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The effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood

by

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DECLARATION OF ORIGINALITY

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ABSTRACT

The effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood

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The prevalence and impact of childhood trauma is so extensive that it has come to be known as a silent epidemic. Trauma affects children's social, biological, psychological, and emotional functioning, which impede their ability for healthy self-regulation. Conventional therapies seem to have limited success in addressing the long-term consequences of trauma, arguably due to a lack of understanding the neurobiological impact of trauma and its effect on therapy with traumatised children. Researchers therefore recommend that therapists in the field of child welfare review the way they work with traumatised children, taking into consideration the neurobiological principles informing trauma interventions.

The goal of this research study was to explore the effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood. As this study aimed to explore more efficient ways of working with traumatised children, applied research was conducted. A mixed methods research approach was utilised in order to combine the advantages of qualitative inquiry and quantitative evaluation. The researcher incorporated a triangulation mixed methods design, combining the single-system design and the phenomenological design at the same time and with equal weight. Data was collected at three consecutive points in the research process to determine the prevalence of trauma-related symptoms and how it changed over time. All three data-collection encounters entailed structured and semi-structured interviews, for which a questionnaire and interview schedule was used respectively. By means of purposive sampling, the researcher with the assistance of social workers from the children's home, selected five participants between nine and 11 years, who presented with trauma-related symptoms, who have been residents of a children's home for more than six months, and who were not involved in any other form of therapy at the time of the research.

The findings of the study were in accordance with literature on the impact of trauma, especially on children in middle childhood, and furthermore correlated with a Gestalt perspective of how trauma affects children. Trauma-related symptoms the participants experienced reflected affect- and behaviour dysregulation, alterations in attention and consciousness, distortions in attribution and worldview, and interpersonal difficulties. Though the participants' responses to trauma, as well as to Gestalt play therapy, varied; improvement was noted in the overall prevalence of symptoms associated with trauma after implementation of the Gestalt play therapy process. In this regard, the research findings indicated a statistically significant improvement in the total prevalence of trauma-related symptoms the participants experienced before being exposed to Gestalt play therapy, as was confirmed by the qualitative findings.

It was concluded that Gestalt play therapy incorporates suggestions for trauma-informed interventions with traumatised children, and with its strong sensory base and utilisation of non-verbal and creative techniques, was an appropriate therapeutic intervention for addressing trauma-related symptoms in children in middle childhood. Based on these conclusions, it is recommended that professionals who work with traumatised children consider trauma-informed practices in the restoration of self-regulation through non-verbal and creative measures in the context of a safe and accepting relationship. As this research involved a small and limited study sample, further research that could add to the transferability of the findings is advised.

Key concepts

- Trauma
- Complex trauma
- Trauma-related symptoms
- Neurobiology
- Self-regulation
- Gestalt play therapy
- Middle childhood

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CHAPTER 1
GENERAL INTRODUCTION TO THE RESEARCH STUDY

1.1 INTRODUCTION

Worldwide, childhood exposure to trauma causes concern due to the high prevalence of trauma exposure as well as the harmful long-term consequences of trauma on children's lives (Coates, 2010:391-392; D'Andrea, Ford, Stolbach, Spinazzola & Van der Kolk, 2012:187; Hamber, 2000:5; Hawley, 2000:5; Louw, Duncan, Richter & Louw, 2007:379; Wasserman, 2005:2; Zilberstein, 2014:296). Trauma refers to events that are emotionally painful, distressing or shocking, and often have lasting mental or physical effects, or causes feelings of helplessness, vulnerability and loss of control for the person (Goldman, 2009:14; Goodyear-Brown, 2010:24; Louw et al., 2007:379). Trauma comes in various forms and traumatic events may be persisting experiences such as child abuse or isolated, short-lived events such as natural disasters (Campbell, 2009:18; Delima & Vimpani, 2011:43; Goldman, 2009:14; Perry, Pollard, Blakley, Baker & Vigilante, 1995:272). What constitutes as a traumatic event differs for each individual (Goodyear-Brown, 2010:23; Le Bel, Champagne, Stromberg & Coyle, 2010:1; Wasserman, 2005:2), but for children these events can include physical or sexual abuse, neglect, domestic violence, bullying, natural disasters, and medical interventions (Perry, 2003:2).

In South Africa, children seem to be at high risk of trauma exposure as the country has been described as having the highest prevalence of violence in the world (Norman, Schneider, Bradshaw, Jewkes, Abrahams, Matzopoulos & Vos, 2010:1), consequently causing a high risk of violence against children (DSD, DWCPD & UNICEF, 2012:3). Of concern is that violence seems to be maintained and carried over from one generation to the next, mostly within the family system where the child's primary attachment figures are also the source of the trauma to the child (DSD et al., 2012:9; Streeck-Fisher & Van der Kolk, 2000:904; Van der Kolk, 2005:402). As such, it heightens children's risk of trauma exposure and their vulnerability to trauma (DSD et al., 2012:9).

The potential consequences of traumatic events are far reaching (Campbell, 2009:18), and exposure to such events can have a profound impact on the emotional, behavioural, cognitive, social, and physical functioning of children (Child Welfare Information Gateway, 2008:2; Coates, 2010:391-392; D'Andrea et al., 2012:187; Ford & Courtois, 2013:x; Hawley, 2000:5; Zelechoski, Sharma, Beserra, Miguel, DeMarco & Spinazzola, 2013:641-642; Zilberstein, 2014:296).

Many children may develop Post-Traumatic Stress Disorder (PTSD) in response to trauma, causing severe disruptions in normal functioning (Goldman, 2009:14). The criteria for PTSD in children are outlined in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychiatric Association, 2013). However, in the past various authors argued that children do not necessarily respond to trauma in a way that matches DSM criteria for PTSD as symptoms of PTSD in chronically traumatised children tend to be masked by cognitive, social, affective and physical problems (Briere & Spinazzola, 2005:402-403; Cook, Spinazzola, Ford, Lanktree, Blaustein, Sprague, Cloitre, DeRosa, Hubbard, Kagan, Liautaud, Mallah, Olafson & Van der Kolk, 2005:391; Foltz, Dang, Daniels, Doyle, McFee & Quisenberry, 2013:12; Goodyear-Brown, 2010:45; Van der Kolk, 2005:406; Zelechoski et al., 2013:641-642).

D'Andrea et al. (2012:189-191) attempted to structure the wide range of symptoms associated with childhood trauma by clustering these symptoms into four broad categories. The categories refer to symptoms that relate to dysregulation of affect and behaviour; alterations in attention and consciousness; distortions in attribution; and interpersonal difficulties.

The inability for emotional self-regulation, or dysregulation of affect, is probably the most prominent consequence of trauma for severely traumatised children (Streeck-Fisher & Van der Kolk, 2000:903, 905; Van der Kolk, 2005:402, 406). A variety of emotional symptoms are commonly found in children exposed to trauma, including emotional lability, numbed affect, anger outbursts, mood disturbances, anxiety, and the inability to understand, express or regulate emotions (Briere & Spinazzola, 2005:402-403; D'Andrea et al., 2012:189; Goldman, 2009:14; Van der Kolk, 2006:5).

The inability to regulate emotions might also manifest in behaviours such as self-injury, aggression, oppositional behaviour, substance use, compulsive sexual behaviour, sleep problems, inability to concentrate, and psychosomatic problems (Briere & Spinazzola, 2005:402-403; Goldman, 2009:14; Goodyear-Brown, 2010:38-40; Perry, 2003:3; Streeck-Fisher & Van der Kolk, 2000:905; Van der Kolk, 2005:407). These behavioural symptoms are often associated with hyperarousal, which refers to a constant state of hypervigilance, where the brain responds to threat even though no threat might be present, causing the child to be anxious and reactive (Perry, 2003:4; Wasserman, 2005:7; Weber & Reynolds, 2004:119).

The category of trauma symptoms that are indicative of alterations in attention and consciousness include symptoms such as dissociation, depersonalisation, memory disturbance, concentration problems, and poor or disrupted executive functioning (D'Andrea et al., 2012:189). Dissociation can be described as alterations in conscious awareness and may mask as inattention, often leading to an inaccurate diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) in children (D'Andrea et al., 2012:189-190; Briere & Spinazzola, 2005:402-403; Goodyear-Brown, 2010:45). According to Streeck-Fisher and Van der Kolk (2000:905), alterations in attention and consciousness might explain why traumatised children tend to struggle with learning and school work.

Traumatised children often have distorted attributions and worldviews, which may cause them to experience pessimism, shame and guilt, a distorted locus of control, and poor self-esteem (D'Andrea et al., 2012:190). Distorted attributions are associated with the identity problems, problems with self-definition, disturbances of body-image, self-blame, helplessness, hopelessness, expectations of rejection and loss, over-estimation of danger, negative self-perception, self-hatred and fears of abandonment that are often noted in traumatised children (Briere & Spinazzola, 2005:402-403; Goldman, 2009:15; Streeck-Fisher & Van der Kolk, 2000:905). D'Andrea et al. (2012:190) point out that as a result of these distorted attributions, traumatised children might furthermore struggle to distinguish between taking responsibility for their own behaviour versus taking responsibility for the behaviours of others.

Children who have been exposed to trauma furthermore often lack interpersonal competencies and tend to experience interpersonal difficulties such as distrust in others, expecting harm from others, diminished social skills, social isolation, poor perspective-taking abilities, poor boundaries, and interpersonal conflict (D'Andrea et al., 2012:190). These difficulties are often related to insecure or disrupted attachment styles found in many traumatised children (D'Andrea et al., 2012:190; Goldman, 2009:15; Zilberstein, 2014:296). The general inability of traumatised children to regulate emotions contributes to poor social skills and conflicted relationships, and as a result these children often lack reliable friends (D'Andrea et al., 2012:190; Van der Kolk, 2006:5).

The way in which children respond to trauma is influenced by their age. Children in middle childhood, the relevant age-group in this study, may respond to trauma with specific age-related emotions and behaviours. They might exhibit regressive behaviours such as bedwetting, thumb sucking, clingy behaviour as well as fear of the dark, strangers or monsters (Kaduson & Schaefer, 2006:6-7). The authors furthermore state that aggressive or

disruptive behaviour, sleep disorders (especially nightmares), exaggerated responses to minor triggers, and psychosomatic symptoms are often a behavioural manifestation of trauma in children in middle childhood. Traumatised children in this developmental phase might withdraw from social interaction, and display poor attention, poor school performance, loss of interest in activities, and distractible or 'spacing out' behaviours (Campbell, 2009:18; Kaduson & Schaefer, 2006:6-7; Louw et al., 2007:379).

The above developmental and behavioural problems experienced by traumatised children can be ascribed to an array of neurobiological effects related to trauma (Delima & Vimpani, 2011:42; Perry, 2006a:21; Teicher, 2000:53; Van der Kolk, 2005:402; Wasserman, 2005:16). It is therefore advised that professionals working with traumatised children take note of emergent findings indicating the effect that trauma has on the structure and functioning of the brain, and how it impacts on behaviour (Campbell, 2009:19; Zilberstein, 2014:294, 300).

The brain functions in a use-dependent fashion, implying that the more a neural pathway (a neural tract connecting one part of the nervous system with another) is used, the more that pathway and its related functions will be strengthened (Wasserman, 2005:24; Zilberstein, 2014:293). Wasserman (2005:24) concludes that as a result of the use-dependent nature of brain development, the brain's neural pathways can become highly sensitised when over-used. Although the use-dependent nature of learning enables humans to survive, it is also the reason why trauma can alter the neural pathways in the brain (Perry et al., 1995:273; Zilberstein, 2014:293). Different parts in the brain, in broad categories the brainstem, limbic system and cerebral cortex, control different functions and are affected by trauma in different ways (Coates, 2010:394-396; Henderson & Thompson, 2011:30; Perry et al., 1995:273).

The brainstem controls the basic functions for survival, such as breathing and heart rate, as well as regulating emotions and the stress response which is made possible by, amongst others, the neuro-endocrine system (Coates, 2010:393; Campbell, 2009:18; Henderson & Thompson, 2011:30; Perry et al., 1995:272; Wasserman, 2005:5). Trauma might cause neuro-endocrine dysregulation, leading to an inability to obtain homeostasis through self-regulation of basic survival functions (Coates, 2010:394; Goodyear-Brown, 2010:27-29; Rosenzweig, 2015:8; Van der Kolk, 2003:303).

The limbic system, often referred to as 'the emotional brain', is responsible for attachment, affect regulation and aspects of emotion (Coates, 2010:395; Perry et al., 1995:272; Wasserman, 2005:5). Childhood trauma can cause limbic system dysfunction and neurobiological changes in the structures of the limbic system, namely the amygdala and

hippocampus (Coates, 2010:395-396; Van der Kolk, 2003:304-305). The amygdala controls the release of hormones associated with the fight or flight response (Campbell, 2009:18; Coates, 2010:395; Rothschild, 2001:20; Van der Kolk, 2003:304). A perception of danger causes a state known as hypervigilance, during which a person's senses are sharpened in order to evaluate the environment for cues related to the danger (Perry et al., 1995:273). Necessary as this is for survival, traumatic experiences may cause over-activation of the amygdala, which results in a state of chronic elevated arousal (Goodyear-Brown, 2010:28; Wasserman, 2005:7, 10; Zilberstein, 2014:294). The hippocampus, the other structure in the limbic system, should be able to process a situation for what it is in reality and stop the fight or flight reaction of the amygdala; however it can become dysfunctional when stress hormones are in excess as a result of an overreacting amygdala (Rosenzweig, 2015:8; Rothschild, 2001:20; Zilberstein, 2014:297). This response might explain a symptom often seen in traumatised children, namely hyperarousal. Children who experience hyperarousal may have trouble sleeping and controlling their memories of the trauma. They further seem to be on constant alert, may exhibit motor hyperactivity and behaviour impulsivity, and experience anxiety, elevated heart rate and shortness of breath. Hyperaroused children may have difficulty learning and paying attention, struggle to maintain positive relationships, and tend to avoid novel situations (Hawley, 2000:6; Perry, Pollard, Blakley, Baker & Vigilante, 1996:5; Van der Kolk, 2006:5; Streeck-Fischer & Van der Kolk, 2000:905; Weber & Reynolds, 2004:119).

The cerebral cortex is the brain centre where incoming information is processed and analysed in order to determine appropriate reactions, and is responsible for rational, logical thought processes, abstract cognition and language (Coates, 2010:396; Henderson & Thompson, 2011:30; Perry et al., 1995:272; Van der Kolk, 2003:307; Wasserman, 2005:5; Weber & Reynolds, 2004:18). However, due to sensitised neurobiological responses to threat, as discussed above, the traumatised individual is often not able to reason about a situation of perceived threat as the prefrontal cortex cannot be accessed in a state of hyperarousal (Campbell, 2009:19; Coates, 2010:395; Rothschild, 2001:17; Van der Kolk, 2003:307). Decreased cortical activity is prevalent especially in Broca's area, which is the expressive speech centre in the brain, causing a reduction in the traumatised child's ability to process language and regulate emotions (Coates, 2010:396; Van der Kolk, 2003:308).

Another brain structure, the corpus callosum that is responsible for integration between the left- and the right hemispheres of the cerebral cortex, was found to be noticeably smaller in traumatised compared to non-traumatised individuals (Henderson & Thompson, 2011:30; Van der Kolk, 2003:309; Weber & Reynolds, 2004:18). The smaller corpus callosum leads to

less integration of the brain hemispheres, dramatic shifts in mood, and problems with attention and memory (Coates, 2010:397; Van der Kolk, 2006:2, 4; Weber & Reynolds, 2004:8).

As evident as it is that trauma can severely affect the well-being of children, it should be emphasised that each child's response to trauma is unique (Wasserman, 2005:2). A number of factors such as age, gender, the nature and duration of the trauma, and the presence of a support system, seem to moderate and influence the individual's unique response to trauma and the impact of trauma (Child Welfare Information Gateway, 2008:3; Louw et al., 2007:381; Perry, 1997:126; Van der Kolk, 2003:293; Wasserman, 2005:14; De Young, Kenardy & Cobham, 2011:241-242). Louw et al. (2007:380) point out that "... not all children will necessarily develop negatively from adversity and traumatic incidents in their lives [and that] some children show remarkable resilience and even optimal development in the face of adversity." Researchers relate resilience in children to advantageous personal, family and community factors (Coates, 2010:391; Cook, Spinnazola, Ford, Lanktree, Blaustein, Cloitre, DeRosa, Hubbard, Kagan, Liautaud, Mallah, Olafson & Van der Kolk, 2007:7; Louw et al., 2007:381).

Nevertheless, trauma could have detrimental effects on a person's life, and professionals in the field of child welfare need to explore effective means for trauma intervention (LaLiberte, Crudo, Gewirtz & Bray, 2013:2). Although various treatment[1] initiatives to address trauma exist, the success of interventions with severely traumatised children are often limited (Gaskill & Perry, 2014:185; Le Bel et al., 2010:2). It was therefore suggested that integrating a neurobiological understanding of therapeutic interventions with traumatised children might enhance positive therapeutic outcomes (Perry, 2003:2; Van der Kolk, 2003:309).

The limitations of conventional therapies firstly include that these therapies emphasise verbalisation and problem-solving that are regulated by cortical brain functions, while the functions of the cortex (language, reasoning and logic) are inaccessible in a constant state of hyperarousal often experienced by traumatised individuals (Baloyi, 2006:17; Gaskill & Perry, 2014:185; Le Bel et al., 2010:2; Van der Kolk, 2006:5-6; Van der Kolk, 2003:309). Secondly, conventional therapies seem unable to activate the lower brain areas that have been affected by trauma, as these areas are unresponsive to language, insight or logic used in verbally-based therapies (Gaskill & Perry, 2014:184-185; Van der Kolk, 2006:5; Zilberstein, 2014:302). Perry (2006a:22) states that "in order to heal (i.e. alter or modify trauma)

[1] The terms *treatment*, *intervention* and *therapy* are referred to interchangeably throughout the research report.

therapeutic interventions must activate those portions of the brain that have been altered by the trauma." Thirdly, retraumatisation is often experienced by traumatised children as almost every situation is perceived as threatening and unsafe (Goldman, 2009:15; Zilberstein, 2014:301). Therefore, traumatised children need interventions to help them contain reactions to triggers and to halt trauma reactions (Rothschild, 2001:22, Van der Kolk, 2003:310; Zelechoski et al., 2013:644).

It is thus advised that conventional therapies be re-examined and expanded as therapists[2] gain appreciation for neurobiological principles related to trauma intervention (Campbell, 2009:19; Gaskill & Perry, 2014:185-186; Perry, 2006a:22). Suggestions for trauma interventions centre on three basic principles, which include establishing safety and competence (Van der Kolk, 2005:407; Wasserman, 2005:18; Zilberstein, 2014:301), dealing with trauma re-enactment (Campbell, 2009:20; Van der Kolk, 2006:5; Zelechoski et al., 2013:644), and fostering integration and self-regulation (Streeck-Fisher & Van der Kolk, 2000:913-915; Van der Kolk, 2006:13; Zilberstein, 2014:302). In effect, researchers suggest that therapy move away from the rational, cognitive and verbal processes involved in conventional therapies, towards the use of metaphor, creative activities, and sensory awareness activities (Campbell, 2009:19; Gaskill & Perry, 2014:186; Van der Kolk, 2006:5).

Gestalt therapy, classified as an experiential (or experience-based) approach to psychotherapy (Fall, Holden & Marquis, 2010:202-203), encompasses a number of aspects which could be relevant to the suggestions for therapeutic intervention with traumatised children, as indicated above. Gestalt play therapy firstly prioritises the provision of a safe and accepting therapeutic environment (Blom, 2006:19, 54; Henderson & Thompson, 2011:227; Oaklander, 2011:172). Furthermore, Gestalt play therapy places an emphasis on non-linear thought and has a strong focus on non-verbal expression through creative techniques, metaphor, fantasy and body movement (Blom, 2006:17). Thirdly, Gestalt play therapy includes specific steps to address sensory and emotional awareness (Blom, 2006:90-102, 123; Oaklander, 2006:24-27, 39), which could enhance self-regulation skills that have been negatively affected by trauma (Streeck-Fisher & Van der Kolk, 2000:913-915). Lastly, Gestalt play therapy also incorporates various strategies to avoid re-traumatisation.

Based on the above considerations, the researcher intended to explore the effect of Gestalt play therapy in addressing trauma-related symptoms in children in middle childhood. The following section outlines Gestalt theory as the theoretical approach applicable to this study.

[2] The terms *counsellor* and *therapist* are interchangeably referred to in literature, though for the purpose of this research the term *therapist* is utilised throughout.

1.2 THEORETICAL FRAMEWORK

The researcher utilised Gestalt theory as theoretical framework for the study. Ruben and Babbie (2008:57) view a theory as "a systematic set of interrelated statements intended to explain some aspects of social life or enrich our senses of how people conduct and find meaning in their daily lives." Key Gestalt theoretical principles are therefore highlighted and the Gestalt perspective of healthy and unhealthy functioning portrayed.

Gestalt therapy is considered "an existential, phenomenological and holistic approach" (Blom, 2006:19). Gestalt relates to the concept of holism, a key Gestalt philosophical underpinning that refers to the notion that the whole involves more than the combination of its distinct parts (Blom, 2006:18; Fall et al., 2010:205). Every person therefore needs to be perceived as a holistic entity within the self, thus the body, emotions, language, thoughts and behaviour, in relation to his or her environment (Blom, 2006:19, 22; Fall et al., 2010:205; Henderson & Thompson, 2011:221). Holism implies that a change in one part or aspect will have an impact on the total functioning of the individual.

Gestalt theory furthermore asserts that all human beings engage in a continuous process of self-regulation whereby the organism attempts to establish equilibrium in an ever-changing environment (Fall et al., 2010:204). Organismic self-regulation, another key theoretical concept of Gestalt theory, is the process whereby the individual can identify needs in the internal and external environment, and find ways to satisfy these needs (Blom, 2006:23; Oaklander, 2011:174). In order to acquire self-regulatory capacity the individual needs appropriate contact (Fall et al., 2010:207). As described by Yontef and Jacobs (2000) in Blom (2006:23), "[o]rganismic self regulation requires identifying with what one senses, feels emotionally, observes, needs or wants, and believes." Therefore, self-regulation necessitates proper awareness of and contact with the self and the environment in the present moment (here and now).

Healthy contact is regarded as the person's "ability to make contact with the environment by making use of their senses, awareness of and suitable use of their body, the ability to express emotions in a healthy manner and the use of their intellect" (Oaklander, 1999:22 in Blom, 2006:52). Awareness allows the person to come into contact with his or her needs and emotions and, for effective contact to take place, awareness on cognitive, sensory and affective levels, is required (Blom, 2006:52). Perls, the originator of Gestalt therapy (Geldard, Geldard & Yin Foo, 2013:39) referred to awareness as the ability to be in touch with the self,

noticing what is happening inside and around the self, and to know what one senses, feels or thinks and how one reacts in a specific moment (Blom, 2006:52-53). Promotion of awareness could thus ultimately support healthy self-regulation (Hardy, 1991 in Blom, 2006:19). Gestalt theory maintains that a healthy functioning person ultimately has the ability to integrate experiences and regain a state of balance in ever-changing circumstances (Blom, 2006:23).

Unhealthy functioning, on the other hand, is primarily seen as a lack of self-regulatory capacities due to lack of awareness and contact (Fall et al., 2010:207-208; Henderson & Thompson, 2011:224). Traumatised children often restrict contact and awareness in order to avoid pain. By restricting various aspects of the senses, body, emotion and intellect, the child's ability to engage in the natural, healthy process of organismic self-regulation, is affected (Blom, 2006:31; Oaklander, 1994:144). Traumatised children therefore struggle to integrate information and to respond appropriately to situations. Unhealthy contact often manifests in inappropriate behaviours that the child engages in as an attempt to cope; behaviours which in Gestalt vocabulary are referred to as contact boundary disturbances (Fall et al., 2010:208; Oaklander, 2011:190).

A Gestalt perspective of unhealthy functioning strongly correlates with one of the main consequences of trauma, namely the lack in ability to self-regulate. Trauma is regarded as a social, physical, cognitive, biological and psychological experience that affects a person's ability to self-regulate (Coates, 2010:393; Schore, 2001:205; Streeck-Fisher & Van der Kolk, 2000:903, 905; Van der Kolk, 2005:402, 406). The Gestalt perspective of holism similarly indicates that trauma that affects one aspect of the child's functioning (e.g. physical trauma) may affect other aspects of functioning, for example emotional, intellectual and behavioural aspects.

The aim of Gestalt therapy is therefore to facilitate healthy functioning by means of effective self-regulation, whereby an individual is enabled to identify and address needs as they arise in the present moment (Fall et al., 2010:207; Henderson & Thompson, 2011:222). This ability relies on enhancing awareness and contact in the here and now in an effort to restore integrated functioning of the senses, body, emotions and intellect. The Gestalt theoretical framework was therefore utilised to determine the way in which the findings of this study are understood.

The Gestalt theoretical framework also relates to the rationale and problem statement of the study. The rationale and problem statememt of the study are discussed in the following section.

1.3 RATIONALE AND PROBLEM STATEMENT

Millions of children across the world are exposed to traumatic experiences to such an extent that it has been referred to as a silent epidemic (D'Andrea et al., 2012:187; Perry, 2003:2; Van der Kolk, 2005:401). In South Africa children seem to be significantly exposed to trauma, as evident in the high incidence of crime, often against children (Baloyi, 2006:17; Bezuidenhout & Little, 2011:5; Hamber, 2000:5). It is estimated that about 50% of South African children are likely to experience some form of abuse before the age of 18 (TEARS Foundation, 2012).

Traumatic experiences could have detrimental psychological, physical, emotional and behavioural consequences for the person, mostly over the long term, which in children often result in dysfunctional behaviour patterns (Baloyi, 2006:17; Oaklander, 2011:190; Van der Kolk, 2005:402; Wasserman, 2005:2). Trauma may further contribute to health concerns and various mental health disorders (Child Welfare Information Gateway, 2008:2; Coates, 2010:391-392; Hawley, 2000:5). In essence, trauma causes difficulty for the individual to cope with everyday life (Perry, 2003:2; Van der Kolk, 2005:406).

As increasingly more children are exposed to violence and other traumatic events, the need to find more effective means to address the harmful consequences of trauma has escalated (Baloyi, 2006:18). Research indicates that a person's reactions to trauma has its roots in neurobiological changes that can permanently alter the structure and functioning of the brain (Campbell, 2009:18; Gaskill & Perry, 2014:183; Le Bel et al., 2010:2; Perry, 2006a:21-22; Van der Kolk, 2005:402). Verbal and cognitive-based approaches to therapy seem inadequate to restore self-regulation, as trauma leads to the suppression of the verbal and cortical functions in the brain (D'Andrea et al., 2012:193). Gaskill and Perry (2014:186) coherently explain that words, reasoning or ideas are not likely to integrate the disorganised sensations and primary regulatory networks in the lower areas of the brain that are affected by trauma. As conventional therapies seem not to have the longed for effect with severely traumatised children, it is suggested that therapeutic interventions should take into account the neurobiological principles of trauma and their influence on treatment (Campbell, 2009:19; Gaskill & Perry, 2014:185; Van der Kolk, 2006:8). Therefore, the mentioned authors suggest that treatment should have a greater focus on non-verbal, basic brain functions instead of primarily verbal, rational, problem-solving techniques.

As indicated in the introduction, Gestalt play therapy incorporates much of the above suggestions as part of the therapeutic process. A literature search through the University of Pretoria library and electronic journal platforms produced no results related to national or international studies that specifically explored the use of Gestalt play therapy to address trauma-related symptoms in children. The researcher takes note of the 'Neurosequential Model of Therapeutics' (Perry & Dobson, 2013:294; Perry, 2009:241; Perry, 2006b:27), as well as the 'Attachment, Self-regulation and Competency (ARC) Intervention model' (Arvidson, Kinniburgh, Howard, Spinazzola, Strothers, Evans, Andres, Cohen & Blaustein, 2011:34) as trauma-specific interventions for traumatised children. However, being trained in Gestalt play therapy and taking into account its experiential and non-verbal focus, the researcher wished to explore the effect that Gestalt play therapy might have in addressing the symptoms associated with trauma in children in middle childhood. The research was conducted with children in a children's home, which is a type of child and youth care centre[3]. These children can be regarded as most vulnerable to trauma (Campbell, 2009:18; Foltz et al., 2013:12; Zelechoski et al., 2013:639).

The research was guided by the following research question: What is the effect of Gestalt play therapy in addressing the symptoms associated with trauma in children in middle childhood?

1.4 GOAL AND OBJECTIVES

The goal of the study was to establish the effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood. The objectives formulated in order to reach this goal were:

- To conceptualise trauma and the impact of trauma on children, with specific reference to the role of neurobiological changes related to trauma and children in middle childhood;
- To quantitatively determine a baseline profile of trauma-related symptoms in participants before implementing Gestalt play therapy;
- To qualitatively explore participants' experiences of trauma-related symptoms before implementing Gestalt play therapy within the same time frame as the baseline profile;
- To conduct a series of 12 Gestalt play therapy sessions with participants;
- To quantitatively determine whether Gestalt play therapy had an impact on trauma-related symptoms in participants, and, within the same time frame, qualitatively explore how participants experienced possible changes in trauma-related symptoms;

[3] Child and youth care centres refer to institutions that provide alternative residential care for children, such as children's homes. The terms are therefore interchangeably referred to, depending on the context in which it is used.

- To make conclusions about the effectiveness of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood.

1.5 RESEARCH DESIGN AND METHODOLOGY

The researcher utilised a mixed methods research approach, combining quantitative and qualitative research in order to obtain rich findings and avoid errors and biases inherent in any single methodology (Delport & Fouché, 2011:434). Quantitative research involved an objective measurement of the participants' trauma symptoms, while qualitative research enabled the researcher to obtain a more in-depth understanding of their experiences. It was noted that, in research with children, the combination of more than one method provides for enhanced representation of children's behaviours (O'Reilly, Ronzoni & Dogra, 2013:171); an advantage which suited the aim of this study. The research study involved applied research, as it seeked to induce change in a practice situation (Fouché & De Vos, 2011:94-95), in this case to explore more effective ways to address trauma-related symptoms in children.

A triangulation mixed methods design, where both qualitative and quantitative methods are used at the same time and with equal weight (Delport & Fouché, 2011:442), was an applicable research design for this study. As the quantitative design for this study, a single-system design, namely the A-B design was utilised (Bradshaw, 2003:887; Strydom, 2011a:165). The single-system design is considered ideal for evaluating the effectiveness of a treatment intervention (Strydom, 2011a:160; Thyer, 2001:254), as was the case in this study. A phenomenological study was used as qualitative research design, as its aim to explore the lived experiences of individuals regarding a certain phenomenon (Fouché & Schurink, 2011:316), fitted with the goal of this study to determine trauma-related symptoms the participants experienced and how it changed throughout the research process.

As children placed in residential settings are regarded as amongst the most traumatised youth (Campbell, 2009:18; Foltz et al., 2013:12; Zelechoski et al., 2013:639-640) the research population constituted of residents of a children's home, who possess specific characteristics with which the research problem was concerned, namely children who experienced trauma (Strydom, 2011b:223). The study sample was selected from children residing in a children's home in Thswane (Strydom, 2011b:224). Purposive sampling was utilised (Strydom & Delport, 2011:392) whereby five participants who met the sampling criteria for the study were selected with the assistance of the social worker at a children's home in Thswane. The criteria involved that participants would be male or female, between the ages of nine and 11 years, who have resided in the identified children's home for more

than six months, who displayed specific symptoms associated with trauma in children in middle childhood, and who were not involved in any other therapy at the time of the research.

As required in a triangulation mixed methods design, both quantitative and qualitative data were collected within the same time frame (Delport & Fouché, 2011:441-442) and, as the single-system design dictates, at different intervals in order to determine whether changes in the trauma symptoms occurred due to the intervention (Strydom, 2011a:161). In this study quantitative and qualitative data were collected during the baseline phase to determine the prevalence of trauma-related symptoms and participants' experiences regarding these symptoms before the Gestalt play therapy intervention. Quantitative and qualitative data collection was repeated twice during the intervention phase: after six weeks and again after 12 weeks of the participants being exposed to Gestalt play therapy.

The same data collection metods and instruments were utilised for all three data collection intervals. For the quantitative data collection, structured interviews were conducted with the use of a self-constructed questionnaire. The questionnaire included an ordinal-level measurement (Delport & Roestenburg, 2011a:179) in which respondents could provide more specific information on the prevalence of trauma-related symptoms. In the development of the questionnaire, the researcher considered the requirements to ensure validity (accuracy) and reliability (consistency) (Babbie, 2013:191; Delport & Roestenburg, 2011a:173, 177). Another way of verifying reliability and validity of data collection, which applied to this study, involved the concept of triangulation by using different data collection methods (Ruben & Babbie, 2008:109), and considering measures from different domains, including observable behaviour, participants' reports of affect as well as physiological indicators (Thyer, 2001:240). In terms of qualitative data collection, the use of an interview schedule to conduct semi-structured one-to-one interviews allowed the researcher to obtain an understanding of the participants' experiences of trauma-related symptoms (Greeff, 2011:352). The researcher conducted the semi-structured interviews directly after completion of the structured interviews. The themes in the interview schedule were thus coherent with the items (trauma-related symptoms) in the questionnaire. During the semi-structured interviews the researcher explored only the symptoms that were indicated as being present during the structured interview, thus not every item in the questionnaire needed to be explored (Greeff, 2011:353). The interviews were voice-recorded with the assent of the children and consent of the director of the children's home, to capture data for accurate retrieval during data-analysis.

Based on the triangulation mixed methods design, quantitative data analysis and qualitative data analysis were dealt with separately (Delport & Fouché, 2011:447). For quantitative data analysis, the researcher made use of descriptive statistics (O'Reilly et al., 2013:193), which provided an indication of the frequency and thus the prevalence of trauma-related symptoms. Two non-parametric tests, namely the Wilcoxon signed-rank test and Friedman's ANOVA were utilised to further analyse quantitative data and provide inferential statistics (Field, 2013:552, 575; Maree & Pietersen, 2007:231, 237). As relevant to the single-system design, the research findings were presented visually by means of simple graphs or plotting, as plotting offers a graphic presentation of changes (improvements, deterioration or even no change) in the problem from baseline to termination of a treatment (Strydom, 2011a:162).

Qualitative data analysis involved reducing the data to communicate the significant patterns the data reveal (Schurink, Fouché & De Vos, 2011:397), for which Creswell's model (2007) of transforming data into findings was used (Schurink et al., 2011:403-404). Data were presented according to themes and sub-themes (Creswell, 2013:185,187), illustrated by direct quotes and supported with literature. Various strategies can be applied to ensure trustworthiness of qualitative findings, of which reflexivity, an audit trail, peer-debriefing and member checking were utilised in this study (Lietz, Langer & Furman, 2006:444, 447, 451, 453).

A pilot study, equally important in both quantitative and qualitative studies (Strydom & Delport, 2011:395), helped the researcher to identify potential problems with the research design and data collection instruments (Strydom, 2011c:236). The researcher pilot tested the questionnaire and interview schedule with two children from the population. The data from the pilot study was excluded from the actual study.

A more detailed description of the research methodology as well as a discussion on how ethical considerations were adhered to, will follow in Chapter 3.

1.6 KEY CONCEPTS

The key concepts of the study include Gestalt play therapy, trauma, trauma-related symptoms, as well as children in middle childhood.

Gestalt play therapy is defined as a process-oriented and humanist form of therapy, that uses the principles and techniques of Gestalt therapy, and includes experiences and exercises and the use of various creative activities to allow a child to express his or her

feelings verbally and non-verbally (Blom, 2006:17, 19-20; Thompson & Henderson, 2007:197). The aim of therapy is to help children to restore the ability to self-regulate, thus their natural functioning, by enhancing awareness and their ability to be in contact.

Trauma refers to events that involve threatened or actual death, injury or danger to a person, to his or her loved ones, or to persons closely associated with the individual. These events are either experienced or witnessed and lead to responses of intense fear, horror or helplessness. In children, trauma may manifest in disorganised or agitated behaviour (Hendricks & Fong, 2006:139). According to the American Psychiatric Association (2013), trauma refers to situations "when a person directly experiences the traumatic event; witnesses the traumatic event in person; learns that the traumatic event occurred to a close family member or close friend (with the actual or threatened death being either violent or accidental); or experiences first-hand repeated or extreme exposure to aversive details of the traumatic event."

Trauma-related symptoms are "specific sets of maladaptive emotional, behavioral, and cognitive problems of a ... child ... rooted in the original *adaptive* responses to a traumatic event. These symptoms may include hypervigilance, impulsivity, anxiety, affect regulation problems, sleep problems, and a host of other abnormalities related to dysfunctional stress response ..." (Perry, 2006b:36-37).

Children in middle childhood refer to children in the age group six or seven to 11 years of age (Papalia, Olds & Feldman, 2008:11; Louw & Louw, 2007:212). Physical development during this time slows down, although motor abilities generally improve. Cognitive development is rapid during this phase, during which children acquire better language and memory skills while their concrete, logic thinking abilities improve. In children in middle childhood, psychosocial development centres on identity formation and children's self-concept becomes more complex and is influenced greatly by peers (Papalia et al., 2008:11).

1.7 LIMITATIONS OF THE STUDY

The researcher identified the following limitations related to this study:

- As the sample size was small and the participants came from one children's home, the research findings cannot be generalised to the broader population.
- As the study involved children in middle childhood, the findings cannot be generalised to children in other age groups.

- The researcher acted both as researcher and therapist, which might account as a limitation in that it could influence objectivity. The researcher attempted to enhance objectivity by employing a mixed methods research design, in which the questionnaire allowed for more objective data collection, while certain measures were followed to enhance the trustworthiness of qualitative data
- The lack of involvement of the caregivers of the participants in the data-collection process is a further limitation of this study. To include caregivers' observations regarding the children's trauma-related symptoms might have added to transferability, as described by Schurink et al. (2011:420). However, the limited amount of time and resources available and the scope of the study, presented constraints to involve the caregivers as part of the data collection.

1.8 CONTENTS OF THE RESEARCH REPORT

Following is an outline of the contents of the research report:

Chapter one provided a general background to the study and included the rationale and problem statement, the goal and objectives of the study, and the theoretical framework of the study. A summary of the research methodology, the key concepts, as well as the limitations of the study were outlined.

Chapter two contains the literature review for the study, focusing on trauma, the neurobiological effects of trauma, and how it relates to symptoms of trauma in children, specifically in the middle childhood years.

Chapter three focuses on trauma-informed interventions, reviewing the limitations to conventional interventions, suggestions for trauma interventions, and Gestalt play therapy, the intervention relevant to this study.

Chapter four provides detailed information on the research methodology, the ethical considerations followed in the study, as well as the research findings of the study.

Chapter five concludes the research report. The researcher highlights the key findings of the study and provides conclusions and recommendations based on the findings of the study.

CHAPTER 2

TRAUMA AND THE IMPACT OF TRAUMA ON CHILDREN IN MIDDLE CHILDHOOD

2.1 INTRODUCTION

Worldwide, children are significantly exposed to traumatic experiences (Hamber, 2000:5). Trauma has various long-term consequences, which in children often manifest as so-called behaviour problems (Coates, 2010:391,392; Hawley, 2000:5; Louw et al., 2007:379; Wasserman, 2005:2). An emerging focus on the neurobiological impact of trauma indicates that these behaviour problems might be ascribed to neurobiological changes in the brain as a result of trauma (Campbell, 2009:18; Gaskill & Perry, 2014:183; Perry, 2006a:21; Zilberstein, 2014:296).

In this chapter, trauma is conceptualised and its impact discussed, with specific reference to the symptoms often associated with trauma. Recognition is given to the neurobiology of trauma, the relevant brain changes and its relation to symptoms of trauma. An overview of the developmental phase of middle childhood is provided as well as on how trauma manifests in children during this specific phase of development.

2.2 CONCEPTUALISING TRAUMA

Trauma refers to “overwhelming, uncontrollable events that psychologically impact victims by creating in them feelings of helplessness, vulnerability, loss of safety and loss of control” (Goodyear-Brown, 2010:24). Traumatic events are furthermore defined as experiences that are emotionally painful, distressing or shocking, which often result in lasting mental or physical effects (Goldman, 2009:14; Louw et al., 2007:379). These events may refer to long-lasting, persisting experiences such as incest, maltreatment or war; or isolated, short-lived events such as natural disasters or accidents (Campbell, 2009:18; Perry et al., 1995:272). It is noted that trauma might include directly experiencing a traumatic event in person, witnessing a traumatic event, or indirectly being informed about a significant other who endured a traumatic event (American Psychiatric Association, 2013).

The perception of and response to traumatic events are unique to each individual (Le Bel et al., 2010:2). What constitutes as trauma for one individual therefore does not necessarily reflect what is true for others; and in the same way one cannot accept that an experience found non-traumatising for another holds true for all (Wasserman, 2005:2). Consequently, trauma comes in various forms. Experiences that typically account for trauma in childhood years are experiences such as parental divorce, loss of a loved one, domestic violence,

physical, sexual or emotional abuse, neglect, rape, violent crimes, bullying, theft, accidents, political unrest or war (DSD et al., 2012:5; Goldman, 2009:15; Goodyear-Brown, 2010:24). It has only recently been acknowledged that acts of omission, such as neglect in its various forms, may be equally traumatising to acts of commission, such as sexual, physical or emotional abuse (Delima & Vimpani, 2011:43; Zelechoski et al., 2013:639). Neglect refers to the failure to respond to a child's basic needs, failure to comply with medical treatment for the child or failure to protect a child from witnessing violence (Delima & Vimpani, 2011:43; DSD et al., 2012:17). Furthermore, the systemic community violence and the high expectation of danger and terror in the world are events that may cause panic, stress and extreme anxiety for children (Campbell, 2009:18; Goldman, 2009:14). To raise awareness and understanding of the potentially traumatising circumstances children live in (Campbell, 2009:18), the prevalence of trauma is briefly discussed.

Childhood exposure to interpersonal trauma is extremely common (D'Andrea et al., 2012:189). In 2003 Perry (2003:2) stated that in the United States alone, conservative estimates of children exposed to traumatic events exceed five million children annually. It was estimated that annually, approximately three million children were physically or sexually abused or neglected, while others were living in or exposed to detrimental circumstances of domestic violence, natural disasters, and medical conditions or treatments, all of which can be considered as traumatic experiences (Perry, 2003:2). Furthermore, Hawley (2000:6) indicates that many of these cases probably never come to light. Statistical data from the United States of America in 2009 indicated that about 1500 children die each year from child abuse or neglect, with 70% of these children being under the age of three years; while Australian national statistics for 2007/2008 indicated that around 26 200 children were abused during that time (Pretorius & Pistorius, 2012:5-6). A global study, the UN Secretary-General's Study on Violence against Children in 2006, identified the gravity of different forms of violence and abuse of children in different settings, and confirms the underreporting of child abuse (Pretorius & Pistorius, 2012:3). The findings of the mentioned Australian study further indicate that child abuse might be associated with social disadvantage and poverty.

Children in developing countries such as South Africa are possibly at higher risk for exposure to trauma (Hamber, 2000:5). This might be due to poverty which increases the risk of various types of violence, and which decreases coping strategies to deal with violence when it occurs (DSD et al., 2012:4). It then appears that violence tends to be concentrated in less economically developed urban areas in the country (DSD et al., 2012:4). South Africa has become known as maintaining a 'culture of violence' (Hamber, 2000:5), which can be described as "a society which endorses and accepts violence as an acceptable and

legitimate means to resolve problems and achieve goals" (Vogelman & Simpson, 1990 in Hamber, 2000:5). This notion seems to be evident in the high violent crime statistics in the country (Baloyi, 2006:17; Bezuidenhout & Little, 2011:5). South Africa has been described as the country with the highest prevalence of violence in the world (Norman et al., 2010:1), including violence against children (DSD et al., 2012:3).

Children in South Africa seem to be significantly exposed to traumatic experiences, both chronic and time-limited (DSD et al., 2012:9). The 2010/2011 statistics from the South African Police Service (SAPS) report a total of over 50 000 crimes against children for the year 2010/2011 (DSD et al., 2012:9). These crimes include murder, attempted murder, assault with grievous bodily harm, common assault and sexual offences; thus the figure does not include the prevalence of neglect and other traumatic experiences (DSD et al., 2012:9). It is furthermore noted that violence against children often occur in the home of the child or other private setting and is therefore not publicly visible, leading to child maltreatment to be unreported or under-reported (DSD et al., 2012:9). Thus, the records often do not portray a true reflection of childhood exposure to trauma. The findings cause concern. In the 2010/2011 year, more than half (52%) of all reported crimes against children (50 000) were sexual in nature, of which 61% of the children were under the age of 15 years and over a quarter (29%) were between 0 and 10 years (DSD et al., 2012:9; SAPS, 2011:11). Statistics determined that at the current rate 50% of children in South Africa will experience some form of abuse by the age of 18 and that the greatest increase in sexual violence is against infants and children under the age of seven years (TEARS Foundation, 2012).

The Children's Act 38 of 2005 and the Child Justice Act (No. 75 of 2008) are the laws governing child protection in South Africa (DSD et al., 2012:31). Child protection refers to measures taken in response to child maltreatment, such as support, care and treatment of traumatised children (Makoae, Roberts & Ward, 2012:11). These laws afford a South African child the right to be protected from any form of maltreatment, abuse and neglect, and include permission for removal of a child, if in their best interest, to alternative care if they suffer maltreatment in their home environment (DSD et al., 2012:31). In 2010 there were 345 registered child and youth care centres in the country, which under the previous Child Care Act would have been registered as children's homes, places of safety or shelters; while 100 more unregistered residential facilities for children existed that fit the criteria for a child and youth care centre (DSD et al., 2012:31). Children's homes, the most common type of residential care, provide longer-term residential accommodation to children who have been abused, abandoned, orphaned or unable to live with family for other reasons. It is noted that

"residential (or out-of-home) care is considered a last resort for children once all other efforts to provide children with a stable family life have been exhausted" (DSD et al., 2012:32). The large number of residential care institutions in South Africa seems to be indicative of the high prevalence of childhood trauma.

Of great concern is that a culture of violence seems to be maintained and carried over from one generation to the next, and mostly within family systems. Worldwide, the majority of people (approximately 80%) responsible for child maltreatment are the child's own parents, while other relatives of the child are to blame for another 10% of cases (Streeck-Fisher & Van der Kolk, 2000:904). Statistics on sexual crimes against children in South Africa similarly confirm that an overwhelming majority (84%) of rapes are perpetrated by males who are known to the victim (DSD et al., 2012:16). Furthermore research indicates that about 20% of people who were abused as children go on to abuse their own children, and 75% of perpetrators of child sexual abuse reported that they had been sexually abused themselves during childhood years (Streeck-Fisher & Van der Kolk, 2000:904). The above figures propose that child abuse and neglect perpetuate violence in adulthood as well as in generations to come and thus contribute to an intergenerational cycle of violence (DSD et al., 2012:13; Perry, 1997:124; Streeck-Fisher & Van der Kolk, 2000:904; Teicher, 2000:64; Van der Kolk, 2005:402).

It is suggested that in order to understand the origins and impact of trauma, it is essential to consider how trauma impacts the developing child (Perry, 1997:124). The impact of trauma is subsequently discussed.

2.3 THE IMPACT OF TRAUMA

It is no simple task to outline the impact of trauma, especially due to the diversity in outcome; nevertheless, traumatic experiences can destroy a child's ability to cope and function in a normal way (Goldman, 2009:14). In this section, the symptoms associated with trauma are summarised, whereafter the neurobiology of trauma is discussed. Further, diagnoses related to trauma are indicated, and finally recognition is given to the unique individual responses to trauma.

2.3.1 Symptoms associated with trauma

Childhood trauma can have a profound impact on the emotional, behavioural, cognitive, social and physical functioning of children (Child Welfare Information Gateway, 2008:2; Coates, 2010:391-392; D'Andrea et al., 2012:187; Ford & Courtois, 2013:x; Hawley, 2000:5).

Following is a summary of some of the most common responses to trauma, categorised in the four symptom clusters indicated by D'Andrea et al. (2012:189), namely affect and behaviour dysregulation, alterations in attention and consciousness, distortions in attribution, and interpersonal difficulties.

2.3.1.1 Affect and behaviour dysregulation

The inability for emotional self-regulation is regarded as one of the most prominent consequences of trauma for severely traumatised children (Cook et al., 2007:5; Goodyear-Brown, 2010:vi, 32). Affective symptoms commonly found in children exposed to trauma are: lability (instability or incongruence in emotions), anhedonia (the inability to experience pleasure from enjoyable activities or experiences), numbed emotions, and explosive anger. Traumatised children often struggle to understand and express emotions, are either hyper-sensitive or avoidant in response to negative stimuli, and will often interpret positive feelings rather negatively (Briere & Spinazzola, 2005:402-403; Cook et al., 2007:5; D'Andrea et al., 2012:189; Goldman, 2009:14, Goodyear-Brown, 2010:vi,32). In short, traumatised children generally can neither regulate their emotional states nor rely on others to help them. Instead they become overwhelmed, resulting in an inability to integrate incoming information and make sense of their experiences, which in turn cause their behaviour to become disorganised (Streeck-Fisher & Van der Kolk, 2000:907; Zelechoski et al., 2013:642). Research denotes a relation between internal emotional dysregulation and behaviour dysregulation for which maltreated children are often known (D'Andrea et al., 2012:189).

The behavioural expressions related to affect dysregulation may include aggression and oppositional or compulsive behaviour (D'Andrea et al., 2012:189). Traumatised children appear to engage in acting-out behaviour, especially during adolescence, and are more likely to engage in self-harm as well as violent behaviour towards others (Goodyear-Brown, 2010:32; Streeck-Fisher & Van der Kolk, 2000:905). These children further show a tendency to utilise emotional avoidance strategies such as substance abuse, and tension reduction activities such as compulsive sexual behaviour, binging and purging, self-mutilation and suicidality, as external ways to reduce distress (Briere & Spinazzola, 2005:402-403). Some traumatised children also present with risk-taking behaviours (Cook et al., 2007:6; Goodyear-Brown, 2010:43). Many traumatised children exhibit behaviour related to hyperarousal, manifested in increased sleep problems, irritability, inability to concentrate, startle reactions, and aggressive behaviour (Goldman, 2009:14; Goodyear-Brown, 2010:32, 37-38).

Dysregulated affect and behaviours do not only manifest in florid externalising symptoms, but also in internalising symptoms such as freeze-responses and emotional breakdown. Avolition (lack of drive or motivation), lack of interest in activities, withdrawal and unresponsive affect are also characteristic of traumatised children (D'Andrea et al., 2012:189). These children may present with decreased reactivity to physical injury, either as a result of being desensitised to pain or as a way of disconnecting their minds from their bodies in order to cope (Goodyear-Brown, 2010:33). Traumatised children might have re-experiencing symptoms which are commonly identified in play re-enactment, nightmares, waking memories as well as disturbing thoughts and feelings about the traumatic event (Goldman, 2009:14; Goodyear-Brown, 2010:32). Young children may withdraw or isolate themselves, regress to earlier developmental phases, experience anxiety, and may develop sleeping and eating disorders, excessive fatigue or somatoform distress. Somatoform distress refers, most broadly, to bodily distress or dysfunction that arises from psychological phenomena (Briere & Spinazzola, 2005:402-403; Goldman, 2009:14; Goodyear-Brown, 2010:32). Apart from affect and behaviour dysregulation, traumatised children may experience difficulties pertaining to attention and consciousness, which will be discussed next.

2.3.1.2 Alterations in attention and consciousness

Various symptoms associated with dissociation and disrupted executive functioning, are recognised as manifestations of alterations in attention and consciousness (Briere & Spinazzola, 2005:402-403; D'Andrea et al., 2012:189-190). Dissociation can be described as "alterations in conscious awareness that arise, in part, from defensive changes in otherwise integrated thoughts, feelings, memories and behaviour" (Briere & Spinazzola, 2005:402). Information and experiences cannot be integrated and as a result thoughts and emotions are disconnected, and physical sensations and repetitive behaviour occur outside conscious awareness (Cook et al., 2007:5). Dissociation can manifest as depersonalisation, derealisation, and memory loss or blackouts and may also mask as inattention, often leading to an inaccurate diagnosis of Attention Deficit and Hyperactivity Disorder (ADHD). Disrupted executive functioning such as concentration problems, the inability to use problem-solving skills, and poor integration of cognitive functions are frequently documented which might explain the notion that traumatised children often struggle with learning and academic performance (Cook et al., 2007:6; D'Andrea et al., 2012:190; Goodyear-Brown, 2010:45; Streeck-Fisher & Van der Kolk, 2000:905).

It has been found that traumatised children often have faulty beliefs about themselves and the world. This aspect is discussed in the next section.

2.3.1.3 Distortions in attribution and worldview

Children exposed to interpersonal violence appear to have distortions in attribution and worldview, displaying as feelings of shame and guilt, altered self-capacities and cognitive disturbances (Briere & Spinazzola, 2005:402-403; Cook et al., 2007:6). Symptoms associated with altered self-capacities include identity problems, distorted locus of control, poor sense of separateness, problems with self-definition, and disturbances of body-image. Common cognitive disturbances include low self-esteem, self-blame, helplessness, hopelessness, expectations of rejection and loss, over-estimation of the extent of danger in the world, negative self-perception, self-hatred, and fears of abandonment (Briere & Spinazzola, 2005:402-403; D'Andrea et al., 2012:190; Streeck-Fisher & Van der Kolk, 2000:905).

A poor sense of self-worth, already a problem in itself, may decrease the likelihood of self-protective behaviours and can furthermore cause problematic interactions with others, which may lead to the worsening of mental health over time and increase risks of psychopathology (D'Andrea et al., 2012:190). Of concern is that children may believe that somehow they have caused the traumatic event and as a result engage in self-blame. Consequently, children may exhibit at-risk behaviours which need to be looked out for. These behaviours may include sudden changes in performance or behaviour, extreme confusion, anger outbursts, harmful behaviour to self or others, over-concern with health or health of loved ones, depression, isolation or withdrawal, and threats of or preoccupation with suicide (Goldman, 2009:15). Children who have been traumatised might furthermore experience difficulty establishing and maintaining healthy relationships, as will be discussed next.

2.3.1.4 Interpersonal difficulties

Disrupted attachment styles seem to be a key feature of interpersonal difficulties experienced by children who were exposed to trauma (D'Andrea et al., 2012:190; Zilberstein, 2014:295). Goldman (2009:15), along with other authors (D'Andrea et al., 2012:190; Streeck-Fisher & Van der Kolk, 2000:907), explains that trauma often lead to disturbances in a child's attachment with the primary caregiver, other family members and friends. Disorganised attachment develops as a result of maltreatment and neglect and has been found to occur in the majority of maltreated infants (Howell, 2011:97; Zilberstein, 2014:295). Disorganised attachment patterns may result in distrust in others, expectation of

harm or rejection, suspiciousness and problems with intimacy (Streeck-Fisher & Van der Kolk 2000:907).

Due to instability and lack of continuity in their environment, traumatised children experience difficulty understanding the self and others and consequently are out of touch with their feelings (Streeck-Fisher & Van der Kolk, 2000:95). The inability to regulate emotions, which traumatised children often experience, scares other children away which may result in a lack of reliable friendships (D'Andrea et al., 2012:191). The social implications of trauma therefore often include low interpersonal efficiency, diminished social skills, inability to understand social interactions, poor perspective-taking abilities, poor personal boundaries, interpersonal conflict, and social isolation (D'Andrea et al., 2012:190-191; Zilberstein, 2014:295-296). Consequently traumatised children often avoid new social settings, might display odd or inappropriate social behaviour, tend to be withdrawn, or bully others (Cook et al., 2007:6-7; D'Andrea et al., 2012:191; Goodyear-Brown, 2010:32; Streeck-Fisher & Van der Kolk, 2000:905-906).

Traumatised children are furthermore known to repeat or re-enact their traumatic pasts for instance by engaging in provocative, dangerous behaviour and unhealthy relationships (Perry, 1997:133; Streeck-Fisher & Van der Kolk, 2000:913). Streeck-Fisher and Van der Kolk (2000:913) point out that "[b]y engaging in acts that seem designed to provoke other children and caregivers to hurt them they seem to deliberately try to undermine many attempts to provide them with safety." This behaviour can be understood as resulting from the worldview that anything new is potentially threatening and therefore, what is familiar is often interpreted as 'safer' even if it is a predictable source of distress (Streeck-Fisher & Van der Kolk, 2000:95). Likewise, it is explained that predictability of threat is important in understanding the impact of trauma, because stress is more tolerable when it is predictable (Perry, 1997:133). Unfortunately, most people in the traumatised child's environment respond to these re-enactments as the primary problem instead of attending to the real cause; thereby becoming part of a replay of the original abusive relationships (Streeck-Fisher & Van der Kolk, 2000:913).

The above developmental and behavioural problems experienced by traumatised children can be ascribed to an array of neurobiological effects due to trauma (Teicher, 2000:53; Wasserman, 2005:16). The neurobiological effects of trauma are discussed in the following section.

2.3.2 The neurobiology of trauma

Neurobiological studies, with their focus on the relationship between observed behaviours and structural and functional changes in the brain, have shown that psychosocial trauma negatively impacts all areas of brain development and functioning and can permanently alter basic brain functions (Delima & Vimpani, 2011:42; Goodyear-Brown, 2011:vi; Perry, 2006a:21; Teicher, 2000:64; Van der Kolk, 2005:402; Zilberstein, 2014:296). Thus, as Campbell (2009:19) emphasises, "[p]rofessionals who are working with traumatized youth need to understand the basics of these changes in the brain." Following, the researcher discusses the basic structure and functioning of the brain, followed by a brief overview of the effects of trauma on neurobiological functioning.

2.3.2.1 The structure and function of the brain

The brain constitutes the most important structure of the human body, as it is the key structure that allows for survival and the regulation of all the functions of the human body (Wasserman, 2005:4). Perry et al. (1995:272) coherently explain the brain's central importance in regulating a person's reactions to trauma, as well as to therapeutic intervention, stating that "[u]ltimately, it is the human brain that processes and internalizes traumatic (and therapeutic) experiences … [and] mediates all emotional, cognitive, behavioral, social and psychological functioning." Professionals working in the field of trauma therefore need to take into account how neurobiological processes influences a person's response to trauma, and how it could influence treatment (Campbell, 2009:19; Gaskill & Perry, 2014:184-185; Van der Kolk, 2006:8).

The brain is composed of different parts or systems that control different functions, and is divided into three main brain areas - the brainstem, the limbic system and the neocortex (Perry et al., 1995:272), as illustrated in Figure 1. The brainstem controls the basic functions related to the Autonomic Nervous System (ANS) such as breathing, heart rate, swallowing, digestion and temperature. The limbic system is part of the Central Nervous System (CNS) and is responsible for attachment, affect regulation and aspects of emotion. The systems in the neocortex are responsible for abstract cognition, critical thinking and language (Perry et al., 1995:272; Wasserman, 2005:5; Zilberstein, 2014:293-294). Although these parts of the brain are referred to as separate entities, they work in a complicated integrated fashion. These different areas of the brain as well as the nervous system all consist of brain or nerve cells, also called neurons, that are specialised to serve specific functions (Perry et al., 1996:2). The neurons are designed to receive and carry over messages throughout the brain and body by means of chemicals known as neurotransmitters (Wasserman, 2005:8).

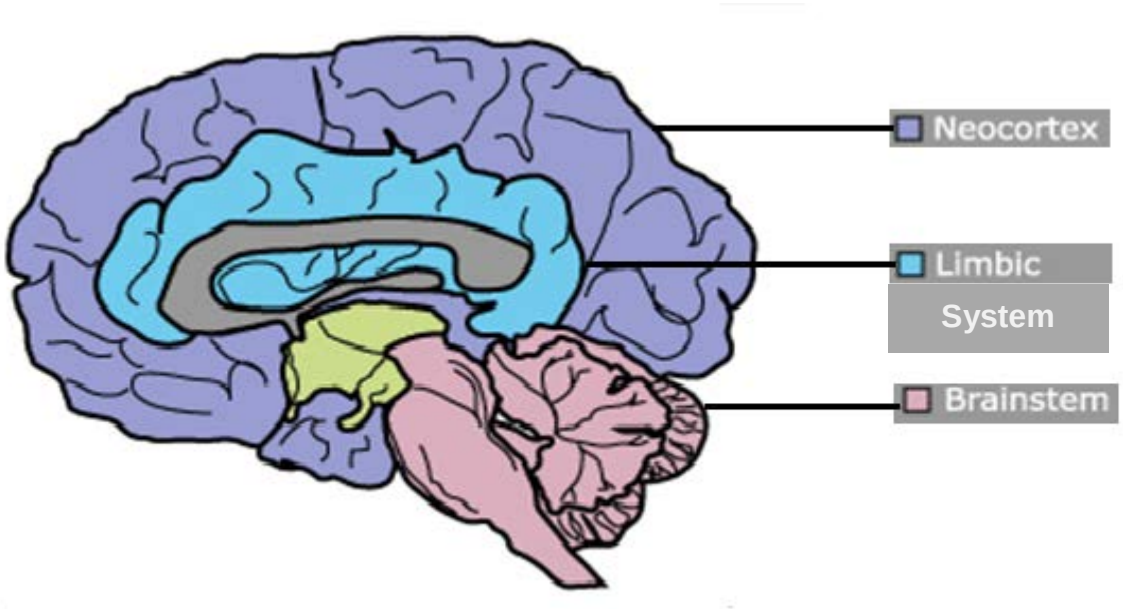

Figure 1: A cross-section of the human brain (adapted from Perry, 2002:3)

The brain is a compound organ organised into systems designed to sense, process, store, perceive, and act on information from the external (visual, tactile, olfactory and auditory) and the internal (hormonal stimuli) environment. These systems enable people to have an internal representation of the external world and ultimately enable learning processes and memories to occur (Mustard, 2002:26-27; Perry, 2002:3; Perry et al., 1995:272).

The way the brain stores information is highly relevant to this study, since it relates to the way trauma memories impact on current behaviour. The brain stores information in a use-dependent fashion which means that the more a particular neural pathway or system is used, the more that pathway and its related roles will become 'built-in' or automatic and, conversely, the less a neural pathway is used the weaker it becomes (Goodyear-Brown, 2010:33; Wasserman, 2005:24; Zilberstein, 2014:297). The neurotransmitters, or chemicals that are released in reaction to stimulation in order to convey information, also play a critical role in brain functioning (Wasserman, 2005:8). As a result of these chemicals the neurons, in much the same way as the brain's neural pathways, decay when not used or become highly sensitised when over-used (Perry et al., 1995:273). This process is referred to as synaptic pruning, which implies the loss of synapses in neurons that are seldom stimulated (Berk, 2013:185). Figure 2 depicts synaptic pruning, indicating the process by which neural pathways form during the course of a child's development and how certain neural pathways are strengthened, while others are pruned in a use-dependent fashion.

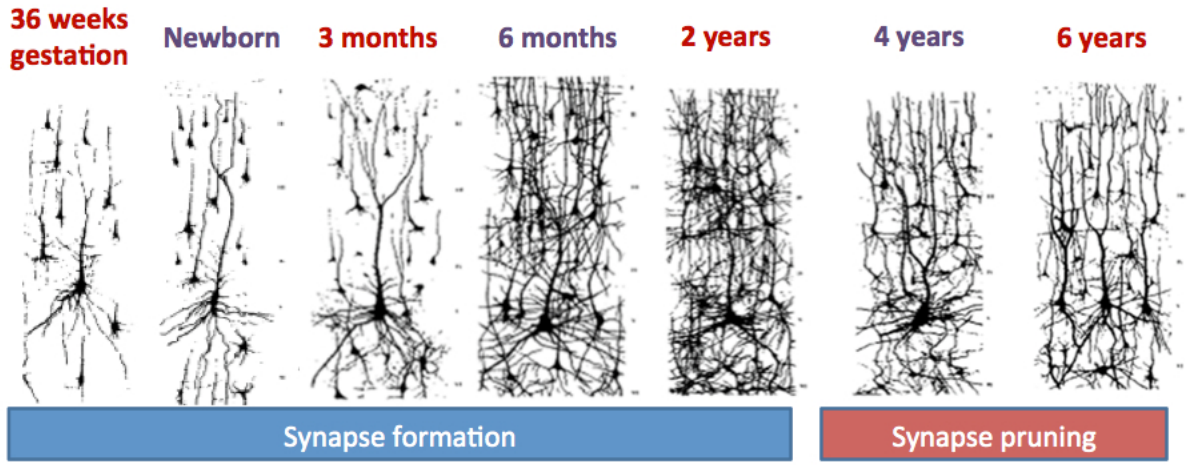

Figure 2: Synaptic pruning (Scharf, 2013)

Although the process of synaptic pruning allows the organism to learn and as result survive, it is also the reason why trauma can damage structures or processes in the brain (Perry et al., 1995:273; Zilberstein, 2014:294). Following, is a review of the possible physiological changes in the brain as a result of trauma, and how it impact on self-regulation.

2.3.2.2 The neurobiological effects of trauma

The neurobiological effects of trauma are extensive and far reaching (Delima & Vimpani, 2011:42; Goodyear-Brown, 2011:vi; Perry, 2006a:21; Teicher, 2000:64; Van der Kolk, 2005:402; Zilberstein, 2014:296). These authors indicate that each main part of the brain involved in self-regulation (the brainstem and neuro-endocrine system, the limbic system, and the neocortex or cerebral cortex) is impacted by trauma, resulting in certain behavioural and emotional manifestations. The impact of trauma on the three main brain areas and the respective emotional and behavioural effects thereof, are subsequently discussed.

- **The brainstem and neuro-endocrine system**

The brainstem controls the basic functions served by the Autonomic Nervous System, such as heart rate, breathing, swallowing, digestion, and temperature and affects a person's levels of alertness, ability to sleep, and sense of balance (Wasserman, 2005:5). It therefore serves to regulate functions people almost automatically do without cognitively thinking about it, and also regulates functions often referred to as 'instinct' for survival (Campbell, 2009:18). These functions are made possible by **the neuro-endocrine system**. The neuro-endocrine system refers to "the system of interaction between the brain, nervous system,

and hormones; with one of its primary roles the regulation of moods, emotions and the stress response" (Coates, 2010:393).

Research proposes that child abuse and neglect physically alters a major portion of the neuro-endocrine system involved in the regulation of stress, namely the hypothalamic-pituitary-adrenocortical (HPA) axis (Coates, 2010:394; Goodyear-Brown, 2010:32; Mustard, 2002:27; Zilberstein, 2014:296). The altered HPA axis causes traumatised individuals to experience difficulties in regulating basic functions, as evidenced in autonomic symptoms such as elevated heart rate, changes in blood pressure, changes in hormone levels, the storage of emotional memories and behavioural symptoms associated with fear and anxiety (Osuch, Ursano, Webster, Hough & Fullerton, 2004 in Campbell, 2009:18; Zilberstein, 2014:296). People's emotional reactions thus affect the way their bodies function, for example in cases of impaired pain perception. While people with impaired pain perception may be hypersensitive to physical contact, they often cannot localise skin contact and have difficulty identifying and categorising parts of their bodies (Streeck-Fisher & Van der Kolk, 2000:911). Furthermore, many traumatised children experience problems with coordination, balance, muscle tone, are easily disoriented in time and space, and struggle with interpreting incoming information, which makes them react inappropriately (Streeck-Fisher & Van der Kolk, 2000:911).

The effect trauma has on the normal structure and functioning of the brainstem and neuro-endocrine system thus seems to contribute significantly to certain long-term effects associated with childhood trauma, such as negative emotional state, overall disorganisation and an inability to obtain homeostasis through self-regulation (Campbell, 2009:18-19; Coates, 2010:393-394). The emotional effects of trauma are also influenced by the way trauma affects the limbic system, as will subsequently be discussed.

- **The limbic system**

The limbic system, also referred to as "the emotional brain", controls emotions and drives fundamental for the person's survival (Coates, 2010:395). The limbic system consists of two major parts: the amygdala and hippocampus (Coates, 2010:395; Rothschild, 2001:20).

The amygdala serves as the 'control centre' for the body's fight or flight response by activating the brainstem, and plays a fundamental role in fear conditioning and the control of aggressive, oral, and sexual behaviour (Campbell, 2009:18; Coates, 2010:395; Goodyear-Brown, 2010:27; Rothschild, 2001:20). The fight or flight response refers to the instinctive

reaction to danger whereby the body prepares the person to either flee from the danger or to fight whatever is causing the danger (Perry et al., 1996:4-5). The body's fight or flight response is primarily biochemical in nature and leads to the release of stress hormones, such as cortisol and adrenaline (Rothschild, 2001:20; Van der Kolk, 1994:256; Wasserman, 2005:13). The release of these hormones, controlled by the amygdala, causes a state known as hypervigilance, during which the person's senses are sharpened in order to evaluate their environment for cues related to the danger (Perry et al., 1995:273). Necessary as this is for survival, traumatic experiences may cause over-activation of this system, resulting in permanent changes in the way it functions (Coates, 2010:395; Wasserman, 2005:10; Zilberstein, 2014:297).

Problems can occur when the same neural pathway are in constant use, or when neurons or neurotransmitters are over-used in a negative context, such as when a child is in a constant state of fear or chronically exposed to unpleasant events (Goodyear-Brown, 2010:28; Perry et al., 1995:274; Wasserman, 2005:7). Sensitisation may then occur through these repeated experiences, causing the neural pathways to be activated with the slightest trigger from the child's surroundings; thus a state of chronic elevated arousal (Goodyear-Brown, 2010:33; Wasserman, 2005:7). Due to the amygdala being unresponsive to and unaffected by stress hormones, the amygdala persists to release stress hormones in a perceived or actual threatening environment (Coates, 2010:395; Rothschild, 2001:20).

The other part of the limbic system**, the hippocampus**, is involved in the processing of information and lends time and spatial context to memories and events (Coates, 2010:395; Mustard, 2002:28; Rothschild, 2001:20). The hippocampus should therefore process the situation for what it is in reality and stop the alarm reaction when a situation does not pose a threat to the person. However, the hippocampus is susceptible to the stress hormones secreted by the amygdala and becomes dysfunctional when these hormones are in excess, which happens as a result of the amygdala overreacting in a state of constant fear, as described above (Rothschild, 2001:20).

The dysfunctional hippocampus, together with the sensitisation of the amygdala's response, might explain hyperarousal, a symptom often seen in traumatised children (Wasserman, 2005:7). Furthermore, due to the hippocampus' involvement in the integration of memories, disrupted hippocampal development (as a result of trauma) may explain the problems that traumatised people have with dissociation and intrusive memories related to the trauma (Margolian & Gordis, 2000 in Wasserman, 2005:11).

The most common and severe long-term consequences of trauma that are related to the neurobiological impact on the limbic system, seem to be dissociation and hyperarousal (Perry, 2003:4). According to Cook et al. (2007:5) dissociation is "the failure to take in or integrate information and experiences." It is believed to develop because children, when faced with traumatic experiences, often do not have the ability to either fight or flee, and will freeze in response to stress in an effort to disengage from the stimuli or to make the stimuli 'disappear' (Perry et al., 1996:6). Threat causes traumatised children to become anxious which in turn increases the child's feeling of being threatened, thereby leading to terror. Consequently, if the child feels extremely terrorised or threatened, the freeze response may escalate into complete dissociation (Perry et al., 1996:6). Dissociation is simply explained as "disengaging from stimuli in the external world and attending to an internal world" (Perry et al., 1996:6). Common examples of dissociation are daydreaming and fantasising, but traumatised children might also display numbing, over-compliance, avoidance and restricted affect as a result of dissociation (Perry et al., 1996:7).

Hyperarousal, on the other hand, refers to a constant state of hypervigilance, such as when the brain responds to threat even though no threat might be present. Hyperarousal causes the child to be anxious and reactive (Perry, 2003:4). Research indicates that "these children have trouble sleeping, can't control their memories of the trauma, and seem to be in constant alert … [and] have difficulty learning and maintaining positive relationships with family and peers" (Hawley, 2000:6). A traumatised child may exhibit motor hyperactivity, anxiety, behavioural impulsivity, sleep problems, and an increased heart rate (Perry et al., 1996:5). Hyperarousal furthermore causes victims of child abuse to become more likely to avoid novelty, including new social settings and relationships (Coates, 2010:399; Streeck-Fischer & Van der Kolk, 2000:905).

The functioning of the emotional brain in traumatised individuals might be severely disrupted. Childhood trauma in the form of neglect, abuse or lack of attachment in infancy can cause limbic system dysfunction, as well as neurobiological changes specifically in the amygdala and hippocampus. (Campbell, 2009:18; Coates, 2010:396). Studies show that in traumatised children these areas are stunted and smaller, which can have wide-ranging effects such as panic and anxiety disorders (Coates, 2010:396). Following, the effects of trauma on the cerebral cortex will be discussed.

- **The cerebral cortex**

The cerebral cortex, also referred to as the neocortex, is the part of the brain responsible for the rational, logical thought processes that require higher cognition and intelligence (Coates, 2010:396; Van der Kolk, 2003:307). The role of the cerebral cortex in responding to a stimulus involves considering, evaluating, and judging the signals coming from the various sensory organs. Incoming information is processed and analysed by the cortex, where the person's reaction will be considered, and signals are subsequently sent to the amygdala, leading to an appropriate response (Campbell, 2009:19; Van der Kolk, 2003:307).

In traumatised individuals, however, the neocortex gets 'bypassed' almost completely, and reactions are based on the functions of lower brain regions. Without the moderating qualities of the executive functioning of the cortex, the limbic system activates the fight or flight response in the brainstem, causing an inability to regulate or cope with an overwhelming flood of emotions (Campbell, 2009:18-19; Rothschild, 2001:19-20). This process results in a state of hyperarousal, as was discussed in the previous section. The traumatised individual is therefore even further 'disabled' in terms of a rational appraisal of the situation as the capacity to register, compare and evaluate experiences and integrate the information for rational problem-solving lies in the prefrontal cortex, that cannot be activated in a state of hyperarousal (Coates, 2010:395).

The cerebral cortex is divided into two interactive hemispheres, the right- and the left hemisphere. Neuroscience has revealed that the two hemispheres of the brain are generally associated with different functions. The left hemisphere is more often associated with logical, analytical thought, causal sequence, and perception and expression of language; while the right hemisphere is associated more with the grasp of rhythm, spatial relationships, intuition, and the perception and expression of emotions (Coates, 2010:396; Clarkson & Cavicchia, 2014:2). The two hemispheres of the brain are closely linked and connected by a 'bridge' called the corpus callosum that is responsible for integration between the two brain lobes (Coates, 2010:396; Van der Kolk, 2003:309; Zilberstein, 2014:296).

Researchers indicate that child abuse and neglect influence the development of the cortex, respectively the left hemisphere, the corpus callosum, and the right hemisphere (Coates, 2010:396; Van der Kolk, 2003:308). The development of the left hemisphere of abused and neglected children seems to be considerably impaired and indicates decreased activity, especially in Broca's area, which is the expressive speech centre in the brain. This effect might reduce the traumatised child's ability to process language and regulate emotion (Van

der Kolk, 2006:2). In a study conducted by the McLean Hospital (2000), the corpus callosum was found to be noticeably smaller in traumatised individuals than in non-traumatised individuals, and irregular activity between the two hemispheres was prevalent (McClean Hospital, 2000 in Coates, 2010:396). It is proposed that a smaller corpus callosum leads to less integration of the hemispheres, which in turn may cause dramatic shifts in mood or personality (Coates, 2010:397). In traumatised individuals the impaired structure and functioning of the cortex, especially the left hemisphere and corpus callosum, together with the deactivated Broca's area might contribute significantly to the difficulty traumatised children have in processing language (Van der Kolk, 2006:2).

With regard to effects of trauma on the right brain hemisphere, studies on the developmental neurobiology of attachment indicate how relational trauma negatively impacts the development of the right hemisphere, specifically the stress-regulating circuit, which in effect hinders the ability for regulating stress related and emotion related processes (Schore, 2013:3; Zilberstein, 2014;295). Furthermore, exposure to trauma leads to dysfunction of the frontal-subcortical brain area and as a result "traumatized individuals have problems with sustained attention and working memory, which causes difficulty performing with focused concentration, and hence, with being fully engaged in the present" (Van der Kolk, 2006:4).

In conclusion, the brain as a whole seems to be severely affected by trauma, especially so by persistent relational trauma, due to the alteration of neurobiological pathways (Perry, 2006a:21; Zilberstein, 2014:294). The neurobiological effects of trauma cause concern because of its long-term impact, as Teicher (2000:64) explains: "[s]tress can cause various hormonal changes that permanently wire a child's brain to cope with a malicious world and through this chain of events violence and abuse may pass from generation to generation." A traumatised individual's brain response to threat may therefore differ from how the brain normally responds to threat. This aspect will be discussed in the following section.

2.3.2.3 The brain's response to threat

The brain's response to threat is ultimately the process that enhances an individual's probability for survival (Perry et al., 1995:273). When environmental signals indicate a potential threat to an organism's safety, the brain creates a coordinated set of autonomic and behavioural processes that encourage an adaptive reaction. While useful in the short term, threat responses that persist over time can have harmful effects on the brain and body (Goodyear-Brown, 2010:29; Perry et al., 1995:273; Zilberstein, 2014:297). Following, is a

brief discussion of the normal threat response versus the traumatised individual's threat response as explained by Campbell (2009:19).

Information comes into the brain from the sensory organs related to touch, smell, taste, vision, or hearing, and is usually conveyed to the thalamus region which determines whether there is a present threat (Campbell, 2009:19). The input is delegated by the thalamus to the prefrontal cortex (the rational, thinking part of the brain) which considers, evaluates and judges this new information, taking into account possible reactions and their associated outcomes. Based on the processed information, the prefrontal cortex conveys a message to the amygdala, which in turn determines the appropriate emotional reaction based on the analysis by the prefrontal cortex (Campbell, 2009:19). This learning experience is then judiciously kept in the hippocampus for future reference.

The reaction to a threat (whether real or perceived) in the brain of a traumatised individual takes a totally different route. Information still enters the brain from various sensory organs, and the thalamus still assesses whether there is a present threat. As from here, however, the brain's functioning deviates from that of a non-traumatised brain, as past trauma experiences produce a trauma reaction in the brain, causing the thalamus to interpret even minor or insignificant triggers as severely threatening events. This process is often referred to as 'emotional hijacking', the 'amygdala alarm' or 'cortical bypass' (Campbell, 2009:19). As a result, the amygdala responds excessively and sends signals to the brainstem to release stress hormones such as cortisol and adrenaline. The brainstem controls functions that are necessary for survival and enhances the person's instinctual capacity. The individual therefore experiences the need to fight or flee which might manifest as troubling behaviours such as impulsive decisions, verbal or physical aggression and self-harm, along with various somatic experiences such as increased heart rate, sweating palms, and increased blood pressure.

The reason for such an exaggerated response to a minor stimulus or perceived threat is that the prefrontal cortex was bypassed and the individual therefore was not able to think rationally about the stimulus (Goodyear-Brown, 2010:29). The above discussion of the amygdala hijack or stress response is illustrated in Figure 3.

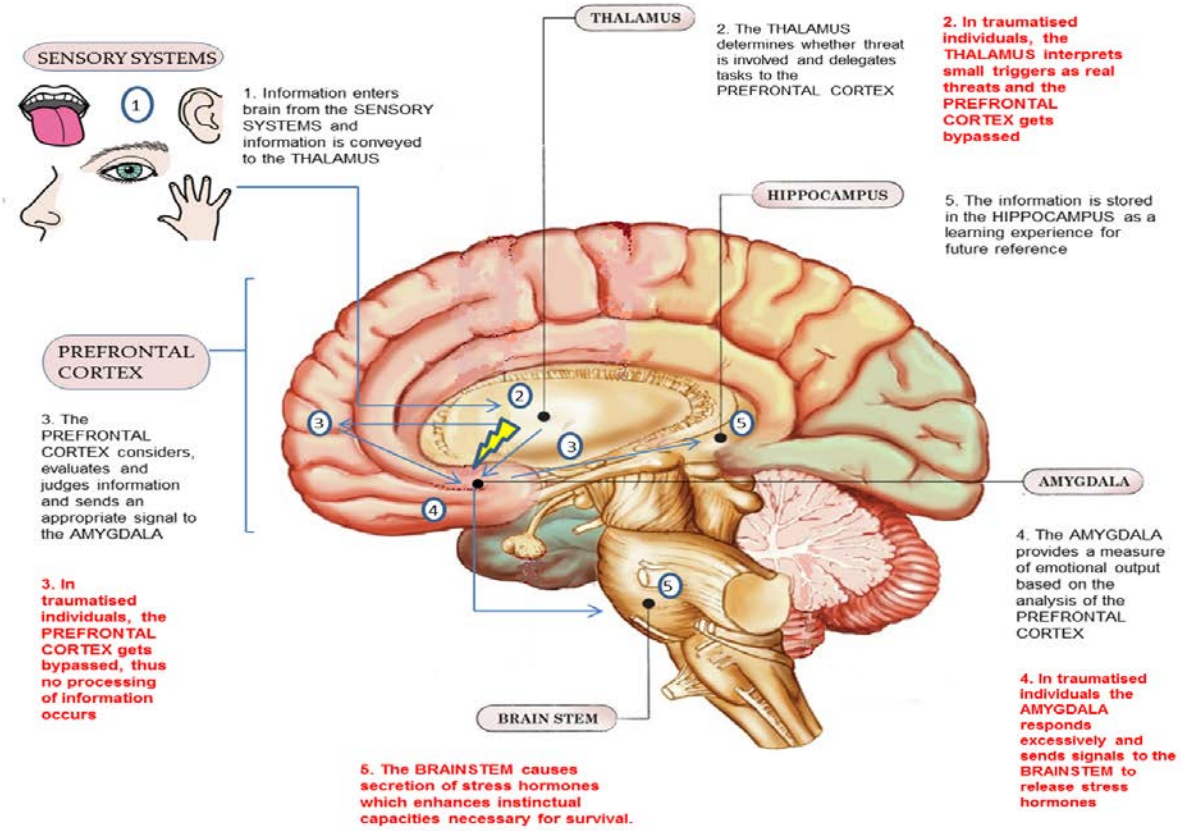

Figure 3: The brain's response to threat (image adapted from Lyle, 2013; information by Campbell, 2009:9)

Usually, during an actual traumatic event, the brain reacts to protect the individual by entering "survival mode." In the case of a traumatised individual, however, "the brain is interpreting every-day stressors as major threats due to the physiological changes that occurred in the brain during prolonged periods of abuse/trauma" (Campbell, 2009:19). Next, a discussion on the diagnoses associated with trauma follows.

2.3.3 Diagnoses associated with trauma

Many children may develop post-traumatic stress disorder (PTSD) in response to trauma, causing severe disruptions in normal functioning (Goldman, 2009:14). PTSD can be viewed as "a multidimensional, spectrum-level phenomenon - involving some combination of three separate but moderately correlated symptom clusters - that reaches disorder status when certain numbers of symptoms per cluster are reported at specified levels" (Briere & Spinazzola, 2005:402). The diagnostic criteria for PTSD are outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (American Psychiatric Association, 2013), as follows:

> The diagnostic criteria for PTSD include a history of exposure to a traumatic event that meets specific stipulations and symptoms from each of four symptom clusters: intrusion, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The sixth criterion concerns duration of symptoms [persistence of symptoms for more than one month]; the seventh assesses functioning [social or occupational distress of impairment]; and, the eighth criterion clarifies symptoms as not attributable to a substance or co-occurring medical condition. Two specifications are noted including delayed expression and a dissociative subtype of PTSD, the latter of which is new to DSM-5. In both specifications, the full diagnostic criteria for PTSD must be met for application to be warranted.

It is emphasised though, that exposure to traumatic events does not always lead to PTSD; and also that traumatised children are not always accurately diagnosed (Briere & Spinazzola, 2005:402-403). Symptoms of PTSD in chronically traumatised children generally are not obvious and tend to be masked by the cognitive, social, affective and physical problems that they experience due to exposure to trauma. Streeck-Fisher and Van der Kolk (2000:905-906) explain that "multiply abused children often experience developmental delays across a broad spectrum, including cognitive, language, motor and socialisation skills, and consequently tend to display very complex disturbances with a variety of different, fluctuating presentations."

As a result traumatised children might be ascribed an array of diagnostic labels, not necessarily accurately claiming the real cause of their behaviour. For instance, dysregulated behaviour often lead to the diagnosis of children as having a range of comorbid conditions such as attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder (ODD), conduct disorder (CD), obsessive compulsive disorder (OCD) or anxiety- and sleep disorders (Cook et al., 2007:4; Cook et al., 2005:391-392; Foltz et al., 2013:13; Streeck-Fisher & Van der Kolk, 2000:905; Van der Kolk, 2005:406; Zelechoski et al., 2013:642). Even though the child may meet the criteria for a particular disorder, he might in fact display hypervigilance in reaction to chronic abuse (Foltz et al., 2013:13; Norton & Norton, 2011:187). This situation is seen as troublesome because "while these children may receive a number of psychiatric labels, none of these diagnoses capture their profound developmental disturbances, or the traumatic origins of their articular presentations" (Streeck-Fisher & Van der Kolk, 2000:905).

Furthermore, Jones and Cureton (2014:268) state that "a growing body of evidence suggests that a traditional diagnosis of PTSD is not sufficient to describe the range and intensity of symptomatology experienced in survivors of unremitting and recurrent abuse, notably abuse during early stages of development."

For this reason the concept, complex post-traumatic stress disorder (C-PTSD), and the interchangeable term, "disorders of extreme stress not otherwise specified" (DESNOS), were considered for inclusion in the DSM-V (Jones & Cureton, 2014:270; Zelechoski et al., 2013:642). Although C-PTSD was not warranted a formal diagnosis in the DSM-V, certain proposed symptoms were incorporated into the reformulated diagnostic criteria for PTSD (Friedman, 2013:554). However, the term *complex trauma* is often referred to, providing context to "repeated interpersonal trauma occurring during crucial developmental periods" (Schore, 2013:3). It describes the dual problem of children's exposure to multiple traumatic events and the immediate and long term impact thereof (Schore, 2013:3). Many children involved in the child welfare system have experienced complex trauma (Cook et al., 2007:4).

It is important to consider that no individual is impacted by trauma in the same way (Louw et al., 2007:380; Papalia et al., 2008:408; Wasserman, 2005:2). In the next section the individualistic nature of people's responses to trauma is discussed.

2.3.4 Individual responses to trauma

As evident and well known as it is that trauma can severely affect the well-being of children (Coates, 2010:391), it is important to consider that each child's response to trauma is unique (Papalia et al., 2008:408; Wasserman, 2005:2; Zilberstein, 2014:298). In this section, the influence of resilience on the child's response to trauma, as well as factors moderating the impact of trauma, are discussed.

2.3.4.1 Resilience

Resilience refers to the ability to readily recover from difficulties, as stated by Louw et al. (2007:380): "[n]ot all children will necessarily develop negatively from adversity and traumatic incidents in their lives … some children show remarkable resilience and even optimal development in the face of adversity." Characteristics of resilient children typically include various advantageous personal, family and community factors (Cook et al., 2007:7; Louw et al., 2007:381).

Werner (2000:121) outlines characteristics of resilient children in the phase of middle childhood, the relevant age group in this study. With regard to personal factors, a sense of competence and self-efficacy appears to be a general hallmark of resilient children. Resilient children tend to have well-developed communication and problem-solving abilities as well as the ability to concentrate and control impulses. They are generally sociable and remarkably independent with a strong internal locus of control – the belief that they are capable of

positively influencing their environment. Assertiveness and achievement-oriented attitudes enhances involvement in activities, hobbies or creative interests, which in turn allow for a sense of mastery and pride. These personality factors together with good social skills and social support structures enhance resilience towards adversity (Werner, 2000:121).

Protective factors within the family, which might furthermore promote a child's resiliency, include socio-economic advantages, small family size (less than four children), a mother's competence, supportive grandparents and especially a close bond with a primary caregiver (Papalia et al., 2008:410, 412; Werner, 2000:122). Various authors agree that a secure attachment with a primary caregiver who makes a sincere commitment to a child's welfare is a powerful source of resilience (Streeck-Fisher & Van der Kolk, 2000:904). Protective factors within the community include reliable friends, supportive teachers, successful school experiences, the involvement of mentors, and a strong religious orientation or faith (Papalia et al., 2008:410, 412; Werner, 2000:122). Within the South African context, Louw and Louw (2014a:431) point to the relevant role of cultural resilience, in addition to the personal, family and community characteristics of resilient children. In this sense, certain cultural practices and ceremonies can promote resilience in children.

Various other factors play a role in determining the effects of trauma. The next section outlines the key factors that typically moderate the impact of trauma.

2.3.4.2 Factors moderating the impact of trauma

There are various factors that play a role in an individual's unique response to trauma and the heterogeneity of impact. Some of the most significant factors are age, the nature and duration of the trauma, the identity of the perpetrator, and the presence of a support system (Child Welfare Information Gateway, 2008:3; Papalia et al., 2008:410; Perry, 1997:126; Van der Kolk, 2003:293; Wasserman, 2005:14).

- **The age of the person**

Age, as one of the factors that may moderate the impact of trauma, necessitates the consideration of several important developmental aspects such as the developmental capacities of the child in terms of his/her cognitive, emotional, social and behavioural functioning, and the neurobiological vulnerability related to childhood (De Young et al., 2011:232; Zilberstein, 2014:294). Young children are particularly vulnerable to both trauma exposure and impact because they have limited coping skills and are strongly dependent on their primary caregiver to protect them emotionally and physically (De Young et al.,

2011:232). There has been a common delusion that young children lack the ability to remember, understand or be affected by trauma. However, research indicates that "very young children can develop and retain memories of traumatic events and are functionally able to present with the emotional and behavioural manifestations of trauma" (De Young et al., 2011:241). Trauma during early childhood may have even worse consequences for the child's development than traumas that occur in later adolescence (Van der Kolk, 2005:403; De Young et al., 2011:232).

Neurobiological vulnerability in childhood is another determining factor related to age, in terms of the heterogeneity of impact. Environmental factors and life stressors can greatly influence brain development (Perry et al., 1996:3-4). Young children's neuropsychological regulation systems, such as the stress- and emotion-regulation systems, are still in the process of rapid development. Exposure to trauma during a critical or sensitive period of brain development, characteristic of early childhood, can therefore have severe and permanent consequences (Streeck-Fisher & Van der Kolk, 2000:905; De Young et al., 2011:241; Zilberstein, 2014:294).

- **The nature and duration of trauma**

In terms of the nature and duration of trauma, various authors agree with the notion that isolated traumatic events may produce rather discrete responses in contrast to chronic trauma such as childhood trauma, severe personal trauma or prolonged abusive or traumatic conditions that have far more troubling and long-lasting effects (Campbell, 2009:18, Streeck-Fisher & Van der Kolk, 2000:903). This occurrence might partially be due to chronic childhood trauma interfering with the capacity to integrate sensory, emotional and cognitive information into a cohesive whole, causing irrelevant responses to subsequent stress (Streeck-Fisher & Van der Kolk, 2000:903). It appears as though multiple forms of abuse have a more severe impact on the emotional regulation systems of children than any single form of abuse or trauma exposure. Researchers found a 38% increased rate of emotional dysfunction following physical abuse, 49% after sexual abuse, and a 113% increase in emotional dysfunction following combined abuse (Teicher, 2000 in Streeck-Fisher & Van der Kolk, 2000:909).

- **The identity of the perpetrator**

The identity of the perpetrator seems to have an influence on the impact of trauma in the sense that trauma inflicted by a perpetrator from whom the child expects safety and protection, can significantly affect the child in different ways (Van der Kolk, 2005:404).

Firstly, the perpetrator obstructs the child from living in a supportive environment, breaks trust, and thus causes a disrupted attachment style. Also, when a child is exposed to trauma within the family system, as with family dysfunction or violence, the caregiver does not fulfil the function of arousal modulation, which causes complications for the child to organise and categorise experiences. Van der Kolk (2005:404) furthermore explains the impact of a known perpetrator as follows:

> When trauma emanates from within the family, children experience a crisis of loyalty and organise their behaviour to survive within their families. Being prevented from articulating what they observe and experience, traumatised children will organise their behaviour around keeping the secret, deal with their helplessness with compliance or defiance, and accommodate in any way they can to entrapment in abusive or neglectful situations.

Furthermore, when the perpetrator emanates from within the child's family, the child's primary attachment figures are not only failing to protect the child, but are also the source of the trauma or maltreatment; a situation which typically worsens the impact of trauma (Cook et al., 2007:4; Streeck-Fisher & Van der Kolk, 2000:904).

- **The presence of a support system**

The presence of a support system, and particularly the parent-child relationship, is therefore another important factor moderating the impact of trauma (Cook et al., 2007:4). Forming an attachment with a primary caregiver is one of the key developmental tasks during childhood and very important in young children as they are completely dependent on their caregivers to provide them with a safe, secure environment and help them gain emotional regulation skills. The child's ability to cope with a traumatic event may be strongly associated with the parent-child attachment style and parents' ability to help their child with affect regulation (De Young et al., 2011:241; Streeck-Fisher & Van der Kolk, 2000:907). Children with secure attachment styles are often buffered from the negative consequences of trauma as "… securely attached children are likely to have had a history of responsive and sensitive caregiving and are therefore more likely to seek and be provided with protection and care …" (De Young et al., 2011:241). On the other hand, children with insecure or disorganised attachments are at even greater risk of negative effects following trauma as they are less likely to engage in emotionally supportive networks that can help them process the experience (De Young et al., 2011:242; Streeck-Fisher & Van der Kolk, 2000:907).

To summarise, the impact of trauma can be regarded as residing on a continuum (Briere & Spinazzola, 2005:401). The effect of trauma is often seen to be determined by a scale of complexity or severity of trauma, where one extreme represents responses to adult-onset,

single-incident traumatic events that occur in individuals with adequate childhood development and mental health. The other extreme relates to responses to early-onset, repetitive, prolonged and highly intrusive traumatic events, which are of an interpersonal nature that occur in individuals who may be more vulnerable to the effects of stress (Briere & Spinazzola, 2005:401).

In essence, traumatic experiences may stifle children's development in the long-run (Coates, 2010:391). In order to understand how children in middle childhood, the relevant age group in this study, are affected by trauma, a brief overview of this developmental stage and the effects of trauma are subsequently presented.

2.4 CHILDREN IN MIDDLE CHILDHOOD EXPOSED TO TRAUMA

The impact of trauma on children in middle childhood can best be understood within the context of the specific developmental phase. However, the effect of context can be understood only within the framework of normative development and change (Huston & Ripke, 2006:8). An overview of normative development during middle childhood is followed by a brief discussion on the effects of early childhood trauma on middle childhood. Finally, the ways in which trauma symptoms manifest in children in middle childhood are discussed.

2.4.1 Middle childhood as developmental stage

The stages of childhood development are based on a social construction involving "an idea about the nature of reality accepted by members of a particular society at a particular time on the basis of shared subjective perceptions or assumptions" (Papalia et al., 2008:11). Accordingly, childhood development has been categorised into the following periods: the prenatal period (conception to birth), infancy and toddlerhood (birth to age three), early childhood (ages three to six), middle childhood (ages six to 11), and adolescence (ages 11 to about 20).

The process of development occurs in three core aspects or domains, namely in the domains of physical-, cognitive- and psychosocial development (Berk, 2013:4). Physical development refers to growth of the body and brain, the development of sensory systems and motor capabilities as well as the child's health. Cognitive development includes change and stability in mental abilities such as learning, memory, language, thinking, reasoning and creativity (Berk, 2013:253), while psychosocial development includes aspects of personality, emotion and social relationships (Louw, Louw & Kail, 2014:9; Papalia et al., 2008:10). These three domains or aspects of the self continuously develop throughout the stages of

childhood. Theories are essential to understanding children's development. However, no single theory could comprehensively explain child development since most only focus on a specific developmental domain (Berk, 2013:5-6; Louw & Kail, 2007:13).

The developmental stage of middle childhood, thus children between the ages of six and 11, is described as a vital process of constant changes which occurs in a complicated manner, allowing children to acquire increasingly complex levels of functioning (Myers, 2002:258). Following is an overview of the physical-, cognitive- and psychosocial development of children throughout the middle childhood years.

2.4.1.1 Physical development

During middle childhood physical growth slows considerably, but change still occurs in children's weight and height (Louw & Louw, 2014b:225-226; Papalia et al., 2008:333). Slight differences in terms of height and weight changes exist for different gender and racial groups, but at the end of middle childhood, children's bodies resemble the bodily proportions of adulthood (Papalia et al., 2008:333). Towards the end of middle childhood the primary teeth are largely replaced by permanent teeth (Louw & Louw, 2007:215).

Although less dramatic than during infancy, significant changes in brain development occur during middle childhood. One such change is a loss in density of gray matter (closely packed neuronal bodies) which reflects the process of synaptic pruning, which refers to the loss of synapses in neurons that are seldom stimulated (Berk, 2013:185). At the same time, an increase in white matter (axons or nerve fibers that transmit information between neurons) occurs, which reflects the myelination (thickening) of these connections and thus the strengthening of certain neural pathways (Papalia et al., 2008:333). During the middle childhood years, significant growth occurs in connections between the temporal and parietal lobes in the brain, which deal with sensory functions, language and spatial understanding (Papalia et al., 2008:333-334). These changes increase the speed and efficiency of brain processes. Experience dependent brain development allows for additional growth and refinement and happens as a result of specific learning experiences (Berk, 2013:191).

With regard to motor development and physical competence, the child's strength, motor skills and physical coordination generally improve (Carter & McGoldrick, 2005:37; Louw & Louw, 2014b:227; Papalia et al., 2008:337). Consequently, improvement in gross motor skills such as jumping, running and sports, and fine motor skills such as writing, painting and drawing, become evident (Louw & Louw, 2007:216-217). During middle childhood organised

sports become prevalent and are often promoted by schools for its various long-term benefits (Papalia et al., 2008:338). Unstructured play involving informal and spontaneously organised play, such as rough-and-tumble play, hop-scotch, chasing, and kicking and throwing balls, peaks in the middle childhood years.

It is noted that the development of vaccines for major childhood illnesses has made middle childhood a relatively safe and healthy developmental stage (Papalia et al., 2008:338). Health is generally better than in any other time in the life span, yet respiratory illnesses such as asthma are common amongst children in middle childhood (Louw & Kail, 2007:24). Overweight in children has become a major health issue in recent years; on the other hand an over-concern with body image becomes prevalent during the middle childhood years and may lead to eating disorders (Papalia et al., 2008:339).

Children in this stage of development need sufficient nutrition and sleep, and Papalia et al. (2008:335-336) summarise the requirements in this regard for children in middle childhood. Nutritionists recommend that children in middle childhood on average need approximately 2400 calories per day acquired through a healthy balanced diet consisting of grains, fruit, vegetables and complex carbohydrates. Children in middle childhood experience a decline in the need for sleep. Approximately 10 to 11 hours of sleep is recommended per day, whereas nine hours per day are sufficient for older children in this age group. Sleep problems, such as resistance to go to bed, insomnia and daytime sleepiness are common during these years. Sleep problems are strongly correlated with psychological and behavioural problems, but also with allergies, ear infections and hearing problems. Even though sleep problems might be expected, it raises concern since earlier sleep problems tend to predict similar problems later in life (Papalia et al., 2008:336). Physical and brain development allow for advances in cognitive development, which will be discussed next.

2.4.1.2 Cognitive development

Cognitive development during the middle childhood years places children in this age category in the concrete operational stage in terms of Jean Piaget's theory of cognitive development. During the concrete operational stage, children become able to think logically and rationally and to solve concrete problems due to their ability to take various perspectives into consideration (Benokraitis, 2005:331). A limitation children experience in terms of cognitive development during the middle childhood phase entails that their thought processes still does not allow them to consider abstract concepts (Berk, 2013:252).

Children in middle childhood tend to gain in their understanding of spatial concepts, causality, categorisation, inductive and deductive reasoning, conservation, and mathematics (Berk, 2013:249-250; Louw & Louw, 2014b:229-230; Papalia et al., 2008:351-352). These authors indicate that causality in its simplest form refer to the notion that children now fully understand cause and effect and can therefore take responsibility for their own actions. Categorisation refers to the ability to categorise objects according to a variety of dimensions. Inductive and deductive reasoning refers to the logical reasoning that particular observation can be attributed to a larger, general group and vice versa, while with the skill of conservation children manage to acknowledge the concept that certain objects can exist in different shapes and still maintain the same properties (Berk, 2013:249-250; Louw & Louw, 2014b:229-230; Papalia et al., 2008:351-352).

Cognitive gains during middle childhood allow children to benefit from formal schooling, since memory and language skills improve significantly (Carter & McGoldrick, 2005:37; Louw & Louw, 2014b:234; Louw & Kail, 2007:24). Throughout the school years children generally show an increase in attention span, concentration, working memory, the ability to process and retain information, and to plan and monitor their own behaviour; all of which are evident of increased executive function (Carter & McGoldrick, 2005:40; Papalia et al., 2008:355). Executive function comprises “the conscious control of thoughts, emotions and actions to accomplish goals or solve problems” (Papalia et al., 2008:355). Development also occurs in relation to a person’s environment and society. Following is a discussion on the psychosocial domain of development, focusing on aspects such as the self-concept, emotions, autonomy as well as peer relations.

2.4.1.3 Psychosocial development

The cognitive advances during the middle childhood years enable children to gain a more complex and balanced regard of their self-concept, taking into consideration and integrating various aspects of the self (Papalia et al., 2008:385). The development of a healthy self-esteem becomes paramount during this stage. According to Erik Erikson’s (1950; 1982) theory of psychosocial development middle childhood is a stage where the psychosocial crisis of industry versus inferiority occurs (Papalia et al., 2008:386). Benokraitis (2005:332) explains that during this crisis or challenge children need to experience that they contribute in a way valued in their society and experience a capacity for productive work. The successful acquisition of this stage of psychosocial development results in feelings of competence. On the other hand, children who do not successfully master this stage might experience a sense of inferiority and feel inadequate (Benokraitis, 2005:332). The author

indicates that a healthy balance should however be maintained, since children might become too industrious and as result neglect a balanced lifestyle.

Emotional development during the stage of middle childhood is evident in the way children in this age group become aware of their own and other's feelings and can regulate their emotions (Louw & Louw, 2014b:260). Emotional self-regulation involves voluntary control of emotions and consequent behaviour; which by this time is developed according to cultural expectations with regard to emotional awareness and expression (Carter & McGoldrick, 2005:37; Papalia et al., 2008:386). These advances in emotional development also allow for the capacity for empathy and pro-social behaviour (Papalia et al., 2008:386) and enable children in middle childhood to take others into consideration, act appropriately in social situations, and deal with difficult situations constructively. The development of moral behaviour, based on the society's norms and values, also start to play a contributing role in children's interactions in social situations (Carter & McGoldrick, 2005:37).

During middle childhood children still greatly depend on their families (Louw & Louw, 2014b:262). The atmosphere in the family, whether supportive or conflict ridden, is one of the key influencing factors on children's development (Papalia et al., 2008:387). Although still dependent, a steady shift in control occurs from the parents to the child, with the latter assuming more autonomy, leading to a shared sense of power between parents and their children. This mutual sense of power is known as co-regulation and causes an overall change in the dynamics of the family since children increasingly make their own decisions and take responsibility for those decisions (Louw & Kail, 2007:24; Papalia et al., 2008:11).

In middle childhood, the peer group plays an increasingly important role in the life of the child (Papalia et al., 2008:12, 351). Peer groups form naturally amongst children, and are influenced by common characteristics such as areas children stay in, schools they attend, racial origin or socio-economic status, as stated by Papalia et al. (2008:399): "[c]hildren look for friends who are like them in age, sex, ethnicity, and interests." Peer groups are greatly beneficial for children's social- and identity development as interaction with peers enhance their communication skills, leadership skills, roles- and rules formation, and their sense of identity within the larger group they belong to. Some of the negative influences of peer groups might however involve prejudice, hostile attitudes towards "outsiders" perceived as different from the self, and anti-social tendencies (Carter & McGoldrick, 2005:39; Papalia et al., 2008:351).

Middle childhood marks the competition for popularity (Papalia et al., 2008:398). Popular children typically have good cognitive abilities, are high achievers, are good at solving social problems, help other children, and are assertive without being disruptive or aggressive; while unpopular children tend to be aggressive, hyperactive, inattentive or withdrawn, act silly or immature, and seem anxious and uncertain (Louw & Louw, 2007:260-261; Papalia et al., 2008:398). Normally, aggression during middle childhood is less common, since by the end of early childhood years children grow less egocentric and develop the capacity for empathy, co-operation and communication. The developmental ability to understand others' perspectives and regulate one's own emotional state allows for healthier and more socially appropriate behaviour (Carter & McGoldrick, 2005:39; Papalia et al., 2008:399, 401-402).

Although early models of childhood development theories tended to de-emphasise the importance of the middle childhood years, more recent models acknowledge the critical development that occur during this stage (Huston & Ripke, 2006:9). Middle childhood is the period when children gain the fundamental skills needed for adult life, and as Huston and Ripke (2006:1) point out, "is a time of marked change in capacities and typical behaviours that have long-term implications for adolescence and adult patterns."

A person's development is known to be influenced by his or her circumstances in life. It needs to be recognised that children in the middle childhood years are not only affected by current traumatic experiences, but that exposure to trauma during the early childhood years could influence development during middle childhood. Thus, before discussing the manifestation of trauma in middle childhood, the researcher will briefly discuss some effects of early childhood trauma on the child's development in middle childhood.

2.4.2 The influence of early childhood trauma

In terms of brain development, the most rapidly developing brain areas during middle childhood are those involved in forming healthy interpersonal relationships and in problem-solving (Cook et al., 2005:393), which are key developmental capacities of the middle childhood years (Cook et al., 2007:5; Huston & Ripke, 2006:9). Trauma impacts on these developmental capacities, as indicated by Cook et al. (2007:5) who state that "[t]raumatic stressors or deficits in self-regulatory abilities impede this development, and can lead to difficulties in emotional regulation, behaviour, consciousness, cognition, and identity formation." Neuroscience research demonstrates that some brain structures develop earlier in life than others, and that those that develop later are influenced by the earlier developments (Mustard, 2002:31; Zilberstein, 2014:293).

With regard to acquiring the necessary cognitive skills during middle childhood, it is recognised that aspects of cognitive development of earlier stages are also of relevance as a child's early years provide the foundation for further development (Ramphela, 2002:v; Zilberstein, 2014:294). The sensorimotor stage in Piaget's theory, for instance, involves that infants' understanding of themselves and the world are primarily acquired through their senses and movement (Benokraitis, 2005:332; Louw & Kail, 2007:24; Papalia et al., 2008:11; Thompson & Henderson, 2007:12). When the child's environment is toxic or neglectful in any way, an infant's sensory and bodily systems are significantly affected (Cook et al., 2007:5), which could limit their capacity for optimal cognitive development.

Another earlier developmental stage in Piaget's theory which often sheds light on the way in which children experience the impact of trauma, is that of the pre-operational stage which is marked by egocentric thinking (Louw & Kail, 2007:24; Papalia et al., 2008:11; Thompson & Henderson, 2007:12). Egocentric thinking causes children to lack the capacity to see experiences in perspective and may lead them to believe that everything is ascribed as directly related to the self, which in effect cause children in early childhood to believe that the traumatic experience was their fault (Louw & Kail, 2007:24; Piaget & Inhelder, 1968 in Streeck-Fisher & Van der Kolk, 2000:906).

Earlier experiences that negatively affect the child's cognitive development could also hamper the achievement of other developmental milestones of middle childhood (Zilberstein, 2014:294). The development of the self-concept, for example, depends to a large extent on the child's cognitive capacities. The consolidation of the self-concept, critical during middle childhood (Cook et al., 2007:5; Huston & Ripke, 2006:9), occurs as children reach the Piagetian concrete-operational stage during which they become more realistic and become able to integrate different aspects of the self into a cohesive self-concept (Louw & Louw, 2014b:229; Papalia et al., 2008:385).

With regard to their psychosocial development, school-age children (six to 12 years) need to master the basic skills needed for adult life in their specific culture (Huston & Ripke, 2006:8; Papalia et al., 2008:386). Therefore, middle childhood is a phase of strengthening the developmental gains of previous psychosocial stages (Huston & Ripke, 2006:8). The acquisition of previous psychosocial developmental tasks thus becomes relevant. From the various psychosocial tasks that need to be acquired during the early childhood years, the first navigation of the infant through the trust versus mistrust stage of development according to Erik Erikson's theory of psychosocial development, seems to be the most vital, and is

critical for the infant's future emotional and social functioning (Erikson, 1950 in Goodyear-Brown, 2010:25). Attachment theory, developed by John Bowlby (1969), likewise proposes that the quality of the early mother-infant interaction influences the infant's cognitions about future social relationships (Cook et al., 2007:4-5; Zilberstein, 2014:295). Research indicates that successful navigation of a child through the initial stages of psychosocial development, results in a child's belief that the caregiver, and by extension the world, can be trusted (Goodyear-Brown, 2010:25; Schore, 2013:5). This belief enables the child to ultimately become a happy and productive member of society (Benokraitis, 2005:331).

In contrast, if a caregiver is insensitive, inconsistent or inappropriately responds to the infant's needs, it may result in a disorganised attachment style, leading to a cognitive model of relationships as being unsafe and unreliable (Schore, 2013:10-11; Zilberstein, 2014:296). Therefore, exposure to traumatic interpersonal experiences during early childhood could challenge a child's initial beliefs and sense of safety, leaving the child to feel overwhelmed and disempowered. Many of the symptoms associated with trauma in children, can be understood in the light of attempts at regaining a sense of control or safety within his environment (Goodyear-Brown, 2010:25).

From the above discussion, it is evident that children who experience trauma or neglect in their early childhood years are still influenced by those events in the middle childhood years, as well as in later life. Some age specific features for trauma-associated symptoms are evident in the different stages of childhood development (Kaduson & Schaefer, 2006:6-7). In the next section, a brief overview of the way trauma may manifest in children in middle childhood is presented.

2.4.3 Manifestations of trauma in children in middle childhood

In this section the symptoms of trauma that are specifically prevalent in middle childhood are discussed according to the four symptom categories as outlined by D'Andrea et al. (2012:189) (refer point 2.3.1 of this report).

2.4.3.1 Affect and behaviour dysregulation

Children in middle childhood who have experienced trauma, might exhibit emotions reflecting fearfulness, regression in terms of their capabilities to handle emotions, and/or suppression of emotions. The emotional impact of trauma, as well as the effects of hyperarousal, often manifest in their behaviour. These aspects are discussed below.

General fearfulness, trauma-related fears, and worry or concern for others are common affective symptoms seen amongst children in middle childhood who have been exposed to trauma (Kaduson & Schaefer, 2006:7). These children often display an increased reliance on their caregivers, indicated by excessive clingy behaviour, anxious attachment and separation anxiety; often suggestive of their fear for abandonment (Goodyear-Brown, 2010:38). Additionally, regression - the loss of previously acquired developmental skills - is also common and manifests as anger outbursts and irrational fears, as well as in behaviours such as bedwetting or thumbsucking (Kaduson & Schaefer, 2006:6; Louw et al., 2007:379; Papalia et al., 2008:409).

Children who have experienced trauma may also attempt to block their emotions (Oaklander, 2006:50). Children in middle childhood may thus react to trauma by exhibiting extreme withdrawal or emotional numbing (Kaduson & Schaefer, 2006:7; Van der Kolk, 1994:253). Another manifestation of affect dysregulation is observed in a loss of motivation and loss of interest in previously enjoyed activities (Kaduson & Schaefer, 2006:7). Furthermore, trauma may manifest as psychosomatic symptoms, such as stomach aches or headaches, for which there is no medical explanation (Goodyear-Brown, 2010:26).

Children in middle childhood often respond to trauma exhibiting symptoms related to hyperarousal, such as anxiety, inattention, aggressive behaviour, disruptive behaviour, sleep disorders (especially nightmares), and reacting to minor triggers in an exaggerated way (Campbell, 2009:18; Kaduson & Schaefer, 2006:6-7). In this regard, neurobiological studies show that “the stresses to which individuals are exposed early in life may modify their ability to moderate and control responses to stress later in life” (Cynader & Frost, 1999 in Young, 2002:4). The brain’s response to trauma involves the release of stress hormones, causing a state of hypervigilance (Coates, 2010:395; Wasserman, 2005:13). Hyperarousal stems from a chronic state of hypervigilance (Perry, 2003:4) and children exposed to long-term trauma, such as being poorly nurtured in early life, therefore tend to retain sustained levels of stress hormones long after situations that cause arousal (Young, 2002:4).

2.4.3.2 Alterations in attention and consciousness

Other symptoms displayed by children in this stage of development, relate to dissociation. Dissociation generally manifests as alterations in attention and consciousness (Briere & Spinazzola, 2005:402-403; D’Andrea et al., 2012:189-190) and may be related to the fact that declining school performance or unwillingness to attend school are common responses to trauma for school-aged children (Louw et al., 2007:379; Papalia et al., 2008:409). These

children may thus struggle to pay attention, and may experience concentration difficulties and learning problems (D'Andrea et al., 2012:189-190; Goodyear-Brown, 2010:45; Streeck-Fisher & Van der Kolk, 2000:905; Van der Kolk, 2006:4). Streeck-Fisher and Van der Kolk (2000:906) note that "[s]everely traumatized children tend to have major deficits in their capacities for integration which is reflected in neuropsychological testing as deficits in executive functioning."

Further, confusion and spacey or distractable behaviour seem to be common symptoms amongst traumatised children in the middle childhood years (Kaduson & Schaefer, 2006:7). These symptoms are often related to lower capacities for attention and for integration of information (Van der Kolk, 2006:2, 4). In middle childhood dissociation may also manifest as immobility, aimless motion or trembling (Kaduson & Schaefer, 2006:7; Van der Kolk, 1994:256).

2.4.3.3 Distortions in attribution and worldview

Trauma symptoms related to distortions in attribution, such as shame, guilt, self-blame and poor self-esteem (Briere & Spinazzola, 2005:402-403; Cook et al., 2007:6) seem to be commonly experienced by traumatised children in middle childhood. Feelings of shame, guilt and depression are common affective symptoms associated with trauma in children in middle childhood (Kaduson & Schaefer, 2006:7). Distortions in attribution may also be carried over from trauma exposure in early childhood, where children due to egocentric thinking tend to blame themselves for the traumatic experiences (Louw & Kail, 2007:24; Piaget & Inhelder, 1968 in Streeck-Fisher & Van der Kolk, 2000:906). As noted by Kegan (1982) in Van der Kolk (2005:404):

> Young children, still embedded in the here-and-now and lacking the capacity to see themselves in the perspective of a larger context, have no choice but to see themselves as the centre of the universe: everything that happens is directly related to their own sensations.

Traumatised children might therefore ascribe traumatic events and the feelings related to that as being their own fault (Louw & Kail, 2007:24; Papalia et al., 2008:11; Thompson & Henderson, 2007:12). These and other factors might lead to a low self-esteem in children, which is yet another symptom often related to trauma (Kaduson & Schaefer, 2006:8).

In reaction to trauma, safety concerns are common, as well as an over-concern with danger rooted in the belief that the world is an unsafe place and that people cannot be trusted (Kaduson & Schaefer, 2006:7-8). School-aged children are known to have the illusion of

omen formation, which is “the belief that there were warning signs that predicted the trauma” (Kaduson & Schaefer, 2006:8). As a result these children believe that if they are alert enough they will be able to recognise these warning signs and consequently avoid future traumatic events. As the worldview of traumatised children tend to include expectations of loss and rejection, and an over-estimation of the extent of danger in the world (Briere & Spinazzola, 2005:402-403; D’Andrea et al., 2012:190; Streeck-Fischer & Van der Kolk, 2000:905), it is proposed that the phenonomon of omen formation can intensify the effects of such a worldview for the child in middle childhood.

2.4.3.4 Interpersonal difficulties

In relation to interpersonal difficulties, it is noted that negative social and emotional experiences in the early years of development “can compromise higher-level neural systems that provide the information needed to bond, imitate, and generally respond in socially responsible ways” (Young, 2002:4). This view is in congruence with various longitudinal studies which observed that children who are reared in dysfunctional families without external support in the early years are at increased risk for anti-social behaviour when they enter the school system (Mustard, 2002:39).

Children who have experienced trauma tend to have relationship problems with peers and family members including problems with acting out behaviour, hostility and aggression (Kaduson & Schaefer, 2006:8). They generally seem to experience difficulty trusting others and often display odd social behaviour. Furthermore, feelings of isolation and stigma are common.

Negative behaviours can have a significant effect on children’s acceptance into the peer group; an important aspect of the psychosocial development of the child in middle childhood (Papalia et al., 2008:12; 351). Children who are aggressive, hyperactive, withdrawn and anxious are generally unpopular amongst their peers (Louw & Louw, 2007:260-261; Papalia et al., 2008:398). Rejection by the peer group can result in feelings of loneliness, depression, poor academic performance, school avoidance, poor self-esteem and distrust in others (Berk, 2013:620), all of which have been discussed in this section as characteristic manifestations of trauma in children in the middle childhood years. It could therefore be stated that manifestation of trauma symptoms in one symptom category can intensify the trauma symptoms in other symptom categories discussed above.

In conclusion, aspects of middle childhood development and experiences during this life stage are known to have long-term consequences, and behaviour patterns that form in middle childhood has been shown to continue into adolescence and adulthood (Huston & Ripke, 2006:9). It is therefore of key concern to address trauma in children in order to moderate or prevent its harmful consequences in later life. Intervention during these early years is critical, since children develop and establish skills for self-awareness and self-regulation, and biological pathways for handling stress become more established (Huston & Ripke, 2006:8; Young, 2002:3).

However, it is suggested that therapeutic interventions with severly traumatised children often show limited success as conventional therapies do not take the neurobiological effects of trauma into account (Gaskill & Perry, 2014:186; Le Bel et al., 2010:2; Perry, 2003:2; Perry, 2006a:22; Van der Kolk, 2003:309). In Chapter 3 the researcher will present an overview of limitations to conventional trauma interventions, subsequent suggestions for trauma interventions, and Gestalt play therapy as a possible intervention for traumatised children.

2.5 SUMMARY

The high exposure to trauma that children experience is a cause of concern due to the harmful consequences of trauma on children's lives, which may continue into adulthood. In this chapter trauma and the prevalence of trauma, worldwide and in the South African context, was conceptualised. The impact of trauma, with acknowledgement of the neurobiology of trauma, as well as individual responses to trauma was indicated. An overview of the developmental stage of middle childhood, the age group relevant to the study, was presented, as well as of the manifestations of trauma characteristic to children in this developmental stage. It was concluded that trauma need to be addressed since behaviour patterns established in middle childhood may have long-term implications for adolescence and adulthood. In the next chapter, trauma interventions are therefore discussed.

CHAPTER 3
TRAUMA-INFORMED INTERVENTIONS

3.1 INTRODUCTION

Based on an overwhelming body of research indicating the impact of trauma on almost every aspect of a person's life, LaLiberte et al. (2013:2) acknowledges that the field of child welfare is at the dawn of a major shift in how it views its work. While trauma may have severe long-term consequences, Perry (2006a:22) amongst others, suggests that treatment can lessen the impact of childhood trauma. In this chapter, the limitations to conventional treatment modalities are outlined, suggestions for trauma interventions are discussed, and finally Gestalt play therapy as a possibly appropriate intervention for traumatised children is reviewed.

3.2 LIMITATIONS AND SHORTCOMINGS OF CONVENTIONAL INTERVENTIONS

Various treatment initiatives have been offered to address trauma, PTSD and trauma-related behaviour problems; however, interventions with severely traumatised children have shown limited success (Gaskill & Perry, 2014:185; Le Bel et al., 2010:2). This might partly be ascribed to a lack of understanding of the way in which both trauma and therapy affect the brain of traumatised children, and failure to integrate this understanding into therapeutic interventions (Perry, 2003:2; Van der Kolk, 2003:309). The limitations of conventional therapies for trauma-related problems in children seem to be the threat it poses for possible re-traumatisation, the inability to access the relevant brain areas affected by trauma, as well as the verbal and rational dominance of these therapies, as will be highlighted below.

3.2.1 Re-traumatisation

One goal of trauma work with children is to restore a sense of safety and protection since traumatised children experience almost every situation as threatening and unsafe, and could thus easily experience re-traumatisation (Goldman, 2009:15; Zelechoski et al., 2013:644). The dysregulation of the neuro-endocrine and limbic systems due to trauma causes significant difficulties for children in terms of emotional self-regulation (Coates, 2010:398). Therefore traumatised children need skills to help them contain reactions to triggers and to halt the trauma reaction (Rothschild, 2001:22) otherwise professionals might unknowingly fuel the trauma reaction (Campbell, 2009:20; Zilberstein, 2014:300).

3.2.2 The inability to access relevant brain areas

The effect trauma has on the normal structure and functioning of the brainstem and basic brain functions, seems to contribute significantly to certain long-term effects associated with an inability to obtain homeostasis through self-regulation (Campbell, 2009:18-19; Coates, 2010:393-394; Schore, 2001:205). Perry (2006a:22) states that "in order to heal (i.e. alter or modify trauma) therapeutic interventions must activate those portions of the brain that have been altered by the trauma." Conventional therapies seem unable to access the lower brain areas as these areas are unresponsive to language, insight or logic used in verbally-based therapies (Gaskill & Perry, 2014:186; Van der Kolk, 2006:5). Behavioural therapy often is the primary approach taken to address behaviour problems in traumatised children, and although effective in managing the children's behaviour some of the time, it often does not meet the deeper psychological needs of the clients (Goodyear-Brown, 2011:xiii) Furthermore, recent concerns have been raised regarding the limitations of behaviour therapy, especially for younger children (Goodyear-Brown, 2010:9).

3.2.3 The verbal and rational dominance of conventional intervention modalities

Conventional therapies emphasise verbalisation and problem-solving that are regulated by cortical brain functions, while the functions of the cortex (language, reasoning, and logic) are inaccessible in the constant state of hyperarousal often experienced by traumatised individuals (Baloyi, 2006:17; Cook et al., 2007:5; Gaskill & Perry, 2014:185; Le Bel et al., 2010:2; Van der Kolk, 2006:5-6). In PTSD reactions it is posited that neurochemicals released during the body's reaction to the stress of a traumatic event may result in a blockage that keeps the linguistic narrative of events separate from important sensory information (Siegel, 2003 in Goodyear-Brown, 2010:20). A child's verbal rehearsal of his narrative over and over again, fragmented from his sensory perceptions of the event, does not seem to result in relief from trauma symptoms neither does it allow for the integration of the experience (Streeck-Fisher & Van der Kolk, 2000:911).

Furthermore, many children cannot or will not talk about their traumatic experiences. Young children my lack the necessary skills to process trauma through a coherent, sequential, verbal narrative (Arvidson et al., 2011:38). Apart from the fact that children are not predominantly inclined to use language as their way of communication, many children have experienced pre-linguistic trauma. This means that the trauma occurred prior to the development of language and consequently there are no words that could truly describe the trauma experience as there were no words at the time trauma occurred (Arvidson et al.,

2011:38; Goodyear-Brown, 2010:11). Certain suggestions are proposed for work with traumatised children, which are subsequently discussed.

3.3 SUGGESTIONS FOR INTERVENTIONS

Clearly, verbally-based conventional treatment techniques for traumatised individuals need to be re-considered in the light of neurobiological principles related to trauma (Campbell, 2009:19; Gaskill & Perry, 2014:186-187; Perry, 2006a:22). Suggestions for alternatives to treatment and intervention techniques centre on three basic concepts: establishing safety and competence, dealing with the stress response, and fostering integration and self-regulation.

3.3.1 Establishing safety and competence

Traumatised children need to develop a sense of safety and a feeling of control within a nurturing environment (Goodyear-Brown, 2010:2, 49; Rothschild, 2001:22; Wasserman, 2005:18; Zilberstein, 2014:301). Safety and competence for children can be enhanced by the formation of a trustworthy therapeutic relationship, neutral fun tasks and experiences of mastery and control (Streeck-Fisher & Van der Kolk, 2000:913-915; Van der Kolk, 2005:407). The therapist's ability to assess the child's developmental level and then meet the child in developmentally appropriate ways will furthermore enhance the child's experience of safety and competence (Goodyear-Brown, 2010:2, 49). Age-related creative techniques such as drawing, acting, stories, and dancing, are regarded as suitable to achieve this goal (Baloyi, 2006:17-18; Wasserman, 2005:17).

Intervention strategies must take into account traumatised children's fear response so that therapists do not unknowingly fuel the trauma reaction (Campbell, 2009:20; Van der Kolk, 2006:5; Zelechoski et al., 2013:644). The restoration of internal safety happens when a child's distress is identified, validated and modulated. Over time this process become internalised and the child builds the capacity for effective self-regulation (Arvidson et al., 2011:38). Safe and successful therapy therefore requires that stress hormone levels be maintained low enough in order to access the higher brain regions, allowing for homeostasis through self-regulation (Campbell, 2009:19; Coates, 2010:398; Rothschild, 2001:22). Creative therapies are suggested for traumatised children. These therapies are regarded as non-threatening while they are also appropriate for activating the limbic system, and could consequently serve to resolve the triggers causing hyperarousal (Gaskill & Perry, 2014:186-187; Wasserman, 2005:17).

3.3.2 Dealing with the stress response

One of the most troublesome consequences of childhood trauma is the resulting physiological dysregulation experienced by the traumatised child. Regardless of the type of trauma suffered, "the extreme nature of the external threat is often matched by an extreme and persisting internal activation of the neuropsychological systems mediating the stress response and their associated functions" (Perry & Azad, 1999:310 in Goodyear-Brown, 2010:105). Due to the constant state of hypervigilance so often prevalent in traumatised children, they tend to have a heightened reactivity that makes it difficult for them to calm down. It is advised that children's pathways to self-regulation and co-regulation with others are addressed, since dysregulation would hamper the attainment of other therapeutic goals (Goodyear-Brown, 2010:107; Zilberstein, 2014:300). Arvidson et al. (2011:41) explain that affect regulation refers to the ability to calm down and soothe the self when distressed or overwhelmed, which can be acquired through co-regulation and sensory experiences provided by the therapist.

Many play therapy strategies can be used to help clients become more aware of their own physiological arousal and subsequently influence their ability to regulate their bodily reactions. A multiplicity of play-based stress inoculation techniques is advised for this purpose. Stress inoculation exercises include deep breathing exercises, progressive muscle relaxation techniques, guided imagery, and biofeedback; all of which can be delivered through play-based interventions (Goodyear-Brown, 2010:19). Moreover, the playfulness inherent in play-based therapies naturally counters the toxicity of anxiety symptoms that manifest as physiological hyperarousal (Goodyear-Brown, 2010:108; Zilberstein, 2014:302). Traumatised children are soothed by routines; it may thus be helpful to begin and end therapy sessions with the same activities each time they come to treatment (Arvidson et al., 2011:41). Relaxation exercises are advised for these routine activities (Goodyear-Brown, 2010:109).

3.3.3 Fostering integration and self-regulation through non-verbal measures

With regard to the verbal and cognitive limitations of conventional therapies, it is advised that children need to approach the trauma through non-verbal and sensory avenues (Goodyear-Brown, 2011:x). This author states that play and play-based interventions allow the child a non-verbal way to communicate their experiences, and that the "healing power of play … brings out relief and access the physiologically encoded memories." Due to trauma being stored mainly in the body (Rothschild, 2001:17) certain sensory aspects of the trauma may have to be addressed in order to restore self-regulatory capacities (Goodyear-Brown,

2010:11). The foundation of the development of self-awareness and self-regulation rests on learning to comprehend the "nuances" of physical sensations. The inability to process sensory experiences into coherent perceptions causes problems for traumatised children to interpret incoming information, which in turn make them react inappropriately (Streeck-Fisher & Van der Kolk, 2000:911). Arvidson et al. (2011:43) further emphasise that due to children's limited emotional understanding and emotional vocabulary, they tend to depend on their bodies to express emotions. Modulation of sensory and bodily experiences should therefore be incorporated as a primary treatment goal, as it will help children to control physiological arousal (Arvidson et al., 2011:43; Zilberstein, 2014:302). These authors state that sensory-focused activities and movement are advised for teaching modulation skills for young children.

The promotion of sensory and emotional awareness can therefore support self-regulation skills in traumatised children (Streeck-Fisher & Van der Kolk, 2000:913-915; Van der Kolk, 2006:13; Zilberstein, 2014:303). Experience-based interventions seem to offer advantages over purely cognitive-based interventions to address chronic and automatic responses to trauma (Perry, 1997:134; Van der Kolk, 2006:5). Movement, breathing, relaxation exercises and experiential techniques are regarded as useful for this purpose (Norton & Norton, 2011:211; Van der Kolk, 2006:6; Zilberstein, 2014:303).

Based on the above recommendations for interventions with traumatised children, it becomes apparent that some of the damage caused by trauma seems to be reversible, with play being one of the components advised. In this regard Goodyear-Brown (2010:vi) states that "play therapy is developmentally based, developed from solid philosophical and theoretical underpinnings, with empirically based research showing its positive impact of healing." Experiential approaches to play therapy seem to integrate many of the desired conditions for trauma-informed treatment (Norton & Norton, 2011:211). Following, Gestalt play therapy as an experiential approach to psychotherapy and the therapeutic process in Gestalt play therapy is summarised.

3.4 OVERVIEW OF GESTALT PLAY THERAPY

This section provides, in short, the background and theoretical base of Gestalt play therapy, by firstly acknowledging the theoretical framework of Gestalt therapy. Subsequently, Gestalt play therapy, its objectives, and the Gestalt play therapy process are discussed.

3.4.1 Gestalt therapy

The concept *Gestalt*, a German word not easily translated into English, refers to the overall configuration or the distinctive way in which parts are arranged into a whole (Blom, 2006:18; Henderson & Thompson, 2011:221); and in terms of Gestalt therapy, to the totality of a person (Clarkson & Cavicchia, 2014:1; Mann, 2010:ix). Gestalt therapy was first developed by Fritz Perls and Laura Perls (Fall et al., 2010:202; Oaklander, 2011:171) and is a form of psychotherapy which is described as a relational therapy that has its roots in phenomenology, holism and existentialism (Blom, 2006:19; Clarkson & Cavicchia, 2014:33; Fall et al., 2010:203; Mann, 2010:5).

Gestalt therapy is firstly phenomenological in that it seeks understanding through what is observable or revealed, rather than through what is interpreted by the observer (Mann, 2010:4). Therapy thus focuses on people's perception of their reality and how they create meaning about their experiences, and has a strong emphasis on awareness in the here and now (Blom, 2006:18-19; Corey, 2013:194; Fall et al., 2010:203).

Secondly, Gestalt therapy is holistic in that the person's experience is explored in the context of their situation or 'field' and in a holistic sense, incorporating all aspects of the self (Mann, 2010:4). Gestalt theory thus maintains that every person needs to be perceived as an entity or a whole, and in relation to their environment (Blom, 2006:19; Fall et al., 2010:205; Henderson & Thompson, 2011:221). The focus is therefore on people "as integrated beings with senses, body, emotion, and intelligence working together" (Henderson & Thompson, 2011:223), as well as on the interdependence between the person and the environment (Blom, 2006:19). Without acknowledging the concept of holism, therapists cannot truly understand or perceive a person (Blom, 2006:19; Clarkson & Cavicchia, 2014:1; Fall et al., 2010:203; Mann, 2010:5). The aim of Gestalt therapy is for a person to discover, explore and experience his or her own wholeness, and the aim of therapy is ultimately the integration of all disparate parts (Clarkson & Cavicchia, 2014:1; Geldard et al., 2013:39).

Thirdly, Gestalt therapy is based on existentialism, according to which people are seen as capable of personal growth and of choosing their behaviour (Blom, 2006:19; Corey, 2013:194). This aspect further relates to dialogic existentialism, a specific form of contact that is concerned with the 'I-thou' contact and withdrawal process and not just with talking. The therapist actively engages in the relationship with the client as part of their situation, paying careful attention to what happens in the dynamic interchange between client and therapist (Mann, 2010:4).

Existentialism further refers to the one key aspect underpinning Gestalt theory, which maintains that awareness of the present and experiencing the present moment in its entirety is at the heart of psychology (Blom, 2006:17; Fall et al., 2010:202; Geldard et al., 2013:39). Gestalt therapy focuses on experiences in the here and now, which means that it places emphasis on the current content or immediate experience of a situation (Fall et al., 2010:203; Geldard et al., 2013:39; Henderson & Thompson, 2011:221). The therapist therefore explores how persons reach out to their world, how they respond to their situation and how past and present situations impact upon clients' processes of reaching out in the here and now (Mann, 2010:4). Being a requirement for effective self-regulation, awareness of the inner self and of the environment is seen as the basis of emotional health (Fall et al., 2010:208; Henderson & Thompson, 2011:244).

In Gestalt therapy, the above three philosophies are applied in an integrated fashion and uphold the relational perspective as their common core (Mann, 2010:4). Violet Oaklander combined the use of Gestalt therapy principles with the use of media to work therapeutically with children (Geldard et al., 2013:40). This constitutes Gestalt play therapy (Blom, 2006:20; Henderson & Thompson, 2011:238) which is subsequently discussed. The theoretical concepts underpinning Gestalt play therapy (Blom, 2006:22-29), namely holism, self-regulation, awareness and contact, were discussed as part of the theoretical framework of the study, in Chapter 1 (point 1.2).

3.4.2 Gestalt play therapy

Gestalt play therapy is defined as "a psychotherapeutic technique that uses the principles and techniques of gestalt therapy during play therapy with the child" (Blom, 2006:20). Gestalt play therapy is a therapeutic approach to address unhealthy functioning in children. Unhealthy functioning is regarded as a lack of self-regulatory capacities due to lack of awareness and contact (Fall et al., 2010:207-208; Henderson & Thompson, 2011:224). Oaklander (2011:190) explains that, in general, traumatised children tend to lack the capacity of self-awareness and healthy contact. They often suppress their senses, body, emotions and intellect, and therefore struggle to integrate information and respond appropriately (Fall et al., 2010:209; Oaklander, 2011:190). Consequently they lack the capacity for self-regulation, resulting in an inability to develop healthy integrated functioning (Geldard et al., 2013:39). This inability for effective contact often manifests in children's behaviour, in Gestalt vocabulary referred to as **contact boundary disturbances** (Oaklander, 2011:90). Contact boundary disturbances refer to mechanisms to disown awareness (Fall et al., 2010:209). Simply stated, the child engages in inappropriate

behaviours in an attempt to cope (Oaklander, 2011:190). Contact boundary disturbances therefore refer to unhealthy, fragmented processes which children engage in to satisfy their needs in a quest for survival (Blom, 2006:31: Oaklander, 1994:144). Introjection, projection, confluence, retroflection, deflection, desensitisation, and egotism are terms used to describe various contact boundary disturbances, which in effect hamper the ability for organismic self-regulation (Blom, 2006:32). These contact boundary disturbances are briefly explained as follows (Blom, 2006:32-39; Corey, 2013:199-200; Fall et a., 2010:210-212):

- Introjection refers to the tendency to allow information from the environement to become one's own truth, without critically reviewing the credibility of others' thoughts, beliefs, ideas or behaviours.
- Projection, as a contact boundary disturbance, can be described as the tendency to ascribe aspects which belong to the self to other objects or individuals, thus avoiding responsibility for one's own behaviour or emotions.
- Retroflection refers to directing emotions or behaviour which is intended to be directed towards the environment, at oneself.
- Deflection refers to behaviour conducted with the intention to avoid making contact with another person, such as avoiding eye-contact or changing the subject during a conversation.
- Desensitisation can be explained as way in which children suppress awareness of painful or uncomfortable sensory experiences related to the trauma.
- Egotism is described as the tendency to avoid subjective, emotional awareness of an experience a person is cognitively aware of, thereby maintaining an objective stance of the self.

The main focus of Gestalt play therapy is the restoration of healthy, integrated functioning, whereby an individual is enabled to identify and address needs as they arise in the present moment (Blom, 2006:29; Fall et al., 2010:207; Geldard et al., 2013:39; Henderson & Thompson, 2011:238). This cycle of needs fulfillment requires the ability of the person to achieve a state or homeostasis or balance, through the process of organismic self-regulation (Blom, 2006:23; Fall et al., 2010:204). Organismic self-regulation refers to the process whereby the organism attempts to establish equilibrium in an ever-changing environment. Through organismic self-regulation the individual is able to identify and respond to the changes within themselves and their environment (Blom, 2006:23; Fall et al., 2010:204; Oaklander, 2011:174). In order to achieve a capacity for self-regulation the individual needs appropriate contact (Fall et al., 2010:207). According to Oaklander (2011:173) "healthy

contact involves the use of the senses, awareness and appropriate use of the body, the ability to express emotions, and the use of the intellect."

In order to promote healthy functioning, the three main **objectives of Gestalt play therapy** are addressed simultaneously during the therapeutic process. As described by Blom (2006:51-54), the objectives firstly involve enhancing children's awareness of their own process so that they can identify their own needs and emotions, which leads to the capacity to address their needs in the here and now, thus allowing for self-regulation. Furthermore, the objectives of Gestalt play therapy involve promoting children's self-supporting behaviour by encouraging them to take responsibility for their own behaviour, and lastly, the aim is to restore integration so that children can devote all their energy to meeting their needs in an appropriate way. Integration requires that the child functions as a holistic entity, using cognition, emotions, body and senses to complete unfinished business, and fully attend to needs (Blom, 2006:54). Integration further focuses on resolving conflicting polarities within the person, for example good-bad, love-anger, which often lead to fragmentation and an inability to function as a holistic being (Blom, 2006:39-41).

According to the Gestalt perspective, change is related to enhanced awareness (Fall et al., 2010:212-213). Throughout the therapeutic process, the client works through a progression of five layers, depicting how people fragment their lives, which Fritz Perls (1970) labelled "the five layers of neurosis" (Fall et al., 2010:213). These layers refer to a process of increasing awareness, whereby the client is assisted to move from a false or synthetic existence, towards awareness and acceptance of the true self (Fall et al., 2010:213; Mann, 2010:211). Working through the five layers towards a better integrated self, is considered as "five steps to a better Gestalt way of life" (Henderson & Thompson, 2011:230). These authors regard the five layers of neurosis as benchmarks in the therapeutic process and suggest that these layers should be incorporated during Gestalt therapy with children.

In short, the **layers of neurosis** are as follows (Blom, 2006:42-45; Fall et al., 2010:213; Henderson & Thompson, 2011:230):

- The phony layer refers to a person's false existence, unconsciously trying to be what he is not. In children, this attempt to uphold a synthetic layer of the personality often occurs due to fragmented functioning in an attempt to fulfil roles expected by themselves or others.

- The phobic layer is regarded as the stage during which a person becomes aware of the false existence and the reasons for maintaining that phony or synthetic layer. Becoming aware of these reasons might cause anxiety for that person.
- The impasse layer constitutes the stage in the therapeutic process during which a person realises that he does not have an alternative way of coping. During this stage, a person is confronted with the decision to find sufficient self-support instead of relying on external support. Children in therapy often experience a sense of paralysis in moving forward from this stage, as engaging in a process of change is often perceived as more threatening and painful than continuing to lead a false existence.
- The implosive layer represents a stage in the therapeutic pocess when a person realises how his fragmented functioning limits his capacity for healthy functioning. The person might start to work towards integration through experimenting with new behaviours in the therapeutic setting, though the energy to free oneself from the paralysis of the impasse layer might lack.
- The explosive layer is the stage during which the person becomes aware of suppressed emotions and acquires the means to complete unfinished business. During this stage, children acquire the energy to restore healthy, integrated functioning.

As Gestalt therapy focuses on achieving awareness in the here and now, the emphasis of therapy is on direct experience (Blom, 2006:57). Oaklander (2011:191) states that “in work with children, experience becomes the key to awareness.” Providing diverse experiences for children is therefore an essential component of the therapeutic process (Oaklander, 2011:191). Henderson and Thompson (2011:230-238) indicate that language, reactions in the body, and experiments are used to provide opportunities for experiences in the here and now. An experiment is defined in Gestalt therapy as “the act of trying something to increase awareness” and provides an alternative to verbal means of interaction (Henderson & Thompson, 2011:232).

Throughout the therapeutic process, the therapist thus introduces various activities that focus on experience and discovery in the here and now (Blom, 2006:57-59, 237). In Gestalt play therapy particular attention is paid to enhance clients’ awareness of their own process, thus what they are doing and how they are doing it (Blom, 2006:51, 59). Self-awareness of one’s process in itself can enable children to adjust in their environment (Fall et al., 2010:208; Henderson & Thompson, 2011:229; Oaklander, 2011:191). Blom (2006:59) emphasises the therapist’s role as observer and listener to assist children to experience and discover aspects of themselves.

The therapeutic process progresses through certain stages, though it is essentially a non-linear process that is dependent on each individual child's needs (Oaklander, 2006:20). In planning and implementing the therapeutic process, the therapist thus respects the uniqueness and individual process of each child in experimenting with experiences to help the child renew and strengthen aspects of the self (Oaklander, 2011:201-202). It is also essential to consider childhood development theories such as Erik Erikson's theory of psychosocial development and Jean Piaget's theory of cognitive development, as well as the child's specific life experiences and trauma in order to understand the child in context (Oaklander, 2011:172). Therefore, the therapeutic process as is discussed in the following section, serves as a guideline and each individual child ultimately determines the pace and focus of the therapeutic intervention. The stages of the Gestalt play therapy process are outlined in the following section.

3.4.3 The Gestalt play therapy process

The Gestalt play therapy process consists of a number of stages: building of a therapeutic relationship, promoting contact, enhancing the child's sense of self, emotional expression, self-nurturing and termination (Blom, 2006:20). For each of the stages the therapist considers certain tasks and assessment criteria to determine individualised treatment goals which are based on the relationship, contact functions (sensory and bodily awareness and cognitive abilities), sense of self, emotional expression, and self-nurturing respectively (Oaklander, 2011:171). These goals guide the process during each session as well as the process of the therapy throughout.

Although the Gestalt play therapy process implies a certain order, it does not always progress in a linear or fixed order from one stage to another. However, the therapeutic relationship is always prioritised and always comes first (Blom, 2006:20, 56; Oaklander, 2011:171; Oaklander, 2006:20). With the subsequent stages, the therapist can go back and forth in the therapeutic process according to the needs of the child (Oaklander, 2006:20). Following is a discussion of the stages of the Gestalt play therapy process, as outlined by Blom (2006:49-151, 237-238) and Oaklander (2006:20-49).

3.4.3.1 Building a therapeutic relationship

Gestalt play therapy strongly relies on the interpersonal relationship between client and therapist that is developed and nurtured over the course of therapy (Blom, 2006:56; Henderson & Thompson, 2011:227). Oaklander (2006:21) regards the I-thou relationship as

the foundation of the therapeutic process and as therapeutic in itself. The fact that the I-thou relationship is considered an essential basis for interaction between the therapist and the child "has an important implication for therapeutic work with children" as stated by Blom (2006:56). An I-thou relationship implies that the therapist and child are seen as equals, despite differences in age, status and education, and is based on conditions of acceptance, respect and non-judgment. Such a relationship provides a safe and accepting environment for the child to gain trust in the therapist, to be open to new experiences, and to develop self-understanding (Blom, 2006:54-56; Oaklander, 2011:172). The relationship is furthermore grounded in the qualities of presence, confirmation, immediacy, inclusion and a commitment to open and direct communication with the client (Clarkson & Cavicchia, 2014:20). These conditions and qualities are the therapist's responsibility, and in this regard Fall et al. (2010:214) emphasise that "Gestalt therapists are considered tools of change." However, from a Gestalt perspective, both the child client and the therapist take responsibility for their choices, behaviour and experiences (Blom, 2006:58). Children usually do not make the decision to come for therapy, and therefore they should be guided towards responsibility and self-determination (Blom, 2006:58).

During this initial stage in therapy, and in each session, particular attention is paid to join with the child and to establish contact and a working alliance with the child in the here and now (Blom, 2006:56-57). Throughout the process of contact-making, it is important to maintain a healthy balance between contact and withdrawal. It is necessary for the child to reach out to the environment to satisfy his needs, but also to withdraw from contact, which reflects the balanced need for self-support and support from one's environment (Blom, 2006:89; Mortola, 2006:28). A therapeutic relationship, in which the child will experience safety and acceptance, is supportive of contact between the therapist and the child and is therefore the focus during the first few therapy sessions with the child, as well as in the initial stage of each therapeutic session (Blom, 2006:54; Oaklander, 2007:196). Effective joining with a child further requires that therapists must be in contact with their own inner child, and value their own creativity and ability to play in order to meet the child on his or her developmental level (Blom, 2006:57). The therapeutic relationship is also enhanced by the establishment of boundaries and limits in order to provide structure and enhance the child's sense of safety during sessions (Blom, 2006:61).

Children who have experienced trauma may find it difficult to build relationships, which may manifest as resistance (Blom, 2006:60-61). Resistance refers to breaking contact and is seen as the child's attempts to cope and protect the self (Oaklander, 2006:23). Resistance might arise as a normal need for self-preservation, especially during this stage of the

therapeutic process (Oaklander, 2006:23). Resistance should be seen as a child's way to take care of himself[4], as resistance usually manifests when a child feels challenged beyond his capabilities and available self-supportive energy (Blom, 2006:59; Oaklander, 2006:23-24). Therefore, resistance is not to be overcome, but respected as a normal part of the process in establishing a safe and reliable relationship (Mortola, 2006:34; Oaklander, 2006:23). Blom (2006:61) advises that the therapist "must be sensitive to the way in which resistance manifests, in order to react to it in an appropriate way." A child's initial resistance may decrease as the therapeutic relationship of trust is established (Oaklander, 2007:196), however it may occur throughout the therapeutic process in situations when children feel unsafe or do not have a sufficiently strong sense of self to deal with unfinished business (Blom, 2006:60).

It needs to be kept in mind that unfinished business, referring to unfulfilled needs, might arise early in the therapeutic process, but to address that material before the relationship is strong enough might scare children and make them defensive (Mortola, 2006:15). Healthy contact and a strong sense of self should therefore be enhanced before sensitive issues are being addressed. Healthy contact requires appropriate sensory and bodily awareness, which is discussed next.

3.4.3.2 Enhancing sensory and bodily awareness

Infants start out to experience their world through their senses, which allows for contact with their environment, providing the primary means through which they gain knowledge about the world, develop a sense of self and gain self-confidence (Blom, 2006:90). Trauma, however, often causes desensitisation and suppression of sensory and bodily awareness to protect the self against pain, and may manifest as contact boundary disturbances (Blom, 2006:31, 90; Oaklander, 2006:22).

Children who present with contact boundary disturbances need various experiences that would enhance their contact-making skills (Blom, 2006:89). Contact-making is essential for children to be able to utilise all aspects of themselves and their environment in order to engage in the process of self-regulation (Mortola, 2006:35, Oaklander, 2006:22). Healthy contact-making involves awareness and appropriate use of one's contact skills, which includes the use of the senses (looking, listening, touching, tasting, and smelling) and of the

[4] For the purpose of this research report, the masculine form of the pronouns is used throughout to avoid unnecessary words, though it might refer to both genders.

body (e.g. gestures and movement) (Henderson & Thompson, 2011:224-225; Mortola, 2006:12-13; Oaklander, 2011:173; Oaklander, 2006:22).

Increased sensory and bodily awareness provides information that can help with awareness and understanding of emotions, since every emotion have a link with the senses and the body (Blom, 2006:91; Oaklander, 2006:25). In Gestalt play therapy, sensory and bodily awareness in itself is therefore of therapeutic value (Blom, 2006:90). Le Bel et al. (2010:3) emphasises that sensory awareness exercises provide "experiential opportunities to help individuals recognize and regulate sensory experiences, identify sensory preferences, and begin to heal the mind through the physical sensations of the body."

Neutral and fun exercises, such as balancing on an inflatable ball, and sensory integration exercises are suggested (Le Bel et al., 2010:3). Blom (2006:92-102) and Oaklander (2006:24-26) suggest various exercises that involve the senses. These exercises involve activities that focus on touch, smell, sight, taste and hearing as well as on breathing and relaxation.

Next, the sense of self, another component of self-support for contact-making (Blom, 2006:89), is discussed.

3.4.3.3 Strengthening the sense of self

An individual's sense of self in essence refers to the way in which an individual perceives and presents himself and includes physical, emotional, intellectual, behavioural, social and creative aspects of the self (Oaklander, 2006:52). Landreth (2002:63) defines the sense of self as "… an organised configuration of perceptions of the self which are admissible to awareness" and it is based on elements such as the perception of one's characteristics, one's position in relation to the environment, the value and qualities of one's experiences or objects, and one's goals and ideals (Landreth, 2002:63). Oaklander (2006:52) explains that generally, children are born with a healthy sense of self, with the ability to make use of their senses, express emotions freely and use intellect to explore their world. Children with a good sense of self can accept themselves, acknowledge their strengths and weaknesses, tolerate criticism, are able to focus on the here and now, and view mistakes or failure as learning opportunities (Blom, 2006:102).

To the contrary, children with a poor sense of self lack self-support and often make use of contact boundary disturbances in order to protect the self (Blom, 2006:102-103). A number

of factors may lead to a poor sense of self in children. Children tend to be egocentric due to their normal developmental process, and therefore often blame themselves for trauma that has occurred (Oaklander, 2011:193). Some children have been exposed to harsh and loveless childhood experiences, which negatively affect their sense of self (Blom, 2006:102). Children also take in many negative messages about themselves (referred to as introjects in Gestalt play therapy), because they do not have the cognitive ability to discriminate between what is true and what is not true (Blom, 2006:103; Oaklander, 2011:193). These negative beliefs inhibit healthy integration, and are often the roots of a low self-esteem or insufficient self-support.

The two dimensions of the sense of self, namely the need to feel lovable and the need to feel capable, are related to the ways in which a poor sense of self manifests. Children who doubt their lovability may be timid, clingy, attention seeking, aggressive or engage in bullying, while those who doubt their capability may be fearful of failure, frightful, resistant to change and easily upset by mistakes (Humphries, 2002 in Blom, 2006:103).

According to Oaklander (2011:193-194) children need support within the self before gaining the inner strength to express blocked emotions. Oaklander (2006:27-31) suggests that the sense of self can be strengthened in the following ways:

- Defining the self: Children are encouraged to talk about themselves through creative measures by which children are learning to define the self (“This is who I am”) and integrating their self-definition into their awareness.
- Choices: A child’s inner strength can be enhanced by providing him with numerous opportunities to make choices. Initially, limited and non-threatening choices are provided in order not to overwhelm the child, progressing towards more complicated choices.
- Experiences of mastery and control: Providing developmentally appropriate opportunities for children to achieve something foster experiences of mastery and control. Mastery is largely a physical experience – the feeling of being in charge, calm and able to engage in focused efforts to accomplish the goal one sets for oneself (Streeck-Fisher & Van der Kolk, 2000:914).
- Playfulness, imagination and humour: Engaging in playful and imaginative activities with a child serves to free and enhance the self of the child, especially for traumatised children in which natural, joyful behaviour is often stifled.
- Boundaries and limits: Children often have difficulty developing a clear sense of self without boundaries and limits, as they tend to become anxious when limits are not

present. Simple rules such as not hurting one another, that certain items are off-limits, and that the sessions begin and end on time, provide a sense of boundaries.

Helping children strengthen aspects of the self gives them a sense of self-worth as well as the inner strength to express suppressed emotions (Blom, 2006:106-107). Emotional expression is subsequently discussed.

3.4.3.4 Emotional expression

A central component of psychotherapy with children is helping them uncover and express blocked emotions, and teaching them healthy ways of expressing and dealing with these emotions (Geldard et al., 2013:54; Oaklander, 2011:196). Therapists may therefore rush towards this stage in therapy, but Blom (2006:119) and Geldard et al. (2013:54) warn that a relationship of safety and trust is essential before this stage can be approached. Increased sensory and bodily awareness and enhanced self-support assist in preparing a child to be able to acquire enough internal support for emotional expression, but two aspects of emotional expression should firstly be addressed, namely emotional awareness and expression of aggressive energy (Blom, 2006:119).

Oaklander (2011:174) explains that some children need to first approach expression of emotions objectively as an attribution outside of themselves. A specific sequence is advised for **raising emotional awareness**, progressing from talking about emotions on a cognitive level to an experiential level (Blom, 2006:123-124). Various techniques and activities to talk about emotions in general are outlined by Blom (2006:125-128), Oaklander (2007:122-123) and Oaklander (2006:39). Activities that enhance emotional awareness, such as talking about various feelings, playing games that involve identifying feelings, experimenting with feelings through music or stories, and drawing or acting out the basic emotions, can help children to become familiar with emotions and the idea of talking about feelings (Blom, 2006:124-125). In relation to traumatised children, Streeck-Fisher and Van der Kolk (2000:914) state that being able to name and tolerate sensations, feelings and experiences gives people the capacity to ‘own’ what they feel. The task of the therapist is to help children get in touch with their feelings and thoughts, which together with self-supportive activities, helps children towards authentic expression.

Aggressive energy refers to the energy required to take action (Blom, 2006:119). This kind of energy is more than a sense of power within; it involves action or movement along with the feeling of power (Blom, 2006:119; Oaklander, 2011:196). Traumatised children are often

confused by this kind of energy (Blom, 2006:119). As Oaklander (2011:196) explains "they either push it down (retroflect) and present themselves as fearful, timid, or withdrawn, or they express the energy beyond their own boundaries (deflect) through hitting, punching, power struggles, and generally acting aggressively." Helping children experience this energy in a safe and contained situation is a prerequisite for the expression of suppressed emotions (Blom, 2006:120).

Oaklander (2011:196) outlines certain conditions that are cardinal for the experience of aggressive energy:

- the experience must be in contact with the therapist;
- the therapist must contain the situation and set clear boundaries so the child knows he or she is safe;
- the activity is exaggerated and encouraged; and
- activities take place in a spirit of fun and playfulness.

Aggressive energy activities can involve smashing clay, pounding drums, throwing dart guns at a target, or hitting a punching bag. The emphasis is on experience rather than content, therefore no emotional content is purposively introduced to the experiences of aggressive energy, although it might arise (Blom, 2006:120; Oaklander, 2011:196). The experience provides children with opportunities to find the power within themselves to be free from any constraints that hinder expression of blocked or suppressed emotions.

In order to process traumatic experiences children often need to develop a pretend space in which they can look at the trauma without reliving the distressing realities of the trauma (Oaklander, 2011:181). However, processing the trauma is essential. The task of therapy is to help traumatised children develop words in order for them to be seen and understood, both by others and by themselves (Blom, 2006:124; Oaklander, 2006:37). To assist in the process of **expressing emotions**, various projective techniques can be utilised. Projection helps a child to externalise experiences and emotions from the self through unknowingly ascribing aspects of the self to something or someone outside of the self, thereby providing a forum for expression of powerful emotions in a non-threatening way (Blom, 2006:124; Oaklander, 2011:181). Schoeman (1996 in Blom, 2006:129) mentions three advantages of projection: projection facilitates awareness in the here and now; it strengthens the self through self-statements, and it facilitates the completion of unfinished business.

When a child tells a story or draws a picture, he externalises aspects of himself and his experience to the story or picture from a safe stance. When he can own those aspects, it strengthens the self and helps integrate experiences (Oaklander, 2006:37). From a Gestalt perspective, the therapist facilitates the process of projection, but do not make interpretations of what the child presents. Any interpretation is used as a guide for further exploration, and information emanating from the projection should be verified with the child (Blom, 2006:134; Oaklander, 2007:188, 193).

Many expressive, creative and projective techniques such as graphic art forms, clay, sand tray scenes, music, storytelling, puppets, fantasy and imagery, movement, and a variety of games are used for dialogue with the child. These modalities lend themselves to powerful projections that can evoke strong feelings (Blom, 2006:124; Oaklander, 2011:181). Geldard et al. (2013:127) advise that therapists should be aware of the possibility of resistance when children are faced with strong emotions and painful issues, which may manifest in different ways of breaking contact. These authors warn that putting pressure on a child to talk about painful issues that he is not ready to deal with, may raise the anxiety of the child and could be "therapeutically disastrous." As discussed earlier, resistance should be expected, respected and sensitively handled in order to maintain a sense of safety (Blom, 2006:59-60; Mortola, 2006:4; Oaklander, 2006:23).

Subsequent to the projection of unfinished business and emotions, the focus of therapy is on teaching the child handling strategies and skills to deal with emotions, as well as on teaching new behaviour in order for the child to achieve adaptive functioning (Blom, 2006:130; Geldard et al., 2013:64). The child is assisted to first experiment with these skills and behaviours within the therapeutic session, for example through role play.

3.4.3.5 Self-nurturing

Self-nurturing involves helping children learn to accept the parts of themselves or their lives that they do not accept and to work towards feelings of self-worth and integration. One of the essential goals of Gestalt play therapy is to assist a child to identify and integrate unacceptable parts of the self (Oaklander, 2006:43). The aim of self-nurturing is to help children to forgive themselves, accept themselves and acquire skills to be good to the self (Blom, 2006:152).

There are various reasons for children becoming aware of unacceptable parts. These reasons include taking in negative messages from external sources, called introjects;

socialisation that makes one believe that it is selfish to be good to the self; egocentrism which causes a child to accept responsibility for the trauma they have endured; as well as a strong critical self all contribute to the lack of self-nurturing abilities in children (Blom, 2006:151; Mortola, 2006:241; Oaklander 2011:199). Fragmentation then often occurs (Oaklander, 2006:43). Developing a self-nurturing stance enables children to be more accepting, caring and nurturing to themselves (Blom, 2006:151; Oaklander, 2006:43).

3.4.3.6 Addressing persistent inappropriate process

Children's symptomatic behaviour is often the reason for referral for play therapy. However, as Gestalt play therapy is not problem-oriented, but rather process-oriented, behaviour or 'problems' are not confronted (Blom, 2006:157; Oaklander, 2006:46). Rather, awareness is enhanced of the child's own process (Oaklander, 2006:46). The symptomatic behaviour usually resolves throughout the process of the child becoming more aware of their internal states and reactions to the environment. However, if some symptomatic behaviour persists, it is addressed during this stage of the therapeutic process by introducing activities and experiments aimed at raising the child's awareness of the persistent behaviour and helping the child to experiment with healthier ways to identify and address their needs (Blom, 2006:157). Oaklander (2006:46) emphasises that "[p]rerequisites to these experiments are the child's new feelings of self-worth and self-support, as well as skills for appropriately expressing his feelings." The therapist should therefore ensure that the child has acquired these skills before addressing behaviour that still causes distress or concern. This more direct focus on the child's symptomatic behaviour thus only takes place after the child has moved through all the other stages of the therapeutic process (Blom, 2006:157).

3.4.3.7 Termination

Termination of the therapeutic process takes place when a client has resolved conflict within the self and, if necessary, has addressed persistent inappropriate behaviour (Oaklander, 2006:47). An indication of progress is evident when a child has developed through the layers of neurosis or personality change towards full integration and healthy functioning. When the child client has therefore reached a stage in their personality development of true acceptance of the self, the false existence has been successfully overcome (Blom, 2006:42; Fall et al., 2010:213; Mann, 2010:211). According to the Gestalt perspective, this change occurs with enhanced awareness (Fall et al., 2010:212). However, at times children might experience too much anxiety, as a normal part of the phobic layer of this process of personality development. The need to terminate therapy, to be resumed at a later stage when the child is ready, might therefore arise (Oaklander, 2006:47).

Gestalt therapy has no definite duration (Fall et al., 2010:220). The duration of the therapeutic process will differ for each individual. In standard practice, the present-oriented, experiential focus of Gestalt therapy promotes brief intervention. Gestalt therapy aims to promote a transition from initial reliance on external support towards reliance on internal support and trust in one's own capacity (Blom, 2006:51). This process of maturation, to reach a point where clients can proceed without help, is a product of being able to access awareness and facilitate healthy contact without the guidance of a therapist (Fall et al., 2010:214). Gestalt therapy is designed to facilitate awareness in a short period of time, upon which clients are able to resolve inner conflicts (Fall et al., 2010:220). In terms of Gestalt play therapy with children, Oaklander (2007:184, 199) advises that children usually reach therapeutic goals within three to six months of weekly sessions after which therapy can be terminated, although it largely depends on each individual child (Oaklander, 2006:47-48).

3.5 GESTALT PLAY THERAPY AS IT RELATES TO SUGGESTIONS FOR TRAUMA INTERVENTIONS

As discussed in the previous section, Gestalt therapy can be classified as an experiential (or experience-based) approach to psychotherapy (Mann, 2010:5) and has its roots in phenomenology, holism and existentialism (Fall et al., 2010:202-203). Gestalt play therapy encompasses a number of aspects which could be relevant to the suggestions for therapeutic intervention with traumatised children that were discussed under point 3.3, namely providing safety, the use of creative activities to access relevant brain areas, the use of non-verbal measures to promote integration, and caution against re-traumatisation.

3.5.1 Sense of safety and control

With regards to a sense of safety and control, a Gestalt approach to play therapy emphasises a number of the conditions suggested for intervention with traumatised children indicated under point 3.3.1. In Gestalt play therapy the interpersonal (I-thou) relationship between client and therapist and the provision of a safe and accepting therapeutic environment are regarded as critical elements (Blom, 2006:19, 54; Henderson & Thompson, 2011:227; Oaklander, 2011:172). Age-related boundaries and limits are established in order to provide structure that contributes to the child's sense of safety in the sessions (Blom, 2006:62). Therapy further includes elements of humour and playfulness to enhance a safe and developmentally appropriate therapeutic environment (Blom, 2006:109; Oaklander, 2006:31). Experiences to enhance a child's sense of self and capacity for self-support, are provided throughout the therapeutic process (Blom, 2006:106-108; Oaklander, 2006:27-29).

Gestalt play therapy is based on the use of play and media such as drawing, the sand tray, clay puppets and storytelling for working with children (Geldard et al., 2013:40; Henderson & Thompson, 2011:238-239). Creative techniques allow the therapist to meet the child on his developmental level, which enhances the child's sense of competence (Baloyi, 2006:17; Goodyear-Brown, 2010:2, 49; Wasserman, 2005:17). These techniques are also non-threatening and thus less likely to trigger hyperarousal in traumatised children (Gaskill & Perry, 2014:186; Wasserman, 2005:167). The use of projective techniques, for example sand trays, stories, drawing, puppets and clay as a forum for the expression of emotions, can facilitate the expression of strong emotions, while at the same time protecting the self-respect of the child (Blom, 2006:128-129). Expression through the medium of play can further support children to gain a sense of mastery and control, and feel empowered (Geldard et al., 2013:176-178).

In terms of the expression of painful emotions, some of the inherent features of Gestalt play therapy can contribute to the child's sense of safety and control. In Gestalt play therapy, strengthening of the child's sense of self is seen as a prerequisite for emotional expression, as a strong sense of self provides the child with the inner strength to express emotions (Blom, 2006:103; Oaklander, 2006:51). The use of projective techniques such as drawing, clay, sand tray work, stories and puppets as a forum for emotional expression, allow children to express strong and painful emotions in a less threatening way (Blom, 2006:124; Oaklander, 2011:181; Oaklander, 2006:83). Gestalt play therapy focuses on the facilitation of the owning of projections and the development of appropriate handling strategies (Blom, 2006:130; Oaklander, 2006:37). In this sense, opportunities to identify, validate and modulate distress are seen as a powerful method to restore the sense of internal safety of traumatised children (Arvidson et al., 2011:38).

3.5.2 The use of creative activities to access relevant brain areas

Gestalt play therapy makes use of various creative activities that engage non-linear thought and allow a child to express thoughts and feelings either verbally or non-verbally (Blom, 2006:17, 19; Thompson & Henderson, 2007:197). It thus relies less on verbalisation only. Verbalisation is regulated by cortical brain functions (language, reasoning, and logic) which are often inaccessible in traumatised individuals (Baloyi, 2006:17; Gaskill & Perry, 2014:184-185; Le Bel et al., 2010:2; Van der Kolk, 2006:5-6).

The non-verbal and non-threatening nature of creative activities could further enhance access to the limbic system, one of the brain areas most severely affected by trauma (Gaskill & Perry, 2014:186; Wasserman, 2005:17). Gestalt therapy is an approach which emphasises right-hemispheric, non-linear thinking. It appears that Gestalt therapy arouses the right brain hemisphere in dealing with perception and memories, in order to more readily symbolise and integrate experiences (Fagan, 1997:67 in Clarkson & Cavicchia, 2014:2).

A Gestalt approach to therapy involves both verbal strategies as well as "attention to the messages of the body" (Henderson & Thompson, 2011:237). The therapeutic process is therefore not only verbal but rather includes other ways by which the client continually interacts with his environment, such as body-language (Clarkson & Cavicchia, 2014:27). Streeck-Fisher and Van der Kolk (2000:991) emphasise the importance of not only focusing on the verbal narratives of traumatic events during therapy, but to combine these narratives with sensory perceptions of trauma in order to more effectively integrate the traumatic experience. In Gestalt therapy specific strategies are used to combine verbal narratives with the messages of the body in order for the client to become more aware of their thoughts and feelings. These strategies include identifying reactions in a part of the body, locating emotions in the body, and repeating and exaggerating bodily movements (Henderson & Thompson, 2011:237-238).

In this section, the value of non-verbal strategies to enhance expression related to traumatic experiences was indicated. In the following section, the relevance of non-verbal strategies in terms of self-regulation is highlighted.

3.5.3 Integration and self-regulation through non-verbal measures

Apart from being a phenomenological and existential approach, the Gestalt approach also include aspects of Wilhelm Reich's (1972) discovery that people store their emotional memories and their defences against these in their muscles and internal organs - understood as premature physiological closure of traumatic experiences (Clarkson & Cavicchia, 2014:13). The Gestalt approach therefore focuses attention on the 'sensing body' as a major route to the psychological integration and release of free energy (Clarkson & Cavicchia, 2014:13, 77). This close attention to body processes and sensation is recognised as fundamental in the treatment of trauma (Clarkson & Cavicchia, 2014:13; Steenkamp, 2013:179-193).

The process of Gestalt play therapy includes specific steps to address sensory and emotional awareness (Blom, 2006:90-102, 123; Oaklander, 2006:24-27; 39). Healthy contact-making involves awareness and appropriate use of the senses (looking, listening, touching, tasting, and smelling) and of the body (Henderson & Thompson, 2011:224-225; Oaklander, 2011:173), as well as the ability to express emotions in a healthy manner and the use of the intellect to express ideas, thoughts and needs (Blom, 2006:29). Streeck-Fisher and Van der Kolk (2000:911, 913-915) propose that the promotion of sensory and emotional awareness could enhance self-regulation skills that have been negatively affected by trauma. As traumatised children often struggle to interpret incoming sensory experiences (Streeck-Fischer & Van der Kolk, 2000:911), addressing sensory aspects is important to restore the child's capacity for self-regulation (Goodyear-Brown, 2010:11). Furthermore, children have limited understanding of and vocabulary to express emotions and therefore tend to use their bodies to regulate emotions, with the result that sensory-focused activities can play a significant role in the modulation of their emotions (Arvidson et al., 2011:43). According to Clarkson and Cavicchia (2014:2) "[t]he Gestalt approach is particularly characterised by the use of metaphor, fantasy and imagery, working with body posture and movement, enactment and visualisation, time distortion and the full expression of feelings involving the whole body in action."

3.5.4 Caution against re-traumatisation

Suggestions for trauma therapy highlight the benefit of direct experience in activities that enhance self-regulation abilities. In Gestalt therapy techniques are not prescribed, but Gestalt therapists are encouraged to invent appropriate 'experiments' which invite people into heightened experience of the body-mind self (Clarkson & Cavicchia, 2014:26). Some traumatised individuals might experience challenges with sensory regulation and therapists therefore need to be cautious in terms of the level of awareness of sensation that is bearable for each client. Some clients may be flooded with intense bodily sensations, which require the therapist to help them regulate or reduce overwhelming sensation. Others may desensitise to the point of dissociation in order to avoid the terror and helplessness of earlier traumatic experiences, which may require expriences to increase awareness of sensations (Clarkson & Cavicchia, 2014:79).

In Gestalt play therapy, enhancing a child's sensory and bodily awareness is regarded as a strategy to improve the child's capacity for self-regulation (Mortola, 2006:35, Oaklander, 2006:22). Activities to enhance sensory and bodily awareness are thus seen as having therapeutic value (Blom, 2006:90). Movement, breathing and relaxation techniques form a

central part of emotional and bodily awareness (Blom, 2006:97-101), which are seen as effective stress inoculation techniques to deal with the hyperarousal often experienced by traumatised children (Goodyear-Brown, 2010:109; Norton & Norton, 2011:211; Van der Kolk, 2006:6). Goodyear-Brown (2010:107) emphasises the importance of enhancing the capacity for self-regulation for traumatised children, as hypervigilance and their inability to calm themselves may obstruct the attainment of overall therapeutic goals.

In addition, raising the emotional awareness of the child is a specifc step in Gestalt play therapy and involves enhancing the child's emotional vocabulary, the ability to identify bodily reactions to emotions, and exposing the child to experiences to become familiar with the idea of talking about emotions in a general and non-threatening manner (Blom, 2006:125-128). With traumatised children, the ability to name and talk about feelings help them with authentic expression of their emotions (Streeck-Fisher & Van der Kolk, 2000:914).

In terms of emotional expression, the Gestalt play therapy approach advocates that children should have a sufficiently strong sense of self before the phase of emotional expression (Oaklander, 2011:193-194). The therapist does therefore not rush to this stage, but firstly ensures that the child has the inner self-support to deal with painful emotions and issues (Blom, 2006:119; Geldard et al., 2013:54). Progress through the therapeutic process is thus determined by the needs of the child (Oaklander, 2006:20).

In Gestalt play therapy resistance is an important phenomenon in determining the pace of therapy. Resistance is accepted as a child's way of protecting the self (Oaklander, 2006:23). The therapist should be aware of the different ways in which resistance can manifest and needs to respect and sensitively handle resistance according to the child's capacity to deal with painful emotions and sensitive issues in the here and now (Blom, 2006:59-60; Mortola, 2006:161). Signs of resistance should therefore be respected and the child's process should ultimately guide the therapist in this regard (Oaklander, 2007:195-196; Oaklander, 2006:23-24).

Gestalt play therapy evidently incorporates many key principles needed in work with traumatised children. In addition, neuroscience research in recent years has been used to reveal the mechanics behind psychotherapeutic modalities (Clarkson & Cavicchia, 2014:206), shedding light on and confirming certain key Gestalt principles used in intervention with traumatised children (Ullman & Wheeler, 2009 in Clarkson & Cavicchia, 2014:206).

As the goal of the research study was to explore the effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood, the researcher will give a brief overview of the planning of the Gestalt play therapy sessions, which served as the intervention in this study.

3.6 THE PLANNING OF THE GESTALT PLAY THERAPY INTERVENTION PROCESS FOR TRAUMATISED CHILDREN IN MIDDLE CHILDHOOD

This section briefly reviews the elements considered in the planning of the intervention process for this research study. As the Gestalt play therapy process served as the foundation for the planning of the intervention process, the theoretical principles and elements of Gestalt play therapy were adhered to throughout the therapeutic process. Additionally, the researcher took into consideration the developmental aspects of children in middle childhood in planning age-appropraite activities to utilise during the intervention process. Lastly, the researcher incorporated trauma-informed suggestions, considering the neurobiological principles related to trauma interventions.

3.6.1 Planning the Gestalt play therapy process

The therapeutic process was implemented with participants individually, as opposed to group therapy, due to the high levels of emotional difficulties of the involved individuals, as highlighted by Geldard et al. (2013:95). The duration of this process was determined in response to Oaklander's (2007:184, 199) notion that change is likely to occur within three to six months of once-weekly sessions (Oaklander, 2007:184, 199). The planned therapeutic process thus consisted of twelve weekly sessions of 45 – 60 minutes long, conducted with the participants individually.

The planning of sessions was primarily based on the stages of the Gestalt play therapy process, as outlined by Blom (2006:237-238) and Oaklander (2006:20-48) and discussed under point 3.4.3 of this report. To cater for traumatised children for whom routines are advised, certain elements were included in the planning of each session (Arvidson et al., 2011:41). However, it was not a structured intervention, as the progression and focus of therapy was based on each individual child's process (Fall et al., 2010:220). The elements that formed the core of the process involved: creating a safe therapeutic relationship, promoting sensory and bodily awareness, strengthening the sense of self, and enhancing emotional awareness and expression in a non-threatening way (Blom, 2006:19, 106, 151, 157; Henderson & Thompson, 2011:227; Mortola, 2006:35; Oaklander, 2011:193, 194, 196). The implementation of these elements is subsequently discussed.

3.6.1.1 A safe therapeutic relationship

In Gestalt play therapy, the therapeutic relationship is primary to any other objectives (Blom, 2006:19, 56; Oaklander, 2006:21; Henderson & Thompson, 2011:227). The first two sessions as well as the beginning of each session therefore focused primarily on establishing a safe therapeutic relationship. This is in accordance with trauma-informed suggestions for intervention, which stresses the importance of assisting children to regain a sense of safety and security, at least in relation to certain places and certain people (Campbell, 2009:19; Goodyear-Brown, 2010:25).

3.6.1.2 Promoting sensory and bodily awareness

Sensory and bodily awareness is considered a prerequisite for further acquisition of therapeutic goals in Gestalt play therapy. Every session therefore commenced with sensory work as it enhanced the children's contact skills and consequently assisted them in the process of acquiring self-regulation. Movement and sensory-focused activities as a means to enable self-regulation in traumatised children are in line with trauma-informed suggestions for intervention which advises that trauma be approached through non-verbal and sensory avenues (Arvidson et al., 2011:43; Gaskill & Perry, 2014:186; Goodyear-Brown, 2010:x; Le Bel et al., 2010:3; Streeck-Fisher & Van der Kolk, 2000:913; Van der Kolk, 2006:13; Zilberstein, 2014:302). Neutral and fun exercises that involve the body and senses were implemented.

Additionally, at the end of each session, a calming exercise was introduced through facilitating breathing and relaxation exercises. Hypervigilance causes heightened reactivity in traumatised children and the inability to calm down, which necessitates for soothing and calming techniques (Goodyear-Brown, 2010:19, 107, 109). Breathing and relaxation exercises were implemented.at the end of every session.

3.6.1.3 Strengthening the sense of self

Gestalt play therapy emphasises the importance of strengthening the sense of self of the child clients, and it therefore constitutes a specific stage in the therapeutic process, as well as in each session (Blom, 2006:105-109; Oaklander, 2006:27-29). It was ensured that the participants had a sufficiently strong sense of self as a prerequisite for emotional expression. Children during middle childhood especially require experiences that lead to competency (Huston & Ripke, 2006:8). Taking into consideration the developmental stage of middle childhood allowed for the planning of activities to be in accordance with the developmental

capabilities of the children, in order to enhance the sense of mastery and control these children experienced in the therapeutic process (Goodyear-Brown, 2010:2, 49).

3.6.1.4 Emotional awareness and expression

During the Gestalt play therapy process, ample opportunities were provided for the children to uncover suppressed emotions, though a safe therapeutic relationship, appropriate sensory and bodily awareness and enhanced self-support was always a prerequisite (Geldard et al., 2013:54; Oaklander, 2011:196). Furthermore, activities that enhance emotional awareness and expression of aggressive energy received primary attention before engaging in emotional expression (Blom, 2006:119, 123), which correlate with trauma-informed suggestions for therapeutic work with children (Streeck-Fisher & Van der Kolk, 2000:914). Various techniques and activities that enhance emotional awareness, such as playing games that involve identifying feelings, experimenting with feelings through music or stories, and drawing or acting out the basic emotions were implemented (Blom, 2006:123-128). Aggressive energy exercises were also incorporated into the planning of each session, in a fun and playful way, such as throwing clay or water balloons at a target (Blom, 2006:120-121).

Opportuntiies for emotional expression were provided in each session of the second half of the therapeutic process. Projective techniques were utilised as it provides therapeutic distance and is a less threatening way for a child to deal with the emotional content of their trauma (Blom, 2006:128-141). The researcher considered activities that are most suitable for children in primary school years (six to 11 years), as outlined by Geldard et al. (2013:175). Stories, clay, drawing and painting, games, collages, puppets, sand tray, and worksheets were utilised. Trauma-informed suggestions for intervention likewise propose that creative therapies is a non-threatening way of working with children, while it also activates the limbic system in the brain which could serve to resolve the triggers of hyperarousal (Gaskill & Perry, 2014:186; Van der Kolk, 2006:12; Wasserman, 2005:17). Particular attention was paid to observe signs of resistance during these exercises, so as to avoid re-traumatisation.

3.7 SUMMARY

In this chapter the researcher reviewed trauma-informed interventions by summarising the limitations to conventional interventions, and suggesting trauma-informed ways of working with traumatised children. Gestalt play therapy appears to be an appropriate approach to address trauma, in terms of many of these suggestions, and were therefore extensively

reviewed. The final section reflects the elements that were adhered to in the planning of a Gestalt play therapy intervention process with children in middle childhood.

CHAPTER 4
RESEARCH FINDINGS

4.1 INTRODUCTION

Research findings on interventions for traumatised individuals indicate that conventional therapies that emphasise verbalisation seem to have limited success, and that interventions that are more efficient in addressing the long-term consequences of trauma are needed (Gaskill & Perry, 2014:185; LaLiberte, 2013:2; Le Bel et al., 2010:2). As discussed in Chapter 3 under point 3.5, Gestalt play therapy appears to include certain aspects that correlate with suggestions for trauma interventions. Gestalt play therapy could thus be an effective and child friendly way to address the symptoms associated with trauma in children, working to alleviate the real causes behind the symptomatology (Blom, 2006:19, 90; Clarkson & Cavicchia, 2014:2, 13, 77, 26, 79; Oaklander, 2011:172). In this chapter, the research methodology that was followed in this study is described, which was intended to explore the effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood. The ethical considerations and the empirical findings of the study are subsequently presented. The research methodology, ethical considerations and empirical findings are discussed in the three main sections of the chapter.

4.2 RESEARCH METHODOLOGY

The goal of the study was to establish the effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood. In this section the research methodology utilised to achieve this goal is discussed, focusing on the research approach, the type of research, the research design, sampling, data collection, data analysis and the pilot study.

4.2.1 Research approach

The researcher utilised a mixed methods research approach, combining quantitative and qualitative research as triangulation in order to enrich the research findings. Delport and Fouché (2011:434) indicate that "[t]riangulation commonly uses a multi-methods approach to data collection to avoid errors and biases inherent in any single methodology."

The study's goal and objectives firstly correlated with what constitutes quantitative research, namely to score objectively observable and measureable behaviour on a measuring instrument (Welman, Kruger & Mitchell, 2012:6). For this purpose, the researcher determined the presence of trauma-related symptoms in children by means of a

questionnaire. However, the character of the study required more in-depth understanding regarding the subjective experiences of the participants and therefore qualitative measures were regarded as equally important (Delport & Fouché, 2011:434). The small number of participants (five participants) involved in the study, further leaned towards a qualitative research approach (Fouché & De Vos, 2011:91). With regards to research with children, as was the case in this study, it is noted that "some researchers argue it is practical to combine more than one method as this allows the two paradigms to complement one another and give a stronger picture of children's behaviours" (O'Reilly et al., 2013:171). Qualitative data thus served to enrich the quantitative findings.

4.2.2 Type of research

The type of research for this study was applied research. Applied research entails the scientific planning of induced change in a troublesome situation and aims to help practitioners accomplish tasks by attempting to solve problems in practice (Fouché & De Vos, 2011:94-95). This study attempted to establish whether Gestalt play therapy is effective in addressing trauma-related symptoms in children and for this reason the study was regarded as an applied research.

The subtype of applied research, evaluation research, was conducted in order to make judgments about the effectiveness and the overall value of some form of practice (Weinbach, 2005:2 in Fouché, 2011:452). There are many different types of evaluations depending on the object being evaluated and the purpose of the evaluation (Fouché, 2011:452). Summative evaluation, which is used to assess the "impact, outcome or worth of a programme" (Fouché, 2011:452), was conducted, to assess the effect of the Gestalt play therapy process in addressing trauma-related symptoms in children in middle childhood. A subdivision of summative evaluation, impact evaluation, was conducted to assess whether any change, intended or unintended, occurred in the target population as a result of the programme (Fouché, 2011:459; Trochim, 2006), in this case the Gestalt play therapy process.

4.2.3 Research design

The triangulation mixed methods design was regarded as most suitable for the purpose of this study, and determined the process through which the objectives of the research study was obtained (Babbie, 2013:116-117). Based on the triangulation design both qualitative and quantitative methods were used at the same time and with equal weight in order to best understand the phenomenon of interest (Delport & Fouché, 2011:442).

The aim of this study was to explore and establish the effectiveness of Gestalt play therapy for children in middle childhood displaying specific trauma-related symptoms. As the **quantitative design** for this study, a single-system design, defined as "a set of empirical procedures used to observe changes in an identified target that are measured repeatedly over time" (Jackson, 2003:248 in Strydom, 2011a:160) was utilised. Authors regard the single-system design as the ideal way in which to evaluate the effectiveness of a treatment intervention (Strydom, 2011a:160; Thyer, 2001:254). Within the single-system design, this study used a case study linked to the basic single-system design, namely the A-B design, which involves a baseline phase (A) and an intervention phase (B) (Bradshaw, 2003:887; Strydom, 2011a:165).

The single-system design does not involve a control group. The lack of a control group generally makes it difficult to determine whether changes measured can be ascribed to the treatment intervention (Fouché, Delport & De Vos, 2011:148). For that reason a baseline phase, which is a unique feature of the single-system design, was implemented (Strydom, 2011a:161). The baseline phase involved establishing the relative stability of target behaviour before the intervention was implemented. Data collected during this phase was compared to data related to the target behaviour that was collected during the intervention phase, thereby contributing to the validity of the study.

In this research the baseline phase involved the collection of data related to the presence of specific trauma-related symptoms in five children in middle childhood residing in a children's home. The intervention phase involved the implementation of the Gestalt play therapy process. The data collected at the baseline (control) phase, was then compared with data collected during the intervention phase (also referred to as the experimental phase) (Strydom, 2011a:162). Measurements were taken at two intervals during the intervention phase to ascertain whether or not changes in the target behaviour could be ascribed to the intervention (Strydom, 2011a:161; Thyer, 2001:245).

In the single-system design, it is important that the content and procedures of the intervention be specific and clear (Strydom, 2011a:162). The Gestalt play therapy process was implemented over a period of 12 weeks (three months), with weekly individual sessions. Oaklander (2007:184) is of the opinion that in general, change in behaviour is likely to occur within three to six months of once-weekly therapy sessions. Although the specific course of therapy depended on the therapeutic needs of each individual participant, the more directive nature of Gestalt play therapy allowed the therapist to include certain steps of the

therapeutic process in every session (refer point 3.6 in Chapter 3), which provided for heightened control of the independent variable.

Phenomenology was utilised as the **qualitative research design** (Fouché & Schurink, 2011:322), as the researcher was interested in understanding the participants' personal experiences with regard to trauma-related symptoms and the meaning they attached to these experiences. By exploring the participants' experiences of trauma-related symptoms throughout the Gestalt play therapy process, the researcher was able to obtain rich data that complemented the quantitative data. A mixed-methods design therefore enabled the researcher to gain more in-depth understanding of the prevalence of trauma-related symptoms as well as participants' experience of these symptoms.

The implementation of the triangulation mixed methods design in this study is illustrated in Figure 4.

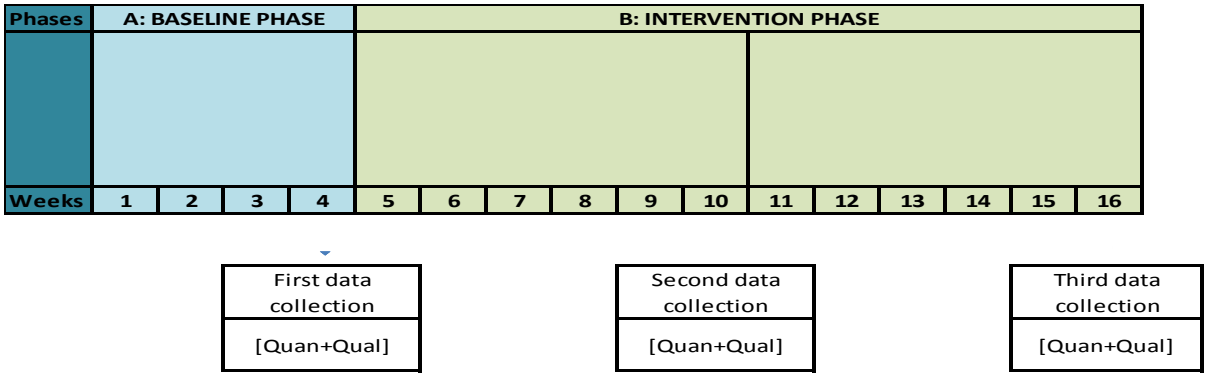

Figure 4: Implementation of the triangulation mixed methods design

4.2.4 Study population and sampling

A study population is the totality of individuals who possess specific characteristics with which the research problem is concerned (Strydom, 2011b:223). The population for this study was children in middle childhood residing in a child and youth care centre, as children placed in residential settings are regarded as amongst the most traumatised youth (Campbell, 2009:18; Foltz et al., 2013:12; Zelechoski et al., 2013:639-640). The research population was thus likely to possess characteristics related to the research problem. However, due to limited resources a distinction is made between the population a researcher would like to generalise to, the 'theoretical population', and the 'accessible population' (Trochim, 2006; Welman et al., 2012:53, 55). The accessible population for this study involved all children in middle childhood residing in a children's home in Tshwane. Written

permission to conduct the research has been obtained from the Director of the identified children's home (Appendix A).

From this population, a sample, which is a small portion of the total population that is actually included in the study and on which time and effort is concentrated (Strydom, 2011b:224; Welman et al., 2012:53), was selected. Although probability sampling is preferable to non-probability sampling in order to ensure that the sample represent the population well (Strydom, 2011b:224), in applied social research there may be circumstances where it is not feasible to conduct random sampling (Trochim, 2006; Welman et al., 2012:57), as was the case in this study. For the purpose of this study, it was important to select children that complied with certain sampling criteria in terms of the presence of trauma-related symptoms over a period of time. Therefore, purposive sampling, a subtype of non-probability sampling, was utilised whereby sampling was based on pre-selected criteria related to the purpose and interest of the study (Strydom & Delport, 2011:392). A sample of five children residing in the identified children's home was selected according to the following sampling criteria:

- male or female, between the ages of nine and 11 years;
- who have resided in the children's home for more than six months;
- who displayed specific symptoms associated with trauma in children in middle childhood (as outlined in the questionnaire); and
- who were not involved in any other therapy at the time of the research.

Five children who complied with the above criteria were selected with the assistance of the social workers at the children's home. Due to the extent of the intervention (12 Gestalt play therapy sessions with each child in the sample) and the scope of the research (a mini-dissertation), a sample size of five children were deemed sufficient for the study.

4.2.5 Data collection

As the study followed a triangulation mixed methods research design, both quantitative and qualitative data were collected within the same time frame (Delport & Fouché, 2011:441,442) and at various intervals (Strydom, 2011a:161). In line with the single-system design, data were collected at different intervals in order to determine whether changes in the problem occurred due to treatment (Strydom, 2011a:161). Quantitative and qualitative data were collected during the baseline phase to determine the prevalence of trauma-related symptoms and participants' experiences related to these symptoms before the Gestalt play therapy intervention commenced. Data were collected only once during the baseline phase, as the sampling criterion that trauma-related symptoms were present for at least one month

indicated relatively stable target behaviour (Strydom, 2011a:162). Data collection (with both quantitative and qualitative measures) was repeated twice during the intervention phase: after six weeks and again after 12 weeks of being exposed to Gestalt play therapy. The same data collection instruments were utilised for all three data collection intervals.

In this section, the implementation of both quantitative and qualitative data-collection follows. Measures to ensure reliability and validity of quantitative data are discussed as part of the development of the quantitative data collection instrument. The rigour and trustworthiness of the qualitative data will be discussed as part of the qualitative data-analysis in section 4.3.6.2.

4.3.5.1 Quantitative data collection

Data collection was determined by the chosen research design (Delport & Roestenburg, 2011a:171). Structured interviews, based on a structured interview schedule, were utilised to quantitatively determine the prevalence of trauma-related symptoms experienced by the participants. The structured interview schedule was in the format of a questionnaire (Delport & Roestenburg, 2011a:186).

Data was collected by means of a self-constructed questionnaire (Appendix B), developed by the researcher. The formulation of an objective quantitative data collection instrument in which the dependent variable is defined in operational terms as specific, measurable indicators, is described as one of the steps in the single-system design (Strydom, 2011a:163). For this to happen, the researcher had to have clarity about the relevant problem to be researched, clear goals and objectives for the research, and a comprehensive review of relevant literature. The researcher developed the questionnaire based on these requirements. The questionnaire involved an ordinal-level measurement, indicating the frequency of trauma symptoms according to a ranking order (Delport & Roestenburg, 2011a:179), so that respondents could provide more specific information on the prevalence of trauma-related symptoms.

Structured interviews with children generally have the advantage that questions or words can be explained if needed, however it may have the disadvantage that children may be eager to please the researcher and may answer what they think the researcher wants to hear (O'Reilly et al., 2013:189-190). During the interviews the researcher presented the questions in the specific wording and order stated in the questionnaire (Welman et al., 2013:165). According to Piaget's theory of cognitive development, children in middle

childhood have increased verbal and rational skills (Thompson & Henderson, 2007:13) and the ability to categorise (Papalia et al., 2008:351). These developmental characteristics enabled the participants in the study to understand the questions, to discern between simplified levels of agreement or non-agreement as was needed for indicating the prevalence of the symptoms experienced, and to answer questions in the questionnaire.

Practically, the above process involves the following: "we formulate a set of questions about the properties of an object from theory, assign a scaling format to these questions, and obtain data that describe the presence of these properties in our respondents" (Delport & Roestenburg, 2011a:172).

- **Reliability and validity**

A measurement can be explained as a description of an object informing the researcher how to make judgments about that object (Grinnell & Unrau, 2008:106). In order for these measurements to produce valuable outputs, validity and reliability need to be ensured. Efforts to ensure the validity and reliability of the self-constructed questionnaire are subsequently discussed.

Validity, also referred to as truthfulness and accuracy, refers to the extent to which an instrument actually measures the relevant concept, and whether it accurately measures the concept (Babbie, 2013:191). Content and face validity are generally considered in the development of the data collection instrument (Delport & Roestenburg, 2011a:173; Welman et al., 2012:142-144). The researcher considered content validity, which is concerned with whether the instrument represents all the elements of the concept under consideration, by including items which reflected symptoms of trauma usually experienced by children in middle childhood according to each of the four symptom categories indicated by D'Andrea et al. (2012:189). The signs of or manifestation of trauma in children of this age group, as described in the literature (Campbell, 2009:18; D'Andrea et al., 2012:189-190; Goodyear-Brown, 2010:26, 38; Kaduson & Shaefer, 2006:6-8; Louw et al., 2007:379; Mustard, 2002:39; Papalia et al., 2008:409; Streeck-Fischer & Van der Kolk, 2000:905-906; Van der Kolk, 1994:253; Young, 2002:4), was considered to ensure face validity. Face validity mainly refers to the superficial appearance of the questionnaire, thus what the instrument appears to measure (Delport & Roestenburg, 2011a:173). Criterion validity refers to the more objective evidence that the instrument measures the relevant concept, compared to another criterion; and finally construct validity involves the degree to which an instrument successfully measures a theoretical construct (Delport & Roestenburg, 2011a:174). Trochim

(2006) however, suggest that construct validity, rather than being a category of validity, is the overarching concept under which the other categories of validity fall. He argues that all the other categories need to be informed and should reflect the theoretical constructs on which those operationalisations were based (Trochim, 2006). The researcher has conducted an in-depth literature review, which included existing instruments that measure trauma in children, and used this information to construct a questionnaire.

Reliability can be explained as the tendency of the measuring instrument to yield consistent and stable results each time it is applied, unless the variable changes (Delport & Roestenburg, 2011a:177; Trochim, 2006; Welman et al., 2012:145). A number of ways to increase reliability of a measuring instrument are suggested. The following measures were implemented to increase the reliability of the self-constructed questionnaire (Salkind, 2006; Neuman & Kreuger, 2003 in Delport & Roestenburg, 2011a:177):

- using multiple indicators of a variable, thus of each of the four trauma symptom categories (D'Andrea et al., 2012:189),
- elimination of items that were unclear,
- increasing levels of measurement by indicating four response levels for each item,
- standardisation of conditions under which the questionnaire was implemented by ensuring a consistent venue and stating items in the same sequence,
- moderating the degree of difficulty of the instrument by stating items in age-appropriate language,
- maintaining consistent scoring procedures, and
- conducting a pilot study to identify potential problems related to the data collection instrument.

Another way of verifying reliability and validity of data collection implemented in the study was triangulation, which involved using different data collection methods and reviewing whether they incline to deliver the same results (Ruben & Babbie, 2008:109). It is advised that, in the use of a single-system design, the researcher considers measures from different domains, including observable behaviour, participants' reports of affect as well as physiological indicators (Thyer, 2001:240).

4.3.5.2 Qualitative data collection

With regards to qualitative data collection, the use of semi-structured one-to-one interviews guided by an interview schedule (Greeff, 2011:353), allowed the researcher to obtain an understanding of the participants' experiences of trauma-related symptoms (Appendix C).

This type of data collection allowed the researcher to obtain an understanding of the participants' experiences of trauma-related symptoms (Greeff, 2011:352).

The researcher conducted the semi-structured interviews directly after completion of each structured interview. The themes in the semi-structured interview guideline thus corresponded with the items (trauma-related symptoms) in the questionnaire. As not every question needs to be asked (Greeff, 2011:353), the researcher only explored themes (symptoms) that were indicated by the participants as being present during the structured interview. The purpose of the qualitative interviews was to provide more in-depth information concerning the trauma symptoms that the participants experienced. It served to clarify certain responses by the participants, for instance, what they meant with the response "often" or "always" and provided the opportunity to gain a better understanding of the participants' experiences. The interviews were voice-recorded, with the assent of the children and consent of the Director of the children's home, to ensure that data could be accurately retrieved for data-analysis (Schurink et al., 2011:404).

The researcher followed some of the guidelines that Babbie (2013:253) and Trochim (2006) suggest to assist a researcher in obtaining adequate responses from participants during interviews. In this regard, the researcher made use of 'silent probes' which are regarded as the most effective way to encourage someone to elaborate, and involved the researcher not doing anything at all but to pause and wait, suggesting to the participants that the researcher is listening for what they will say next. Responses were also enhanced through 'overt encouragement' in a way that did not imply approval or disapproval of what the participants said and would be less likely to bias the subsequent results. Overt encouragement involved simple gestures such as saying "Uh-huh" or "OK" after the participant completed a thought or pauses. At times participants were asked to elaborate on or clarify their responses to elicit more detail. Active listening, or what Trochim (2006) refer to as 'repetition', was often implemented, reflecting the participants' responses as a means to indicate that they are being heard. These measures granted the participants the best opportunity to convey their experiences, and ensured understanding by the researcher.

4.2.6 Data analysis

As the research followed a triangulation mixed methods design, quantitative data analysis and qualitative data analysis were dealt with separately (Delport & Fouché, 2011:447). The quantitative data-analysis employed basic statistic procedures, descriptive statistics as well as inferential statistics (Fouché & Bartley, 2011:251), while the qualitative data-analysis

involved an extensive process of data interpretation, utilising Creswell's model (2007) as outlined in Schurink et al. (2011:404-418). Following, the implementation of the data-analysis phase are outlined. The measures employed to obtain rigour in qualitative data are also discussed at this point.

4.2.6.1 Quantitative data analysis

For quantitative data analysis, the researcher largely utilised descriptive statistics as "those that describe your data set and give you some indication as to the frequency of how often things occur, for example, how often a specific symptom or event occurred for a young person" (O'Reilly et al., 2013:193). Descriptive statistics describe the basic features of the data in a study by organising, summarising and interpreting the data and form the basis of quantitative analysis of data (Fouché & Bartley, 2011:251; Trochim, 2006). The three major characteristics of a single variable that are generally described for each of the variables in a research study, namely the distribution, the central tendency and the dispersion (Fouché & Bartley, 2011:251), were determined and provided information on the prevalence of trauma-related symptoms experienced by the participants in the study.

In terms of levels of measurement, ordinal measurements were employed for the purpose of this study, where attributes are rank-ordered (Fouché & Bartley, 2011:250; Trochim, 2006). The ordinal level of measurement informed decisions on how to interpret the data and what further statistical analysis would be appropriate. As the research sample was small and ordinal measurements were repeated over time with the same participants and using the same measuring instrument, two non-parametric tests, namely Friedman's ANOVA and the Wilcoxon signed-rank test were utilised to further analyse quantitative data (Field, 2013:552, 575; Maree & Pietersen, 2007:231, 237).

Friedman's ANOVA is used when researchers want to compare three or more ordinal measures used within the same group at different time intervals (Maree & Pietersen, 2007:231, 237). Therefore, Friedman's ANOVA test was used to determine potential changes across all three measurements in the study: the baseline measurement and the subsequent measurements after six and 12 weeks respectively. Various hypotheses were tested: the change in the total trauma value of all participants over the three measurements; the change in the trauma value for specific trauma symptoms and symptom categories over the three measurements; and finally the change in the trauma value for participants individually over the three measurements. The Wilcoxon signed-rank test is used to compare two variables in a single sample, such as a pretest and posttest, and is based solely on the

difference between the two scores. In this study the Wilcoxon signed-rank test was employed to determine changes between measurements one and two, one and three, and two and three. The Wilcoxon signed-rank test was thus performed whenever Friedman's ANOVA results indicated a significant change in trauma-related symptoms over the three measurements.

As relevant to the single-system design, the data are presented visually by means of simple graphs or plotting, and not in the form of complex statistics. Plotting offers a graphic presentation of changes (improvements, deterioration or even no change) in the problem from baseline to termination of the treatment (Strydom, 2011a:162). Graphic presentation often displays patterns that indicate beneficial effects of treatments (Thyer, 2001:241) that the non-parametric tests may not reflect.

4.2.6.2 Qualitative data analysis

The qualitative analysis was based on the data acquired through semi-structured interviews with the participants. Qualitative data analysis involved "reducing the volume of raw information, sifting significance from trivia, identifying significant patterns and constructing a framework for communicating the essence of what the data reveal" (Schurink et al., 2011:397). The researcher utilised Creswell's model of qualitative data-analysis (2007) as outlined in Schurink et al. (2011:403-404) in order to thoroughly engage in a process of transforming data into findings. Creswell's model involves three main stages, namely preparation of data collection, classification of data and presentation of data. Some of the stages in this model often occur simultaneously or in a circular fashion as opposed to occurring in a linear or systematic manner (Creswell, 2013:182). Similarly, qualitative data-analysis is not a subsequent phase to data collection, as analysis already commences during the interviews. Creswell (2013:182) therefore incorporates preparation for data collection as an integral part of qualitative data-analysis.

In preparing for data recording the researcher first confirmed the date and time of the appointments with the participants, and secured a suitable venue for data collection interviews. Recording instruments (voice recorder and note pad) were arranged beforehand to ensure accurate capturing of information (Schurink et al., 2011:404). The semi-structured one-to-one interviews followed immediately after the structured interviews and the exploration of themes were thus informed by the responses given during the structured interviews. Consequently, not all the indicators in the interview schedule were explored. The researcher transcribed the interviews, based on the voice recordings, and incorporated field

notes that provided more clarity (such as non-verbal gestures by the participants that either confirmed or rejected a probe). In order to become familiar with the data, the researcher read and re-read the transcriptions several times, whilst at the same time making notes in the form of key concepts, short phrases or ideas, as advised by Creswell (2013:183).

Classification of data required organising the data and coding information that supports unifying concepts (Creswell, 2013:184-186). Common topics or words discussed by participants were identified. Colour codes were used to identify themes and sub-themes, which were interpreted and discussed as part of the results of the research report. Interpretation requires that identified codes and themes must be reviewed in the context of literature (Creswell, 2013:186-187). Literature that was consulted, as well as the researcher's personal observations and experience were applied to interpret the results. Data was then interpreted within the larger context of the research: the effect of Gestalt play therapy in addressing the symptoms associated with trauma in children in middle childhood.

Data was summarised and presented visually in a graphic format (Creswell, 2013:185,187) to indicate themes and sub-themes (Table 3). The themes and sub-themes were discussed and supported with verbatim quotes obtained from the interviews, incorporating literature from the literature review and Gestalt theory as theoretical framework for the study. The aim was to provide an in-depth understanding of the participants' subjective experiences of trauma-related symptoms and of the possible changes in the symptoms during the Gestalt play therapy process.

- **The trustworthiness of qualitative findings**

It is of utmost importance to establish rigour in qualitative data analysis, in order to enhance the quality of qualitative data. Rigour requires that the researcher "engages in activities that would assist us in giving priority to the meaning of participants over those which are our own" (Lietz et al., 2006:444). Therefore although co-construction on the part of the researcher is an integral part of the qualitative research process, the research needs to maintain trustworthiness, where findings as closely as possible reflect the meanings as described by the participants (Lietz et al., 2006:444). The authors, in line with Lincoln and Guba (1999) in Schurink et al. (2011:420), suggest various strategies that can be applied to ensure trustworthiness, of which reflexivity, an audit trail, peer-debriefing and member checking were utilised in this study.

Reflexivity required that the researcher acknowledge that complete objectivity throughout the research process is not possible, and that she reflected on how personal decisions, perceptions or actions might influence the meaning and context of the experiences under investigation (Lietz et al., 2006:447). Researchers are a central part of the research, which makes it difficult to guarantee complete objectivity. In this study ensuring objectivity was even more complicated due to the fact that the researcher was also the therapist. As the role of the interviewer is significantly different from the role of the therapist, the researcher was highly aware of the possible influence of this aspect. Therefore, the researcher used an audit trail, which helped her to adopt a "self-critical eye" when interpreting the findings, as advised by Schurink et al. (2011:423). Further, the use of a questionnaire as a quantitative data collection instrument supported a more objective indication of the presence of trauma-related symptoms. During the semi-structured interviews, only the symptoms that were indicated in the structured interviews were explored. Thus, triangulation of different methods was used to enhance the trustworthiness of the qualitative findings (Schurink et al., 2011:420).

In order to minimise reactivity and bias the researcher utilised peer-debriefing strategies, where the researcher consulted with a colleague outside of the research in identifying themes from the information (Lietz et al., 2006:451). This consultation provided valuable insight with regard to the qualitative findings, as the colleague did not have detailed information about the therapeutic process that formed the intervention for the study and could therefore objectively review the qualitative data in terms of identifying themes and sub-themes. The researcher and the colleague engaged in a critical discussion in which consensus was reached in terms of the themes and sub-themes that were identified.

Member checking was another way of contributing to the trustworthiness of the study, avoiding bias or misunderstandings. Member checking allowed the researcher to clarify that she correctly understood the information provided by the participants, as the participants could confirm or challenge the accuracy of the researcher's understanding of the information (Lietz et al., 2006:453). Throughout the research study, the researcher paid attention to develop a safe relationship in which participants would feel safe to freely express their views. Within the interviews various opportunities were created for the participants to clarify what they meant after the researcher conveyed her understanding of the information. During debriefing, which was incorporated into every session and at the end of the study, misunderstandings were clarified. The researcher is of the opinion that debriefing had a positive effect as it further established trust and embedded the interviews in an understanding of the participants and their contexts.

As a further measure to ensure the quality of data collection, it is of significant importance that a pilot study be conducted. The pilot study for the quantitative and qualitative research procedures is subsequently described.

4.2.7 Pilot study

Research procedures are generally tested before actual data gathering and data analysis can take place. Conducting a pilot study helps researchers to thoroughly familiarise themselves with regards to the project they are planning to undertake and to identify potential problems with the design and research instruments (Strydom, 2011c:236). A pilot study is equally important in both quantitative and qualitative studies (Strydom & Delport, 2011:395). The researcher pilot tested the questionnaire and interview schedule with two children from the population; thus children with the same characteristics as the sample. The data from the pilot study were excluded from the actual study.

The questionnaire was tested with regards to aspects such as the length of the questionnaire, wording and clarity of questions (Strydom, 2011c:242). The researcher used the questionnaire as a structured interview schedule (Delport & Roestenburg, 2011a:186). It became apparent that asking the children to indicate their responses on the questionnaires themselves would more effectively involve them in the interviews. However, the formal style of ticking answers on a questionnaire seemed to be strongly associated with school activities, where a tick is generally used to indicate a correct answer. In order to conduct data-collection in a more child-friendly manner the researcher requested participants to place a sticker at the relevant response, instead of the more formal pen marking. Creative activities tend to instill a sense of ‘safe distance’ in work with children (Mortola, 2006:35) and seemed to have provided the desired benefits in terms of providing participants with a sense of safety that promoted their engagement in the structured interviews.

The qualitative interview schedule was tested to determine whether appropriate and accurate information could be obtained (Strydom & Delport, 2011:394). During the pilot test, the researcher observed that the participants seemed anxious if they could not see their responses on the questionnaire, to which the research would refer back in conducting the interviews. In the actual data gathering, therefore, the researcher left the questionnaire in front of the participants during the semi-structured interviews. Also, it became apparent during the pilot study that the participants tended to discuss similar symptoms together; feeling frustrated when the researcher would ask questions for which the answer was implied during an earlier discussion. Questions for the structured interviews were read as

they appeared on the questionnaire (Delport & Roestenburg, 2011a:186), whereas the semi-structured interviews were "guided rather than dictated by the schedule" (Greeff, 2011:352). The researcher therefore attempted to group the discussions of similar symptoms together in probing for qualitative data during the interviews.

4.3 ETHICAL CONSIDERATIONS

The goal of ethics in social sciences research is to ensure that the participants' rights are adhered to and that no one is harmed as a result of research activities (Trochim, 2006; Welman et al., 2012:181). The study was approved by the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (Appendix D). The researcher adhered to all the ethical guidelines and requirements of the University of Pretoria for social research. The ethical considerations relevant to this study are subsequently discussed.

4.3.1 Informed consent and voluntary participation

Trauma, the focus of this research, is a very personal and sensitive matter. The nature of social research often represents an intrusion into people's lives since "[p]articipation in research disrupts the subject's regular activities … and requires that people reveal personal information about themselves" (Neuman, 2014:75). Voluntary participation is therefore required, implying that no coercion is allowed (Ruben & Babbie, 2008:287; Strydom, 2011d:117; Trochim, 2006). Closely related to this principle is the requirement of informed consent, which means that prospective research participants must be fully informed about the procedures and risks involved in research and must give their consent to participate (Babbie, 2013:34; Trochim, 2006; Welman et al., 2012:201). The participants need to voluntarily choose to take part in the study, after being fully informed of the procedures and implications of the study (Ruben & Babbie, 2008:287; Strydom, 2011d:117).

Researchers have to recognise that, despite their age, children also have autonomy to make decisions about participation, and should therefore respect children's decisions (O'Reilly et al., 2013:39). The researcher thus informed the child participants in this study regarding the goal and objectives of the study, the nature of the study, the fact that they could choose to participate, and that they had the freedom to withdraw at any stage. This was conveyed by means of a voluntary assent letter, formulated in age-related language (Appendix E). Furthermore, informed consent by the legal guardian was obtained. As the children in the children's home are, by court procedures, placed in the care of the children's home, the director of the children's home provided written consent for each child to participate in the study (Appendix F). The written assent and consent included permission to use a voice-

recorder during the data collection interviews. The therapeutic sessions, which did not form part of data collection, were not electronically recorded.

4.3.2 Avoidance of harm

Ethical standards require that researchers do not put participants in a situation where they might be at risk of harm, either physically or psychologically, as a result of their participation, regardless of whether they volunteered to participate in the study or not (Ruben & Babbie, 2008:290; Strydom, 2011d:115; Trochim, 2006). However, due to the sensitive nature of some studies the possibility exists that participants may be harmed psychologically due to recollection of painful memories (Neuman, 2014:71), as with this study.

Gestalt play therapy, which was the intervention for this study, places emphasis on empowering participants through strengthening the child's sense of self and self-regulatory abilities (Blom, 2006:19) and could thus help to counteract the likelihood of harm. Minimising harm also relates to the principle of beneficence and non-maleficence (O'Reilly et al., 2013:40), which indicates that research, although always carrying an element of risk, can have benefits for child participants especially if researchers take precautions to prevent harm. The researcher took considerable care not to cause harm and made preparations for dealing with any emotional distress that may have arisen. Participants were fully informed about the nature of the study and that they were allowed to withdraw from the study at any time. In terms of the data collection interviews, any misunderstandings could be addressed as part of debriefing (Neuman, 2014:72), while the researcher could also detect signs of emotional distress that might have occurred. The participants were informed in the letter of informed assent that they could be referred to a social worker at the children's home, should they experience any emotional distress as a result of the research. However, none of the participants experienced emotional distress due to their participation in the research and no further arrangements were needed.

The caregivers and social workers at the children's home furthermore provided a holding environment as they were thoroughly aware of each child's background and current functioning, and were able to respond immediately should any distress arise for any of the participants. Further, participants who might have decided to leave the study would be referred to the social worker at the children's home for follow-up intervention. In the case where participants might not have been ready for termination after completion of the study, the researcher would have either continued with the therapeutic process or would have referred the involved participant(s) to one of the social workers at the children's home. No

participants withdrew from the study and none of the participants needed to continue with play therapy sessions after completion of the research. As the participants resided in the children's home, they would be continuously monitored for any emotional difficulties, as the case would be with all other children in the children's home.

4.3.3 Debriefing of participants

Debriefing was done at the end of every session and at the end of each data collection interview. The debriefing sessions provided the participants with the opportunity to reflect on their experience of the research (Strydom, 2011d:122). During debriefing misconceptions were worked through and questions answered. Debriefing sessions assisted in minimising possible harm by helping the participants process their experience of the research process.

4.3.4 Privacy, anonymity and confidentiality

Due to the sensitive nature of the research and the involvement of child participants, it was of utmost importance to respect the privacy of participants, which refers to the participants' right to disclose only that which they choose to, to whom they choose to (Strydom, 2011d:119). Confidentiality and anonymity are two standards that are applied in order to help protect the privacy of research participants (Babbie, 2013:35; Trochim, 2006). The researcher upheld the confidentiality of participants by assuring that their identifying information would not be made available to anyone who was not directly involved in the research study. Anonymity essentially means that the participants will remain unidentified throughout the study - even to the researchers themselves. Although anonymity is a stronger guarantee of privacy, it is not always possible to uphold anonymity due to the nature of the study (Babbie, 2013:36; Trochim, 2006), as in this study which required face-to-face interactions between the researcher and the participants.

Although anonymity, or non-identification, from the researcher could not have been upheld in this study, anonymity was respected by allocating codes or pseudonyms to participants, keeping identifying information separate from the data, and taking measures to manage and protect data (O'Reilly et al., 2013:47). Strict confidentiality was maintained throughout the research (Babbie, 2013:36; Ruben & Babbie, 2008:290). Discussion and clarification of confidentiality was especially important, as child participants in research often hold false beliefs that information will be shared with other adults (O'Reilly et al., 2013:48). No one, with the exception of the researcher and her supervisor, was allowed access to any of the raw data such as the voice recordings and notes that were obtained during the study. The colleague who was involved in peer-debriefing had access to the transcriptions of the semi-

structured interviews, however these transcriptions contained pseudonyms instead of the names of the participants. The participants were informed that their identities would not be made known during the research process or in the research report. The raw data will be securely stored according to the stipulations of the University of Pretoria.

4.3.5 Deception of participants

Transparency, thus no deception or misleading of participants, is a requirement for research (Babbie, 2013:38; Neuman, 2014:75; Ruben & Babbie, 2008:291). The researcher was completely honest and transparent with regard to the research project and what it entailed. The researcher was not aware of any unintended deception that occurred, but would have rectified it immediately should it have happened.

4.3.6 Competence of the researcher

The competence of the researcher is especially important when sensitive issues are involved (Strydom, 2011d:123). The researcher ensured that she conduct the research in an ethically correct manner. The researcher is further trained in Gestalt play therapy and has obtained experience in implementing the therapeutic process in her work situation. She was able to consult with her supervisor should any uncertainties arise during the implementation of the therapeutic process for this research. She has previous experience of research as she completed research as part of the BSW (Bachelors of Social Work) programme. She further completed a theoretical module in research methodology as part of her masters' studies.

4.4 RESEARCH FINDINGS

The empirical findings of the study will be presented in two sections. Section A will contain the biographical information of the participants as a background to the presentation of the research findings. Section B will contain the quantitative and qualitative findings as obtained from the structured and semi-structured interviews respectively, in an integrated discussion.

4.4.1 Section A: Biographical information of the participants

The sample of five participants was selected with the assistance of the social workers at the children's home, according to the sampling criteria for this study. Pseudonyms were used to identify the individual participants for the purpose of the research report. The biographical details of the participants are summarised in Table 1 below.

Table 1: Biographical profile of participants

Participant	Age (years)	Gender	Race	School grade	Duration of stay in the children's home	Number of alternative care placements
Violetta	10	Female	White	5	>6 months	3rd placement in alternative care
Dorithea	11	Female	Black	4	>6 months	4th placement in alternative care
Suzie	11	Female	White	5	>6 months	3rd placement in alternative care
Charl	10	Male	White	4	>6 months	1st placement in alternative care
DJ	11	Male	White	5	>6 months	1st placement in alternative care

From the sample of five participants, two were male and three female. One participant was black while all the others were white. All the participants were Afrikaans-speaking. These participants were between the ages of ten (two participants) and eleven (three participants) and either in Grade 4 (two participants) or Grade 5 (three participants).

The participants have been residents of the identified children's home for between seven months and five years at the time the research study commenced. For two participants their placement in the children's home was their first placement in alternative care, while the other three participants also had previous placements in alternative care. All the participants were removed from the care of their parents or primary caregivers more than two years ago.

All of the participants experienced a traumatic past, which were then the reasons for their placement in alternative care. All the participants experienced neglect, while three were also exposed to sexual and physical abuse and pornography, and one has been orphaned. Many children involved in the child welfare system have experienced complex trauma (Cook et al., 2007:4), as was the case with the participants of this study. Traumatised children on the severe end of the trauma continuum, who thus endured trauma for a prolonged period at a young age, often suffer from complex trauma which provides some insight with regard to the complex presentation of symptoms often manifested in traumatised children (Schore, 2013:3).

4.4.2 Section B: Empirical findings

This study followed a triangulation mixed methods design (Delport & Fouché, 2011:442), with both quantitative and qualitative methods of data collection. The quantitative and qualitative findings for the study are presented in this section.

This section is structured in five main sections:

- Firstly, the context regarding the presentation of the quantitative findings is provided in order to avoid repetition at relevant points of discussion (point 4.4.2.1).
- Secondly, an overview is provided of the prevalence of trauma symptoms and how these symptoms changed over the three measurements (point 4.4.2.2).
- Thirdly, the prevalence of the 23 individual trauma indicators that were measured by means of the questionnaire, are presented (point 4.4.2.3).
- Fourthly, the findings are presented according to five trauma categories (point 4.4.2.4), in line with the way in which trauma symptoms are commonly grouped together (D'Andrea et al., 2012:189). In each of these categories, the quantitative findings are presented first, followed by a discussion of the qualitative findings.
- Finally, a brief presentation follows on the prevalence of trauma symptoms for the individual participants over the course of the three measurements (point 4.4.2.5).

The chapter is concluded with a brief discussion of the research findings.

4.4.2.1 The presentation of the quantitative findings

For the purpose of this study the concept *prevalence of trauma symptoms* represents the measurable variable as measured by the frequency of responses at the various levels of measurement ("never", "rarely", "often", or "always") for the trauma symptom indicators in the questionnaire. Firstly, the statistical procedures followed to calculate the prevalence of trauma symptoms will be described.

The quantitative data was derived from the participants' responses to the 23 trauma symptom indicators in the questionnaire. As common in the use of a Likert scale (Delport & Roestenburg, 2011b:211-212), the participants could scale their responses according to whether each indicator was true for them on different levels, namely "never", "rarely", "often" or "always". However, some of the indicators were stated in the negative, as required in the structuring of a measuring instrument (Delport & Roestenburg, 2011a:177). As such, the responses reflected different meanings with regard to the prevalence of the trauma symptoms. For instance, the response "never" to the statement "I am excited about every

new day" reflects a high prevalence of the trauma symptom that could indicate depressed mood. On the other hand, the response "never" to the statement "I have nightmares" reflects no prevalence of trauma symptoms according to this particular trauma symptom. The researcher therefore reversed negative scores in the questionnaire in order for the responses to become aligned (Field, 2013:203).

Next, adding a value to each response a participant made, allowed for quantification of the responses (Fouché & Bartley, 2011:252-253). A value was assigned to each of the responses in the following way: "never" = 0 (no prevalence); "rarely" = 1 (minimal prevalence); "often" = 2 (moderate prevalence); and "always" = 3 (high prevalence). The trauma value of three (3) is therefore the highest possible value for indicating prevalence of trauma symptoms in this study, while a trauma value of zero (0) is the lowest possible value indicating the prevalence of trauma symptoms.

In order to calculate the prevalence of trauma symptoms, the *frequency* of responses was therefore multiplied by the *value* assigned to the response. For example, when viewing all the participants' (5) responses (23 each) in the first measurement (115 responses in total), 45 trauma indicators were marked as occurring "never"; 34 as "rarely"; 22 as "often"; and 14 as "always". Thus, the prevalence of trauma symptoms for the first measurement was calculated as follows: (45*0) + (34*1) + (22*2) + (14*3) = 120 (refer Table 2). Considering both frequency and levels (value) of each response allowed for a more distinct presentation of the prevalence of trauma symptoms.

The quantitative findings in terms of the prevalence of trauma symptoms are described by descriptive statistics based on the univariate analysis of the data, and according to the three major characteristics of a single variable that are generally described for the purpose of descriptive statistics: the distribution, the central tendency and the dispersion (Babbie, 2013:418-424; Trochim, 2006). Firstly, the distribution of the data is indicated by frequency distributions that can be depicted as either a table or a graph and may be displayed using percentages (Babbie, 2013:419; Trochim, 2006). In this study, apart from one frequency table displaying percentages (Table 2), a basic graphic portrayal of the data is presented, indicating the prevalence of trauma symptoms, as measurable variable. Secondly, the central tendency of the distribution is described by the 'mean' of the data, thereby providing a view of the average prevalence of trauma symptoms amongst the participants. Finally, dispersion refers to the spread of the values around the central tendency and can be described by the standard deviation (Babbie, 2013:425). The standard deviation shows the relation that a set of scores has to the mean of the sample. A standard deviation close to

zero (0) indicates that the data points tend to be very close to the mean of the set, while a high standard deviation indicates that the data points are spread out over a wider range of values (Babbie, 2013:425; Trochim, 2006; Welman et al., 2011:230). Therefore, the standard deviation indicates how representative the figure is of the entire sample. When the mean respresents the data well, most of the scores will be close to the mean and the standard deviation will be small in relation to the mean (Field, 2013:28).

To determine whether change occurred in the prevalence of trauma symptoms over the three measurements, inferential statistics were used to test hypotheses about differences in measurements on the sample of subjects (Maree & Pietersen, 2007:231, 237). Two non-parametric tests were utilised in this study. Friedman's ANOVA test was conducted in order to test the hypothesis that Gestalt play therapy might have an effect in addressing symptoms associated with trauma, thus to answer the research question of the study. For each of the data correlations that have been tested, a null-hypothesis was drawn, in effect hypothesising that no change is prevalent in the trauma value and thus measurement 1, 2 and 3 reflects the same trauma value: H_0: μ1 = μ2 = μ3. The alternative hypothesis therefore constituted: H_a: at least one average differs from the others. The inferential statistics are not discussed in detail, only referring to the test statistics (f-value) and the statistical significance (p-value) as required for Friedman's ANOVA (Maree & Pietersen, 2007:231, 237). Significance was determined based on a 95% level of significance ($p \leq 0.05$).

Wherever statistical significance between measurements was prevalent, the Wilcoxon signed-rank test was employed and the results indicated. The Wilcoxon signed rank test was used to compare changes (Maree & Pietersen, 2007:231, 237) between measurements 1 and 2, 2 and 3, and 1 and 3. In this case the null-hypothesis, that no change occurred between two measurement (H_0: μ= 0), was tested for each of the above-mentioned comparisons. The alternative hypothesis (H_a: μ ≠ 0) would therefore indicate that the comparisons are not equal and change did occur. Consequently, wherever the smallest p-value was indicated, the most significant change occurred, thereby indicating between what measurements the most change occurred in prevalence of trauma symptoms. Again statistical significance was determined at a 95% level of significance ($p \leq 0.05$).

To summarise, the quantitative research findings will be displayed by the use of simple graphs, as required in the use of a single-system design (Strydom, 2011a:162), indicating prevalence of trauma symptoms and the way it changed over time. Thereafter the findings are briefly discussed, and followed by a discussion of the qualitative findings, as relevant to the specific section.

In the following section, the focus will be on the total prevalence of trauma symptoms and the changes over the three measurements.

4.4.2.2 The prevalence of trauma symptoms

The goal of this study was to establish the effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood. In order to portray the effect of Gestalt play therapy, the **quantitative findings** are presented in terms of prevalence of trauma symptoms and how it changed over time.

A holistic analysis of the data was conducted to determine the change in the total prevalence of trauma symptoms (23 indicators) for all participants (five participants) over the three measurements (measurements 1, 2 and 3 respectively). Each measurement therefore reflects a figure that represents the measurable variable, prevalence of trauma symptoms, calculated as described above. Figure 5 represents the results for each of the three measurements, indicating how the total prevalence of trauma symptoms changed over time.

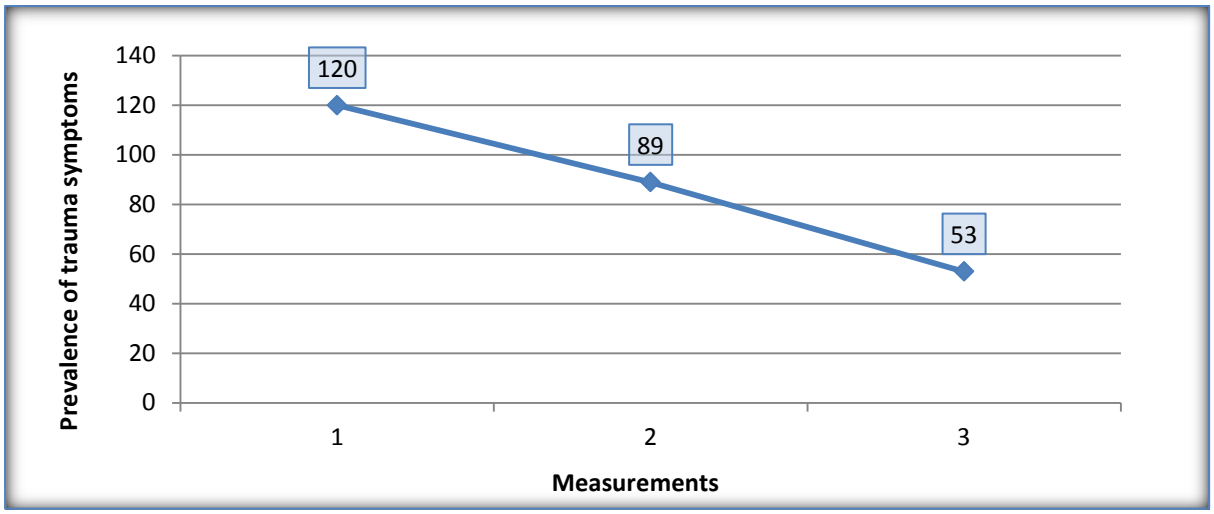

Figure 5: Change in the total prevalence of trauma symptoms over the three measurements

It is evident that the total prevalence of trauma symptoms decreased over the three measurements from a total of 120 to a total of 53. The central tendency, described by the mean of the prevalence of symptoms, progressively decreased from 1.04 (std. deviation[5] = 1.04) in measurement 1, to a mean of 0.77 (std. deviation = 0.86) in measurement 2, and finally a mean of 0.46 (std. deviation = 0.58) in measurement 3. The reduction in the

[5] The abbreviation *std. deviation* refers to the term *standard deviation.*

standard deviations relative to the means indicate that the mean of the data became increasingly representative of all the participants' responses.

Based on the p-value ($p < 0.0001$), the null hypothesis is rejected and it can therefore be concluded that a statistically significant improvement was apparent in terms of the total prevalence of trauma symptoms for all the participants cohesively, over the three measurements ($p < 0.0001$; $f = 13.58$). Furthermore, based on the Wilcoxon signed rank test, it appears that the largest change in the prevalence of trauma symptoms occurred between measurement 2 and 3, or throughout between measurement 1 and 3 ($p < 0.0001$ for both). The statistical calculations therefore support the fact that the Gestalt play therapy intervention led to a reduction in the total prevalence of trauma symptoms.

In Table 2 the number of times the presence of a trauma symptom was indicated (*frequency*) for the respective values assigned according to the responses at the different levels in the questionnaire (*value* 0, 1, 2 or 3) is indicated for each of the three measurements. The table also reflects the percentages of frequencies that each value represented within each measurement (*% within measurement*). The *total* represents the accumulated frequency and the respective percentage of times that each value was indicated in the responses for all three measurements.

Table 2: The frequency of respective values for each measurement

Value	Frequency	Measurements 1	2	3	Total
0	Frequency	45	51	66	**162**
	% within Measurement	39.1%	44.3%	57.4%	**47.0%**
1	Frequency	34	46	46	**126**
	% within Measurement	29.6%	40.0%	40.0%	**36.5%**
2	Frequency	22	11	2	**35**
	% within Measurement	19.1%	9.6%	1.7%	**10.1%**
3	Frequency	14	7	1	**22**
	% within Measurement	12.2%	6.1%	0.9%	**6.4%**
Total	Frequency	115	115	115	345
	% within Measurement	100.0%	100.0%	100.0%	100.0%

From the above table it can be drawn that the largest percentage of the responses reflects no or minimal prevalence (adding to 83.5%) of trauma symptoms (value 0 or 1) over all three measurements, indicating a relatively low overall prevalence of trauma symptoms. However, a notable percentage (adding to 16.5%) of the overall responses reflected moderate to high prevalence of trauma symptoms (value 2 or 3).

When comparing the responses from the first to the third measurement, the percentage of responses reflecting moderate or high prevalence of trauma symptoms was rather high (31.3%) during the first measurement, before the Gestalt play therapy process was implemented. Of importance is that these responses (carrying a value of 2 or 3) decreased over the three measurements, while the responses reflecting no or minimal prevalence of trauma symptoms (carrying a trauma value of 0 or 1) increased. These changes are visually presented in Figure 6, which reflects the percentage of times that certain trauma values (0, 1, 2 and 3) were indicated for measurement 1, 2 and 3 respectively.

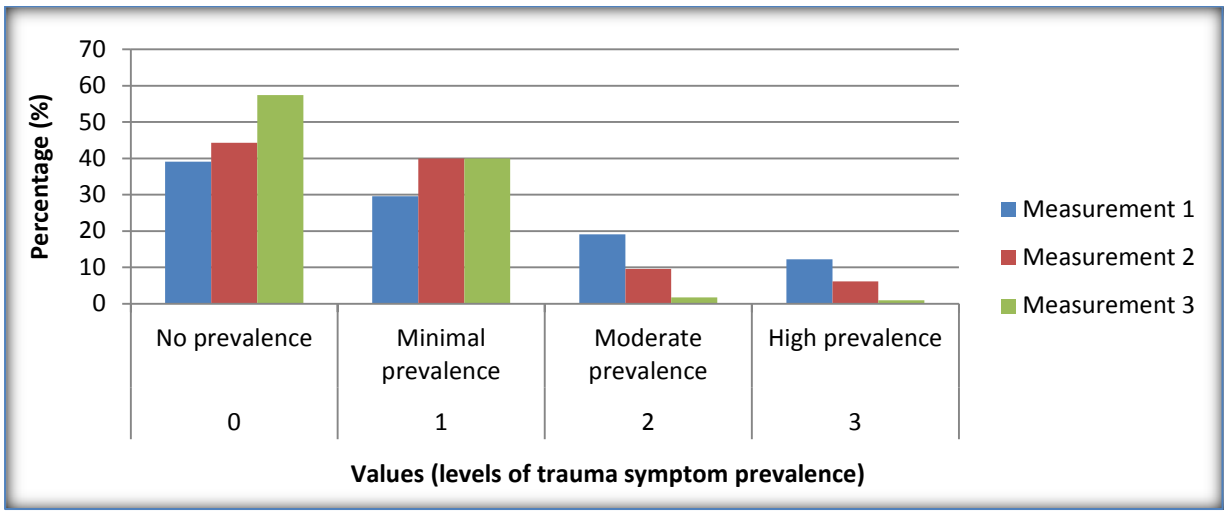

Figure 6: Frequency of values (levels of trauma symptom prevalence) for measurement 1, 2 and 3 respectively

Considering the percentages of trauma values 2 and 3 in the figure above, notable changes are evident. The four sets of data displayed in Figure 6 indicate a reduction in the total prevalence of trauma symptoms from measurement 1 to measurement 3. Firstly, the frequency of the respective trauma values during the first measurement for values 2 and 3 are indicative of notable prevalence of trauma symptoms. For both these values, the frequency of the trauma symptoms during the second measurement declined to almost 50% of the prevalence indicated during the initial measurement. A marked reduction in values 2 and 3 is further reflected in the final measurement. The frequency of the responses which indicated moderate to high prevalence of respective trauma symptoms (values 2 and 3)

therefore reduced and was substituted by responses indicating no or minimal prevalence of trauma symptoms (values 0 and 1).

The **qualitative data** supports the quantitative findings in view of a reduction in the prevalence of trauma symptoms. It became apparent that participants experienced an improvement in the trauma symptoms over time. Participants generally expressed that certain symptoms they experienced difficulty with "just changed" - specifically indicating that the difficulties "decreased" or "became better." Even Charl, for whom the quantitative results did not indicate a reduction in trauma symptoms, experienced a different view of the self. The following are examples of change that the participants experienced[6]:

> *"I like that I have changed … not to hit things anymore … Almost everything … changed for the better."* (DJ)
>
> *"I received therapy; it has helped … it worked."* (Suzie)
>
> *"I like myself [because] … I don't know … I probably just changed a lot."* (Charl)

Considering the changes in the total prevalence of trauma symptoms over time, it is evident that Gestalt play therapy succeeded in reducing trauma symptoms experienced by the participants. Subsequently, the prevalence of trauma symptoms will be presented according to each of the 23 indicators of trauma that were measured in the questionnaire, followed by a presentation on how the prevalence of trauma symptoms changed for each indicator over the three measurements.

4.4.2.3 Prevalence of individual trauma symptoms

It became apparent from the data that certain trauma symptoms seemed to be more prevalent than others. Consequently, the quantitative analysis of data as reflected by individual indicators provides additional insight with regard to the trauma symptoms that the participants experienced, and thus the effect of Gestalt play therapy on these individual trauma symptoms. In this section, the prevalence of trauma symptoms are presented according to the accumulated prevalence of individual trauma indicators, followed by a more detailed presentation of the change in the symptoms as reflected by the prevalence of individual indicators over the three measurements.

[6]The verbatim quotes were translated into English for the purpose of the report.

- **Accumulated prevalence of individual trauma indicators**

In Figure 7 below the accumulated prevalence of each of the 23 indicators is depicted, reflecting the prevalence of the trauma symptoms for all participants during all three measurements.

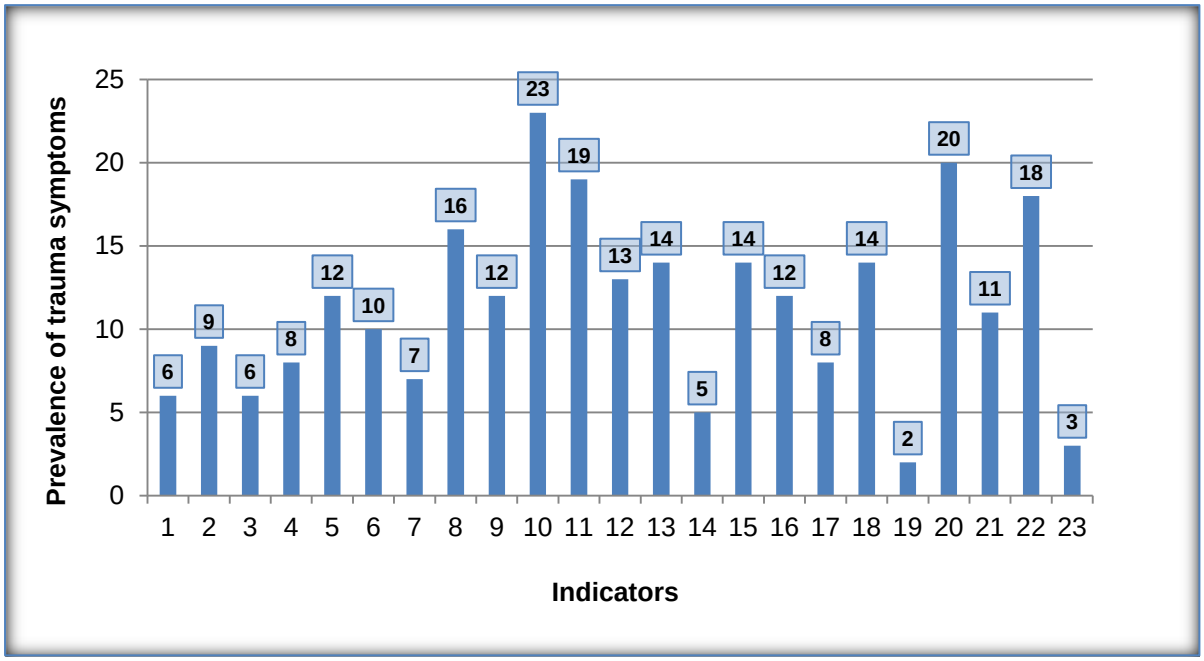

Figure 7: Accumulated prevalence of individual trauma indicators

From the above figure it is evident that the symptoms that were more prevalent over all three measurements were fighting (indicator 10), daydreaming (indicator 20), anger (indicator 11), headaches or stomach aches (indicator 22) and hypervigilance (indicator 8). On the other hand indicators with the lowest prevalence over all the measurements were school avoidance (indicator 19), bed wetting (indicator 23), low self-esteem (indicator 14), depressed mood (indicator 1) and inattention (indicator 3).

This presentation of the above data does not, however, reflect the dynamics of the quantitative data inherent in the objective of this study: to indicate change in trauma symptoms. More detailed data is therefore provided next to indicate the change in the prevalence of individual trauma symptoms over the three measurements.

- **Change in prevalence for individual trauma indicators**

Figure 8 portrays the prevalence of trauma symptoms as measured by each indicator and how the prevalence of symptoms changed over the three measurements.

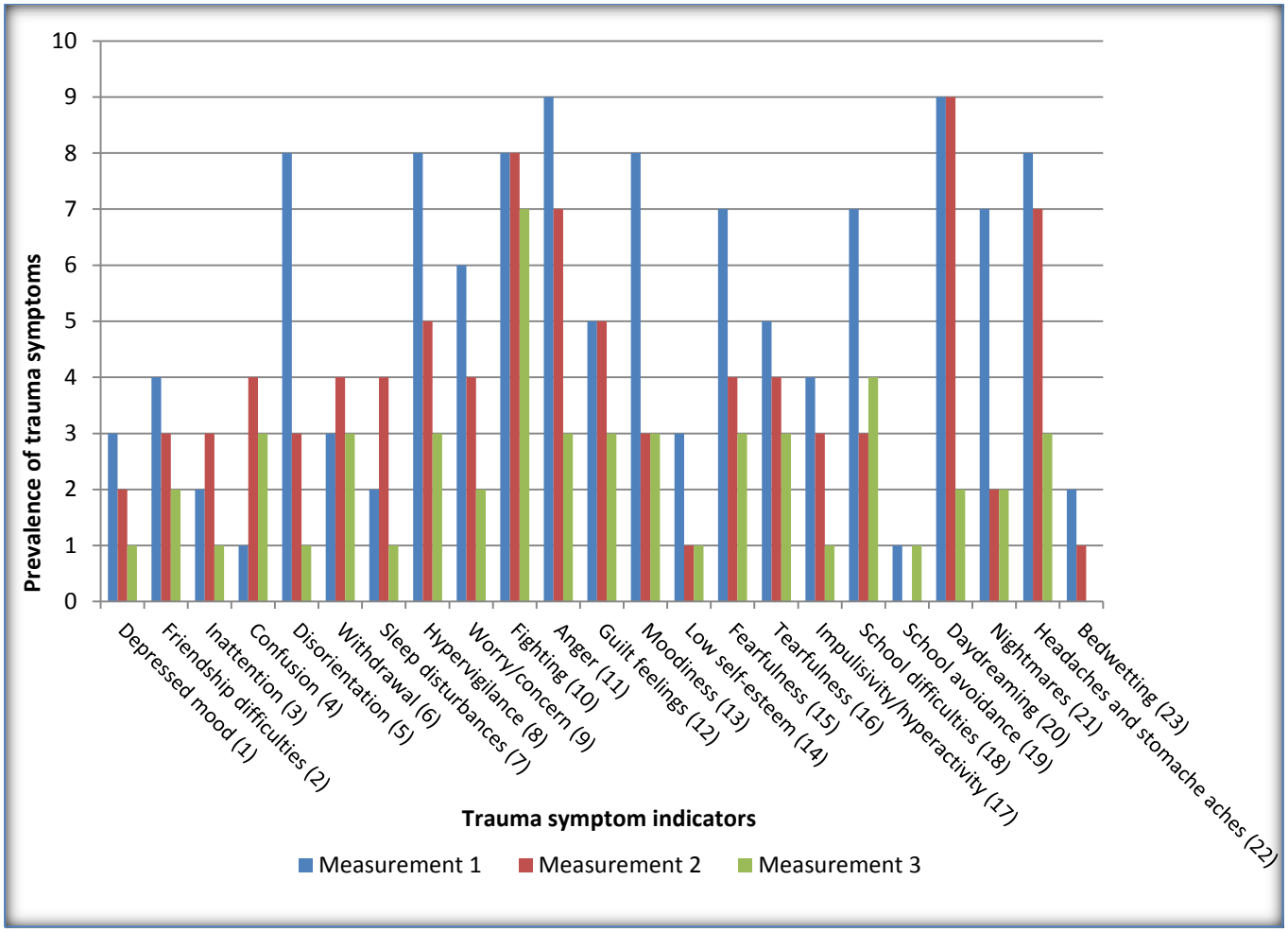

Figure 8: Change in prevalence of individual trauma indicators

For the individual indicators, the trauma symptoms reflecting the highest prevalence in the first measurement were anger (indicator 11) and daydreaming (indicator 20), followed by disorientation (indicator 5), hypervigilance (indicator 8), fighting (indicator 10), moodiness (indicator 13) and headaches and stomach aches (indicator 22), thus reflecting some similarities to the accumulated totals, as presented in Figure 7. As the first measurement was the baseline measurement, it is recognised that these symptoms were prevalent for at least four weeks before the research commenced, as stated in the sampling criteria. The indicators that showed the lowest prevalence of symptoms in the first measurement were confusion (indicator 4) and school avoidance (indicator 19).

Most of the indicators reflect a decrease in the prevalence of trauma symptoms from the first to the third measurement and thus show an improvement in terms of the trauma symptoms experienced by the participants. Symptoms pertaining to disorientation (indicator 5) and daydreaming (indicator 20) seemed to have decreased most, while the symptom related to fighting (indicator 10) seems to have maintained the highest prevalence throughout and

improved by the smallest margin. Although a number of indicators showed a substantial improvement from the first to the third measurement, for example indicators 8 (hypervigilance), 11 (anger), 13 (moodiness), 15 (fearfulness), 21 (nightmares) and 22 (headaches and stomach aches), the only symptom that presented with a statistically significant improvement ($p < 0.0383$) was indicator 5, namely disorientation.

The trauma symptoms experienced by the participants in this study correlate with the symptoms of trauma generally experienced by children in middle childhood, as outlined by Kaduson and Schaefer (2006:6-7). The indicators of trauma that were most prevalent in the study seem to relate to either dissociative symptoms (indicators 20 and 5) or hyperarousal symptoms (indicators 11, 8, 10 and 13). These symptom groups are known as the two most common and severe long-term consequences of trauma (Perry, 2003:4). The two indicators that scored the highest in terms of prevalence of trauma symptoms and also showed the most improvement were both related to dissociation (indicators 5 and 20). Dissociation refers to disconnecting from external stimuli and resultant disintegration (Perry, 1996:6), and requires contact skills to improve self-regulatory abilities (Fall et al., 2010:207). The improvement in terms of these symptoms might thus be ascribed to attention being paid in Gestalt play therapy to enhance contact and awareness in the here and now (Oaklander, 2011:173).

Apart from the gradual improvement in terms of most of the symptoms, certain exceptions were prevalent in the data. The prevalence of symptoms in the two indicators related to the school context, namely school difficulty (indicator 18) and school avoidance (indicator 19), initially decreased, but then increased again between the second and third measurement, however maintaining a prevalence of trauma symptoms lower than initially measured. In this case the context might have contributed to these changes. Gestalt theory, with holism as theoretical underpinning, emphasises that an individual cannot be fully perceived without giving recognition to their context (whether environmental, social or spiritual), and that change in one area could affect other areas (Clarkson & Cavicchia, 2014:1; Blom, 2006:19; Fall et al., 2010:203; Henderson & Thompson, 2011:221; Mann, 2010:5). The final measurement occurred during the school examination period and it could therefore be expected that individuals might experience increased challenges relating to school work. This situation might explain the higher prevalence of trauma symptoms for these two indicators during the third measurement.

Four trauma symptoms, namely inattention (indicator 3), withdrawal (indicator 6), sleep disturbances (indicator 7) and confusion (indicator 4), showed an initial increase in

prevalence from measurement 1 to measurement 2. Symptoms then decreased to a prevalence lower than the initial measurement, except for the symptom confusion (indicator 4) which reflected a prevalence higher than reflected in the first measurement. In Gestalt play therapy specific attention is paid to enhance awareness in the here and now (Blom, 2006:90; Oaklander, 2006:24). As the individual becomes more aware of processes in the self (Blom, 2006:51), participants were likely to become more aware of certain symptoms they experienced. Enhanced awareness is often associated with the so-called phobic layer in the layers of neurosis (Perls, 1970), as discussed in Chapter 2, during which the individual becomes aware of the false existence they have tried to maintain. Awareness of this false existence tends to increase anxiety in individuals (Blom, 2006:42; Fall et al., 2010:212-213). As anxiety is known to be a trigger for dissociative symptoms such as confusion and inattention (Perry, 1996:6), enhanced awareness might explain the sudden increase of the symptoms during the second measurement. It is acknowledged that awareness might have occurred at different times for individual participants and also in terms of particular symptoms, depending on each individual's context and progress in the therapeutic process.

Notable was the fact that the symptom related to fighting (indicator 10), which showed a relatively high prevalence in the first measurement, showed minimal change in prevalence and remained the symptom with highest prevalence in the third measurement. This could be a manifestation of the inability to regulate emotions and the consequent behaviour, as often found in traumatised children (D'Andrea et al., 2012:189; Streeck-Fisher & Van der Kolk, 2000:907), and could further be ascribed to the context of the children's home, where often the most severely traumatised children are cared for in a group setting (Foltz et al., 2013:12). The extreme level of trauma often experienced by children in residential care settings, has a significant impact on the emotional and behavioural trauma symptom presentation of children (Foltz et al., 2013:15). The fact that fighting was and remained highly prevalent therefore might be ascribed, in part, to the notion that "other child residents of the facility can also be a source of violence, especially if the child perpetrators have themselves previously been subjected to violence and abuse" (DSD et al., 2012:32).

To summarise, the individual indicators of trauma symptoms evidently show different patterns of change throughout the research, some indicating gradual improvement while others show fluctuating patterns. Symptoms of trauma are commonly divided into symptom categories (D'Andrea et al., 2012:189). In the following section, the research findings will be discussed according to these symptom categories.

4.4.2.4 Changes in prevalence of trauma symptoms for the respective symptom categories

Literature commonly distinguishes between various trauma symptom categories inherent to trauma. In this section the research findings will be presented according to the symptom categories as outlined by D'Andrea et al. (2012:189), as discussed in Chapter 2. These categories refer to affect and behaviour dysregulation, alterations in consciousness and awareness, distortions in attribution and worldview, and finally, interpersonal difficulties. For the purpose of the discussion of the research findings, the two aspects in the first category, namely affect dysregulation and behaviour dysregulation, are discussed as separate symptom categories. The research findings indicate that symptoms of trauma were prevalent in all five symptom categories.

In each of the symptom categories discussed below, the quantitative data are firstly presented. The quantitative data will include a holistic view of the change in the prevalence of trauma symptoms for the specific symptom category, as well as a presentation of the change in the trauma value for the individual indicators of each symptom category. Thereafter, the qualitative findings which correlate with the symptom category will be presented as sub-themes, illustrated with verbatim quotes and interpreted in relation to literature. The themes (symptom categories) and sub-themes are summarised in Table 3 below.

Table 3: Themes and sub-themes

THEMES	SUB-THEMES
1. Symptom category: Affect dysregulation	1.1: Fearfulness 1.2: Overwhelming emotion 1.3: Anger 1.4: Emotional lability
2. Symptom category: Behaviour dysregulation	2.1: Aggression 2.2: Hypervigilance 2.3: Nightmares and sleep disturbances 2.4: Psychosomatic symptoms 2.5: Tension reduction and avoidance strategies
3. Symptom category: Alterations in attention and consciousness	3.1: Poor concentration 3.2: Daydreaming and disorientation 3.3: School performance
4. Symptom category: Distorted attribution and worldview	4.1: Self-perception 4.2: Guilt feelings 4.3: External locus of control 4.4: Worry and concern
5. Symptom category: Interpersonal aspects and relational difficulties	

- **Theme 1: Symptom category: Affect dysregulation**

Affect dysregulation refers to the inability to regulate one's emotional states and is one of the most prominent consequences associated with trauma in children (Cook et al., 2007:5; Goodyear-Brown, 2010:vi, 32). In this study, affect regulation was measured by the following indicators: depressed mood (indicator 1), anger (indicator 11), moodiness (indicator 13), fearfulness (indicator 15) and tearfulness (indicator 16). The prevalence of trauma symptoms for all the indicators related to affect dysregulation, and how it changed over the three measurements, are presented in Figure 9.

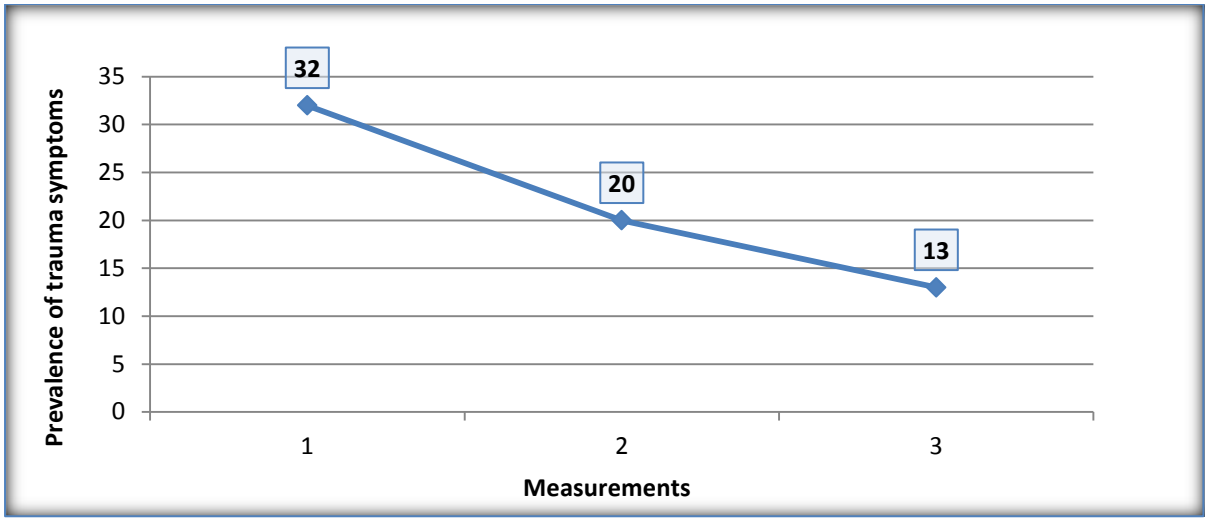

Figure 9: Change in prevalence of trauma symptoms for affect dysregulation

It is evident that the prevalence of trauma symptoms within this symptom category, representing symptoms associated with affect dysregulation, decreased over the three measurements from a prevalence of 32 to 13. The mean (average) of 1.28 (std. deviation = 1.14) in measurement 1, decreased to a mean of 0.8 (std. deviation = 1.0) in measurement 2, and finally measured a mean of 0.52 (std. deviation = 0.51) in measurement 3. The decrease in the standard deviation indicates that the mean of the data closely represented all the responses. This indicates that Gestalt play therapy had a marked effect on the prevalence of the symptoms in this trauma category, for the participants overall.

Based on the p-value ($p < 0.0166$), the null hypothesis that no difference exists in the mean of the prevalence of trauma symptoms for this symptom category for measurement 1, 2 and 3, is rejected. It can be concluded that a statistically significant improvement was apparent in terms of the total prevalence of trauma symptoms for this symptom category over the three measurements ($p < 0.0166$; $f = 4.34$). The Wilcoxon signed rank test, which indicates change over time (Maree & Pietersen, 2007:237), revealed that the most significant decrease in the prevalence of trauma symptoms occurred between measurement 1 and 3 ($p < 0.001$) with quite a significant change between measurement 1 and 2 ($p = 0.0327$) as well.

Within this symptom category, the relevant trauma indicators show different patterns of change. The change in the prevalence for trauma symptoms related to the individual indicators associated with affect dysregulation is presented in Figure 10.

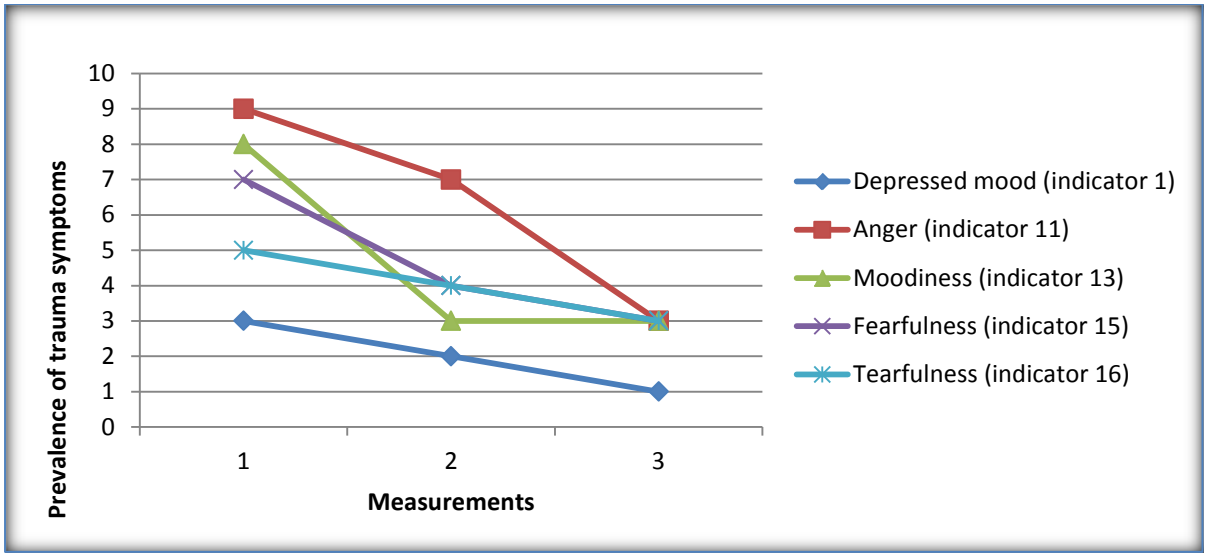

Figure 10: Change in prevalence of trauma symptoms for indicators related to affect dysregulation

In this symptom category the most noticeable changes occurred in the symptoms related to anger (indicator 11), moodiness (indicator 13) and fearfulness (indicator 15), with moodiness showing a marked decrease between measurement 1 and 2. Indications of tearfulness (indicator 16) and depressed mood (indicator 1), showed gradual, however less change over the three measurements

The above changes in the symptom category are reflected in the **qualitative findings** obtained in the study. The qualitative findings are discussed in the following sub-themes: fearfulness, overwhelming emotions, anger and emotional lability.

- **Sub-theme 1.1: Fearfulness**

Most of the participants indicated that they experienced fearfulness. Some fears related to realistic, concrete experiences, while others can be regarded as more irrational fears. Concrete fears included aspects such as fear of being chased by a dog (Charl), being reprimanded by someone (Dorithea) or, in the words of one of the participants: "… I am very scared … of the court [and] … in the evenings when I am alone … at the children's home" (Suzie). In contrast, other fears appeared to be unrealistic and occurred mostly at night:

> "*As I looked up there, it looked like a monster's face that is looking at me. … [then] I pray and then I fall asleep … or I cry myself to sleep. [The other children] say: 'Why are you so scared if you are so big?"* (Violetta)

> *"I feel scared … in the evenings of things that I feel are surrounding me … I get scared because I hear sounds … scary things … Then I see the shadow and something moving there, but when I look it does not move anymore."* (Dorithea)

"*Sometimes I am scared … my heart beats very fast."* (DJ)

Children who have been exposed to trauma, such as the case with the participants, tend to experience emotions related to fearfulness (Kaduson & Schaefer, 2006:7; Louw et al., 2007:379; Papalia et al., 2008:409). Their fears are often irrational in nature and seem to arise from suspicion and a general feeling that the world is not a safe place (Kaduson & Schaefer, 2006:8). Furthermore, somatic behaviours, such as DJ who experienced a rapid heart rate when scared, are common symptoms related to fearfulness (Campbell, 2009:18).

By the final measurement, fearfulness seemed to have subsided for most of the participants, although still minimally present for some participants. Participants indicated the following:

"I think … in a few weeks I have not been scared." (Charl)

"[It] is going well … [my fear is] less severe …" (Dorithea)

It seems that one participant developed the ability to reason logically regarding the emotion of fear, as indicated by Violetta who experienced a significant victory over her fears:

"I tell myself that there is not something in the room that is going to catch me … I do not know [how it changed] … I just thought everything over and [realised] that it does not exist" (Violetta)

The ability to manage one's fears, as the participants acquired, could be ascribed to improved self-regulatory abilities (Arvidson et al., 2011:41), which is one of the key objectives of Gestalt play therapy (Blom, 2006:29, 52; Fall et al., 2010:208).

- **Sub-theme 1.2: Overwhelming emotions and tearfulness**

The participants reported that they frequently experienced overwhelming emotions and tearfulness or crying, which are symptoms often associated with traumatised children (Streeck-Fisher & Van der Kolk, 2000:907). The participants indicated various factors which seemed to provoke overwhelming emotions, including traumatic memories, an inability to regulate emotions which resulted in general tearfulness, and emotions related to weekend visits. With regard to traumatic memories, one participant mentioned:

"I feel like crying about my mother and father when we were taken away from them, yes … and I will get mad at my foster parents and also a little sad when I hear things about [my past]. If someone says something about my brother again then I easily cry." (Suzie)

General tearfulness and increased reliance on caregivers is commonly experienced by traumatised children (Goodyear-Brown, 2010:38), as depicted in the words of one participant:

> *"I sometimes cry because I am angry … [and] … sometimes when I am too excited, I cry … like when I was happy that I am going out [of the children's home for a visit] for the first time … [I cry easily] if I have to come back after I have been out [for a weekend-visit]."* (Dorithea)

Another key matter causing sadness and crying for most of the participants seemed to relate to peer relations. Poor peer relations are commonly noted amongst traumatised children (D'Andrea et al., 2012:191). One participant explained how her emotions would be affected by friends:

> *"I [often] cry myself to sleep … [I cry] about friends at school that are nasty to me … and here [at the children's home] … When my friends are nasty to me … I go to the restroom, I sit [there and] dry my tears ... And as I stand there by the door I pray for the Lord to help me not to cry anymore and then I carry on with my life."* (Violetta)

In the final interview all the participants who initially experienced overwhelmed emotions showed an improvement in terms of affect regulation. They mentioned that although they still felt like crying in certain situations, they have found ways of handling these emotions, as evident in the following quotes:

> *"I do not cry anymore when [my holiday parents] come to drop me off … [I feel sad but] … then I just think about something else … I will say it is going well … better [than what it was]."* (Dorithea)

> *"[My tearfulness] changed … [when friends now are nasty to me] I go and tell the teacher … or I apologise even if it was not me."* (Violetta)

> *"… only when they [my friends] insulted me [I felt like crying] … but I did not cry … I ignored it."* (Suzie)

It was noted that only the female participants acknowledged to feeling sad or tearful. The boys were reluctant to acknowledge incidents of crying. Charl, in particular, almost seemed resistant towards acknowledging negative emotions in himself: *"I never feel like crying … no!"* This could be indicative of how children suppress negative emotions, especially when functioning in the false layer in the layers of neurosis (Blom, 2006:42; Fall et al., 2010:213; Mann, 2010:211). It could also be ascribed to general emotional display rules in society that result in gender-differences in the expression of emotions (Berk, 2013:412-413).

- **Sub-theme 1.3: Anger**

Anger was an affective symptom often experienced by all the participants. Anger outbursts are often noted as affective symptoms of trauma in children in middle childhood (Kaduson & Schaefer, 2006:6; Louw et al., 2007:379; Papalia et al., 2008:409).

Various causes seemed to be related to the participants' anger. One participant reported to become angry in response to reminders of past experiences and due to irritability, often noted in traumatised children (Goldman, 2009:14; Goodyear-Brown, 2010:37), while other participants became angry in response to perceived injustice. The following quotes illustrate common causes for the participants' anger:

> *"When I think of it [past traumatic events] now … I will get angry at them [my mother and father and foster parents] … I am … still angry with them now … [and] I get angry easily, very easily … when I am irritated and people come to me and they interfere. Then I get angry …"* (Suzie)
>
> *"… then I get so angry, because he falsely accuses me."* (Charl)
>
> *"I get angry … because they lie and tell the teacher that it was me who cursed."* (DJ)
>
> *"They treat my sister unjustly … then I get angry about it."* (Violetta)

Interpersonal aspects, a theme discussed in-depth later under the symptom category related to interpersonal difficulties, have been markedly related to feelings of anger in the participants. Traumatised children's inability for emotional regulation often causes them to experience difficulties with peers (D'Andrea et al., 2012:191), which appeared to be the case for all the participants. The participants explained in this regard:

> *"[I get angry] when children tease me and are nasty to me."* (Dorithea)
>
> *"Yes, they make me angry … at the children's home … [I get angry easily] … yes … with a little boy. He gets me into trouble. Another boy kicks my chair the whole time, then I get so angry."* (Charl)
>
> *"I always get angry when they [my friends] … make jokes with me, but I do not like those jokes and I did tell them so, and then they carry on [joking] with me …"* (Violetta)
>
> *"[I get angry] when the children curse my mother."* (DJ)
>
> *"[I get angry] when children are nasty to me without reason*." (Suzie)

One of the participants was aware that he gets angry and frustrated with himself at times, which might be related to his need to be 'perfect' at all times:

> *"[I also get angry] when I cannot manage something … like in the exam … I knew the name because I have studied it, but I forgot. Then I got so angry! I get angry at myself, because I just forget it all the time."* (Charl)

Improvement in terms of the participants' experience of anger became apparent by the second and third measurement, during which anger seemed to have subsided for all of the participants. Two of the participants ascribed the improvement directly to their experiences in therapy. The participants indicated improvement, stating:

> *"I don't get angry easily anymore … I received therapy. It has helped … [since] two, three weeks ago."* (Suzie)

> *"I don't get angry that easily anymore … [it changed, because] … I came here [to therapy] and did all the nice things; then I realised that the friends don't do anything to me and it [what they are saying] is not true … now I ignore them."* (DJ)

> *"I don't [get angry] that easily anymore … I just turn around and walk away … when my friends are nasty to me. It is indeed better … I calm down … I cool off … and then I go and tell the friend that I am sorry."* (Violetta)

> *"People … don't fight with me anymore, then I don't get so angry anymore."* (Dorithea)

The ability to control one's anger, prevalent for most of the participants, is indicative of increased emotional regulation (Campbell, 2009:18; Coates, 2010:393; Schore, 2001:205).

- **Sub-theme 1.4: Emotional lability**

It emerged from the qualitative data that some of the participants had difficulty with emotional lability. Emotional lability refers to emotional instability, incongruence or inconsistent moods, which is commonly found in children exposed to trauma (Cook et al., 2007:5; Goodyear-Brown, 2010:vi, 32), as reflected in the following quotes:

> *"Aunt X [the caregiver] also said that I have mood swings … she says I get upset easily … it is true … I have mood swings!"* (Violetta)

> *"Yes, I [often] don't feel in a good mood."* (Suzie)

> *"People say that I am moody. Sometimes when I am sad or angry, for instance … it happens to me about two times a week."* (DJ)

By the second measurement, improvement in terms of experiencing inconsistent moods started to become apparent for some of the participants, as explained by one participant:

> *"It is going well … I don't get angry that quickly anymore … and then suddenly I am happy again."* (Dorithea)

The following quotes by the participants indicate enhanced awareness of and an ability to describe their internal states, an indication of enhanced emotional awareness (Blom, 2006:123-124):

> *"When I did not sleep well at night, and I get up in the morning, and the people get nasty to me, then I have mood swings … I feel unhappy, tired, weak … I don't have strength in me …"* (Violetta)

> *"[People say that I am 'moody'] … when someone made me angry in the morning and then I take it out on the others … but … I ignore those children now. Today when they talked to me I ignored them flat. I received therapy from [the researcher] … it has worked."* (Suzie)

According to Gestalt theory, enhanced awareness of one's own process can in itself lead to change in behaviour (Fall et al., 2010:208; Henderson & Thompson, 2011:229; Oaklander, 2011:191), as the quote by Suzie illustrates. It became evident that some of the participants acquired the ability to regulate their emotions and consequently control their behaviour.

It is worth mentioning that there was a minimal prevalence of trauma symptoms related to depressed mood indicated in the quantitative findings. Similarly, no information in the qualitative data emerged that indicated the presence of a depressed mood amongst the participants.

Literature on trauma, middle childhood and Gestalt theory serve to confirm the findings in this sub-theme and provides insight with regards to the symptoms the participants experienced and how it changed throughout the course of the therapeutic process.

The inability for emotional self-regulation is one of the most prevalent consequences of childhood trauma (Cook et al., 2007:5; Goodyear-Brown, 2010:vi, 32). Affective symptoms, similar to the sub-themes that emerged from the qualitative findings, are commonly noted in literature on traumatised children and includes, *inter alia*, affective symptoms such as explosive anger, lability, hypersensitivity or avoidant responses to negative stimuli, overwhelming emotions or negative affect and fearfulness (Briere & Spinazzola, 2005:402-403; Cook et al., 2007:5; D'Andrea et al., 2012:189; Goldman, 2009:14; Goodyear-Brown, 2010:vi, 32). These symptoms are associated with, and explained by, the neurobiology of trauma which confirms that structural and functional changes in the brain may contribute to difficulties often experienced by traumatised children. Trauma impacts the development of the right hemisphere, specifically the stress-regulating circuits, which in effect hinder the ability for stress related and emotion related processes (Schore, 2013:3). A lack of integration between the two hemispheres of the cortex is common in traumatised children,

which may lead to dramatic shifts in mood and personality (Coates, 2010:396-397), confirming some of the sub-themes that emerged throughout this study.

Children in middle childhood generally show gains in cognitive development, which allow them to think logically and rationally, and take into consideration others' perspectives (Benokraitis, 2005:331). Emotional growth also occurs during this phase, enhancing children's ability for awareness of emotions and the ability to regulate and voluntarily control their emotions (Carter & McGoldrick, 2005:37; Papalia et al., 2008:386). These advances in cognitive and emotional development allow children in middle childhood to consider others, act appropriately in social situations and to deal with difficult situations constructively (Carter & McGoldrick, 2005:37). However, traumatised children during this developmental phase are inclined to express trauma through regressive symptoms, which refers to the loss of previously acquired developmental capacities (Kaduson & Schaefer, 2006:6). Regression might manifest in children's affect as irrational fears or anger outbursts (Kaduson & Schaefer, 2006:6; Louw et al., 2007:379; Papalia et al., 2008:409), as was also confirmed by the findings of this study.

According to the Gestalt perspective, children who have been exposed to trauma often lack healthy contact, which results in an inability for emotional awareness and regulation (Oaklander, 2011:190). This might be due to the traumatised child's attempt for self-protective measures to avoid being hurt. However, lack of contact leads to the inability to identify and meet needs, and the child may therefore engage in inappropriate ways to cope (Fall et al., 2010:207; Henderson & Thompson, 2011:224; Oaklander, 2011:190). The aim of Gestalt play therapy, to enhance awareness of their process, can therefore restore healthy functioning whereby an individual is able to identify needs and address them in the here and now - the essence of self-regulation (Fall et al., 2010:208; Henderson & Thompson, 2011:229; Oaklander, 2011:191). The improvement in each of the affective symptoms the participants experienced could be ascribed to the increased awareness that developed throughout the therapeutic process.

Affect dysregulations and behaviour dysregulation are closely associated (D'Andrea et al., 2012:189; Streeck-Fisher & Van der Kolk, 2000:907), as clearly evident with the strong link between anger and aggression that was prevalent for some of the participants. The subsequent symptom category depicts the research findings related to behaviour dysregulation.

- **Theme 2: Symptom category: Behaviour dysregulation**

The difficulties traumatised children experience with regard to self-regulation has been found to have a strong association with behaviour problems for which traumatised chidren are known (D'Andrea et al., 2012:189).

In this study, behaviour dyregulation was measured by the following indicators of trauma: sleep disturbances (indicator 7), hypervigilance (indicator 8), fighting (indicator 10), school avoidance (indicator 19), nightmares (indicator 21), headaches and stomache aches (indicator 22), and bedwetting (indicator 23). Figure 11 below indicates the prevalence of trauma symptoms for all the indicators related to behaviour dysregulation and how it changed over the three measurements.

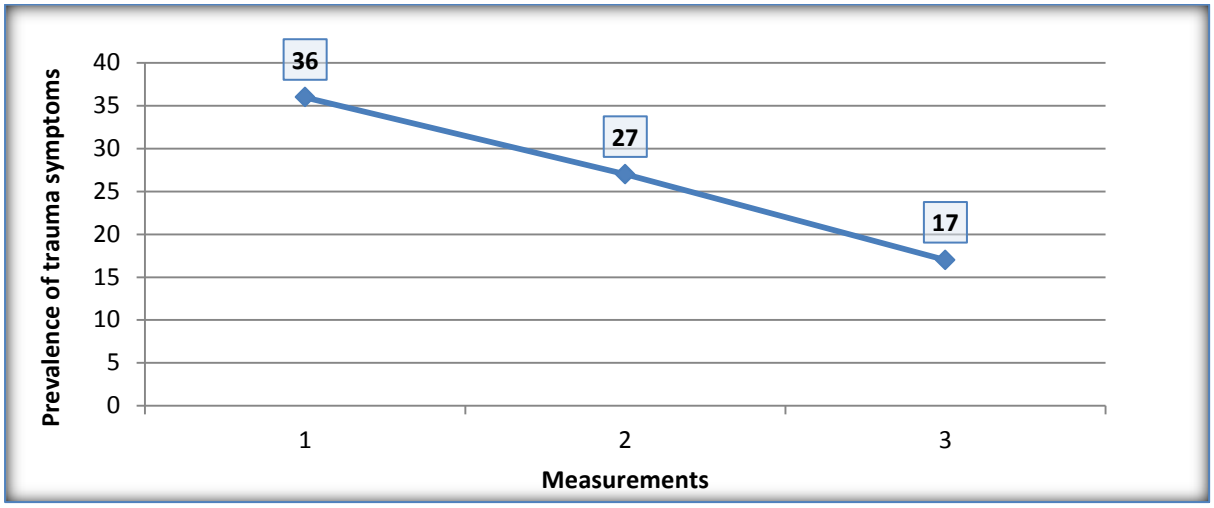

Figure 11: Change in prevalence of trauma symptoms for behaviour dysregulation

From the above figure it is evident that the prevalence of trauma symptoms for behaviour dysregulation decreased over the three measurements, from a total of 36 to a total of 17. The mean of 1.02 (std. deviation = 1.11) in measurement 1, decreased to a mean of 0.78 (std. deviation = 0.9) in measurement 2, and finally measured a mean of 0.49 (std. deviation = 0.7) in measurement 3. The relatively small standard deviations indicate that the mean of the data set reflects the responses of the participants accurately.

Utilising Friedman's ANOVA to test the hypotheses, the null hypothesis was rejected. Marginal statistical significance ($p < 0.0525$) was apparent in the improvement in terms of the prevalence of trauma symptoms for this symptom category over the three measurements ($p < 0.0525$ and $f = 3.03$). The Wilcoxon signed rank test revealed that the most significant

decrease in terms of the prevalence of trauma symptoms for this symptom category occurred between measurement 1 and 3 (p = 0.0180).

Within the symptom category related to behaviour dysregulation, the relevant indicators changed in different ways. In Figure 12 below the change in the prevalence of trauma symptoms are indicated for the individual indicators related to behaviour dysregulation.

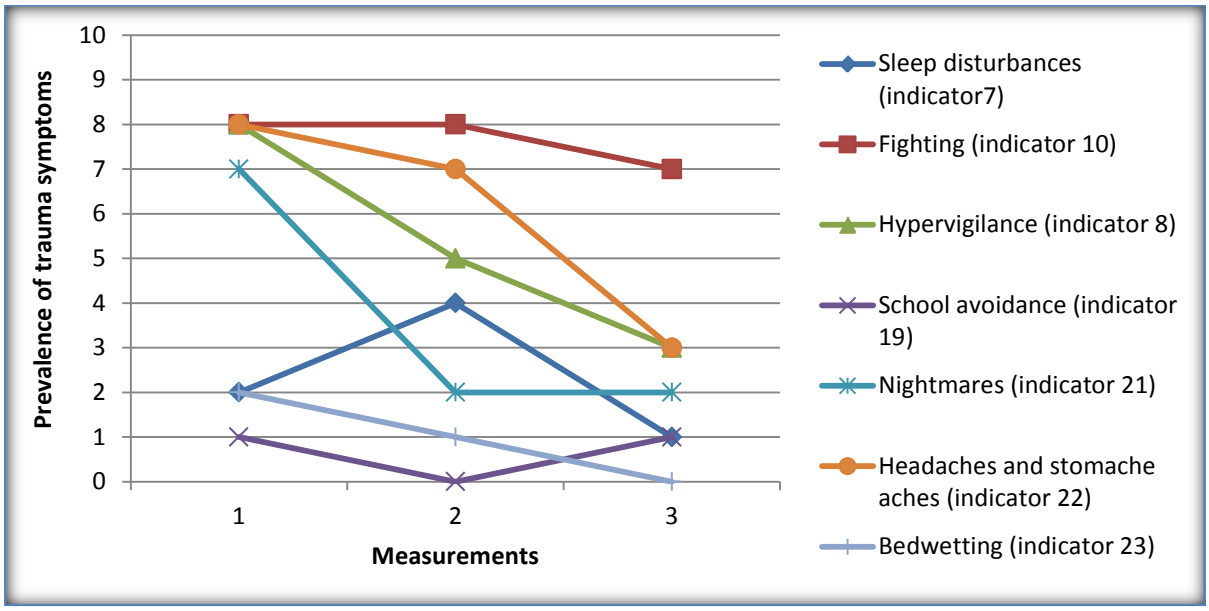

Figure 12: Change in prevalence of trauma symptoms for indicators related to behaviour dysregulation

Within this category of trauma symptoms, the most prevalent patterns are briefly discussed. Trauma symptoms related to hypervigilance (indicator 8), fighting (10) and headaches and stomache aches (22) evidently scored the highest prevalence during the first measurement and remained the three indicators with the highest symptom prevalence throughout all the measurements. As was also seen in the holistic view of all the trauma indicators, fighting (indicator 10) remained the indicator with the highest prevalence of all 23 trauma indicators.

On the other hand, indicators representing sleep disturbances (7), school avoidance (19) and bedwetting (23) scored the lowest prevalence of trauma symptoms and remained the lowest in the final measurement. All the indicators, except school avoidance (19), showed a decrease in the prevalence of trauma symptoms from the first to the third measurement and an improvement in terms of symptoms related to behaviour dysregulation is therefore apparent.

It emerged from the **qualitative data** that the participants experienced various behavioural difficulties. The most prevalent of these difficulties seemed to relate to aggression and oppositional behaviour, avoidance or tension reduction strategies, hypervigilance manifested in increased startle reactions, and sleep disturbances and nightmares. These difficulties are discussed as the sub-themes in this section.

- **Sub-theme 2.1: Aggression**

The research findings indicate that the participants were often involved in fights and resorted to aggression in dealing with conflict situations. Literature confirms that traumatised children appear to engage in acting out behaviours and, in middle childhood these children are more likely to engage in aggressive behaviour (Goodyear-Brown, 2010:32).

The participants' aggression manifested in verbal and physical aggression, often noted as consequences of trauma in children (Goodyear-Brown, 2010:29). Although some participants (Violetta and Charl) indicated that they engaged in acts of verbal aggression, the participants mostly mentioned that they reverted to physical aggression, which occurred commonly at school and at the children's home. In this regard, participants stated the following:

> *"I actually said … two nasty things to her … or three … I fight with words … not with my fists. [Sometimes I get so angry] that I just want to hit … I go and lie down on my bed, hit my teddy, hit my cushion …"* (Violetta)

> *"When somebody … fights with me and is nasty to me … then we yell at one another … [I got in trouble at school because of fighting] just because I pushed somebody … he kicked me and pinched me … then I kicked him. When we fight at the children's home … with a little boy … he just gets me into trouble … and then I punched him like this and then he started crying."* (Charl)

> *"My control is not very good, because … my day will turn out well and then people come who irritate me … and then I want to kill them. I will probably not kill them, but I mean I just want to give them a 'knock-out' so that they can stop. My patience is very, very little. I cannot keep myself patient. I will not go and lie down and calm down … when I hit something then I can calm down."* (Suzie)

Various triggers for the aggression experienced by the participants were evident and were often attributed to insults or provocative behaviour by peers. The insults were either directed at the dignity of the participant self, or the dignity of his family members. For two participants in particular, insults to their family served to be a sensitive topic, leading to aggression, while participants also reacted aggressively to other acts of provocation by peers. Participants mentioned:

> *"If people say things about my family … if they insult my family then I will … become so angry. I will hit them so badly … I will lose my mind completely. I have been in a fight yes … because of people who insulted my family … I remember this little boy … he cursed my family and I had turned around and hit him with a fist. … When they make 'jokes' with me, then I don't take it as 'jokes'… then they laugh at me … then I … hit them."* (Suzie)

> *"[I fight] just sometimes … that is when they curse my mother or my family very badly … then I get very angry … but only when they badmouth my mother … say nasty things … then sometimes I punch him … about once or twice a week."* (DJ)

> *"[I fight] when he takes my goods and I tell him to stop it, then he starts fighting with me … such as when they take my goods or they kick me."* (Charl)

> *"… when L was nasty to me … I first yelled at her, then she pushed me … and then I pushed her … so that she fell into the road, there where the cars drive."* (Violetta)

Family loyalty, evident in situations like this, is often noted in traumatised children and no matter how badly they have been treated by the family members the child tends to protect them, maintaining a sense of loyalty (Van der Kolk, 2005:404). The children's home where a number of traumatised children were being cared for, seemed to have offered unique challenges for the participants. The interaction of so many children, who have all been traumatised and who consequently present with 'typical behaviour problems' might have contributed to the high prevalence of fighting amongst them, and is often experienced in child and youth care centres, such as children's homes (DSD et al., 2012:32; Foltz et al., 2013:15).

Aggression was still prevalent by the second measurement, but improvement started to become apparent, as indicated by one of the participants who started to weigh the consequences of her actions, as opposed to her previous behaviour.

> *"No, I want to hit her … but when we do that we get punished … so sometimes [I control myself] … I go tell the caregiver and then she reprimands her … or I hit her … either one of those two."* (Suzie)

The frequency of aggressive acts that the participants initially reported varied greatly, from "almost daily" to "once or twice a week." At the time of the second measurement, this frequency appeared to have decreased to occur only "once a week" to "once a month", indicating improvement with regards to the trauma symptom of aggression. By the final measurement, most of the participants managed to control and regulate their aggressive behaviour, which could be an indication that rational thought processes were increasingly involved, rather than reactions based on immediate fight or flight responses (Campbell,

2009:19). In terms of aggressive behaviour, participants mentioned the following during the final data collection interviews:

> *"No, like this afternoon L and them started to insult me again and then I just ignored it … Yes, I said nothing back. Nothing!"* (Suzie)
>
> *"The fighting … has improved. It still happens sometimes that other people are nasty to me … [but] then I go and tell someone."* (Dorithea)
>
> *"It became less … [I] don't [fight] that often anymore, now - just sometimes."* (Violetta)
>
> *"It happens … many times that I manage to say 'I just ignore them.' It [ignoring them] is like doing something … I get angry and then I just go and tell the teacher and then the anger goes away. I like … that I have changed … not to hit things anymore."* (DJ)

It is noted that although the quantitative data show minimal improvement in the trauma indicator related to fighting (indicator 10), the qualitative data clearly indicates an improvement in aggressive behaviour. Next, hypervigilance, evident in startle reactions by participants, are discussed.

- **Sub-theme 2.2: Hypervigilance**

Hypervigilance, a term that explains a state during which a person's senses are sharpened in order to evaluate their environment for cues related to danger (Perry et al., 1995:273), appeared to be prevalent for most of the participants. Some of the participants indicated that they were sensitive to sight, while others indicated that they were sensitive to sound or noise. In both instances, participants indicated that they would be easily startled and be highly vigilant all the time. The following quotes are indicative of the participants' sensitisation to sounds and sights related to perceived threats:

> *"If I hear sounds or things then I get scared … like the wind that is blowing, because I am afraid it is thieves or something. [And] I sometimes get the feeling that people are following me, then I look back all the time."* (Suzie)
>
> *"If a door slams then I get startled, then I am scared."* (DJ)
>
> *"Sometimes in the evenings I hear sounds, then I get a fright. … When I turned around I got a fright because of her jacket that was standing there. I was really startled! I got a big fright! … [Another time] I saw shadows against the windows … I saw something move the whole time."* (Violetta)
>
> *"When I want to go to sleep, I hear the things again. I get startled by scary sounds … [afraid] that it might do something to me."* (Dorithea)

Some traumatised individuals might be more inclined to be triggered by sounds, while others might be sensitised with regards to sights or even smells or physical sensations (Perry et al.,

1995:274). In a state of constant fear, the individual's body becomes conditioned to be ready for any danger, and in effect awaits any threat. This sensitised response then leads a person to react inappropriately to even minor triggers related to perceived threat (Goodyear-Brown, 2010:28; Perry, 2003:4; Wasserman, 2005:7).

Their hypervigilance appeared to affect the participants in different ways, for example their sleep, behaviour and bladder control. Participants explained these effects as follows:

> *"… then I keep my eyes open … until I fall asleep*." (Dorithea)

> *"[When I get startled] I wake up and then I cannot sleep again."* (Suzie)

> *"When I get a fright from something, I do not stand still - I run! … Even if I run my legs this short, I will still run. I am scared! It feels as though [my heart] is going to jump out [of my chest]. … [And] I will wet my pants."* (Violetta)

Responses such as described above are usually due to the reaction of the sympathetic nervous system, which in effect interrupt calm integrated thought and reactions and prepares one to fight or flee (Campbell, 2009:19).

By the second measurement some of the participants experienced a slight improvement in terms of their hypervigilant responses. Violetta indicated an increase in awareness as she was able to ascribe her threat response to the scary thoughts she entertains and explained her feelings as follows:

> *"I get startled by movements and sounds … It is just like when I see or hear things then it lies in my … subconscious … and then I think about it … Yes, I feel cornered [but] … I just told myself it is not true."* (Violetta)

By the final measurement, a notable improvement was evident for most of the participants, except for one participant (Suzie) who indicated: *"[being startled] is still a little severe … I get startled easily, I awake easily [due to sounds]."* However, she indicated that the startle response has lessened, and she acquired strategies to calm down. The participants indicated:

> *"[I get startled] … then I go and wake up some of the older children … I sit with them until I am calm and then I go to sleep again."* (Suzie)

> *"[The startle reactions] is going a little better … I just do not pay attention to it. When someone tells me scary things to frighten me, then I tell myself it does not exist."* (Dorithea)

> *"I am not scared of that [sounds and sights] anymore. I do not know [how it changed] … I just suddenly realised that I do not need to get a fright or get scared anymore."* (Violetta)

The above information points to an improvement with regard to hypervigilant responses experienced by the participants and they seem to have acquired the ability to override instinctive emotional responses (Campbell, 2009:19; Van der Kolk, 2003:307). In the following section the discussion will focus on the participants' experiences of nightmares and sleep disturbances, which are closely related to hypervigilance (Perry, 2003:4).

- **Sub-theme 2.3: Nightmares and sleep disturbances**

Most of the participants, all female, experienced disruption of their sleeping patterns. Sleep disturbances are noted to be commonly experienced by traumatised children and can include sleep disorders, waking memories and nightmares (Briere & Spinazzola, 2005:402; Goldman, 2009:14; Goodyear-Brown, 2010:32). The participants mentioned various reasons for them experiencing difficulty sleeping. These reasons incluced hyperarousal, fearfulness and stress as illustrated respectively by the following quotes:

> *"…when I want to sleep, then I hear the things again. I do not struggle to fall asleep - I sleep and then I awake from things that I think are surrounding me."* (Dorithea)

> *"[The stories about Bloody Mary] is also what I am scared of … so I cannot sleep."* (Violetta)

> *"I rarely sleep well. I stress about the next day's tests or something … or I stress about what happened now … such as court cases and stuff … then I stress and then I struggle to sleep."* (Suzie)

For two participants, nightmares seemed to be the most prevalent reason for their inability to sleep. They indicated that they would typically awake from nightmares and then could not sleep again. One participant's nightmares related to traumatic memories, referred to in literature as re-experiencing symptoms (Goldman, 2009:14; Goodyear-Brown, 2010:32), while another participant's nightmares related to fears. The participants indicated:

> *"I often have nightmares … about my mother and brother … my foster parents … and about people who want to shoot me. … Yes, miserable stuff … violent! … I have [recurring nightmares] … but sometimes it gets more violent."* (Suzie)

> *"I get very big nightmares … most of the nights. … It is the things that I am afraid of that causes me to have nightmares … I wet my bed … sometimes … when I have nightmares."* (Violetta)

By the third measurements, two participants seemed to have experienced an improvement in their inability to sleep, while their nightmares have also subsided. They described these changes as follows:

> *"It is a lot better now … I do not lay awake no. If I am tired, I am tired - then I sleep. … I do not get nightmares that often anymore … a lot less [since] I think three weeks, two weeks ago."* (Suzie)

> *"[I lie awake] for about three, five minutes then I sleep again. … Never! Never [do I have nightmares] anymore … I do not know, but [the nightmares] are just gone - just gone! Suddenly it is just gone!"* (Violetta)

In term of sleeping patterns, DJ and Charl experienced the polarity, indicating that they always slept well. When explored further it became evident that Charl did often wake up around midnight. However, he did not seem to experience this disturbance in his sleep as problematic, as indicated in the following quote:

> *"I awake by myself while the other children are still asleep - about one o'clock … then I keep myself busy. … It is nice. I am just excited."* (Charl)

Some participants presented with psychosomatic symptoms, as will be disussed in the next section.

- **Sub-theme 2.4: Psychosomatic symptoms**

Psychosomatic symptoms, also known as somatoform distress, refer to physical pain or discomfort that is experienced without any real medical reasons for the sensations (Briere & Spinazzola, 2005:403). One participant mentioned manifestations of psychosomatic symptoms, as illustrated below:

> *"I always get headaches and stomach aches … when I have nightmares … the stomach aches remain until I get back from school ..."* (Violetta)

The other participants all acknowledged having experienced stomach aches or headaches, though most of the participants were able to ascribe specific, concrete reasons to those sensations. They related their headaches or stomach aches to aspects such as concentrating hard in class, eating too much, drinking too little water or running long distances.

The above explanations reflect the participants' concrete thoughts, characteristic of children in middle childhood (Papalia et al., 2008:351), regarding the headaches and stomach aches they experienced. Although these concrete explanations might have been the real reasons for the participants' somatic symptoms, it might also indicate the participants' thought processes in an attempt to make sense of and explain their psychosomatic experiences, given the fact that psychosomatic symptoms are often a behavioural manifestation of trauma in children in middle childhood (Goodyear-Brown, 2010:26; Kaduson & Schaefer, 2006:6-7).

What is of importance in the context of this study is that the symptoms experienced by Violetta seemed to have lessened by the final measurement, as indicated in her words:

> *"The aches are just gone since … I think about three, two, four weeks ago."* (Violetta)

In could be that the change in Violetta's symptoms was as a result of the Gestalt therapeutic process. As with the prevalence of psychosomatic symptoms, only one participant showed signs of using specific strategies to lower their emotional distress.

- **Sub-theme 2.5: Tension reduction and avoidance strategies**

Tension reduction and avoidance strategies serve as a way for traumatised children to reduce the emotional pressure and turmoil they experience (Briere & Spinazzola, 2005:402). Such strategies were apparent for one participant, and manifested in smoking, drinking, self-mutilation and risk-taking behaviour. The participant described these behaviours as follows:

> *"We have cut ourselves with blades … and we have cut pretty deep. I will run away from the children's home, for a week … and then I cannot come back until I have calmed down … I smoke and I cut myself, and I use drugs and all such things … I did [smoke] a few times this year. … I have hit my fist many times, and yes it was blue and it hurt … but it has sometimes helped me."* (Suzie)

In the context of traumatised children, the above trauma symptoms are regarded as avoidance strategies, which include absconding behaviour, and tension reduction strategies, evident in behaviours such as drinking, substance abuse and self-mutilation (Briere & Spinazzola, 2005:402-403). Although Suzie expressed her desire to engage in tension reduction behaviour at times in an attempt to reduce the emotional turmoil she experienced, she decided not to engage in such behaviour any more. At the time of the second measurement this participant seemed to have made the decision not to engage in behaviour that is neglectful to the self. She mentioned in this regard:

> *"I lay on my bed one evening and then I realised what it [smoking, drinking, using drugs, cutting myself] will do to my life and that it would not get me anywhere in life … so then I promised that I will never smoke or do this stuff again."* (Suzie)

Although the participant's decision might not necessarily lead to behavioural change, it is deemed relevant to point to the Gestalt perspective of awareness of her behaviour. According to Gestalt theory awareness is the ability to be in touch with the self with what one senses, feels or thinks and how one reacts in a specific moment (Blom, 2006:52-53) and therefore, enhancing awareness could support healthy self-regulation (Blom, 2006:19). The aim of Gestalt play therapy is to enhance children's awareness in order to help them to

restore their abililty to self-regulate (Blom, 2006:17, 19-20; Thompson & Henderson, 2007:197). It could therefore be proposed that Suzie's awareness of her behaviour could be a starting point for positive behaviour change.

Literature provides insight regarding experiences of behaviour dysregulation, the symptom category disussed in this section. Children in middle childhood are generally able to think rationally, control their impulses and monitor their behaviour (Carter & McGoldrick, 2005:40; Papalia et al., 2008:355). Their developmental ability for emotional regulation furthermore enables them to voluntarily control their emotions and consequent behaviours, therefore allowing healthier and pro-social behaviour (Carter & McGoldrick, 2005:37, 39; Papalia et al., 2008:386). However, traumatised children often are not capable of these functions due to the way trauma affected their self-regulatory capabilities (Cook et al., 2007:5). The inability for self-regulation was evident in the behavioural manifestations of trauma in the participants.

Traumatised children tend to present with a variety of behavioural symptoms, including aggressive or violent behaviour towards the self or others, sleep disturbances, hypervigilance and other internalised symptoms, such as psychosomatic symptoms (Briere & Spinazzola, 2005:403; D'Andrea et al., 2012:189; Goldman, 2009:14; Goodyear-Brown, 2010:32; Kaduson & Schaefer, 2006:7). Similar behavioural symptoms that were experienced by the participants, namely aggression, hypervigilance, sleep disturbances and nightmares, are related to hyperarousal which is one of the most common and severe symptoms of trauma in children (Perry, 2003:4). Goodyear-Brown (2010:29) explains that hyperaroused children typically experience the need to fight or flee which may manifest as troubling behaviours such as impulsive decisions, verbal and physical aggression, and self-harm, along with various somatic experiences. The mentioned behaviours were evident for the participants in this study.

When taking into consideration the literature on the neurobiology of hyperarousal, the lack of self-regulation in traumatised children becomes understandable. Hyperarousal is argued to occur due to sensitisation of the fight or flight response in combination with the dysfunction of the amygdala to stop the alarm reaction (Wasserman, 2005:7). This situation is also referred to as the 'amygdala alarm', 'cortical bypass' or 'emotional hijacking' as it causes the prefrontal cortex to be bypassed, and the individual therefore cannot think rationally under conditions of perceived threat (Campbell, 2009:19; Goodyear-Brown, 2010:29).

According to the Gestalt perspective, children engage in inappropriate behaviour to meet their needs, because of fragmented functioning and a consequent lack of capacity for self-regulation (Blom, 2006:31; Fall et al., 2010:207). Gestalt play therapy therefore promotes children's self-supporting behaviour by encouraging them to take responsibility for their own behaviour and to restore integration so that children can devote all their energy to meeting their needs in an appropriate way (Blom, 2006:51-52; Henderson & Thompson, 2011:228). However, healthy integrated functioning is not taught on a cognitive behaviour level, but rather through increasing awareness and contact in the here and now (Fall et al., 2010:203; Henderson & Thompson, 2011:221). Throughout the Gestalt play therapy process, improvement became apparent in the participants' ability for self-regulation and consequent responsibility to regulate their behaviour, which could have occurred due to increased awareness. The improvement in their ability to regulate their behaviour, thus the reduction in the prevalence of trauma symptoms related to behaviour dysregulation, was confirmed in this study by the quantitative and the qualitative findings.

Some of the difficulties that traumatised children tend to experience relate to alterations in attention and consciousness. Subsequently, symptoms associated with this symptom category are discussed.

- **Theme 3: Symptom category: Alterations in attention and consciousness**

Trauma symptoms associated with dissociation and disrupted executive functioning are manifestations of alterations in attention and consciousness (D'Andrea et al., 2012:189). In this study, the trauma symptoms associated with alterations in attention and consciousness were measured by the indicators of inattention (indicator 3), confusion (indicator 4), disorientation (indicator 5), impulsivity or hyperactivity (indicator 17), school difficulties (indicator 18), and daydreaming (indicator 20). In Figure 13 below, the change in the sum of the prevalence of trauma symptoms for all the indicators related to alterations in attention and consciousness are presented.

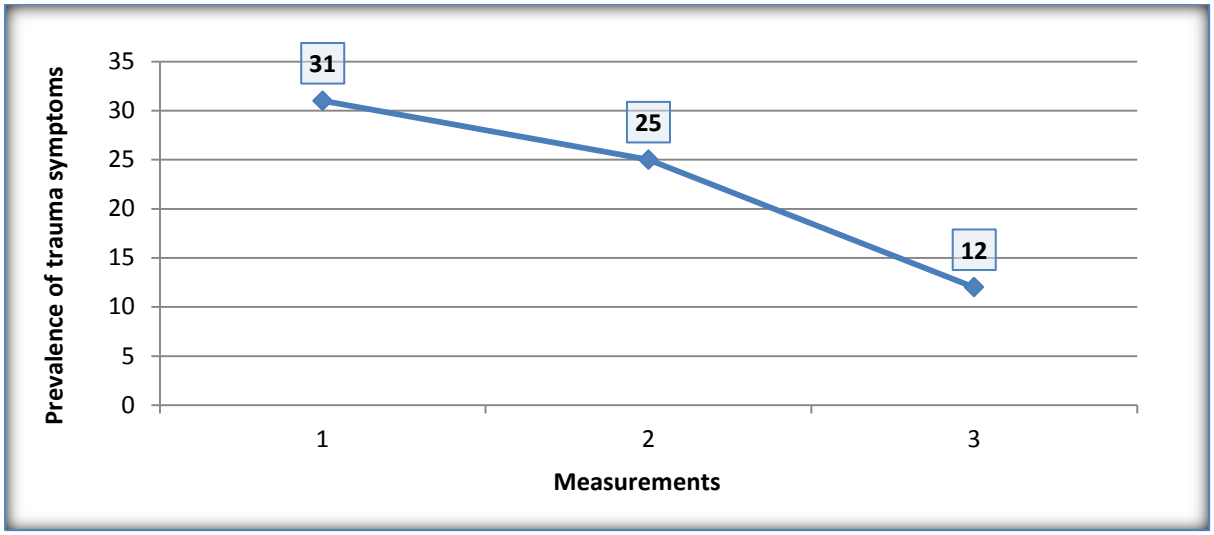

Figure 13: Change in the prevalence of trauma symptoms for alterations in attention and consciousness

From Figure 13 it is evident that the prevalence of trauma symptoms for this symptom category decreased over the three measurements from 31 to 12. The mean of 1.03 (std. deviation = 1.03) in measurement 1, decreased to a mean of 0.83 (std. deviation = 0.83) in measurement 2, and finally measured a mean of 0.4 (std. deviation = 0.5) in measurement 3. The standard deviations are close to 0 and therefore the mean reflects the dispersion of the data accurately, and was representative of all the participants' responses.

A statistically significant improvement was apparent in the total prevalence of trauma symptoms for this symptom category according to Friedman's ANOVA ($p < 0.0116$; $f = 4.69$). The Wilcoxon signed rank test revealed that the most significant decrease in prevalence of trauma symptoms occurred between measurement 1 and 3 ($p = 0.0028$).

In Figure 14 the change in the prevalence of trauma symptoms are indicated for the individual indicators of symptoms related to alterations in attention and consciousness.

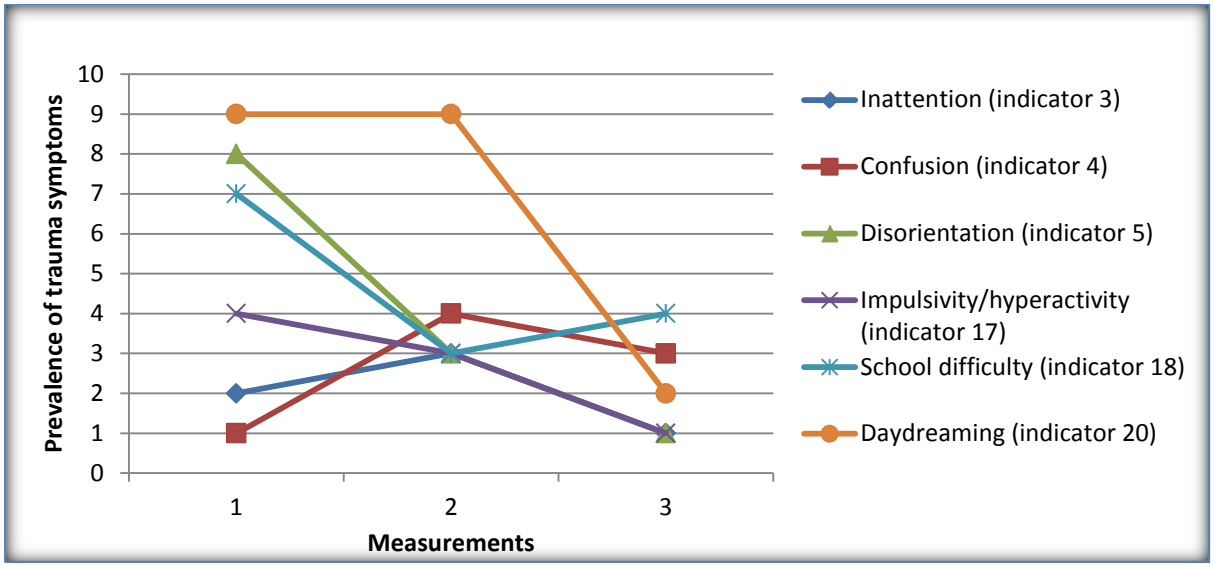

Figure 14: Changes in the prevalence of trauma symptoms for indicators related to alterations in attention and consciousness

From the above figure certain patterns of change are evident for the various trauma symptom indicators within this symptom category. It appears that the trauma symptom, daydreaming (indicator 20), initially scored the highest in terms of the prevalence of trauma symptoms compared to other indicators in this symptom category, followed by disorientation (indicator 5) and school difficulty (indicator 18). Daydreaming (indicator 20) also maintained the highest prevalence during measurement 2, before rapidly decreasing towards the final measurement. By the final measurement, all trauma symptom indicators related to alterations in attention and consciousness were only minimally prevalent.

From the **qualitative data** it became apparent that many of the difficulties the participants experienced relate to alterations in consciousness and attention. Patterns which emerged from the qualitative data are discussed in sub-themes related to poor concentration, daydreaming and disorientation, and school difficulties.

- **Sub-theme 3.1: Poor concentration**

Poor concentration appeared to be one of the least prevalent symptoms the participants experienced when only considering the quantitative data. However, from the qualitative data it emerged that some of the participants were unable to concentrate and stay focused on a task, as illustrated in the following quotes:

> *"Study time then it is not easy [to concentrate], because the children are making a noise … [and] … I can remember [the answers], but then I think of something else and then I forget it … the answer disappears."* (Charl)

> *"Sometimes in class I do not pay attention, because it is boring and the teacher talks you to sleep."* (DJ)

It seems that the inability to concentrate on a task could have been worsened by the prevalence of impulsive and hyperactive behaviours. Although children in middle childhood tend to have an increase in attention span (Carter & McGoldrick, 2005:40; Papalia et al., 2008:355), the following quotes depict the participants' perceptions that they experienced difficulty in this regard:

> *"If I have to sit still the whole day … then it is a little difficult … then I ask the teacher whether I may go to the bathroom."* (DJ)

> *"But I mean, one cannot sit still the whole day."* (Suzie)

> *"Yes, I feel like standing up because we sit the whole time."* (Violetta)

Children who have been exposed to trauma often present with concentration problems and hyperactive behaviours and are often misdiagnosed as having ADHD (Cook et al., 2007:6; D'Andrea et al., 2012:190; Goodyear-Brown, 2010:45; Streeck-Fischer & Van der Kolk, 2000:905). The qualitative findings indicate that both these symptoms were experienced by the participants in the study.

The participants' abilities to concentrate appeared to have improved by the final measurement. Suzie and Dorithea both mentioned that they manage to stay focused on tasks, while an improvement with regards to impulsivity was also evident, as Violetta and DJ both stated that *"never anymore"* do teachers have to tell them to sit still. One participant indicated:

> "*Not anymore [do I struggle to concentrate]. … I decided that I should not be lazy and that I should pay attention or else I will get bad marks."* (Violetta)

Poor concentration holds close relation to inattention, but for the purpose of this study inattention will be discussed next, since it is explained as a masking symptom of dissociation, along with daydreaming and disorientation (Cook et al., 2007:5).

- **Sub-theme 3.2: Daydreaming and disorientation**

From the interviews with the participants, it seemed that some of the participants experienced dissociative symptoms. Dissociation can be explained as "failure to take in or integrate information and experiences" (Cook et al., 2007:5), or as Perry et al. (1996:6) explain: "disengaging from stimuli in the external world and attending to an internal world."

From the qualitative data, daydreaming, disorientation and confusion seemed to be prevalent and could reflect dissociative symptoms.

Daydreaming, a common example of dissociation (Perry et al., 1996:7) appeared to be one of the most common symptoms experienced by the participants, both at school and at the children's home. The participants explained the experience as a sense of losing touch with reality, and it became apparent that daydreaming typically occurred in less desirable situations that might have caused anxiety for some of the participants; a common trigger for dissociative responses (Perry et al., 1996:6). Participants mentioned:

> *"Sometimes I just feel as though I am in dreamland [and] feel far away from reality … after school and sometimes in school time … mostly at the children's home."* (Suzie)

> *"Sometimes in class I do not pay attention … I sit and daydream … I want to go home and lie in bed; I do not feel well … in Maths [almost every day]. I sit and look at the birds … I think about a story of a little boy … there was a fight ... [and] the boy looked up to the sky and said that he wished he was a bird so that he could fly away when trouble comes."* (Violetta)

> *"I sit [and] I think of the things in my head. Then I feel like I dream in my head. … [it occurs] most of the school days when I do not feel like being wherever I am currently … nowhere [else] no … because then I am happy.*" (DJ)

Closely associated with daydreaming, was the theme of disorientation, which appear to be prevalent for the participants. The participants commonly noted that they felt threatened by this sense of disorientation, which occurred in different contexts. Their experiences are reflected in the following quotes:

> *"When it was a busy day or something … it feels as though I am … I don't know … as though I am at another place."* (Suzie)

> *"… then I forgot where I was … I was scared."* (DJ)

> *"… [then I] wonder why I am standing there … [and] sometimes I forget in what class I should be … I walked into the wrong class and sat down. It was scary."* (Violetta)

> *"It [feeling disorientated] feels scary."* (Dorithea)

The above discussion with regard to disorientation, also to some extent reflects experiences of confusion. Confusion seemed to be another symptom prevalent for some of the participants, and was ascribed to various reasons, such as being overwhelmed by many things at once or when one's mind "does not take well." These experiences seem to

accurately reflect the explanation of dissociation by Cook et al. (2007:5) as the "failure to take in or integrate information" as illustrated by the following quotes:

> *"[I feel confused] sometimes … when many people talk to me at the same time or when I have to do many things at the same time … [and] my [caregiver] says our minds do not take well … [when] our minds are not all well in there."* (Suzie)

> *"When I say the wrong things … they say my mind does not take well - I am a little crazy."* (Dorithea)

> *"Other people say that I am confused … like when I walked into the wrong class."* (Violetta)

It is described in the literature that disorientation or spacey behaviours, as well as confusion, as seemingly experienced by the participants, are common symptoms of trauma in children in the middle childhood years (Kaduson & Schaefer, 2006:7).

A marked improvement in terms of the prevalence of the above symptoms was evident by the final measurement, which the participants ascribed to different reasons, such as the need to study and internal motivation. The participants' views are presented in the following quotes:

> *"Because we had to study so much, I do not dream anymore [and] I never feel [disoriented] anymore."* (Dorithea)

> *"I used to do it [daydream] in class, but now not anymore."* (DJ)

> *"It is now less that way … I do not know … it just became less in my mind … probably because it is exams now … [and] I have to concentrate on the exam."* (Suzie)

> *"[It now happens] only rarely … now and then every week in Math. [It has improved because] … I sleep more at night. I have decided that I am going to pull up my socks [pull myself together] and start working."* (Violetta)

Charl displayed a unique pattern throughout the exploration of themes related to dissociation. He was the only participant who never acknowledged to experiencing any of these symptoms and appeared to show resistance, as illustrated by the following quote:

> *"Other people never say that I am confused … no, then they are the ones that are confused … [and] I never feel as though I am dreaming while I am awake … I sleep where my bed sleeps."* (Charl)

It can be hypothesised that his general denial of any symptoms could be due to the fact that traumatised children often do not accept certain attributes that do not fit the perception of their self-construct (Oaklander, 2006:199).

Children who were exposed to trauma often experience problems related to their school performance. This aspect is subsequently discussed.

- **Sub-theme 3.3: School performance**

The qualitative research findings indicate that the participants mostly maintained a positive attitude towards school and very rarely presented with school-avoidance strategies. However, all of the partipants indicated that they experienced difficulties in terms of their school performance.

The research findings indicated that the participants struggled with schoolwork and failed some of their subjects. These difficulties furthermore seemed to have caused stress and anxiety for some of the participants. Participants mentioned the following in this regard:

> *"I struggle with English ... it is not my subject … I do not like it … because I fail English and that is bad."* (Charl)
>
> *"I often struggle with my school work … only with Math … I have 3% for Math … that is why I say I am struggling."* (Violetta)
>
> *"Tests are also stressfull … [I stress] every time when it is the subjects that I am failing, yes … [I fail] Afrikaans and Math."* (Suzie)
>
> *"Sometimes when we are writing a test … I stress that I am going to receive poor marks … [and] I struggle quite a bit … with Math … it is difficult to sit and study … I do not always [understand it]."* (Dorithea)

Poor school performance is often noted amongst traumatised children (Louw et al., 2007:379; Papalia et al., 2008:409). Very often their learning problems are related to the inability to pay attention and the inability to integrate information as a result of their exposure to trauma (D'Andrea et al., 2012:189-190; Goodyear-Brown, 2010:45; Streeck-Fischer & Van der Kolk, 2000:905; Van der Kolk, 2006:2, 4).

Some of the participants relied on the teachers to assist them with their schoolwork. However, the participants did not consistently have resources available at the children's home. As mentioned, Charl indicated this fact as the main reason why he struggled with school work. His opinion on this matter points to the lack of someone who can assist with homework or studying as well as the lack of private space to study:

> *"[I struggle with school work] like when one has to find information about something … and it is difficult to find it because … there is not a caregiver at the children's home every day who can show one around at the library [and]*

> *… at study time it is not that easy [to concentrate], because the children make a noise and I have to sit in the corridor and do homework."* (Charl)

The above quote highlights the context of the children's home, which makes it understandable that other challenges commonly experienced by the participants seemed to relate to the limited educational resources available at the children's home. However, the pattern was again noticed that, where four participants took ownership of the fact that they struggled with school work, Charl ascribed his learning difficulties only to factors outside of the self.

The difficulties the participants experienced in terms of school performance improved quite remarkably by the second measurement, whereafter it somewhat worsened again. As discussed in section 4.4.2.3, this might have been due to the fact that the final measurement took place during the school examinations, which increased the participants' anxiety regarding schoolwork, as implied in the quote by one participant:

> *"… and now [I stress] mainly just about the exam, because I do not know whether I am going to pass or what."* (Suzie)

Nevertheless, by the final measurement most of the the participants indicated improved performance at school and seemed to have developed a positive regard for learning, as the following quotes reflect:

> *"I am happy to go to school, because then I can learn about new things."* (Violetta)

> *"… I used to struggle a little with … Math, but now I have done so well with my Math … yes, I have 80 for Math! … [and I do not struggle with] English anymore … because I started learning now … I just started to work then I knew almost everything about English …"* (Charl)

Of interest is that Charl willingly admitted that he previousy struggled with two subjects, while he initially ascribed his learning difficulties to the learning environment. From a Gestalt theory perspective, this could be ascribed to the fact that traumatised children tend to suppress painful emotions and, as mentioned earlier, often do not accept attributes that do not fit their self-perception (Blom, 2006:60-61; Oaklander, 1994:144; Oaklander, 2006:199). Now that the topic of maths is not so negative or painful, he seems to show less resistance towards admitting previous challenges he experienced (Blom, 2006:61).

DJ had only positive remarks regarding school throughout the process, as indicated by the following quote: *"[I still enjoy going to school] … since always … I said it the first time, the*

second time and the third time." His positive attitude was however mostly ascribed to the social aspect thereof: *"[I enjoy it because] I see my friends."*

In terms of the broader theme of alterations in attention and consciousness, literature provides insight with regard to the trauma-related symptoms the participants in this study experienced.

Throughout the school years children's executive functioning generally improve, which means that children in middle childhood generally have an increased attention span, improved concentration abilities, working memory and improved ability to process and retain information (Carter & McGoldrick, 2005:40; Papalia et al., 2008:355). Therefore, the difficulties the participants experienced with similar functions were unlikely to be ascribed to limitations of their developmental stage. However, as indicated in the literature, traumatised children often struggle with learning and school performance, which might be associated with disrupted executive functioning, concentration problems and poor integration of cognitive functions (Cook et al., 2007:6; D'Andrea et al., 2012:189; Goodyear-Brown, 2010:45; Louw et al., 2007:379; Papalia et al., 2008:409; Streeck-Fisher & Van der Kolk, 2000:905). Furthermore, confusion and distractible behaviour are specifically indicated to be common symptoms of traumatised children in this age group (Kaduson & Schaefer, 2006:7) and could negatively affect a child's ability for learning and for age-related academic performance.

Studies on the neurobiology of trauma indicate that trauma affects the cerebral cortex, which is the part of the brain that is responsible for rational, logical thought processes that require cognition and intelligence (Coates, 2010:396; Van der Kolk, 2003:307-308). The impaired functioning of the cortex (as discussed in Chapter 2) includes, *inter alia*, frontal-subcortical dysfunctions which cause difficulty for traumatised individuals in "performing with focused concentration, and hence, with being fully engaged in the present" (Van der Kolk, 2006:4). It was evident from the qualitative findings how symptoms of alterations in attention and consciousness impeded the functioning of the participants, causing them to become inattentive and together with the concentration difficulties, caused challenges related to school performance.

The Gestalt perspective likewise indicates that traumatised children often suppress their senses, bodies, emotions and intellect and therefore struggle to integrate information and respond appropriately to information (Fall et al., 2010:208; Oaklander, 2011:190). The suppression of the mentioned functions is addressed through enhancing contact and

awareness in the here and now (Oaklander, 2011:173). By utilising creative techniques that allows for non-threatening experiences in therapy, as used in Gestalt play therapy (Blom, 2006:19-20; Clarkson & Cavicchia, 2014:2), the limbic system is accessed (Wasserman, 2005:17). The limbic system plays a fundamental role in dissociative symptoms (Wasserman, 2005:11), which refer to the failure to take in or integrate information (Cook et al., 2007:5). As was evident from the quantitative and qualitative findings, the participants experienced an improvement in the symptoms associated with alterations in attention and consciousness, which could possibly be ascribed to an increase in the participants' awareness in the here and now. Enhancing awareness in the here and now is a central aspect of the Gestalt approach to therapeutic intervention and could therefore enhance integrated functioning.

In addition to the affective, behavioural and cognitive effects of trauma discussed so far, trauma is also known to impact negatively on children's attributions and worldview (D'Andrea et al., 2012:190). The following symptom category relates to these distortions.

- **Theme 4: Symptom category: Distortions in attribution and worldview**

D'Andrea et al. (2012:190) outlined a category of trauma symptoms indicative of distorted attribution, including feelings of shame or guilt, altered perceptions of a persons' own capacities, as well as cognitive disturbances. In this research study, the following trauma indicators represented symptoms associated with distorted attribution and worldview: worry and concern (indicator 9), guilt feelings (indicator 12) and low self-esteem (indicator 14). In Figure 15 below, the change in the total prevalence of trauma symptoms for all these indicators is presented.

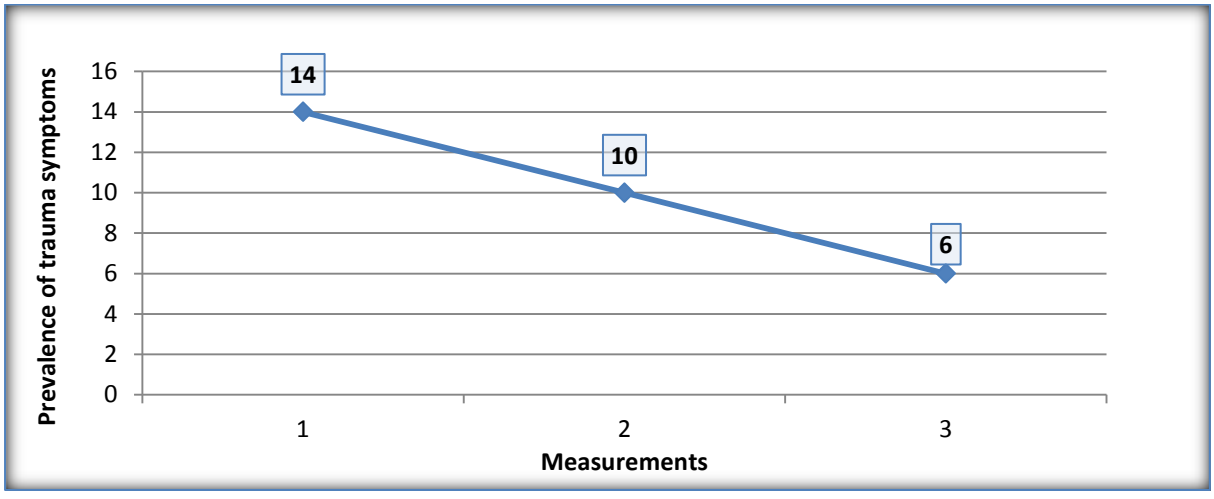

Figure 15: Change in prevalence of trauma symptoms for distortions in attribution and worldview

From the above figure, it is evident that the prevalence of trauma symptoms for this symptom category decreased over the three measurements from a prevalence of 14 to a prevalence of six (6). The mean of 0.9 (std. deviation = 0.88) in measurement 1, decreased to a mean of 0.67 (std. deviation = 0.72) in measurement 2, and finally measured a mean of 0.4 (std. deviation = 0.51) in measurement 3. The standard deviation indicates that the averages of the data set represent the responses of all the participants accurately. No statistically significant improvement was apparent in the prevalence of trauma symptoms for this symptom category ($p < 0.1416$; $f = 2.05$).

In Figure 16 below, the change in prevalence of trauma symptoms are indicated for the individual indicators related to distortions in attribution and worldview.

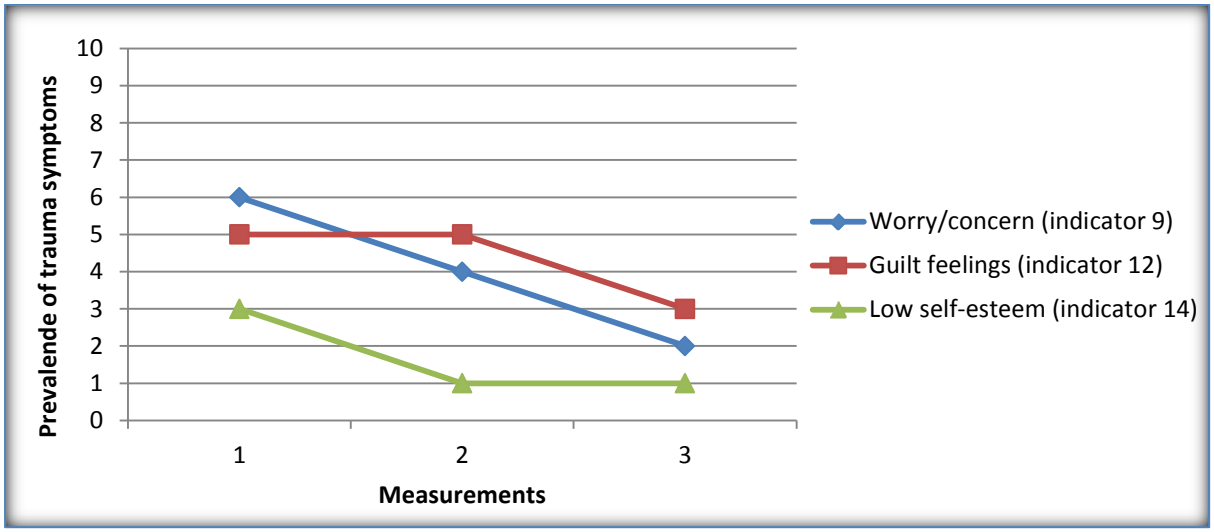

Figure 16: Change in prevalence of trauma symptoms for indicators related to distortions in attribution and worldview

Within this symptom category, worry or concern (indicator 9) and guilt feelings (indicator 12) seemed to be quite prevalent amongst the participants and both indicators decreased throughout the duration of the Gestalt therapeutic process. Low self-esteem (indicators 14) was only minimally prevalent in the first measurement, but decreased further over time.

From the **qualitative data** it became apparent that the participants maintained certain negative ideas of themselves and the world. The themes that emerged related mostly to false perceptions about the self and a general distrust in the world, characteristic of distorted attribution and worldview (D'Andrea et al., 2012:190).

- **Sub-theme 4.1: Self-perception**

Although the participants did not mention difficulties they experienced concerning their self-esteem per se, it became apparent that in some way they had negative self-perceptions. It emerged that the participants did not perceive themselves to be worthy of acceptance, just the way they are. Two of the participants behaved in ways that could be indicative of their fear of rejection, as implied in the following quotes:

> *"The people that I now have - the holiday people - I really love them … and I promised that I am never going to smoke again. So I do not want to break their hearts if they find out I smoke … they will not be mad; they will be disappointed."* (Suzie)

> *"I wanted to play with D and with S and them … I could not decide with whom … and they wanted me to choose. I actually wanted to choose D, but it would make S and them angry with me … and then I told them that I do not want D to play along."* (Violetta)

It is noted that traumatised children often have an expectation to be rejected (D'Andrea et al., 2012:191; Streeck-Fisher & Van der Kolk, 2000:905). In the case of Violetta, the importance of belonging to the peer group for children in middle childhood, could also play a role. Pressure by more socially prominent peer group members can prompt a group member to banish some children from the peer group (Berk, 2013:623), as evident in Violetta's decision.

By the second and third measurements, participants expressed experiences of a changed self-perception and indicated a sense of self-acceptance and a positive regard for the self, as the following quotes reflect:

> *"I do not really worry about what others think of me [and] I like who I am. … I do not know … I probably just changed a lot."* (Suzie)

> *"I like who I am … that I have changed. There are many things that I like about myself … I like the way I am … [and] what I look like."* (DJ)

Enhancing the child's sense of self is a particular focus of Gestalt play therapy and is indicated as a specific step in the therapeutic process (Blom, 2006:19, 102-103; Oaklander, 2011:171. Throughout the therapeutic process, the therapist integrate strategies to enhance the child's sense of self, thus a sense of feeling lovable and capable (Blom, 2006:103; Oaklander, 2006:27-31). It could thus be that their exposure to Gestalt play therapy contributed to the more positive self-perception of the above two participants. Closely related to the topic of self-perception, guilt feelings were also noted and are subsequently discussed.

- **Sub-theme 4.2: Guilt feelings**

Most of the participants indicated that they experienced guilt feelings. It seems that these feelings were often associated with interpersonal conflict, as indicated by the following participants:

> *"… so I think that time the devil took hold of me. I feel guilty … about the things that I have said and done*." (Violetta)

> *"When I am in a fight then it just feels as though it was not only them who were guilty … I am also guilty."* (Suzie)

> *"I feel guilty, because I was also guilty …"* (Charl)

Ego-centric thinking, as a normative aspect of development, causes children to lack the capacity to see experiences in perspective and they might consequently engage in self-blame and guilt feelings (Thompson & Henderson, 2007:12; Streeck-Fisher & Van der Kolk, 2000:906). However, guilt feelings are often noted in traumatised children (Briere & Spinazzola, 2005:402; Cook et al., 2007:6; Kaduson & Schaefer, 2006:7).

As with the quantitative findings, the qualitative findings indicated that feelings of guilt were still prevalent by the final measurement. However, there seemed to be a change in that the guilt was rather related to a feeling of concern for the other party, as the following quotes indicate:

> *"I feel a little guilty about it … because they get into more trouble than me. I feel guilty until we made peace … and if they do not accept it I leave them be until they are better … [I can forgive myself] yes."* (Suzie)

> *"I was also guilty … but … now he is going to get into big trouble because he has lied."* (Charl)

The development of pro-social behaviour usually starts to play a contributing role in dealing with social situations during middle childhood years (Carter & McGoldrick, 2005:37). Developmentally, the participants could thus be capable of engaging in pro-social behaviour and understand emotional display rules that show concern for other children (Berk, 2013:413). One of the objectives of Gestalt play therapy is to enhance a sense of responsibility for one's own behaviour (Blom, 2006:52). Further, the Gestalt play therapy process includes a specific focus on self-nurturing, thus on teaching children to forgive and accept the self (Blom, 2006:152). Their exposure to Gestalt play therapy might have contributed to the change in terms of some of the participants' experiences in terms of guilt feelings.

- **Sub-theme 4.3: External locus of control**

An external locus of control, a belief held by many traumatised individuals that the outcomes of actions are dependent on events outside one's personal control (Briere & Spinazzola, 2005:402-403; D'Andrea et al., 2012:190), was also evident in the qualitative research findings. The participants appeared to lack a sense of responsibility, which was evident in the way they justified their behaviour. Participants indicated:

> *"I can indeed hurt him back if he hurts me … Then she would ask what happened and then the other one lies … and then I get in trouble."* (Charl)

> *"She lied and then I got into trouble … and she kicked me again this afternoon; I am going to kick her back … then it is fair."* (Suzie)

> *"And then I screamed at her, because if she can [scream at me], I can [scream at her] as well."* (Violetta)

It is noted that children in middle childhood in the concrete-operational phase of cognitive development, generally understand causality, which in its simplest form refers to the notion that children now fully understand cause and effect, and therefore can take responsibility for their own actions (Louw & Kail, 2007:24; Papalia et al., 2008:11, 351). However, the participants rather ascribed their actions to be dependent on external events and used this to justify their behaviour. This lack of responsibility can be ascribed to an external locus of control often prevalent in traumatised children, where no responsibility is taken for one's actions, because control is attributed to aspects outside of the self (Briere & Spinazzola, 2005:402-403). From a Gestalt theory perspective, this notion of attributing aspects of the self onto others is seen as a contact boundary disturbance referred to as 'projection' (Blom, 2006:33). Contact boundary disturbances are seen as inappropriate behaviours that the child usese in an attempt to cope with life (Fall et al., 2010:208; Oaklander, 2011:190).

By the second measurement one of the participants indicated an enhanced sense of responsibility. This participant acknowledged that there are other ways of handling disputes amongst peers than to retaliate:

> *"It is fair when they reprimand me for fighting back. … I could have [rather] told the caregiver."* (DJ)

Helping children to take resonsiblity for choices and for their behaviour is a key objective of Gestalt play therapy (Blom, 2006:52; Henderson & Thompson, 2011:228). Although it could not be conclusively stated that the change in DJ's perception was due to the Gestalt play therapy, it could be argued that his exposure to Gestalt play therapy could have contributed to this change.

Children who are exposed to trauma tend to have general feelings of worry and concern. These aspects also emerged as a theme, which is subsequently discussed.

- **Sub-theme 4.4: Worry and concern**

The research findings indicate that some participants often experienced worry and concern. These worries and concerns related to the self and to others, and impeded their functioning. Some worries were rooted in reality and seemingly related to prior experiences, causing substantiated concerns, while other worries appeared to be unrealistic and based on suspicion. Participants indicated:

> *"I lie awake at night, worrying … most nights … 6 out of 7 nights. I worry that my father might call me and he is drunk again, or he says things about my mother and all their crazy things. [And] … I stress [because] what if I also get hurt like the uncle [who fell with the bicycle] … and I do not want to get hurt … I can take pain, but it should not be something severe like that."* (Suzie)

> *"[I worried] because it felt as though I am not going to find anything to eat …"* (Violetta)

Worries and concerns are known as symptoms of trauma in children in middle childhood, rooted in the belief that the world is an unsafe place (Kaduson & Schaefer, 2006:7-8). In terms of exposure to trauma, school-aged children are known to have the illusion that there were warning signs that predicted the trauma, referred to as 'omen formation'. Consequently, they believe that if they pay attention they would be able to recognise these warning signs and in effect avoid future traumatic events (Kaduson & Schaefer, 2006:8). The notion of 'omen formation' might explain the worries and concerns that were expressed by the participants, as they seemed to be pre-occupied with avoiding future traumatic events.

By the final measurement, Suzie acknowledged that she still tended to get worried, but that she realised the irrationality of her worries, while Dorithea indicated a marked improvement in this regard:

> *"I still worry about them [my holiday parents], but now … I know they are safe … but I just sometimes worry about them … until I see them again then it gets better."* (Suzie)

> *"I never worry anymore … I do not think about what might happen [in future] … I just think about what is happening now."* (Dorithea)

From a Gestalt theory perspective, Dorithea seems to have acquired a key ability, namely not to live according to past experiences or future fears, but to rather experience every

moment in the here and now. Awareness and contact in the here and now is a key objective of Gestalt play therapy (Fall et al., 2010:203; Henderson & Thompson, 2011:221).

Literature provides more clarity with regard to the category of symptoms discussed in this theme that emerged from the findings. Children in middle childhood acquire the capacity for logical and realistic thinking (Benokraitis, 2005:331; Berk, 2013:253). They also become capable of integrating different aspects of the self into a cohesive self-concept (Harter, 1998 in Papalia et al., 2008:385). Exposure to trauma can have a significant effect on children's reasoning and self-concept, as was evident in the sub-themes discussed in this section. During the middle childhood years, children who have been exposed to trauma tend to experience feelings of shame and guilt (Kaduson & Schaefer, 2006:7), which may negatively affect the child's self-esteem and thus his or her self-concept (Kaduson & Schaefer, 2006:8). Furthermore, traumatised children tend to develop the belief that the world is an unsafe place and that people cannot be trusted (Kaduson & Schaefer, 2006:7-8). This aspect could explain some participants' over-concern with danger or threat. In effect, trauma impedes the development of a healthy self-attribution and worldview.

The Gestalt perspective likewise maintains that traumatised children tend to have faulty beliefs about themselves and the world, due to egocentric thinking, negative messages about the self and the cognitive inability to discriminate between what is true and what is not true (Blom, 2006:103; Oaklander, 2011:193). Two focus areas of Gestalt play therapy could be particularly relevant to address aspects related to addressing symptoms in the trauma symptom category related to distortions in attribution and worldview. Firstly, strengthening the sense of self throughout the therapeutic process can enhance children's sense of self-worth (Blom, 2006:103). Secondly, through developing a self-nurturing stance in children, children can learn to accept and forgive the self, and learn to be good to the self (Blom, 2006:152). Overall, awareness and acceptance of the true self is enhanced as children progress through the five layers of neurosis (Blom, 2006:46; Fall et al., 2010:212-213; Mortola, 2006:241; Oaklander, 2006:199), which are regarded as "five steps to a better Gestalt way of life" (Henderson & Thompson, 2011:230). The development of self-acceptance and a sense of self-worth were evident for some of the participants by the final measurement and it could be proposed that Gestalt play therapy could have contributed to this. Next, the interpersonal difficulties that the participants experienced are discussed.

- **Theme 5: Symptom category: Interpersonal difficulties**

Traumatised children often experience interpersonal difficulties. In this regard, D'Andrea et al. (2012:190) point out that various relational aspects between individuals might be challenged due to traumatic experiences and disrupted attachment styles. These aspects include, *inter alia,* distrust, poor social skills, interpersonal conflict, poor boundaries and social isolation or withdrawal (Cook et al., 2007:6-7; D'Andrea et al., 2012:190-191; Goodyear-Brown, 2010:32; Streeck-Fisher & Van der Kolk, 2000:905-906).

In this research study, two indicators namely friendship difficulties (indicators 2) and withdrawal (indicator 6) were used to measure the prevalence of trauma symptoms for the symptom category of interpersonal difficulties. In Figure 17 below, the sum of the prevalence of trauma symptoms for this symptom category, and how it changed over time, is presented.

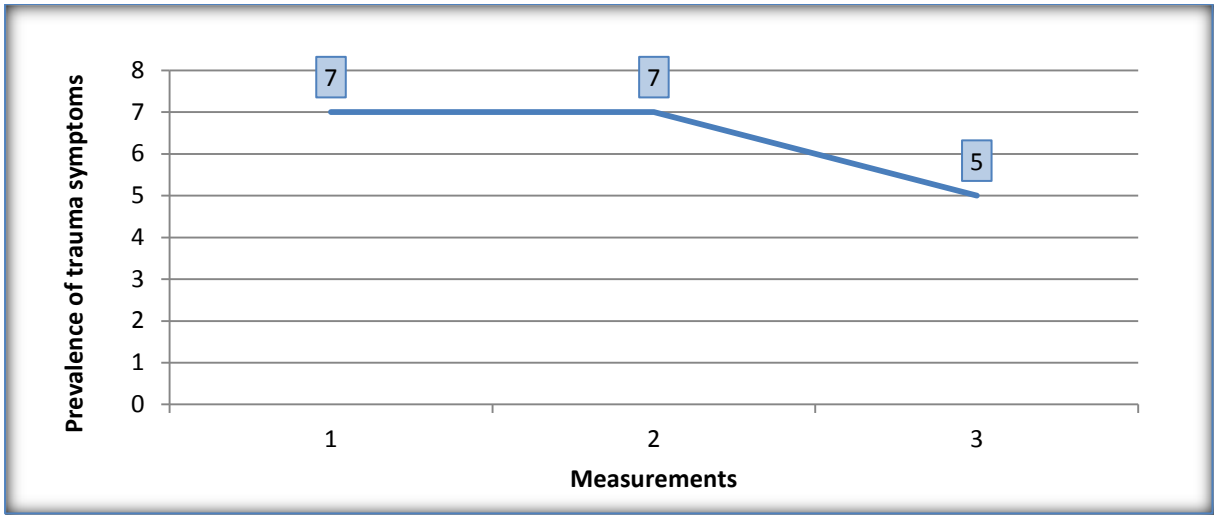

Figure 17: Change in the prevalence of trauma symptoms for interpersonal difficulties

From Figure 17 it is evident that the prevalence of trauma symptoms within symptom category 5 decreased over the three measurements, although minimally. The mean of 0.7 (std. deviation = 0.82) in measurement 1, remained the same in measurement 2 (std. deviation = 0.67), and finally measured a mean of 0.5 (std. deviation = 0.71) in measurement 3. According to the statistical analysis, no statistical significance was apparent in the improvement in terms of the prevalence of trauma symptoms over the three measurements for this symptoms category ($p < 0.7845$; $f = 0.24$).

In the following figure (Figure 18) the change in the prevalence of trauma symptoms are indicated for the individual indicators related to interpersonal difficulties.

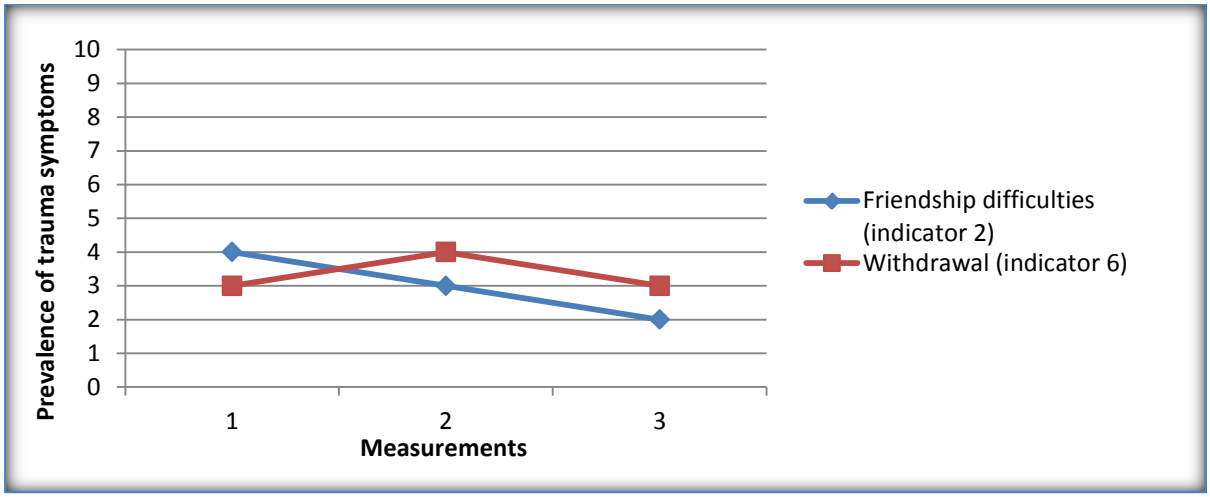

Figure 18: Change in the prevalence of trauma symptoms for indicators related to interpersonal difficulties

The prevalence of trauma symptoms in both indicators can be regarded as minimal. Friendship difficulties (indicator 2) progressively decreased over time, reflecting a lower prevalence than withdrawal symptoms (indicator 6), which showed no improvement in terms of the prevalence of trauma symptoms from the first to the third measurement.

The **qualitative findings** serve to substantially enrich the quantitative finding with regard to interpersonal aspects. Even though the quantitative data showed a minimal prevalence of symptoms related to interpersonal difficulties, valuable insights were provided by the qualitative findings when the presence of other symptom indicators were explored. The participants expressed experiences of relational difficulties in interaction with peers, as well as distrust in others.

It became evident from the data that the participants valued their peer relationships as one of the most important factors in their lives. However, peer relationships presented unique difficulties. Nasty comments and behaviour by peers appeared to be especially prevalent amongst the girls in the study sample. Rejection by peers was also mentioned and the participants consequently experienced feelings of isolation. The following quotes illustrate the hostile behaviour and insults the participants experienced:

> *"My friends are nasty to me at school … [and] other people are nasty to me because they do not want to play with me [and] … they run away from me at school … then I go and sit in the class and talk to myself. Then I feel as though I do not fit in."* (Violetta)

> *"L terrorises me … she says I look stupid. I do not like to be part of a group because, for instance, the one would gossip about the other and I do not like that."* (Suzie)

> *"J said I stole her things, then she said … I am a stealing thief. When nobody wants to play with me … they are playing with other friends … it makes me feel sad. Then I sit and play on my own."* (Dorithea)

The peer group plays an important role during middle childhood and provides the child with opportunities for friendship and affection (Louw & Louw, 2007:257). Relational difficulties such as interpersonal conflict, rejection by peers and feelings of isolation are often experienced by traumatised children (Cook et al., 2007:6-7; D'Andrea et al., 2012:191; Goodyear-Brown, 2010:32; Kaduson & Schaefer, 2006:8; Streeck-Fischer & Van der Kolk, 2000:905-906). A lack of reliable friends and interpersonal conflict, as seemed to be experienced by the participants, are commonly noted in traumatised children due to their inability for self-regulation (D'Andrea et al., 2012:191). Although a link between poor peer group relationships and their own inability for self-regulation were not evident in the above quotes, the research findings in sub-themes 1.3 and 2.1 respectively, indicate that the participants experienced anger and engaged in acts of verbal and physical aggression towards other children.

Furthermore, some participants indicated feelings of distrust towards peers, as well as towards caregivers. The following quotes portray the participants' experiences in this regard:

> *"I do not know … I do not think there is someone that I trust … I do not even trust the caregivers there at the children's home. The caregiver said if she gets angry she will take it out on the children."* (Suzie)

> *"J is the only friend I really trust."* (Charl)

> *"But if I go and wake up Aunt X [the caregiver] when I have nightmares … then she says: 'Oh, just go and sleep!"* (Violetta)

Experiences of distrust in relationships and an expectation of insufficient care are often noted in traumatised children as a result of disorganised attachment styles (Streeck-Fisher & Van der Kolk, 2000:907). Apart from trauma which in itself often causes distrust, it is acknowledged that the context of care can further contribute to feelings of distrust in children in residential care. The care context may be negatively affected as a result of staff members who are likely to feel overwhelmed and frustrated (DSD et al., 2012:32).

An improvement in terms of peer relationships and trust became apparent by the final interview, as indicated in the following quotes:

> *"Friends often want to play with me … friends are less nasty to me, and I am less nasty to them."* (Violetta)

> *"Friends enjoy playing with me."* (Dorithea)

"It [my distrust in friendships] is a lot better." (Suzie)

The improvement the participants experienced in terms of relational difficulties might be ascribed to improved self-regulation that was developed thoughout the Gestalt play therapy process (Fall et al., 2010:207; Henderson & Thompson, 2011:222), as Violetta's quote suggests. In this regard, the qualitative findings for the first two trauma symptom categories (related to affect and behaviour dysregulation respectively), indicated that in the third data collection interviews the participants were better able to control their anger (refer sub-theme 1.3) and their aggression towards others (refer sub-theme 2.1).

The research findings for this trauma symptom category correlate with literature on middle childhood, trauma and Gestalt play therapy. The participants reflected the central importance peer groups assume during middle childhood years, as confirmed in the literature (Louw & Louw, 2007:257; Papalia et al., 2008:399). Despite great advances in emotional development during middle childhood years, which allows for the capacity of positive pro-social behaviour (Carter & McGoldrick, 2005:37; Papalia et al., 2008:386), the contrary might also occur. Certain negative influences, such as prejudice, hostile attitudes and anti-social tendencies are also common during this phase of development (Carter & McGoldrick, 2005:39; Papalia et al., 2008:351). It became apparent from the qualitative data, that these complexities in peer relations impacted the participants' emotions, as reference were made to sadness, anger and emotional lability due to peers' hostile attitudes and behaviour, discussed in previous sub-themes.

Although interpersonal conflict with friends might be common during middle childhood, literature on trauma attests that it might be worsened by the social implication of trauma (D'Andrea et al., 2012:191). The participants experienced difficulties trusting others, which is often prevalent in traumatised children, especially those who have disrupted attachment styles (Schore, 2013:10-11; Streeck-Fisher & Van der Kolk, 2000:907). When children's caregivers are unresponsive to their needs, as the participants reported to have experienced in the children's home, patterns of a disorganised attachment style tend to become established in children. This may result in distrust in others, expectation of rejection or harm, and problems with bonding (Schore, 2013:10; Streeck-Fischer & Van der Kolk, 2000:907), which might have contributed to some of the sustained relational difficulties the participants experienced.

Nontheless, improvement was apparent in aspects of interpersonal difficulties that were experienced by the participants. There were indications of improvement in reliable friendships, as distrust, rejection and conflict were noted to have lessened. Gestalt play therapy is a relational therapy and pays considerable attention to the therapeutic relationship (Blom, 2006:19, 56; Henderson & Thompson, 2011:227). The experience of a safe and trustworthy relationship might in itself serve to be therapeutic for certain individuals (Blom, 2006:56; Oaklander, 2006:21), which might have influenced the improvement in interpersonal aspects participants indicated. Improved self-regulation can contribute to positive interpersonal relationships (D'Andrea et al., 2012:191) and might have further influenced the participants' abilities for healthy relationships.

4.4.2.4 Change in prevalence of trauma symptoms for individual participants

Figure 19 represents the change in the prevalence of trauma symptoms for each participant individually in the three measurements, therefore throughout the Gestalt therapeutic process.

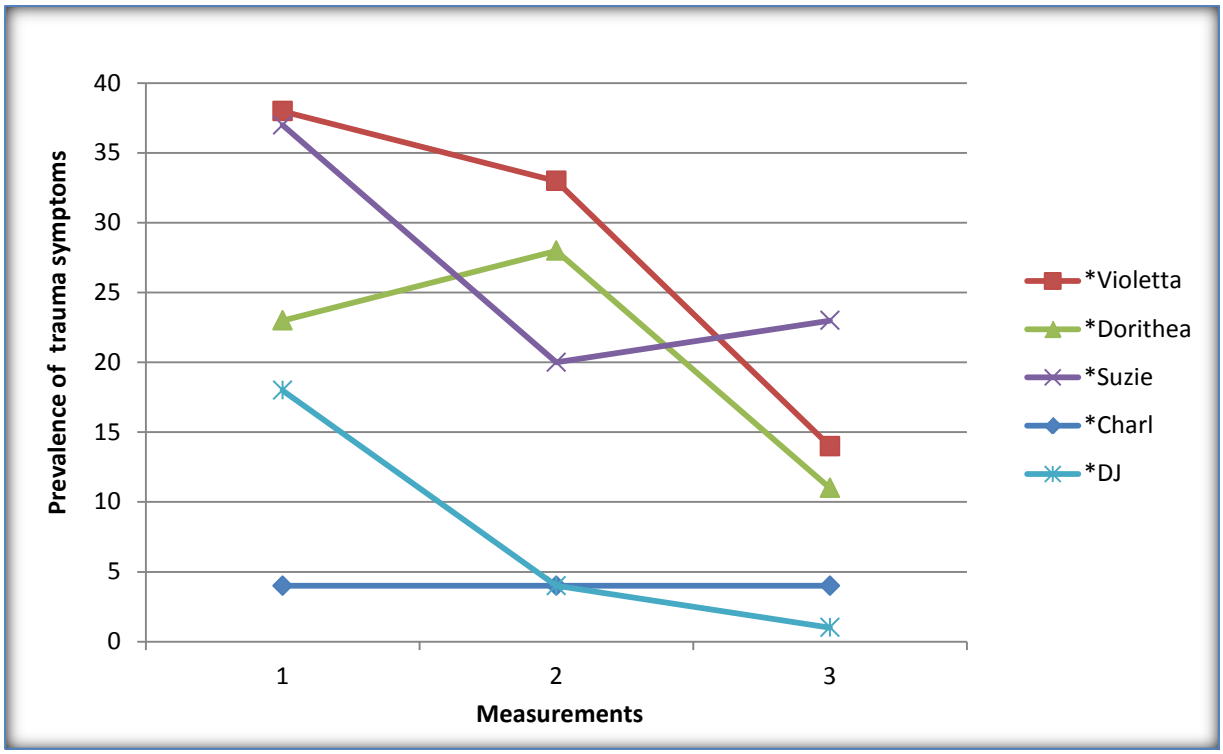

Figure 19: Prevalence of trauma symptoms for individual participants for measurement 1, 2 and 3

From Figure 19, it is evident that **Violetta** scored the highest prevalence of trauma symptoms in both measurement 1 and 2, even though a slight decrease was prevalent from the first to the second measurement. The most significant decrease ($p = 0.0005$) in the

prevalence of trauma symptoms for this participant is evident in the steep decline in the prevalence of symptoms between measurement 2 and 3, which the Wilcoxon signed rank test likewise revealed. A statistically significant improvement was apparent in the total prevalence of trauma symptoms over the three measurements for Violetta ($p < 0.0030$).

During measurement 1, **Suzie** scored the second highest prevalence of trauma symptoms compared to the other participants. The prevalence of symptoms reflected during measurement 1 decreased most significantly towards the second measurement ($p = 0.0028$), before showing an upward trend, however still far below that of the initial measurement. A statistically significant improvement was moreover apparent in the total prevalence of trauma symptoms over the three measurements for Suzie ($p < 0.0002$).

Suzie was the only participant for whom the trauma value increased during the second part of the intervention. The increase in prevalence of trauma symptoms between measurement 2 and 3 might be related to the context of the school examination which increased anxiety for Suzie. According to the concept of holism in Gestalt theory, context plays an important role and an individual's functioning cannot be distinguished from the envionment (Blom, 2006:19; Fall et al., 2010:205; Henderson & Thompson, 2011:221).

Dorithea initially scored the third highest prevalence of trauma symptoms, which increased towards the second measurement, before significantly decreasing between measurement 2 and 3 ($p = 0.0008$) to a prevalence far below that of the initial measurement. A statistically significant improvement was apparent in terms of the prevalence of trauma symptoms over the three measurements for Dorithea ($p < 0.0026$).

Dorithea was the only participant for whom the prevalence of trauma symptoms increased during the first part of the intervention. This increase could be explained by enhanced awareness, as Dorithea might have become more in contact with her own thoughts and feelings during the first part of the Gestalt play therapy process. Change, from a Gestalt perspective, is related to enhanced awareness (Fall et al., 2010:212-213). However, increased awareness often causes a sense of anxiety as the child moves from the false layer to the phobic layer, as described in Gestalt theory's layers of neurosis (Blom, 2006:42; Fall et al., 2010:212-213). Therefore, there is a common tendency for children's symptoms to initially become worse, before it becomes better.

From Figure 19, it is evident that **DJ** scored the second lowest prevalence of trauma symtoms in measurement 1, which decreased markedly towards measurement 2, and finally

resulted in the lowest prevalence compared to the other participants. A statistically significant improvement was apparent in terms of the total prevalence of trauma symptoms over the three measurements for DJ. The Wilcoxon signed rank test revealed that the most significant decrease in prevalence of trauma symptoms for this participant occurred between measurement 1 and 3 ($p = 0.0002$).

Charl presented with a particularly low prevalence of trauma symptoms during the first measurement. As evident in Figure 19, the prevalence of trauma symptoms maintained stable throughout the three measurements. No decrease in the prevalence of trauma symptoms was prevalent throughout the therapeutic process for this participant, and the null-hypothesis could therefore not be rejected.

The low indication of prevalence of trauma symptoms for Charl might indicate profound resilience in the face of a severely traumatic childhood (Louw et al., 2007:380). On the other hand it might be explained by Gestalt theory, which attests that individuals tend to function in a false existence, as indicated by Perl's layers of neurosis, where a lack of awareness results in the fact that unfinished business and unhealthy functioning is not accepted into the person's self-concept (Fall et al., 2010:213). In the false layer of neurosis, children tend to deny problems and make use of projection as a contact boundary disturbance, according to which they blame others and the environment for their problems (Blom, 2006:33; Corey, 2013:199). As indicated a number of times in the discussion of the qualitative findings, this could be applicable to Charl's functioning.

4.5 SUMMARY

The Gestalt theoretical framework and the neurobiological theory of trauma in children determined the way in which the findings of this study were understood. Trauma is regarded as a social, physical, cognitive, biological and psychological experience that affects a person's ability to self-regulate (Coates, 2010:393; Ford & Courtois, 2013:x; Schore, 2001:205; Streeck-Fisher & Van der Kolk, 2000:903, 905; Van der Kolk, 2005:402, 406). Gestalt perspective likewise maintains that traumatised children often suppress awareness in order to avoid pain. By restricting various aspects of the senses, body, emotion and intellect, the child's ability to engage in the natural, healthy process of organismic self-regulation, is affected (Blom, 2006:31; Fall et al., 2010:207, 208; Henderson & Thompson, 2011:224; Oaklander, 1994:144).

Traumatised children consequently struggle to integrate information and respond appropriately to situations (Fall et al., 2010:208). The inability for self-regulation often manifests in children's behaviour, in Gestalt vocabulary referred to as contact boundary disturbances, as they engage in inappropriate behaviours in an attempt to cope (Oaklander, 2011:190). The participants in this study displayed various difficulties that indicated an inability for self-regulation. These difficulties strongly correlated with the symptoms commonly associated with trauma, representing the symptom categories of affect and behaviour dysregulation, alterations in attention and consciousness, distorted attribution and worldview, as well as interpersonal difficulties (Child Welfare Information Gateway, 2008:2; Coates, 2010:391-392; D'Andrea et al., 2012:189; Hawley, 2000:5).

As Gestalt play therapy seemed to incorporate many of the suggestions for trauma interventions, as discussed in Chapter 3, Gestalt play therapy was used as intervention in this study, with the aim to facilitate effective self-regulation and healthy functioning by means of enhancing awareness and contact in the here and now, and restoring integrated functioning of the senses, body, emotions and intellect (Blom, 2006:23; Fall et al., 2010:207; Henderson & Thompson, 2011:222; Oaklander, 2011:174). It appeared, considering the quantitative and qualitative findings, that the Gestalt play therapy process was effective in terms of lowering the symptoms associated with trauma in children in middle childhood.

The research methodology, the ethical considerations relevant to this study and the research findings were presented in this chapter. The key findings, conclusions and recommendations, as well as an indication of the achievement of the goal and objectives of the study will be presented in Chapter 5.

CHAPTER 5
KEY FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Based on an overwhelming body of research indicating the impact of trauma on almost every aspect of a person's life, LaLiberte et al. (2013:2) acknowledge that the field of child welfare is at a dawn of how it views its work. Various treatment initiatives have been taken to address trauma, PTSD and trauma-related behaviour problems, however, often with limited success (Gaskill & Perry, 2014:185; Le Bel et al., 2010:2). This might partly be ascribed to a lack of integrating an understanding of the neurobiology of trauma into therapeutic interventions (Perry, 2003:2; Van der Kolk, 2003:309). Researchers suggest that verbally-based conventional treatment techniques for traumatised individuals need to be re-considered in the light of neurobiological principles related to trauma (Campbell, 2009:19; Gaskill & Perry, 2014:186; Perry, 2006a:22). Gestalt play therapy encompasses a number of aspects which could be relevant to the suggestions for therapeutic intervention with traumatised children, which then formed the rationale of this study. The goal of the study was thus to establish the effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood.

In this chapter, the key findings of the research study are firstly presented. Conclusions which are based on the key findings follow where after recommendations are made for interventions with traumatised children in middle childhood. As this study presented with certain limitations and on the other hand led to further questions, suggestions for future research are outlined. Finally, the attainment of the goals and objectives of the research study is discussed.

5.2 KEY FINDINGS OF THE RESEARCH STUDY

The key findings of this study are presented in response to the research question, which was as follows: What is the effect of Gestalt play therapy in addressing syptoms associated with trauma in children in middle childhood? The following key findings are highlighted:

5.2.1 Literature

Literature, as discussed in Chapter 2 and Chapter 3, provided valuable insight with regard to the findings of the research study.

- Worldwide as well as in South Africa, children are extensively exposed to various forms of traumatic events. Children in alternative care, who are being cared for in residential settings such as children's homes, are regarded as amongst the most traumatised youth.
- The severe long-term consequences of trauma cause concern as it may impede children's capacity for healthy functioning. Due to the impact of trauma, traumatised children often present with a variety of affective, behavioural, cognitive and interpersonal symptoms.
- Neuroscientific research indicates that the long-term consequences of trauma might be ascribed to neurobiological changes in the brain as a result of trauma, which can permanently alter the way the brain functions.
- Children in middle childhood present with specific symptoms of trauma, as developmental aspects have an influence on the impact and expression of trauma. Although children in middle childhood generally have the developmental ability to regulate emotions, think rationally, control their impulses, and engage in pro-social behaviour; traumatised children are often not capable of these abilities due to the way trauma affected their self-regulatory capabilities.
- The Gestalt perspective of children's responses to trauma are in line with the symptoms represented in all five symptom categories, namely affect dysregulation, behaviour dysregulation, alterations in attention and consciousness, distortions in attribution and worldview, and interpersonal difficulties.
    - According to a Gestalt perspective traumatised children often lack healthy contact, which results in an inability for emotional awareness and regulation.
    - The Gestalt perspective explains that fragmented functioning, which results in a lack of capacity for self-regulation in children, leads them to engage in inappropriate behaviours to meet their needs.
    - It is argued that traumatised children often suppress their senses, bodies, emotions and intellect and therefore struggle to integrate information and respond appropriately to information.
    - The Gestalt perspective maintains that traumatised children tend to have faulty beliefs about themselves and the world, due to egocentric thinking, negative messages about the self and a lack of the cognitive inability to discriminate between what is true and what is not true, which affect their sense of self-worth.
    - The Gestalt perspective explains that various relational aspects between individuals might be challenged due to traumatic experiences and disrupted attachment styles.

- The effects of trauma can be addressed through therapy, though limited success is often obtained. It is argued that conventional therapies have certain constraints in working with severely traumatised children, such as the rational and verbal dominance thereof.
- It is argued that conventional therapies need to be reviewed in consideration of the neurobiological principles related to the effects of trauma. Thus, trauma-informed suggestions for intervention center on aspects such as fostering safety and security for the child, and utilising non-verbal and creative measures to address trauma.
- Gestalt play therapy principles are in accordance with trauma-informed suggestions. Gestalt play therapy aims to foster healthy functioning by restoring self-regulatory abilities in traumatised children, with particular focus on enhancing sensory and emotional awareness through creative and non-verbal measures.

5.2.2 Prevalence of trauma symptoms

From the research findings it was clear that the trauma symptoms experienced by the participants were in accordance with literature on trauma in middle childhood.

- All the participants have been exposed to severe forms of trauma, including sexual and physical abuse, pornography, neglect, and being orphaned. The participants thus endured multiple forms of trauma for prolonged periods of time, mostly at the hands of their own parents and other relatives.
- Not all the participants presented with the same prevalence of trauma symptoms, which confirms the notion that the perception of and response to traumatic events are unique to each individual.
- When considering the total prevalence of trauma symptoms, thus the total frequency of symptoms over all four levels (or values) indicated in the questionnaire, and over all three measurements, the overall prevalence of trauma symptoms seemed to be relatively low. Of the total prevalence in all three measurements, 6.4% of the responses indicated a high prevalence of trauma symptoms (a value of 3, indicated in the questionnaire as “always” occurring), while 10.1% of the responses indicated a moderate prevalence of symptoms (a value of 2, indicated in the questionnaire as occurring “often”); adding to 16.5% of the total prevalence of trauma symptoms.
- However, the prevalence of trauma symptoms at the first (baseline) measurement, indicated quite a high prevalence of trauma symptoms on the moderate and high levels, indicating a total of 31.3% of the responses (level 2 = 19.1%, level 3 = 12.2%).
- In terms of the accumulated prevalence of trauma symptoms in all three measurements, certain trauma symptoms seemed to be more prevalent than others, especially those

indicating fighting, daydreaming, anger, headaches or stomach aches, and hypervigilance. These symptoms relate mostly to hyperarousal, one of the most common and severe consequences of trauma.

- When looking at the individual symptoms in the first (baseline) measurement, the following symptoms were more prevalent: fighting, daydreaming, confusion, hypervigilance, guilt feelings, headaches or stomach aches, fearfulness, school or learning difficulties, and nightmares. Being the baseline measurement, it implied that the participants have experienced these symptoms for at least four weeks prior to the measurement.
- Participants presented with trauma symptoms in all five the trauma symptom categories, namely affect dysregulation, behaviour dysregulation, alterations in attention and consciousness, distorted attribution and worldview, and interpersonal difficulties. Of these categories, the highest prevalence of trauma symptoms at the baseline phase were behaviour dysregulation (indicating a prevalence of 36), followed by affect dysregulation (a prevalence of 32), and alterations in attention and consciousness (a prevalence of 31). Interpersonal difficulties presented with the lowest prevalence of trauma symptoms, being seven (7), while distorted attribution and worldview presented with a prevalence of fourteen (14). It should be recognised that the last two trauma categories were measured by two and three indicators respectively, while the other categories included between five and seven indicators.
- In the symptom category *affect dysregulation*, symptoms related to anger, moodiness and fearfulness were indicated as most prevalent in the quantitative findings at the first measurement. These findings were supported by the qualitative findings, where the participants described their experiences related to fearfulness, anger, overwhelming emotions, and emotional lability. It seems that the participants' affect were often influenced by triggers such as traumatic memories and contextual factors such as peer interaction, however for some participants their emotions seemed to be related to irrational thoughts and beliefs.
- In the symptom category *behaviour dysregulation*, symptoms related to fighting, hypervigilance, as well as headaches or stomach aches, were initially most prevalent according to the quantitative research findings. Again, the qualitative data supported the quantitative findings. With regard to fighting, participants reported provocative behaviour by peers to be a common trigger for their aggression. Although not highly prevalent in the quantitative findings, the qualitative findings indicated that the participants often experienced nightmares and sleep disturbances as well as hypervigilance, which was

confirmed by their discussions regarding their startle reactions to sounds and sudden movements. One participant further highlighted that she used behavioural strategies, known as tension reduction strategies, in an effort to cope with her circumstances. These could however be considered as negative coping strategies as it included substance abuse and self-mutilation.

- Symptoms related to *alterations in attention and consciousness* were prevalent for most participants. The qualitative findings were in accordance with the quantitative findings, which indicated daydreaming and disorientation to be the most prevalent symptoms in this symptom category. These two symptoms of dissociation were also the most prevalent amongst all trauma-related symptoms measured. Dissociative symptoms were evidenced in participants' experiences of feeling cut off from reality, daydreaming and feeling disoriented. These symptoms mostly occurred in response to less desirable situations – a common trigger for dissociative states. School or learning difficulties were also noted to be prevalent in both quantitative and qualitative findings. Although the quantitative findings did not portray inattention as having a notable prevalence in the first measurement, poor concentration emerged as a prominent theme in the qualitative findings.
- In the symptom category related to *distortions in attribution and worldview*, all the indicators, namely worry or concern, guilt feelings and low self-esteem, showed a minimal prevalence. This was confirmed by the qualitative findings, which were reflected by a seemingly less intense description by the participants of their experience of the symptoms. However, in terms of self-perception, the participants seemed unable to define and accept all aspects of themselves. Furthermore, an over-concern with danger, evidenced in worries and concerns, seemed to be prevalent. In this category, an additional theme was identified in the qualitative findings, namely the external locus of control where the participants tended to ascribe their actions and the consequences thereof to others or the environment. In the literature on trauma, an external locus of control is described as a common trauma symptom in children. According to Gestalt theory, this behaviour is regarded as a contact boundary disturbance, namely projection, which relates to children's efforts to cope with their situation.
- In the last symptom category, *interpersonal difficulties*, a very low prevalence of trauma symptoms were recorded according to the two relevant indicators. The qualitative data portrayed a somewhat more intense experience of interpersonal difficulties than indicated by the quantitative data. It transpired that participants seemed to have problems related to peer relationships and to trusting others. It could be argued that the challenges that some participants experienced in terms of the trauma categories of affect and behaviour

dysregulation might have had a negative effect on their peer relationships.

- The prevalence of trauma symptoms varied amongst the five participants. Two participants, both females, showed quite a high prevalence of trauma symptoms, while two participants (one female and one male) showed a more moderate prevalence of symptoms in the baseline (first) measurement. One male participant presented with minimal trauma symptoms, which remained on the same level through all three measurements.

5.2.3 Change in the prevalence of trauma symptoms

The research findings indicated that change occurred in terms of the prevalence of trauma-related symptoms over the three measurements.

- The quantitative research findings showed a statistically significant improvement in terms of the total prevalence of trauma symptoms for all the participants over the three measurements. In this regard, the prevalence of trauma symptoms on the moderate (value 2) and high (value 3) levels showed a steady decline, with a concurrent increase in the responses indicating no prevalence of symptoms (value 0).
- The largest improvement in terms of the prevalence of trauma symptoms occurred between the second and third measurements, therefore between six and 12 weeks of the participants being exposed to Gestalt play therapy as intervention.
- Although the quantitative findings showed a statistically significant improvement in the total prevalence of trauma symptoms, only one individual symptom, namely disorientation, showed a statistically significant improvement in terms of its prevalence.
- Notable, is that one of the most prominent symptoms related to the neurobiological effects of trauma, namely dissociative symptoms, showed remarkable improvement in terms of its prevalence, as measured by the relevant indicators.
- On the other hand, one indicator, namely fighting, seemed resistant to change when considering the quantitative findings alone.
- Some symptoms increased in prevalence from the first to the second measurement, which is in line with the notion in Gestalt play therapy that symptomatic behaviour often becomes worse before it improves.
- Change was prevalent in all five symptom categories, though the most observable change was in the symptom category *affect dysregulation*. The prevalence of trauma symptoms related to affect dysregulation decreased significantly over the three

measurements, improving from a prevalence of 32 to 13. In this symptom category, anger which initially was the most prevalent affective symptom, decreased by the largest amount. Participants in this regard indicated that they did not get angry as easily anymore and that they gained control over their emotions, as derived from the qualitative findings.

- The symptom category of *alterations in attention and consciousness* also showed a statistically significant improvement in terms of the prevalence of trauma symptoms (from 31 to 12). Symptom indicators pertaining to daydreaming and disorientation seemed to have decreased by the largest amount. The qualitative findings likewise reflected a notable improvement in these two symptoms related to dissociation. Participants mentioned that they have acquired the ability for enhanced awareness of external and internal factors.
- A marginal statistically significant improvement was apparent in the prevalence of trauma symptoms for the symptom category *behaviour dysregulation*. However, the prevalence of trauma symptoms in this category did decrease from 36 to 17. The qualitative findings add perspective in this regard, indicating experiences of marked improvements in the participants' regulation of behaviour. The prevalence of the indicator for fighting, for example, remained high throughout the three measurements, but the qualitative data revealed that the participants were of the opinion that they acquired the ability to consider the consequences of their behaviour and to ignore insults, thereby curtailing their fighting behaviour. The participants also largely experienced an improvement in terms of their hypervigilant responses and nightmares. Nightmares, which was the most prominent sleep disturbance experienced by the participants, improved remarkably throughout the process as the respective participants indicated minimal to no prevalence of nightmares by the final measurement.
- No statistically significant improvement was apparent in terms of the prevalence of symptoms in the category *distortions in attribution and worldview,* though prevalence of trauma symptoms decreased from 14 to six (6). From the qualitative findings it was evident that the participants developed healthier attributions. Low self-esteem, as a trauma symptom indicator, decreased minimally, though various positive experiences of a changed 'self' were noted in the qualitative findings in this regard. Furthermore, the participants displayed a stronger internal locus of control, as their sense of responsibility increased.
- Although the symptom category *interpersonal difficulties* did not present with statistically significant improvement, certain positive changes were noted in the qualitative findings. With regard to their initial interpersonal difficulties, participants mentioned improved

interpersonal efficiency and thus less conflict between friends, as well as a heightened sense of trust in friends.

- Contextual factors seemed to play a role in the changes in the prevalence of trauma symptoms. Fighting which, according to quantitative findings, have decreased only minimally might have been influenced by the group setting in which the participants were being cared for. As the other children in the residential care setting have also endured trauma and would thus also be more inclined to display symptomatic behaviour, the possibility for conflict in the care setting would increase. Furthermore, the symptoms related to school performance, which seemed to have worsened by the final measurement after an initial improvement, might have been influenced by the fact that the school examination occurred during the final measurement.
- The way individual participants experienced changes in terms of trauma-related symptoms, differed. When viewing changes in the prevalence of trauma symptoms for each participant individually, four of the five participants presented with statistically significant improvements in terms of the prevalence of trauma-related symptoms. One participant indicated no change in the total prevalence of trauma symptoms over time. The initial measurement for this participant also indicated a minimal prevalence of trauma-related symptoms, despite the selection by the social workers on account of the presence of trauma-related symptoms. From a Gestalt perspective, the apparent absence of trauma-related symptoms for this participant in both the quantitative and qualitative findings might be an indication of the participant's functioning in the false layer of neurosis, during which a person tends to suppress awareness of painful emotions. It was noted that this participant also tended to present with resistance throughout the therapeutic process which, according to the Gestalt perspective, could indicate that he was not ready to deal with sensitive issues.

5.2.4 Methodology and theoretical framework

The key findings in terms of the methodology and theoretical framework are as follows:

- The self-constructed questionnaire seemed to be suitable to provide an indication of the prevalence of trauma symptoms experienced by the participants.
- The qualitative findings served to enrich the quantitative findings as it indicated the participants' experiences of symptoms and of change in terms of these symptoms over time.

- Overall, literature on trauma, middle childhood and Gestalt play therapy supported the data interpretation in terms of understanding the symptoms of trauma, as well as the changes which occurred.

5.3 CONCLUSIONS

In light of the above findings, the following conclusions can be drawn:

- The participants' exposure to multiple forms of trauma for prolonged periods of time during a critical phase in their development, confirms the notion in literature that many children involved in the child welfare system, such as a children's home, have experienced complex trauma.
- The prevalence of trauma symptoms indicated in the research findings correlated with trauma symptoms described in the literature, specifically for children in middle childhood. It furthermore confirmed literature which states that individuals' responses to trauma are unique.
- The symptoms that were most prevalent for the participants, represented symptoms related to hyperarousal and dissociation, which are considered the most common and severe long-term consequences of trauma that are also explained by the neurobiological effects of trauma on the brain. Thus, the findings confirmed the literature regarding the impact of trauma.
- Children in middle childhood generally develop in terms of emotional growth, the ability to control their behaviour, to think rationally and perform with focused attention, obtain a balanced self-perception and act pro-socially. However, traumatised children in this developmental stage are often not capable of these functions due to the way in which trauma affects their self-regulatory abilities. Symptoms in all five trauma categories, namely affect dysregulation, behaviour dysregulation, alterations in attention and consiousness, distortions in attribution and worldview, and interpersonal relationships, could be seen as manifestation of the effects of trauma on the self-regulation of children in middle childhood.
- Interrelatedness of trauma symptoms became apparent in this study. Hypervigilance and nightmares, for example, resulted in sleep disturbances, which could have negatively affected school performance. In the same way, affect and behaviour dysregulation could have led to the problems the participants experienced in their interpersonal relationships.
- The trauma-related symptoms experienced by the participants seemed to often be triggered or sustained by the care context, for example the fighting behaviour amongst

children in the children's home and provocative behaviours by peers. The care context also seemed to affect the participants' functioning in terms of a lack of facilities and resources. It can be concluded that it is important to consider holism in that one cannot perceive a child in isolation from his environment.

- An emergent understanding of the neurobiology of trauma attests that trauma physically alters structures and functions in the brain, causing an inability for self-regulation. Gestalt play therapy, with its core objective of restoring healthy self-regulation through sensory and non-verbal measures, seems to include the relevant suggestions for trauma-informed interventions which take into account the neurobiological effects of trauma. Based on theory on Gestalt play therapy as well as on the findings of the study it could be concluded that Gestalt play therapy seems to be an appropriate intervention for traumatised children. The decrease in responses indicating moderate to high prevalence of trauma symptoms, with the concurrent increase in responses indicating no or minimal prevalence of trauma symptoms, confirms the reduction in the total prevalence of trauma symptoms. Considering the reduction in the total prevalence of trauma symptoms over time, supported by the qualitative findings indicating positive changes due to the involvement in the Gestalt play therapy process, it is evident that Gestalt play therapy succeeded in addressing trauma symptoms experienced by the participants.
- It seems that change in the prevalence of trauma symptoms are related to the duration of the intervention, as evident in the greater improvement in terms of the prevalence of trauma symptoms between the second and third measurement in this study, and thus between six and 12 weeks of being exposed to Gestalt play therapy.
- In terms of the individual changes observed in the participants, it can be concluded that each child moves through the stages of the therapeutic process at their own pace and responds to Gestalt play therapy in unique ways.
- The Gestalt theoretical framework is furthermore regarded as a relevant theory for the interpretation of the research findings. Concepts of Gestalt theory clearly manifested in this study in terms of the effects of trauma on children's awareness, contact-making and self-regulation and the resulting effect on their emotions and behaviours, which might be linked to the participants' experiences of trauma-related symptoms. Further, the concept of holism was relevant in understanding certain findings. For instance, the inability to concentrate could have affected the participants' school performance, while for some participants their inability to regulate their behaviour and emotions, could have affected their peer relationships.

- Gestalt play therapy might have addressed the trauma-related symptoms in different ways, as indicated in the following examples:
  - *Affect dysregulation* can be ascribed to the neurobiological changes that occur in the limbic system, brainstem and neuro-endocrine system as a result of trauma. Gestalt theory likewise states that traumatised children often lack the ability for emotional awareness and regulation due to a lack of healthy contact functions. The aim of Gestalt play therapy, to enhance awareness and healthy contact functions, can therefore restore an individual's ability to identify needs and address them in the here and now.

    The participants' improved ability for affect regulation, evident in the quantitative and qualitative findings, could therefore possibly be ascribed to the increased emotional as well as sensory and bodily awareness that developed throughout the therapeutic process.
  - *Behaviour dysregulation* is evident in the fact that traumatised children present with a myriad of behavioural problems. The behaviours are mostly related to hyperarousal, one of the most prevalent and severe consequences of trauma. Hyperarousal can be explained by the neurobiological effect of trauma which alters the way the limbic system functions. A Gestalt perspective of traumatised children maintains that fragmented functioning causes a lack of capacity for self-regulation in children, which lead them to engage in inappropriate behaviours to meet their needs. Integrated functioning enables children to devote all their energy to meeting their needs in an appropriate way.

    The reduction in behaviour dysregulation symptoms can be seen as indicative of enhanced self-regulation and integrated functioning, which could be as a result of Gestalt play therapy.
  - *Alterations in attention and consciousness* are associated with the effect of trauma and the neurobiological impact of trauma on the cerebral cortex. Furthermore, symptoms related to dissociation, which is another common and severe long-term consequence of trauma, is also related to the effect of trauma on the limbic system. In Gestalt play therapy, a lack of integration is understood to occur due to suppressed senses, emotions and intellect, and is therefore addressed through enhancing contact and awareness in the here and now. By utilising creative techniques that allow for non-threatening experiences in therapy, as used in Gestalt play therapy, the limbic system could be accessed.

As was evident from the quantitative and qualitative findings, the participants experienced an improvement in the symptoms associated with alterations in attention and consciousness, which might be ascribed to the focus of Gestalt play therapy to enhance contact and awareness in the here and now.

- *Distortions in attribution and worldview* can be related to the effect of trauma on aspects of the self, such as a cohesive self-concept and a balanced self-perception, with a result that feelings of shame and guilt and a low self-esteem are common in traumatised children. By strengthening the sense of self throughout the Gestalt therapeutic process, children's sense of self is generally enhanced as integration are established when a child progress through the layers of neurosis towards self-acceptance.

  An increase in self-acceptance and sense of self-worth were evident for some of the participants, which could be ascribed to the Gestalt therapeutic process. Additionally, a key objective in Gestalt play therapy, which involves enhancing children's sense of responsibility for their own behaviour, might also be linked to the development of a stronger internal locus of control in the participants as opposed to their initial external locus of control.

- The effect of trauma on *interpersonal relationships* is often evident in a lowered capacity of positive pro-social behaviour based on low interpersonal efficiency, as appeared to be the case with the participants. Gestalt play therapy pays considerable attention to establish a safe therapeutic relationship as the experience of a safe and trustworthy relationship might in itself serve to be therapeutic for certain individuals.

  Gestalt play therapy with its relational focus seemed to have provided a safe and secure base for participants' abilities for relationship formation, on which trust was able to develop and extend to other individuals. Improved self-regulation skills might have further influenced the participants' abilities to form healthy relationships.

- As the qualitative findings substantially enriched the quantitative findings, it can be concluded that the methodology of a triangulation mixed methods design as utilised in this research study, was appropriate. Furthermore, the small standard deviation of the averages in the quantitative findings could be an indication that the self-constructed questionnaire served as a relevant data collection instrument to obtain reliable information.

The findings and conclusions of this study provide substance for recommendations to address the effects of trauma, and lead to further research questions, which is outlined in the next section.

5.4 RECOMMENDATIONS

Based on the findings of this study, certain recommendations for practice are outlined, and suggestions for future research made.

5.4.1 Recommendations for practice

Recommendations for working with traumatised children are outlined in this section:

Children in residential care

- Professionals, caregivers and staff members in residential care settings need to be informed about the way trauma impacts children in different stages of development. The neurobiological impact of trauma is significant and sheds light on the way in which professionals should engage with traumatised children. Therefore, the caregivers and staff at residential care settings, who take care of traumatised children, need to be informed regarding these impacts.
- Caregivers in residential care settings need to be educated about the effects of trauma on children and how it may manifest on aspects such as their emotions, behaviour, academic performance and interpersonal relationships, as well as on ways in which to structure the environment to minimise potential triggers for trauma reactions.
- Children who have been traumatised are not likely to reach out to others to help them, as they tend to not rely on others. However, they desperately need assistance and safe relationships in order to develop capacities for self-regulation and therefore should be closely monitored by staff members in residential care settings.

Social science proffesionals and educators

- It is recommended that all professionals in the field of social sciences, who work with children who have been exposed to trauma, obtain knowledge of the neurobiological effects of trauma so as to better understand the psychosocial functioning of traumatised children. Thus, social work students should be exposed to this knowledge already on an undergraduate level.

- Many of the psychosocial effects of trauma will manifest in the context of the school setting. It is therefore paramount that teachers and school staff be informed and educated about the way trauma impacts on children. School governing bodies should enable teachers to be trained in ways in which to deal with children who may become dysregulated in order to prevent disruptions in the classroom setting and protect traumatised children from experiencing retraumatisation.

Parents of traumatised children

- Social sciences professionals should educate parents whose children have been exposed to trauma about the possible manifestations of trauma, the need to address the trauma because of the neurobiological impact thereof, as well as on how to support their children. Parent education is especially important for foster parents and adoptive parents.

Trauma-informed interventions

- Conventional therapies which focus on verbalisation and rational thoughts have to be reconsidered in the light of neurobiological studies on trauma. In this regard, social sciences professionals who work with traumatised children can take the following aspects into consideration:
  - Children's self-regulation need to be addressed as primary therapeutic goal, since it would hamper obtainment of other therapeutic goals.
  - Due to the way trauma impacts brainfunctioning and the verbal and cognitive limitations of conventional therapies, it is recommended that children approach their trauma through nonverbal and sensory avenues.
  - Sensory and bodily awareness is recognised as a major route to the psychological integration and fundamental in the treatment of trauma. Techniques and activities to promote sensory and emotional awareness can thus enhance self-regulation skills that have been negatively affected by trauma.
  - Creative therapies are suggested for traumatised children, since it is regarded as non-threatening while also activating the limbic system, which consequently could resolve the triggers of hyperarousal.
- Based on the research findings, it is recommended that social sciences professionals regard trauma interventions as a longer term intervention with children.
- Professionals who work with traumatised children should take into consideration that all individuals respond uniquely to trauma and work through the therapeutic process at their

individual pace. The therapeutic process should therefore be adapted to the process of each individual child.

- Children who have been traumatised need experiences to enhance their sense of competence and personal power to strengthen their sense of self. It is of key concern therefore that professionals who work with traumatised children consider developmental aspects in order to apply age-appropriate therapeutic goals and activities.

5.4.2 Suggestions for future research

- The research study was an exploratory study with a small sample size. Based on the promising findings, both quantitative and qualitative, it is recommended that social sciences professionals conduct more research studies on interventions with traumatised children. The following suggestions are made for these studies:
    - That larger sample sizes are included,
    - That research be conducted with children of different age groups, from diverse cultures and language groups in order to improve transferability of the findings,
    - That the perception of caregivers be explored in terms of the effect of interventions on the functioning of children in their natural environment,
    - That the research study be repeated in different contexts, for example with children in foster care, children who have been exposed to different forms of trauma, and with traumatised children who are not in the statutory care system. Comparisons in this regard might provide further insight as to how best to support traumatised children.
    - That a longitudinal study with similar focus be conducted to determine the long-term effect of Gestalt play therapy on trauma-related symptoms.
- It is recommended that research studies on interventions with traumatised children should include caregivers of children in residential care. These studies could focus on the following:
    - Research in residential settings, establishings caregivers' level of understanding regarding the impact of trauma on children, might add valuable insight in terms of the need for education regarding trauma-informed care.
    - Research determining the effect of trauma-informed education on the quality of care in residential settings is advised.

5.5 ACCOMPLISHMENTS OF THE GOAL AND OBJECTIVES

The goal of the study was to establish the effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood. This goal was reached through the following objectives:

- **To conceptualise trauma and the impact of trauma on children, with specific reference to the role of neurobiological changes related to trauma and how it applies to children in middle childhood**

Chapter 2 included an overview of what trauma entails, considering the emergent understanding regarding the neurobiology of trauma. The associated consequences were discussed, paying particular attention to how symptoms manifest in children in middle childhood. In Chapter 3, literature on limitations of conventional therapies and suggestions for intervention with traumatised individuals, incorporating neurobiological principles, were outlined. Gestalt play therapy was briefly discussed in terms of its appropriate elements and reviewed to provide context with regard to the therapeutic process that was implemented.

- **To quantitatively determine a baseline profile of trauma-related symptoms in participants and to qualitatively explore participants' experiences of trauma-related symptoms before implementing Gestalt play therapy within the same time frame as the baseline profile**

A self-constructed questionnaire was utilised to conduct structured interviews with the participants in the study before the implementation of Gestalt play therapy as the intervention in this study. The participants were selected to meet certain sampling criteria, one of which involved the presence of trauma symptoms for a period of at least one month, which allowed for relatively stable baseline data. A semi-structured interview was conducted immediately after the structured interview in order to gain more in-depth information regarding the participants' experiences of trauma symptoms that were indicated in the questionnaire.

- **To conduct a series of 12 Gestalt play therapy sessions with participants**

Twelve Gestalt play therapy sessions were conducted with each participant. These sessions were conducted on a weekly basis, each session with duration of 45 to 60 minutes. Although progress through the therapeutic process was determined by the process of each individual

participant, each session maintained a certain structure involving three main phases in order to include certain elements suggested for trauma intervention in each session. Firstly, a sensory and bodily awareness phase was included during which the participant's foreground could also be dealt with. The second phase included the main activity in line with the particular focus area of the session, always involving creative techniques. Finally, a relaxation exercise concluded the session and debriefing was conducted.

- **To quantitatively determine whether Gestalt play therapy had an impact on trauma-related symptoms in participants, and, within the same time frame, qualitatively exploring how participants experienced possible changes in trauma-related symptoms**

In line with the single-system design, data were collected at two points in the intervention phase. Data were collected after six weeks of Gestalt play therapy and again after 12 weeks, using the same data collection methods that were utilised in the baseline phase, namely questionnaires and semi-structured interviews. The quantitative and qualitative findings of the study were presented in Chapter 4, thereby achieving this objective.

- **To make conclusions about the effectiveness of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood.**

In Chapter 5, a concise discussion of the key research findings, as well as conclusions based on these findings were reported. Recommendations for practice and for future research were presented.

Achievement of the goal and objectives of the study, allowed the researcher to answer the research question as indicated in point 5.2.

5.6 CONCLUDING STATEMENT

The effect of trauma on the normal structure and functioning of the brain seems to contribute significantly to certain long-term effects associated with symptoms of trauma. Perry (2006a:22) states that "in order to heal (i.e. alter or modify trauma) therapeutic interventions must activate those portions of the brain that have been altered by the trauma." Conventional therapies seem unable to access these lower brain areas as these areas are unresponsive to language, insight or logic used in verbally-based therapies (Gaskill & Perry, 2014:185; Van der Kolk, 2006:5). Gestalt play therapy incorporates trauma-informed

principles which consider the neurobiological impact of trauma. Based on the findings of the study, the developmentally-sensitive, sensory-based, creative qualities inherent to Gestalt play therapy, implemented within a safe therapeutic relationship, seemed to have a positive effect in addressing symptoms associated with trauma.

REFERENCES

American Psychiatric Association. 2013. *Diagnostic and statistical manual of mental disorders*. 5th ed. Available: http://www.ptsd.va.gov/professional/pages/dsm5_criteria_ptsd.asp (Accessed 2013/12/03).

Arvidson, J., Kinniburgh, K., Howard, K., Spinazzola, J., Strothers, H., Evans, M., Andres, B., Cohen, C. & Blaustein, M.E. 2011. Treatment of complex trauma in young children: Developmental and cultural considerations in application of the ARC Intervention model. *Journal of Child & Adolescent Trauma,* 4(1):34-51.

Babbie, E. 2013. *The Practice of Social Research.* 3rd ed. London: Wadsworth, Cengage Learning.

Baloyi, L. 2006. Teddy Bear Therapy: An application. *Child Abuse Research in South Africa,* 7(2):17-25.

Benokraitis, N.V. 2005. *Marriages and families: Changes, Choices, and Constraints*. 5th ed. New Jersey: Pearson Education.

Berk, L.E. 2013. *Child Development.* 9th ed. Boston: Pearson Education.

Bezuidenhout, C. & Little, K. 2011. Crime and Criminology. In Bezuidenhout, C. (Ed.) *A South African Perspective on Fundamental Criminology.* Cape Town: Pearson Education South Africa (Pty) Ltd.

Blom, R. 2006. The *handbook of Gestalt play therapy: Practical guidelines for Child therapists*. London: Jessica Kingsley Publishers.

Bradshaw, W. 2003. Use of Single-System Research to Evaluate the Effectiveness of Cognitive-Behavioural Treatment of Schizophrenia. *British Journal of Social Work*, 33(7):885-899.

Briere, J. & Spinazzola, J. 2005. Phenomenology and psychological assessment of complex posttraumatic stress. *Journal of traumatic stress*, 18(5):401-412.

Campbell, J.S.W. 2009. Trauma & the brain: Physiological and chemical changes. *The healing magazine*: *The Kids Peace Institute,* 14(1):18-20.

Carter, B. & McGoldrick, M. 2005. Self in context: The individual life cycle in systemic perspective. In Carter, B. & McGoldrick, M. (Eds.). *The expanded family life cycle: Individual, family, and social perspectives*. 3rd ed. Boston: Pearson Education.

Child Welfare Information Gateway. 2008. *Long-term consequences of child abuse and neglect.* Washington, DC: Child Welfare Information Gateway, U.S. Dept. of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau.
Available: http://purl.access.gpo.gov/GPO/LPS124672 (Accessed 2013/04/01).

Clarkson, P. & Cavicchia, S. 2014. *Gestalt counselling in action*. 4th ed. Los Angeles: SAGE publications.

Coates, D. 2010. Impact of Childhood Abuse: Bio psychosocial pathways through which adult mental health is compromised. *Australian Social Work Journal,* 63(4): 391-403.

Cook, A., Spinazzola,J., Ford,J., Lanktree, C., Blaustein, M., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E. & Van der Kolk, B.A. 2007. Complex trauma in children and adolescents. *Focal Point*: *Traumatic Stress/Child Welfare*, 21(1):4-8.

Cook, A., Spinazzola,J., Ford,J., Lanktree, C., Blaustein, M., Sprague, C., Cloitre, M., DeRosa, R., Hubbard, R., Kagan, R., Liautaud, J., Mallah, K., Olafson, E. & Van der Kolk, B.A. 2005. Complex trauma in children and adolescents. *Psychiatric Annals,* 35(5):390-398.

Corey, G. 2013. *Theory and Practice of Counseling and Psychotherapy.* 9th ed. Belmont, CA: Brooks/Cole Cengage Learning.

Creswell, J. W. 2013. *Qualitative inquiry and research design: Choosing among five approaches*. 3rd ed. Los Angeles: SAGE.

D'Andrea, W., Ford, J., Stolbach, B., Spinazzola, J. & Van der Kolk, B.A. 2012. Understanding interpersonal trauma in children: Why we need a Developmentally Appropriate Trauma Diagnosis*. American Journal of Orthopsychiatry,* 82(2):187-200.

Delima, J. & Vimpani, G. 2011. The neurobiological effects of childhood maltreatment: An often overlooked narrative related to the long-term effects of early childhood trauma. *Family Matters*, 2011(89):42-52.

Delport, C.S.L. & Fouché, C.B. 2011. Mixed methods research. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik Publishers.

Delport, C.S.L. & Roestenburg, W.J.H. 2011a. Quantitative data-collection methods: questionnaires, checklists, structured observation and structured interview schedules. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers.

Delport, C.S.L. & Roestenburg, W.J.H. 2011b. Quantitative data-collection methods: indexes and scales. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers.

DSD, DWCPD & UNICEF. 2012. *Violence Against Children in South Africa*. Pretoria: Department of Social Development/Department of Women, Children and People with Disabilities/ United Nations Childrens Fund.
Available: http://www.cjcp.org.za/uploads/2/7/8/4/27845461/vac_final_summary_low_res.pdf

De Young, A.C., Kenardy, J.A. & Cobham, V.E. 2011. Trauma in early childhood: A neglected population. *Clinical Child and Family Psychology Review*, 14(3):231-250. Brisbane: University of Queensland.

Fall, K.A., Holden, J.M. & Marquis, A. 2010. *Theoretical models of counseling and psychotherapy*. 2nd ed. New York: Taylor & Francis.

Field, A. 2013. *Discovering Statistics using IBM SPSS Statistics.* 4th ed. London: SAGE.

Foltz, R., Dang, S., Daniels, B., Doyle, H., McFee, S. & Quisenberry, C. 2013. When diagnostic labels mask trauma. *Reclaiming Children and Youth Journal,* 22(2):12-17.

Ford, J.D. & Courtois, C.A. (Eds.). 2013. *Treating Complex Traumatic Stress Disorder in Children and Adolescents: Scientific Foundations and Therapeutic Models.* New York: Guilford Press.

Fouché, C.B. 2011. Evaluation research. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers

Fouché, C.B. & Bartley, A. 2011. Quantitative data analysis and interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers.

Fouché, C.B., Delport, C.S.L. & De Vos, A.S. 2011. Quantitative research designs. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers

Fouché, C.B. & De Vos, A.S. 2011. Formal formulations. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers.

Fouché, C.B. & Schurink, W. 2011. Qualitative research designs. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers.

Friedman, M. J. 2013. Finalizing PTSD in DSM-5: Getting here from there and where to go next. *Journal of Traumatic Stress*, 26(5):548–556.

Gaskill, R.L. & Perry, B.D. 2014. The Neurobiological Power of Play: Using the Neurosequential Model of Therapeutics to Guide Play in the Healing Process. In Malchiodi, C.A. & Crenshaw, D.A. (Eds.). *Creative Arts and Play Therapy for Attachment Problems.* New York: The Guilford Press.

Geldard, K., Geldard, D. & Yin Foo, R. 2013. *Counselling Children. A Practical Introduction.* 4th ed. London: SAGE.

Goldman, L. 2009. Kids living with fear: recognizing and healing the trauma. *The Kids Peace Institute: The healing magazine,* 14(1):14-17.

Goodyear-Brown, P. 2010. *Play Therapy with traumatized children: A Prescriptive approach.* New Jersey: John Wiley & Sons.

Greeff, M. 2011. Information collection: interviewing. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers.

Grinnell, R.M. & Unrau, Y.A. 2008. *Social work research and Evaluation: Foundation of Evidence-based Practice*. 7th ed. New York: Oxford University Press.

Hamber, B. 2000. "Have no doubt it is fear in the land": An exploration of the continuing cycles of violence in South Africa. *South African Journal of Child and Adolescent Mental Health*, 12(1):5-18.

Hawley, T. 2000. *Starting smart: How early experiences affect brain development*. 2nd ed. Washington, D.C.: Zero to three: Ounce of prevention fund.

Henderson, D.A. & Thompson, C.L. 2011. *Counseling children*. 8th ed. Belmont, CA: Brooks/Cole Cengage Learning.

Hendricks, C.O. & Fong, R. 2006. Ethically Sensitive Practice with Children and Families. In Webb, N.B. (Ed.) *Working with Traumatized Youth in Child Welfare.* New York: The Guilford Press.

Howell, E.F. 2011. *Understanding and Treating Dissociative Identity Disorder: A Relational Approach.* New York: Routledge.

Huston, A.C. & Ripke, M.N. 2006. *Developmental contexts in middle childhood: Bridges to adolescence and adulthood.* New York: Cambridge University Press.

Jones, L.K. & Cureton, J.L. 2014. Trauma redefined in the DSM-5: Rationale and implications for Counselling Practice. *The Professional Counselor Journal*, 4(3):257-271.

Kaduson, H.G. & Schaefer, C.E. 2006. *Short-term play therapy for children*. 2nd ed. New York: The Guilford press.

Landreth, G. 2002. *Play therapy: The art of the relationship*. 2nd ed. New York: Brunner-Routledge.

LaLiberte, T., Crudo, C., Gewirtz, A. & Bray, C. 2013. Trauma-informed child welfare practice. *CW360': a comprehensive look at a prevalent child welfare issue*. University of Minnesota. Available: http://cascw.umn.edu/wp-content/uploads/2013/12/CW360-Ambit_Winter2013.pdf (Accessed 2013/06/27).

Le Bel, J., Champagne, T., Stromberg, N. & Coyle, R. 2010. Integrating sensory and trauma-informed interventions: A Massachusetts State Initiative, Part I. *Mental Health Journal,* 33(1):1-5.

Lietz, C.A., Langer, C.L. & Furman, R. 2006. Establishing trustworthiness in qualitative research in social work: Implications from a study regarding spirituality. *Qualitative social work,* 5(4): 441-458.

Louw, D.A., Duncan, N., Richter, L. & Louw, A.E. 2007. Vulnerabilities, Resilience & Rights of Children. In Louw, D.A. & Louw, A.E. (Eds.). *Child and adolescent development.* Bloemfontein: Psychology Publications.

Louw, D.A. & Kail, R. 2007. Basic Concepts of Child and Adolescent Development. In Louw, D.A. & Louw, A.E. (Eds.). *Child and adolescent development.* Bloemfontein: Psychology Publications.

Louw, D.A., Louw, A.E. & Kail, R. 2014. Basic Concepts of Child and Adolescent Development. In Louw, D.A. & Louw, A.E. (Eds.). *Child and adolescent development.* 2nd ed. Bloemfontein: Psychology Publications.

Louw, A.E. & Louw, D.A. 2014a. Vulnerabilities, Resilience & Rights of Children. In Louw, D.A. & Louw, A.E. (Eds.). *Child and adolescent development.* 2nd ed. Bloemfontein: Psychology Publications.

Louw, A.E. & Louw, D.A. 2014b. Middle Childhood. In Louw, D.A. & Louw, A.E. (Eds.). *Child and adolescent development.* 2nd ed. Bloemfontein: Psychology Publications.

Louw, A.E. & Louw, D.A. 2007. Middle Childhood. In Louw, D.A. & Louw, A.E. (Eds.). *Child and adolescent development.* Bloemfontein: Psychology Publications.

Lyle, D.P. 2013. PTSD: Blame Your Hippocampus/Amygdala Complex. Available: writersforensicsblog.wordpress.com/2013/05/17/ptsd-blame-your-hippocampusamygdala-complex/3-limbic-system-1/ (Accessed 2015/06/05).

Maree, J.G. & Pietersen, J. 2007. Overview of statistical techniques. In Maree, J.G. (Ed.) *First steps in research.* Pretoria: Van Schaik.

Makoae, M., Roberts, H. & Ward, C. 2012. *Child maltreatment prevention readiness assessment: South Africa.* Pretoria: HSRC.

Mann, D. 2010. *Gestalt therapy: 100 key points and techniques*. New York: Routledge.

Mortola, P. 2006. *Windowframes: Learning the art of Gestalt Play Therapy the Oaklander way.* California: The Gestaltpress.

Mustard, J.F. 2002. Early child development and the brain. In Young, M.E. (Ed.). *From early child development to human development*. Washington, D.C.: The World Bank.

Myers, R.G. 2002. Role of the private sector in early child development. In Young, M.E. (Eds.). *From early child development to human development*. Washington, D.C.: The World Bank.

Neuman, W.L. 2014. *Social research methods: qualitative and quantitative approaches.* 8th ed. Essex: Pearson Education.

Norman, R., Schneider, M., Bradshaw, D., Jewkes, R., Abrahams, N., Matzopoulos, R. & Vos, T. 2010. Interpersonal violence: An important risk factor for disease and injury in South Africa. *Population Health Metrics*, 8(32):1-11.

Norton, C.C. & Norton, B.E. 2011. Experiential play therapy. In Schaefer, C.E. (Ed.). *Foundations of play therapy.* 2nd ed. New Jersey: Wiley.

Oaklander, V. 2011. Gestalt play therapy. In Schaefer, C.E. (Ed.). *Foundations of play therapy*. 2nd ed. New Jersey: Wiley.

Oaklander, V. 2007. *Windows to our children.* 3rd ed. London: Karnac.

Oaklander, V. 2006. *Hidden Treasure. A Map to the Child's Inner Self.* 2nd ed. London: Karnac.

Oaklander, V. 1994. Gestalt play therapy. In O'Connor, K. & Schaefer, C.E. (Eds.) *Handbook of play therapy, vol 2.* New York: John Wiley & Sons.

O'Reilly, M., Ronzoni, P. & Dogra, N. 2013. *Research with Children. Theory & Practice.* London: SAGE Publications.

Papalia, D.E., Olds, S.W. & Feldman, R.O. 2008. *A child's world: Infancy through adolescence*. 11th ed. New York: McGraw International.

Perry, B.D. & Dobson, C.L. 2013. The Neurosequential Model of Therapeutics. In Ford, J.D. & Courtois, C.A. (Eds.). *Treating Complex Traumatic Stress Disorder in Children and Adolescents: Scientific Foundations and Therapeutic Models.* New York: The Guilford Press.

Perry, B.D. 2009. Examining Child Maltreatment through a Neurodevelopmental Lens: Clinical Applications of the Neurosequential Model of Therapeutics. *Journal of Loss and Trauma*, 14(4):240-255.

Perry, B.D. 2006a. Fear and learning: Trauma-related factors in the adult education process. *New directions for adult and continuing education,* 2006(110):21-28.

Perry, B.D. 2006b. Applying Principles of Neurodevelopment to Clinical Work with Maltreated and Traumatized Children: The Neurosequential Model of Therapeutics. In Webb, N.B. (Ed.). *Working with Traumatized Youth in Child Welfare.* New York: The Guilford Press.

Perry, B.D. 2003. *The effects of traumatic events on children: an introduction*. Report prepared for The Child Trauma Academy. Available: www.childtrauma.org (Accessed 2013/05/12).

Perry, B.D. 2002. *The Amazing human Brain and human development: Lesson 1: Beginning with the human brain.* Unpublished manuscript by the Child Trauma Academy. Available: www.childtraumaacademy.com/amazing-brain/lesson01/printing.html (Accessed 2013/08/16).

Perry, B.D. 1997. Incubated in terror: Neurodevelopmental factors in the 'cycle of violence'. In Osofsky, J. (Ed.). *Children in a violent society.* New York: The Guilford Press.

Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L. & Vigilante, D. 1996. *Childhood Trauma, the neurobiology of adaptiation & use-dependent development of the brain.* Report prepared for The Child Trauma Academy. Available: www.trauma-pages.com/a/perry96.php (Accessed 2013/09/07)

Perry, B.D., Pollard, R.A., Blakley, T.L., Baker, W.L. & Vigilante, D. 1995. Childhood Trauma, the neurobiology of adaptiation & use-dependent development of the brain: How states become traits. *Infant Mental Health Journal*, 16(4): 271-291.

Pretorius, D. & Pistorius, A. 2012. Introduction and definitions of child abuse. In Pretorius, D., Mbokazi, A.J., Hlaise, K.K. & Jacklin, L. (Eds.). *Child Abuse. Guidelines and Applications for Primary Healthcare Practitioners.* Cape Town: Juta & Company Ltd.

Ramphela, M. 2002. Foreword. In Young, M.E. (Ed.). *From early child development to human development*. Washington, D.C.: The World Bank.

Rosenzweig, J.M. 2015. Neurobiological Underpinnings for Trauma-Informed Care: A Primer. *Focal Point: Trauma-Informed Care,* 29(1):7-9.

Rothschild, B. 2001. Post-traumatic Stress Disorder. *Self & Society*, 28(5):15-23.

Ruben, A. & Babbie, E.R. 2008. *Research methods for social work.* 6th ed. Belmont, CA: Thomson Brooks/Cole.

SAPS. 2011. *South African Police Services Annual Crime Report 2010/2011.* Available Online: http://www.saps.gov.za/ statistics/reports/crimestats/2011/crime_situation_ sa.pdf (Accessed 2015/09/12).

Scharf, G. 2013. *Early Parenting Matters to Everyone*. Available: grahamscharf.com/wp-content/uploads/2013/12/Synaptic Pruning.jpg (Accessed 2014/07/02).

Schore, A.N. 2013. Relational trauma, brain development, and dissociation. In Ford, J.D. & Courtois, C.A. (Eds.). *Treating Complex Traumatic Stress Disorders in Children and Adolescents: Scientific foundations and therapeutic models*. New York: The Guilford Press.

Schore, A.N. 2001. The effect of early relational trauma on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, 22(1–2): 201–269.

Schurink, W., Fouché, C.B. & De Vos, A.S. 2011. Qualitative data analysis and interpretation. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers.

Steenkamp, J.O. 2013. A SHIP perspective on creating a healing space for the integration of trauma. *Journal of Alternative Medical Research*, 5(3):179-193.

Streeck-Fischer, A. & Van der Kolk, B.A. 2000. Down will come baby, cradle and all: diagnostic and therapeutic implications of chronic trauma on child development. *Australian and New Zealand Journal of Psychiatry,* 34(2000):903-918.

Strydom, H. 2011a. Single-system design. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik Publishers.

Strydom, H. 2011b. Sampling in the quantitative paradigm. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers.

Strydom, H. 2011c. The pilot study in the quantitative paradigm. In De Vos, A.S. Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers.

Strydom, H. 2011d. Ethical aspects of research in the social sciences and human service professions. In De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds.). *Research*

at grass roots: For the social sciences and human service professions. 4th ed. Pretoria: Van Schaik Publishers.

Strydom, H. & Delport, C. S. L. 2011. Sampling and pilot study in qualitative research. In De Vos, A.S. Strydom, H., Fouché, C.B. & Delport, C.S.L. (Eds). *Research at grass roots: For the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik Publishers.

TEARS (Transform Education About Rape and Sexual Abuse). 2012. Development of a Nationally Accessible Assistance and Support Network for Victims of Rape and Sexual Abuse. Available: http://www.tears.co.za/Downloads/Tears%20Presentation.pdf (Accessed 2013/04/01).

Teicher, M.H. 2000. Wounds that time won't heal: The neurobiology of child abuse. *Cerebrum: The Dana Forum on Brain Science*, 4(2):50-67.

Thompson, C.L. & Henderson, D.A. 2007. *Counselling children.* 7th ed. London: Brooks/Cole.

Thyer, B.A. 2001. *The handbook of social work research methods.* Belmont, CA: SAGE Publications.

Trochim, W.M. 2006. The Research Methods Knowledge Base. 2nd ed. Online publication. Available: http://www.socialresearchmethods.net/kb/ (Accessed 22/04/2015).

Van der Kolk, B.A. 2006. *Clinical implications of neuroscience research in PTSD*. Report (uncorrected proof) prepared for the Annals of the New York Academy of science. Available: www.traumacenter.org (Accessed 27/09/2013).

Van der Kolk, B.A. 2005. Developmental trauma disorder: Towards a rational diagnosis for chronically traumatized children. *Psychiatric Annals,* 35(5):401-408.

Van der Kolk, B.A. 2003. The neurobiology of childhood trauma and abuse. *Child and Adolescent Psychiatric Clinics,* 12(2003):293-317.

Van der Kolk, B.A. 1994. The body keeps the score: Memory and the evolving psychobiology of post traumatic stress*. Harvard Review of Psychiatry,* 1(15):253-265.

Wasserman, E. 2005. Understanding the effects of childhood trauma on brain development in native children. Report prepared for the *U.S. Department of Justice.* Available: http://www.tribalinstitute.org/download/Understanding%20the%20Effects%20of%20Childhood%20Trauma%20on%20Brain%20Development%20in%20Native%20Children.pdf (Accessed 11/09/2013).

Weber, D.A. & Reynolds, C.R. 2004. Clinical perspectives on neurobiological effects of psychological trauma. *Neuropsychology review*, 14(2):115-129.

Welman, C., Kruger, F. & Mitchell, B. 2012. *Research Methodology.* 3rd ed. Cape Town: Oxford University Press Southern Africa.

Werner, E.E. 2000. Protective factors and individual resilience. In Shonkoff, J.P. & Meisels, S.J. (Eds.). *Handbook of Early Childhood Intervention*. 2nd ed. New York: Cambridge University Press.

Young, M.E. 2002. *From early child development to human development*. Washington, D.C.: The World Bank.

Zelechoski, A.D., Sharma, R., Beserra, K., Miguel, J.L., DeMarco, M. & Spinazzola, J. 2013. Traumatized Youth In Residential Treatment Settings: Prevalence, Clinical Presentation, Treatment, and Policy Implications. *Journal of Family Violence*, 28(6):639-652.

Zilberstein, K. 2014. Trauma's Neurobiological Toll: Implications for Clinical Work with Children. *Smith College Studies in Social Work*, 84(2):292-309.

APPENDIX A

PERMISSION LETTER FROM THE ORGANISATION

PRESIDENT KRUGER
KINDERHUISE | CHILDREN'S HOMES
Groei tot hulle volle potensiaal | Growing to their full potential

Research : **Permission Letter** **2014**

Researcher : Nanet van der Burgh

nanetgrobb@gmail.com

Hereby I Jakobus Vorster grant provisional permission for the researcher, Nanet van der Burgh, under supervision of Dr MP le Roux to conduct her research project at and with the involvement of our organisation.

Permission is granted for the proposed study whereby the researcher aims to establish the effects of Gestalt play therapy in addressing the symptoms associated with trauma. The proposed study involves the evaluation of an intervention programme and therefore, as required, the involved participants would not be involved in any other programme/intervention during the implementation of the research project in order not to influence the validity of the research findings.

J. Vorster	Pretoria	6/2/2014
Nanet van der Burgh	Place	Date
Dr MP le Roux	Place	Date

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APPENDIX B

QUESTIONNAIRE

Research project

"The effects of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood"

Researcher: Nanet van der Burgh

Dear participant

Sometimes things happen that makes one experience feelings or events that make it difficult to go through every day. In this questionnaire are some feelings or events which children may sometimes experience. I want to find out which of these feelings and things you experience in your life. I will read a few sentences out loud to you and give you a chance to answer each. There are 23 statements. Each statement says something about feelings, thoughts or events which might be in your life. You can answer whether you agree with these statements or not. You can say specifically whether it is true in your life ALWAYS, OFTEN, RARELY or NEVER. There is no right or wrong answer. Just listen carefully to each question and give an answer that is true for your life. It will take approximately 15 minutes to go through all of the statements.

After we have gone through all the statements, we will talk a little more about some of them. You may then tell me more about your answers.

Your answers will help me to understand what might and might not help children that have gone through difficult times. Remember that the answers you give here will stay completely private. This means that nobody other than me will know what your answers were. My study leader (teacher) will be able to read your answers, but she will not know that it came from you, because I will use pseudonyms ('fake' names) on your forms. All these forms will be safely locked away at the University of Pretoria for many years.

If you have any other questions about the research you are welcome to ask me.

Thank you very much

Nanet van der Burgh

Questionnaire

Nr	Statements	Never	Rarely	Often	Always
1	I am excited about every new day				
2	Friends enjoy playing with me				
3	Teachers say I do not pay attention in class				
4	Other people say I am confused				
5	I sometimes forget how I got to a certain place				
6	I am on my own, separately				
7	I sleep well				
8	I get a fright from sudden movements or sounds				
9	I worry easily				
10	I get in trouble because of fighting with others				
11	I get angry easily				
12	I feel guilty				
13	People say that I am ‘moody’ (have ‘mood swings’)				
14	I like who I am				
15	I feel scared easily				
16	I cry easily				
17	Teachers reprimand me for not sitting still				
18	I struggle with my school work				
19	I enjoy going to school				
20	It feels as though I am dreaming while I am awake				
21	I get nightmares				
22	I get headaches or stomach aches				
23	I wet my bed				

Navorsingsprojek

"The effects of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood"

Navorser: Nanet van der Burgh

Beste deelnemer

Soms gebeur dinge met 'n mens wat kan maak dat 'n mens gevoelens of gebeure ervaar wat dit moeiliker maak om deur elke dag te gaan. In hierdie vraelys is daar 'n paar gevoelens of gebeure wat kinders kan ervaar. Ek wil uitvind watter van hierdie gevoelens en gebeure jy ervaar. Ek sal 'n paar sinne vir jou hardop lees en vir jou kans gee om op elkeen te antwoord. Daar is 23 sinne. Elke sin sê iets oor gevoelens, gedagtes of gebeure wat dalk in jou lewe mag wees. Jy kan antwoord of jy saamstem of nie. Jy kan spesifiek sê of dit waar is in jou lewe ALTYD, BAIE KEER, MIN KERE, of NOOIT nie. Daar is nie 'n regte of verkeerde antwoord nie. Luister net mooi na elke vraag en gee 'n antwoord wat waar is vir jou lewe. Dit sal ongeveer 15 minute neem om deur al die sinne te gaan.

Nadat ons deur al die sinne gegaan het, sal ons bietjie meer oor 'n paar van hulle praat. Jy kan my dan meer oor jou antwoorde vertel.

Jou antwoorde sal my help om beter te verstaan wat vir kinders, wat deur 'n moeilike tyd gegaan het, help en wat nie help nie. Onthou dat jou antwoorde heeltemal privaat sal bly. Dit beteken dat niemand anders behalwe ek sal weet wat jou antwoorde was nie. My studieleier (onderwyseres) sal jou antwoorde kan lees, maar sy sal nie weet dat dit van jou af kom nie omdat ek 'n skuilnaam op jou vorms sal skryf. Hierdie vorms sal veilig toegesluit bly by die Universiteit van Pretoria.

As jy enige verdere vrae het oor die projek is jy welkom om my te vra.

Baie dankie

Nanet van der Burgh

Vraelys

No	Stelling	Nooit	Min kere	Baie keer	Altyd
1	Ek is opgewonde oor elke nuwe dag				
2	Maats speel graag saam met my				
3	Onderwysers sê ek let nie op in die klas nie				
4	Ander mense sê ek is deurmekaar				
5	Ek vergeet soms hoe ek by ‘n sekere plek gekom het				
6	Ek is eenkant op my eie				
7	Ek slaap lekker				
8	Ek skrik vir skielike bewegings of geluide				
9	Ek bekommer my maklik				
10	Ek kom in die moeilikheid oor ek met ander baklei				
11	Ek word maklik kwaad				
12	Ek voel skuldig				
13	Mense sê ek is buierig (het ‘mood swings’)				
14	Ek hou van wie ek is				
15	Ek voel maklik bang				
16	Ek huil maklik				
17	Onderwysers raas met my oor ek nie stil sit nie				
18	Ek sukkel met my skoolwerk				
19	Ek gaan graag skool toe				
20	Dit voel of ek droom terwyl ek wakker is				
21	Ek kry nagmerries				
22	Ek kry hoofpyn of maagpyn				
23	Ek maak my bed nat				

APPENDIX C

INTERVIEW SCHEDULE

Interview schedule

Only themes relevant to the answers in the questionnaire that are indicative of the presence of trauma symptoms, will be explored.

I would like us to discuss some of the answers that you gave in the form that we have just completed. I will name the answers and will then ask you to tell me a bit more about each of them.

Themes

1. **Emotions**
   - Statement 1: I am excited about every new day
   - Statement 9: I worry easily
   - Statement 11: I get angry easily
   - Statement 13: People say that I am 'moody' (have 'mood swings')
   - Statement 15: I feel scared easily
   - Statement 16: I cry easily

2. **Behaviour**
   - Statement 10: I get in trouble because of fighting with others
   - Statement 23: I wet my bed
   - Statement 8: I get a fright from sudden movements or sounds
   - Statement 21: I get nightmares
   - Statement 7: I sleep well
   - Statement 22: I get headaches or stomach aches
   - Statement 19: I enjoy going to school

3. **Attention and concentration**
   - Statement 3: Teachers say I do not pay attention in class
   - Statement 17: Teachers reprimand me for not sitting still
   - Statement 18: I struggle with my school work
   - Statement 20: It feels as though I am dreaming while I am awake
   - Statement 4: Other people say I am confused
   - Statement 5: I sometimes forget how I got to a certain place

4. **View of self and world**
   - Statement 14: I like who I am
   - Statement 9: I worry easily
   - Statement 12: I feel guilty

5. Interpersonal relationships

- Statement 2: Friends enjoy playing with me
- Statement 6: I am on my own, separately

Onderhoudskedule

Slegs temas relevant tot die antwoorde in die vraelys wat dui op die teenwoordigheid van simptome van trauma, word geëksploreer.

Ek wil graag dat ons ‘n bietjie meer praat oor sommige van die antwoorde wat jy gegee het op die vorm wat ons so pas voltooi het. Ek sal die antwoorde noem en dan vir jou vra om vir my meer oor elkeen van hulle te vertel.

Temas

1. **Emosies**
   - Stelling 1: Ek is opgewonde oor elke nuwe dag
   - Stelling 15: Ek voel maklik bang
   - Stelling 11: Ek word maklik kwaad
   - Stelling 13: Mense sê ek is buierig (het ‘mood swings’)
   - Stelling 16: Ek huil maklik

2. **Gedrag**
   - Stelling 10: Ek kom in die moeilikheid oor ek met ander baklei
   - Stelling 23: Ek maak my bed nat
   - Stelling 8: Ek skrik vir skielike bewegings of geluide
   - Stelling 21: Ek kry nagmerries
   - Stelling 7: Ek slaap lekker
   - Stelling 22: Ek kry hoofpyn of maagpyn
   - Stelling 19: Ek gaan graag skool toe

3. **Aandag en konsentrasie**
   - Stelling 3: Onderwysers sê ek let nie op in die klas nie
   - Stelling 17: Onderwysers raas met my oor ek nie stil sit nie
   - Stelling 18: Ek sukkel met my skoolwerk
   - Stelling 20: Dit voel of ek droom terwyl ek wakker is
   - Stelling 4: Ander mense sê ek is deurmekaar
   - Stelling 5: Ek vergeet soms hoe ek by ‘n sekere plek gekom het

4. **Siening van self en wêreld**
   - Stelling 14: Ek hou van wie ek is
   - Stelling 9: Ek bekommer my maklik
   - Stelling 12: Ek voel skuldig

5. Verhoudingsaspekte

- Stelling 2: Maats speel graag saam met my
- Stelling 15: Ek voel maklik bang
- Stelling 6: Ek is eenkant op my eie

APPENDIX D

ETHICAL CLEARANCE FROM THE UNIVERSITY OF PRETORIA

[redacted]

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI VA PRETORIA

Faculty of Humanities
Research Ethics Committee

11 August2014

Dear Prof Lombard

Project:	The effect of Gestalt play therapy in addressing symptoms associated with trauma in children ih middle childhood.
Researcher:	Mrs N Van der Burgh
Supervisor:	Dr MP le Roux
Department:	Social work and Criminology"
Reference number:	28178662

Thank you for your response to the Committee's correspondence of 11 July 2014.

I have pleasure in informing you that the Research Ethics Committee formally approved the above study at an *ad hoc* meeting held on 11 August 2014. Data collection may therefore commence.

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

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

We wish you success with the project.

Sincerely

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

APPENDIX E

LETTER OF INFORMED ASSENT

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work & Criminology

Researcher: Mrs Nanet van der Burgh

Contact details: cell: 073 156 9903; email: nanetgrobb@gmail.com

Institution: Department of Social Work and Criminology, University of Pretoria

INFORMED ASSENT BY PARTICIPANT

Name of participant: _____

1. Title of the study

The effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood.

2. Purpose of the study

The purpose of the study is for Nanet van der Burgh to find out whether play therapy can help children to deal with their feelings or what happens in their lives.

3. Procedures

I will be asked to take part in 12 play therapy sessions in the office of Nanet van der Burgh. We will do different activities and talk about my feelings and what happens in my life. Each session will last about 45 minutes.

We will fill in a form with sentences about my feelings and my life and will then talk about my answers. Nanet will record our discussion on a voice recorder so that she can remember everything exactly as I tell it to her. We will complete the form before we start the sessions and then two more times thereafter.

4. Possible discomfort

I understand that if I take part in the study, we will talk about my feelings and what happens in my life. At the end of each session, Nanet and I will discuss how the session was for me. If I feel uncomfortable at any time during the study, I can tell Nanet and she will arrange that I can talk to the social worker at the children's home.

5. Benefits of the study

If I take part in the study, it may help Nanet to find ways to help other children to deal with their feelings and with what happens in their lives. It may also help me understand my own feelings better.

6. Right of participation

I can choose if I want to take part in the study. If I take part and then at any time wish to stop, I can tell Nanet. If I decide to stop, no one will be angry at me.

7. Rewards

I understand that I will not get money or gifts for taking part in the study.

8. Confidentiality

Only Nanet will know what we talk about in the sessions and what is written on the forms. If there is anything that Nanet needs to talk about with the social worker at the children's home, she will discuss it with me first. Nanet will write a report about the information, but my real name will not be used. Therefore no one will know my name or who I am. At the end of the study, all the information will be safely locked away at the University of Pretoria for 15 years.

If I have any questions about the study, I can ask Nanet van der Burgh or ask the social worker at the children's home to contact Nanet on 073 156 9903.

I understand my rights in taking part in the study. I understand what the study is about and why and how it will be done. I am willing to take part in the study.

Participant: _____ Date: _____

Researcher: _____ Date: _____

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Fakulteit Geesteswetenskappe
Department Maatskaplike Werk & Kriminologie

Navorser: Mev Nanet van der Burgh

Kontakbesonderhede: sel: 073 156 9903; e-pos: nanetgrobb@gmail.com

Instelling: Department Maatskaplike Werk en Kriminologie, Universiteit van Pretoria

INGELIGTE TOESTEMMING DEUR DEELNEMER

Naam van deelnemer: _____

1. Titel van die studie

Die effek van Gestaltspelterapie om simptome aan te spreek wat geassosieer word met trauma in kinders in die middelkinderjare. ("The effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood")

2. Die doel van die studie

Die doel van die studie is dat Nanet van der Burgh kan uitvind of spelterapie kinders kan help om hul gevoelens en wat in hul lewe gebeur, te hanteer.

3. Prosedures

Ek sal gevra word om deel te neem aan 12 spelterapiesessies in Nanet van der Burgh se kantoor. Ons sal verskillende aktiwiteite doen en praat oor my gevoelens en wat in my lewe gebeur. Elke sessie sal omtrent 45 minute lank wees.

Ons sal ook 'n vorm invul met sinne oor my gevoelens en my lewe en sal daarna praat oor my antwoorde. Nanet sal ons gesprek opneem sodat sy alles kan onthou presies soos ek dit aan haar gesê het. Ons sal die vorm invul voor ons met die sessies begin en later nog twee keer.

4. Moontlike ongerief

Ek verstaan dat as ek aan die studie deelneem, ons sal praat oor my gevoelens en wat in my lewe gebeur. Ek en Nanet sal aan die einde van elke sessie praat oor hoe die sessie vir my was. As ek enige tyd in die studie ongemaklik voel, kan ek vir Nanet sê en sy sal reël dat ek met die maatskaplike werker by die kinderhuis kan praat.

5. Voordele van die studie

As ek aan die studie deelneem, kan dit vir Nanet help om maniere te kry om ander kinders te help met hul gevoelens en wat in hull ewe gebeur. Dit kan ook vir my help om my eie gevoelens beter te verstaan.

6. My regte om deel te neem

Ek kan kies of ek aan die studie wil deelneem. As ek deelneem en dan op enige tyd besluit om op te hou, kan ek dit vir Nanet sê. As ek kies om op te hou, sal niemand vir my kwaad wees nie.

7. Beloning

Ek verstaan dat ek nie geld of geskenke sal kry as ek aan die studie deelneem nie.

8. Vertroulikheid

Slegs Nanet sal weet waaroor ons in die sessies praat en wat op die vorms geskryf is. As daar iets is waaroor Nanet met die maatskaplike werker by die kinderhuis moet praat, sal sy dit eers met my bespreek. Nanet sal 'n verslag oor die inligting skryf, maar my regte naam sal nie gebruik word nie. Daarom sal niemand weet wat my naam is of wie ek is nie. Aan die einde van die studie sal al die inligting vir 15 jaar veilig by die Universiteit van Pretoria gestoor word.

As ek enige vrae oor die studie het, kan ek vir Nanet vra of vir die maatskaplike werker by die kinderhuis vra om vir Nanet te kontak op 073 156 9903.

Ek verstaan my regte om aan die studie deel te neem. Ek verstaan waaroor die studie gaan en hoe dit gedoen sal word. Ek sal graag aan die studie wil deelneem.

Deelnemer: _____ Datum: _____

Navorser: _____ Datum: _____

APPENDIX F

LETTER OF INFORMED CONSENT

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Social Work & Criminology

Researcher: Mrs Nanet van der Burgh

Contact details: 073 156 9903; email: nanetgrobb@gmail.com

Institution: Department of Social Work and Criminology, University of Pretoria

INFORMED CONSENT BY LEGAL GUARDIAN

Name of guardian: _____

Name of participant: _____

1. Research title

The effect of Gestalt play therapy in addressing symptoms associated with trauma in children in middle childhood

2. Purpose of the research study

The purpose of this research is to explore the effect Gestalt play therapy might have in addressing the symptoms associated with trauma in children in middle childhood.

3. Procedures

The researcher will firstly establish a baseline measurement to determine the presence and severity of trauma symptoms experienced by the participant. For this purpose, a questionnaire will be completed to determine the presence of trauma symptoms, followed directly by an interview to explore the participant's experiences of the symptoms that he/she experiences. After the baseline measurement, which will be conducted in one interview, the researcher will conduct 12 individual Gestalt therapy sessions (of approximately 45 minutes each) with each participant. Sessions will be conducted once a week. Similar to the baseline measurement, the questionnaire and the interview will be repeated at two intervals during the research (one interview after six weeks and another interview after 12 weeks) in order to determine possible changes in trauma-related symptoms and the participant's experiences thereof. The researcher will make a voice recording of the three data collection interviews with the permission of the participant to ensure precision of the data collected.

The questionnaires, the recordings and transcripts thereof will only be accessible to those directly involved in the research, namely the researcher and her supervisor. Participants will not be identifiable as pseudonyms rather than their names will be used.

4. Risks involved in the research study

The possibility exists that the participant may experience emotional distress as the therapy or interviewing could trigger emotions and memories associated with previous trauma. Emotional distress will be dealt with as part of the therapeutic intervention. Further, debriefing will occur at the end of every therapeutic session as well as after the research process to discuss the participant's experiences and clarify any misconceptions. If the participant, at the end of the 12 sessions seems not to be ready for termination of therapy, the researcher will proceed with the sessions until an appropriate transition can be made to the social worker at President Kruger Children's Home.

5. Benefits of the research study

There are no direct benefits or any financial gains for the participant or the legal guardians for participation in this study. However, participation in this study may contribute to a better understanding of the possible effect of Gestalt play therapy in addressing symptoms associated with trauma in children and may assist in finding effective interventions for traumatised children. The Gestalt therapeutic process is a child-focused, relational intervention and an empowering process that intends to enhance a strong sense of self and self-regulatory abilities in children. As such, it might be to the benefit of the participants.

6. Voluntary participation

The participant is under no obligation to participate, and should he/she choose to withdraw after the study has commenced, he/she will be allowed to do so immediately without any negative consequences.

7. Confidentiality of information

The information provided by participants will be handled with strict confidentiality and participants will not be identifiable. Digital recordings will be stored electronically and the transcripts, as well as questionnaires, will be secured in a locked cabinet. Only the researcher and her supervisor will have access to the research data. After completion of the research all the research information will be safely stored at the Department of Social Work and Criminology, University of Pretoria, for a period of 15 years. The results of this research may appear in professional publications, be presented at professional conference or utilised for future research purposes, but participants' privacy will be respected.

8. Contact details

If more information is required about this research, please feel free to contact the researcher at: e-mail: nanetgrobb@gmail.com or cell number: 073 156 9903.

9. Permission for participation in the research study

I, the undersigned, have read the information provided above and all my questions have been answered satisfactorily. I give consent for the above-named minor in my legal care to voluntarily participate in this research study.

I have received a copy of this letter.

Guardian: _____ Date: _____

Researcher: _____ Date: _____