing) DAP (Draw a Person) Individual Structured questionnaire with each drawing. Sandpit/Psychotherapy. Build your world in the sand.
Instruments/Materials	White paper; pencil; Crayons; Koki's; Sandpit with sand Figurines; Individual Structured questionnaire with each drawing; Video recorder.

Session 8: 19 August 2021	**Intervention session**
Theme	Psychotherapy, Positive Psychology Bibliotherapy/Explore the real me.
Activities	Finish "Dream collage" Read a story about the "Bowl of Light" Start to create your own "Bowl of Light" with clay. Read the story about the "Perfect Bowl of Light". Read another imagination story and draw a picture about it.
Instruments/Materials	A3 paper for the collage, Magazines, Pritt glue, Colour crayons, Koki's, Stickers, Clay, Story books, Video recorder.

Annexure A-3

Agtergrond Kennis Onderhoud met Ouers

1. KIND SE NAME, OUDERDOM,

GEBOORTEDATUM_____

2. SKOLE BYGEWOON?

_____

3. EMOSIONELE GEMOEDSTOESTAND? - HUILERIG, EMOSIONELE UITBARSTINGS AFSKEID NEEM, SELFVERTROUE, KONSENTRASIE, HULPVAARDIG, SELFSTANDIG?

_____

_____

4. SOSIALE ONTWIKKELING MET MAATS? IS DIE KIND MEDEDEELSAAM?

_____

_____

5. ENIGE BEKOMMERNISSE VAN OUERS?

_____

_____

6. VERHOUDING MET FAMILIE, MAATS, ONDERWYSER?

_____

_____

7. WIE DISSIPLINEER DIE KIND EN HOE?

_____

_____

8. VROEË ONTWIKKELING VAN DIE KIND IN TERME VAN: KOMPLIKASIES TYDENS SWANGERSKAP, KOMPLIKASIES TYDENS GEBOORTE, GEBOORTEPROSES-NORMAAL/ KEISER?

_____

_____

9. ONTWIKKELINGSMYLPALE VAN DIE KIND?

_____

_____

10. LOOP, KRUIP, ENIGE PROBLEME?

_____

11. KIND SE SLAAPGEWOONTES/EETGEWOONTES

_____

_____

12. GESONDHEID VAN DIE KIND?

_____

_____

13. HET DIE KIND AL ENIGE BESERINGS OPGEDOEN/MOTIVEER?

_____

_____

_____

14. KIND SE SPRAAK, VERBALE UITDRUKKING?

_____

_____

15. STRESSORS IN GESIN BV. EGSKEIDING, VERHUIS, TRAUMA, HOSPITALISERING, WERKVERLIES, INBRAAK, GEWELD, DOOD VAN FAMILIE OF DIER?

16. STERKPUNTE VAN KIND

17. STRUIKELBLOKKE

18. HOE SOM EK MY KIND OP?

19. WAT VERWAG EK AS OUER VAN DIE TERAPEUT/NAVORSER?

20. HET DIE KIND AL OOIT ENIGE VORM VAN TERAPIE ONTVANG/MOTIVEER?

Annexure A-4

Onderhoud met Onderwyser

1. Is daar enige verandering in die leerder se gedrag? Indien wel, beskryf dit asseblief.
2. Hoe sal u die leerder se angs vlakke beskryf?
3. Is daar enige verbetering in die leerder se welstand sowel as sy gemoedstoestand? Indien wel beskryf dit.
4. Wat is u grootste bekommernis aangaande die leerder op die huidige stadium?

Annexure A-5

Draw-a-Person Interview (Dap)

1. Name of person?_____
2. Age? _____
3. What is she/he thinking?_____
4. What makes her/him happy?_____
5. What makes him/her sad?_____
6. Who is _____ favourite person?
7. What does _____do in her/his free time?
8. What does he/she like to do best?_____
9. What does she/he really not like doing?_____
10. What makes _____ angry?
11. What makes _____ scared?
12. What does _____ think is the worst thing to do?
13. What is the best thing that ever happen to_____?
14. What is the worst thing that ever happen to_____?
15. If _____ had to live on an island, who would _____ like to be with?
16. Let's say _____ had a dream, what would it be about?
17. What is going to happen to _____ in the future?
18. What does _____ often worry about?
19. If _____ had three wishes, what would they be?

Annexure A-6

Kfd (Family Drawing) With Child

1. What is each one of the family doing?_____
2. What is the best thing about this family?_____
3. What is the worst thing about this family?_____
4. What does this family do together?_____
5. What would you never change about this family?_____
6. If you could change one thing about this family, what would it be?_____
7. What do you like about mom?_____
8. What do you like about dad?_____
9. What do you not like about mom?_____
10. What do you not like about dad?_____
11. Who in the family understands you when you are sad?_____
12. Who in the family makes you sad?_____
13. Who in the family makes you happy?_____
14. Who in the family makes you angry?_____
15. Who in the family makes you scared?_____
16. Who in the family gets the angriest?_____
17. Into which animal would you change family members?_____

Annexure A-7: An example of the transcript data

Name: Pieter Interview 1	**Dialogue, Transcript of the Intake interview, 25th March 2021.**	Time: 41 min Codes:
Mother: line 1	He is very much OCD, routine based, in my opinion emotionally immature. From a teacher's side as well as a parent's side. Cries very easily, I have a four-year-old who is much stronger than him. When things don't go her way, she will not have a meltdown as he does. He was fine in gr R, it started in the middle of grade 1 after lockdown.	OCD, emotionally immature. Line 2
Ingrid du Plessis:	Who was his teacher in gr R?	
Mother:	***she was a lovely teacher, they moved overseas, but I still have contact with her. Grade one was also lovely, he had a wonderful teacher. And this year *** they all have been great! In grade R we did not have the anxiety so much, grade 1 with covid.	
Ingrid du Plessis:	How did he handle covid?	
Mother:	2020, was a disastrous year! He started gr 1 really well, he is a very shy and insecure little boy. Nervous of change, hates change. Gr 1 was a big year for him, new uniform and everything. He was fine, absolutely well, he did well. In the beginning of March even before lockdown, I started noticing that he had bad ticks. I had a meeting with his teacher and asked her if she think that his anxiety causes the ticks. When he got home, he had these ticks. Doesn't like being shouted at. His very	Gr 1 disaster! Line 20. Started with ticks. Lockdown happen, worsen the anxiety. Line 37

Annexure B: Official Documentation

Annexure B-1

Ethical Clearance Certificate

FACULTY OF EDUCATION
Ethics Committee

RESEARCH ETHICS COMMITTEE

CLEARANCE CERTIFICATE	CLEARANCE NUMBER: **EDU207/20**
DEGREE AND PROJECT	PhD Exploring how the subjective wellbeing of young, traumatized children with anxiety can be supported
INVESTIGATOR	Mrs Ingrid du Plessis
DEPARTMENT	Educational Psychology
APPROVAL TO COMMENCE STUDY	18 December 2020
DATE OF CLEARANCE CERTIFICATE	02 May 2023
CHAIRPERSON OF ETHICS COMMITTEE:	Prof Funke Omidire

Mr Simon Jiane
Prof Irma Eloff

This Ethics Clearance Certificate should be read in conjunction with the Integrated Declaration Form (D08) which specifies details regarding:

- Compliance with approved research protocol,
- No significant changes,
- Informed consent/assent,
- Adverse experience or undue risk,
- Registered title, and
- Data storage requirements.

Fakulteit Opvoedkunde
Lefapha la Thuto

Annexure B-2

Example of an Informed Consent Form (Child Participant)

Dear Parent(S)

Your child is invited to participate in a study. The following information regarding the study is provided so that you can decide if you would like your child to take part. You must be aware that your child's participation is voluntary and that he/she may withdraw from the study at any time.

The study is being undertaken by Ingrid du Plessis. I am currently busy with my PhD Educational Psychology at the University of Pretoria. My supervisor for the study is Prof. Irma Eloff, at the University of Pretoria. The purpose of my study is to explore how the subjective wellbeing of traumatized children with anxiety can be supported.

This research process includes an assessment and intervention program through informal play, art activities and intervention strategies during weekly visits with your child at school. Observation of the child at their school environment will also be part of the study as well as interviews with the teachers and the parents of the child involved. In the case of 'Lockdown" procedures, the study may be extended on an online environment. This will only occur in extreme circumstances.

All activities that your child participate in, will remain confidential, as well as anonymous. No human rights may be violated during the study. All data and confidential documents will be protected using password-protection. At the end of the study I undertake to discuss the initial findings with all participants.

We also would like to request your permission to use the data, confidentially and anonymously, for further research purposes, as the data sets are the intellectual property of the University of Pretoria. Further research may include secondary data analysis and using the data for teaching purposes. The confidentiality and privacy applicable to this study will be binding on future research studies.

If you have any queries, before, during or after the study, you are welcome to contact me or Prof. Eloff.

Thank you in advance

Ingrid du Plessis

083 758 1266

Professor Irma Eloff

(012) 420 3513

Annexure B-3

Informed Consent Form for Parents

Dear Parent(s)

You are invited to participate in a study. The following information regarding the study is provided so that you can decide whether you would like to take part. You must be aware that your participation is voluntary and that you may withdraw from the study at any time.

The study is being undertaken by Ingrid du Plessis. I am currently busy with my PhD in Educational Psychology at the University of Pretoria. My supervisor for the study is Prof. Irma Eloff at the University of Pretoria. The purpose of my study is to explore how the subjective wellbeing of traumatized children with anxiety can be supported.

This research process includes an assessment and intervention program through informal play, art activities and intervention strategies during weekly visits with your child at school. Observation of the child at their school environment will also be part of the study as well as interviews with the teachers and the parents of the child involved. In the case of 'Lockdown" procedures, the study may be extended on an online environment. This will only occur in extreme circumstances.

All activities that you participate in, will remain confidential, as well as anonymous. No human rights may be violated during the study. All data and confidential documents will be protected using password-protection. At the end of the study I undertake to discuss the initial findings with all participants. I would also appreciate your input, before the findings are finalised.

We also would like to request your permission to use the data, confidentially and anonymously, for further research purposes, as the data sets are the intellectual property of the University of Pretoria. Further research may include secondary data analysis and using the data for teaching purposes. The confidentiality and privacy applicable to this study will be binding on future research studies.

If you have any queries, before, during or after the study, you are welcome to contact me or Prof. Eloff.

Thank you in advance.

Ingrid du Plessis

083 758 1266

Professor Irma Eloff.

(012) 420 3513

Annexure B-4

Letter of Informed Assent to a Minor Child

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Education

LETTER OF INFORMED ASSENT TO A MINOR CHILD

A research project of the University of Pretoria

To explore how the subjective wellbeing of traumatized children with anxiety can be supported.

To be read to children under the age of 18 years

Wat maak ons hier?

Partykeer wil mense sekere dinge uitvind. Dit word 'n projek genoem. Om dit te kan doen het hulle sekere mense of kinders nodig om hulle te help. Ek is besig met 'n projek en wil vir julle vra of julle my wil help en wil deelneem aan hierdie projek. As julle besluit om deel te neem aan hierdie projek, gaan ons lekker saam gesels, ons gaan speletjies speel en 'n hele dagboek maak vir elkeen waarin on salles gaan bêre wat ons gemaak het sodat julle weer daarna kan kyk en kan gebruik. Hierdie projek gaan oor kinders soos julle wat van Graad R tot in Graad 7 is. Ons gaan gesels oor wat julle angstig maak en wat ons saam kan doen om julle beter te laat voel. Daarom gaan ons lekker saam gesels, speel en baie van mekaar leer.

Ek gaan ook vir julle juffrouens en vir mamma en pappa vra om ons ook te help met die projek. Ek wil ook vir julle sekere dinge leer wat julle gaan gebruik wanneer julle bang of angstig voel. En om sekere situasies beter te hanteer. Mamma en pappa het gesê julle mag deelneem aan die projek, nou moet julle net besluit of julle wil deelneem of nie?

Wat gaan met ons gebeur?

As julle gaan besluit om deel te neem aan hierdie projek, gaan ek een dag, elke week skool toe kom en dan met julle in my terapiekamer werk. Ons gaan gesels, kunsaktiwiteite doen en speel. Ek gaan ook nou en dan skool toe gaan en gaan kyk wat julle in julle klaskamers doen. Ek gaan ook met julle juffrouens en met mamma en pappa gesels. Indien ons moontlik weer in 'n grendeltydperk ingaan, sal ek moontlik aanlyn sessies met julle moet doen. Met ander woorde, dan gesels en werk ons op die rekenaar met mekaar. Dit sal net gebeur indien die grendeltyd vir 'n lang tydperk voortduur. In hierdie projek gaan daar nie regte of verkeerde antwoorde wees nie. Alles wat julle gaan doen en vir my gaan vertel gaan reg wees. Net soos wat julle pappa n gereedskapsboks het waarin hy alles bêre om dinge by die huis reg te maak, gaan ons saam vir

julle 'n gereedskapsboks maak wat vir julle kan help om beter te voel wanneer julle onseker, bang of angstig is.

Die ander kinders by die skool gaan nie weet dat julle my help nie. Ek gaan nie vir hulle van julle vertel nie. Ek gaan ook niks vir julle juffrouens of maats vertel wat julle vir my vertel nie. As julle sê ek mag, dan gaan ek elke keer as ons gesels dit op video neem sodat ek weer daarna kan kyk en luister. Ek wil ook by julle hoor of ek mag fotos neem oor alles wat ons gaan maak. Ek gaan ook vir niemand die videoopnames wys nie. En ek gaan ook vir niemand sê wat julle name is nie.

Gaan ons seerkry?

Nee, glad nie. As julle moeg raak terwyl ons besig is, dan sê julle net vir my julle is moeg dan rus ons 'n bietjie, of dan kom ek op 'n ander dag weer terug as julle weer lus het om aan te gaan. Julle hoef ook nie al die vrae wat ek vir julle gaan vra te beantwoord nie, net die wat julle wil antwoord. As ons iets gaan speel en julle wil nie aan die speletjie deelneem nie, dan sê julle net vir my dan hoef julle nie daaraan deel te neem nie. Ek gaan nooit kwaad raak vir julle as julle nie aan iets wil deelneem nie. Ek gaan ook nie met julle raas nie.

Gaan hierdie projek vir ons help?

Ek hoop dat hierdie projek vir julle sal help om beter te voel. Ek hoop dat dit wat ek julle gaan leer en wys vir julle sal help wanneer julle dit nodig het. Ek hoop ook dat die projek vir julle sal help om julleself te help in minder lekker dae en in situasies wanneer julle dit nodig het.

Wat as ons vrae het?

Julle mag enige tyd vir my vrae vra oor die projek. As julle nie nou aan enige vrae kan dink wat julle wil vra nie, kan julle my later bel by 083 758 1266 of vir die tannie wat vir my help. Haar naam is Professor Irma Eloff en haar nommer is 012 420 3513. Julle kan ook vir my julle vragies vrae as julle my weer sien of julle kan vir mamma en pappa vra om vir my te vrae as julle nie self wil nie.

Weet ons ouers van hierdie projek?

Ja, ek het al vir mamma en pappa vertel van hierdie projek en vir hulle verduidelik wat ons gaan doen as julle besluit om ook deel te neem. Julle hoef nie nou dadelik te besluit of julle wil deelneem nie. As ek huis toe gaan kan julle eers met mamma en pappa gesels daaroor en later vir my sê.

Moet ons deelneem?

Nee, julle hoef nie. Niemand sal kwaad wees vir julle as julle nie wil deelneem nie. Julle moet sê of julle wil deel wees of nie. As julle nou ja sê en later besluit maar eintlik wil julle nie, dan mag julle ophou. Dit is julle besluit.

a) As julle julle name op hierdie papier skryf, dan beteken dit dat julle ja sê om deel te neem aan hierdie projek end at julle weet waaroor hierdie projek gaan en wat met julle gaan gebeur. As julle later wil ophou, dan moet julle net vir my sê dan hou ons dadelik op.

Hantekening van leerder_____ Datum_____
Hantekening van navorser_____ Datum_____

b) As julle nou weer julle name hier gaan skryf, beteken dit dat julle ja sê dat ek ons gesprekke op video mag neem asook fotos mag neem van die werk wat ons gaan doen. Ek gaan nie julle name vir enige iemand gee nie. as julle nie wil hê ek mag ons gesprekke op video neem of fotos neem nie, dan moet julle vir my sê dan doen ek dit nie.

Hantekening van leerder_____ Datum_____
Hantekening van navorser_____ Datum_____

As julle enige verdere vrae oor hierdie projek het dan kan julle vir my skakel by 083 758 1266 of vir Prof Irma Eloff by 012 420 3513. As julle enige verdere vrae het oor wat jou regte as deelnemer is dan kan julle die Etiese Kommitee van die Universiteit van Pretoria se Opvoedkunde Fakulteit skakel by 012 420 5656.

Baie dankie

Ingrid du Plessis

Annexure B-5:

Informed consent form for the teachers

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Education

INFORMED CONSENT FORM FOR TEACHERS

Dear teacher,

You are invited to participate in a study. The following information regarding the study is provided so that you can decide whether you would like to take part. You must be aware that your participation is voluntary and that you may withdraw from the study at any time.

The study is being undertaken by Ingrid du Plessis. I am currently busy with my PhD in Educational Psychology at the University of Pretoria. My supervisor for the study is Prof. Irma Eloff at the University of Pretoria. The purpose of my study is to explore how the subjective wellbeing of traumatized children with anxiety can be supported.

This research process includes an assessment and intervention program through informal play, art activities and intervention strategies during weekly visits with the participating children at school. Observation of the child at his/her school environment will also be part of the study as well as interviews with the teachers and the parents of the children involved. All activities that the teachers and parents participate in, will remain confidential, as well as anonymous. No human rights may be violated during the study. All data and confidential documents will be protected using password-protection. At the end of the study I undertake to discuss the initial findings with all participants. I would also appreciate your input, before the findings are finalised.

We also would like to request your permission to use the data, confidentially and anonymously, for further research purposes, as the data sets are the intellectual property of the University of Pretoria. Further research may include secondary data analysis and using the data for teaching purposes. The confidentiality and privacy applicable to this study will be binding on future research studies.

If you have any queries, before, during or after the study, you are welcome to contact me or Prof. Eloff.

Thank you in advance.

Ingrid du Plessis
083 758 1266

Prof Irma Eloff
(012) 420 3513

Annexure B-6: Consent Letter from Gauteng Department of Education.

GAUTENG PROVINCE
REPUBLIC OF SOUTH AFRICA

8/4/4/1/2

GDE RESEARCH APPROVAL LETTER

Date:	04 November 2020
Validity of Research Approval:	08 February 2021– 30 September 2021 2019/667
Name of Researcher:	Du Plessis I
Address of Researcher:	495 Eagle Creed
	Drive, Eagle Canyon
	Honeydew Manor
Telephone Number:	083 758 1266
Email address:	ingrid@netcad.co.za
Research Topic:	Exploring how the subjective wellbeing of young traumatised children with anxiety can be supported
Type of qualification	PhD Educational Psychology
Number and type of schools:	1 Primary School
District/s/HO	Johannesburg North

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:

1. 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.

Making education a societal priority

Office of the Director: Education Research and Knowledge Management
7th Floor, 17 Simmonds Street, Johannesburg, 2001
Tel: (011) 355 0488
Email: Faith.Tshabalala@gauteng.gov.za
Website: www.education.gpg.gov.za

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. **Because of COVID 19 pandemic researchers can ONLY collect data online, telephonically or may make arrangements for Zoom with the school Principal. Requests for such arrangements should be submitted to the GDE Education Research and Knowledge Management directorate. The approval letter will then indicate the type of arrangements that have been made with the school.**
4. **The Researchers are advised to make arrangements with the schools via Fax, email or telephonically with the Principal.**
5. 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.
6. A letter / document that outline 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.
7. 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.
8. 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.
9. 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.
10. 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.
11. It is the researcher's responsibility to obtain written parental consent of all learners that are expected to participate in the study.
12. 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.
13. 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.
14. 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.
15. 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.
16. 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

Mr Gumani Mukatuni
Acting CES: Education Research and Knowledge Management

DATE: 09/11/2020

Making education a societal priority

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