

Chapter One

Introduction

Keywords in this chapter:

- *Background literature*
- *Motivation for the study*
- *Identify the research problem*
- *Goals and Objectives of the study*
- *Methodology*

1.1 Background literature

An increased understanding of the harmful effects of alcohol consumption has led to a growing awareness of fetal alcohol syndrome (FAS) and its effects on the child. According to the MA Policy (1993:1), fetal alcohol syndrome is the leading cause of environment- related birth defects and a common cause of mental retardation. Streissguth in Brown (1999: 320) associates secondary disabilities with fetal alcohol syndrome ranging from mental health problems, disrupted school experiences including cognitive delays to trouble with the law.

Consumption of excessive alcohol especially amongst farm workers has long been known to be a major public health problem in the agricultural sector of South – Africa. Areas of the Western Cape has been found to have among the highest incidence of fetal alcohol syndrome in the world with over 7.5 percent of children between the age of five – eight years (Te WaterNaude, Charlton, Sayed, Dausab, Marco, Rendall – Mkosi & London 2000: 1).

Other characteristics features associated with Fetal alcohol syndrome according to Viljoen (1997: 1) are secondary disabilities, characteristic facial features and other organ abnormalities.

It is clear that Fetal alcohol syndrome refers to a constellation of physical, behavioral and cognitive abnormalities. Viljoen (1997: 2) believes that five thousand – ten thousand children are born every year in the Western Cape with some form of Fetal alcohol syndrome.

This incidence is higher in low social economy communities and in socially marginalized groups featuring high rates of alcoholism (May, Brooke, Gossage, Croxford, Adnams, Jones, Robinson & Viljoen 2000: 1910).

These conditions are compared by a culture of heavy drinking, especially in winegrowing areas (Viljoen1997: 4).

Although the physical characteristics are well known this research main focus is to develop a profile, to enable people working with children suffering from

Fetal Alcohol Syndrome to also identify emotional characteristics of this syndrome that will support them in treating and assisting these children.

1.2 Choice of research

The motivation for this study was inspired by two determinants firstly on a professional level; the child with Fetal alcohol syndrome is part of the mainstream school education system and their parents struggle with important decisions (Timler, & Olswang 2001: 48). Parents have the best information about a child's daily life outside of school and teachers are the most knowledgeable about the child's educational opportunities and challenges.

This differences in the child's performance across home and school contexts may contribute to differing perceptions between families and educators about the child's specific challenges and what the child needs. Identifying and resolving differences between families and teachers are necessary for optimum planning because the quality of cooperation between parents and teachers is critically important to a child's successful emotional development. Resolving discord seems compelling for the population of children with alcohol – related disabilities (Fetal alcohol syndrome) who are known to be at increased risk for mental health problems, disrupted school experiences and criminal conduct as they approach adolescence (Streissguth, Barr, Kagan, Bookstein 1996: 94). Streissguth in Burd, Cox, Fjelstad, & McCulloch (2000: 128) found that over 90 percent of people with Fetal alcohol syndrome had mental health problems, 60 percent expelled from school, 60% trouble with the law and 50percent has been or were in jail.

Due to these conditions it seems necessary to do a research and compile a profile which will refer to specific characteristics such as hyperactivity and impulsivity and focus on emotional behaviour of the child with Fetal alcohol syndrome, so that parents, teachers and other individuals working with the child with Fetal alcohol syndrome knows how to handle him.

Secondly on a personal level, considerations to do this study included the researcher's personal interest and biases, current trends in helping strategies for children with Fetal alcohol syndrome and the ability to use gestalt therapy as a frame of reference for this research.

1.3 Bracketing and determining the researchers bias

As part of the process of preparing for data collection and later data analysis, steps were taken to clarify the researcher's intentions, to test her assumptions and to make biases and prejudices explicit. After consulting with professionals such as the researcher's supervisor the researcher learned a great deal about her, that she integrates multi –dimensional strategies, is open minded and intuitive.

1.4 Problem formulation

From the above motivation the following problem arises. No profile that focuses on specific behaviour and emotional characteristics of the child suffering from Fetal alcohol syndrome exists, that can serve as assistance or guide for people working with the child suffering from fetal alcohol syndrome. Existing profiles focus on the clinical characteristics, which includes the physical and cognitive developmental characteristics.

Children express themselves through behaviour. Behaviour's such as impulsivity, unawareness and hyperactivity of the child with Fetal alcohol syndrome alert teachers and caregivers to be aware of their specific needs. These behaviours, which sensitize caregivers and educators, are an expression of the child's attempt to regain emotional balance. The child with Fetal alcohol syndrome, experience emotional imbalance if he does not externalize his emotional imbalance and are very often not identified as in need of support and are not helped. Many children with Fetal alcohol syndrome in South Africa presents a poorly asserted self – image, hyperactivity and impulsivity.

No research has been carried out to date on the integration of a gestalt helping strategy to regain emotional balance in the child with Fetal alcohol syndrome.

1.5 Goal and Objectives

The main goal of this research is to formulate a profile that focuses on specific characteristics of the child with fetal alcohol syndrome, focusing on his emotional awareness by integrating the gestalt helping strategy as a tool that can assist play therapists, parents and teachers working with the child with fetal alcohol syndrome to recognize emotional imbalance and emotional unawareness. To reach this goal the following objectives will be met.

1.5.1 Objectives

- To conduct a literature review by means of descriptive research to understand the functioning and characteristics of the child with Fetal alcohol syndrome
- To identify children with Fetal alcohol syndrome in the Western Cape by means of research selection procedures and use the Conner symptom checklist to indicate if the child with Fetal alcohol syndrome portrait hyperactivity, impulsivity and inattention

- To describe a profile of children with fetal alcohol syndrome by means of a standardized symptom checklist and gestalt play therapy
- To use play therapy as a method to gather information and to learn the child how to handle behaviour appropriate (play therapy is used to learn the children to cope with his behaviour)
- To compile a profile within the gestalt to be a guidance to people in contact with the child with fetal alcohol syndrome by means of integrating all relevant information

1.6 Methodology

In this chapter the researcher will focus briefly on research design, research approach and research type. A detailed discussion regarding the research design, research approach and research type is given in chapter four.

1.6.1 Research Design

According to Mouton (2002: 55) research design describes the plan of how the researcher intends on conducting the research and how data will be collected to construct a profile on the child with Fetal alcohol syndrome.

Research in this study is aimed at being descriptive. Descriptive research presents a picture of the specific details of a situation or social setting (Fouchè, 2002: 109). The researcher begins with a well - defined subject and conducts research to describe it accurately. This type of research design assists the researcher in understanding and observing the occurrence of fetal

alcohol syndrome, which in turn enabled the researcher to present a profile (emotional behaviour) that will serve as a tool or assistance to those working with the child with fetal alcohol syndrome (Hart 1998: 47).

1.6.2 Research approach

Research approach can be described as the strategies of inquiry (De Vos et al 2002: 271). A research approach is necessary to help the researcher structure his study. For this phenomena studied a single approach cannot succeed in encompassing the child with Fetal alcohol syndrome in their full complexity. Cresswell has three models of combinations to gather information (De Vos 2002: 365).

These three models can be listed as follow:

- Two phase model
- Dominant – less – dominant model
- Mixed methodology model

The research will be based on Creswell's Dominant- less –dominant model. This model by Cresswell helped the researcher to understand and observe the child with Fetal alcohol syndrome in a manner that helped the researcher to construct a profile of the child with Fetal alcohol syndrome.

The researcher present the study within a single, dominant paradigm which is the Quantitative component consisting out of the Conner symptom checklist , completed by the teachers who took part in the study, and the less – dominant paradigm which is the Qualitative component of the study consisting out of participating observation of the child with Fetal alcohol syndrome by using gestalt play therapy to help the child with Fetal alcohol syndrome regain emotional balance in his life. This researcher will use Conners' symptom checklist to be completed by the participating teacher (Quantitative) and a small Qualitative component (Gestalt play therapy, participating observation to be completed by some of the participating children) in the data collection phase. The advantage of this approach is that it offers a consistent paradigm in the study and still gathers limited information to probe in detail on aspects of the study (De Vos et al 2002: 366).

By using this model the researcher gathered information from the child with fetal alcohol syndrome, which was diagnosed as a child with Fetal alcohol syndrome by a medical doctor, by means of participating observation and gestalt play therapy which is described as the Qualitative component of the study and the Conner symptom checklist completed by teachers which is described as the Quantitative component, to compile a profile to assist people working with the child with Fetal alcohol syndrome. The reason for choosing this approach is that the children in this study are not able to complete questionnaires by themselves and by using the Qualitative component; the researcher is still able to get valuable information from the child that is important in the creation of a profile of child with fetal alcohol syndrome.

The researcher will show in Table 1.1 how components of the Quantitative and Qualitative approach are used in this study.

Table 1.1 Components of Quantitative and Qualitative approaches used in the study

Quantitative approach (Dominant)	Qualitative approach (less- Dominant)
Purpose is to test if the child with Fetal alcohol syndrome portrait hyperactivity, impulsivity and inattention	Purpose is to construct a detailed descriptions of the Fetal alcohol syndrome child by means of participating observation
Concepts are converted into operational definition; results appear in numeric form and are eventually reported in statistical language	The natural language of the child with Fetal alcohol syndrome is used in order to come to a genuine understanding of their world.
Conner symptom checklist is used to gather information	Play therapy is used to gather information and to teach the child through play activities to deal with

	emotional issues. This was done in a group.
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The quantitative approach is based on positivism and the main goal is to measure the social world objectively and to predict human behaviour. Quantitative study can be defined as inquiry into social or human problems in order to determine whether the predictive generalization is true (Fouche, & Delport 2002: 77). In this study the researcher wants to determine whether the child with Fetal alcohol syndrome portrait behaviour such as hyperactivity and impulsivity. In contrast the qualitative approach in this study is based on antipositivism and is interpretive and holistic in nature. The main goal of the qualitative approach in the study is to understand the child with Fetal alcohol syndrome and to observe his emotional behaviour.

1.6.3 Type of Research

Applied research was used because it will help the researcher to make recommendations or to propose solutions for problems as experienced by people working with the child with Fetal alcohol syndrome (Hart 1998: 46). This type of research was chosen to compose a profile (to propose solutions) to assist / help people working with the child with Fetal alcohol syndrome as well as enabling them to identify the characteristic of the child with Fetal alcohol syndrome.

The research is descriptive of nature and this design will assist the researcher to understand the occurrence of fetal alcohol syndrome, which in turn will enable the researcher to present a profile of emotional behaviour that will serve as a tool to those working with the child with Fetal alcohol syndrome. The researcher is of the opinion that a profile may serve as a tool and / or assistance for people working with the child with Fetal alcohol syndrome. This profile can also benefit and contribute to the helping relationship towards the child with Fetal alcohol syndrome.

1.6.4 Methods of Data collection

The method of data collection in this study is quantitative and qualitative and based on Cresswell dominant – less – dominant model. The quantitative aspect (dominant) is constructed out of a symptom checklist the Conner symptom checklist that focuses on hyperactivity and impulsivity. The reason for using the Conner symptom checklist is that it is standardized and indicates behaviour that the literature review in the child with Attention Deficit Hyperactive Disorder are also being portrait by the child with Fetal alcohol syndrome. This checklist is a comprehensive inclusive list with behavioural components listed as items (see Addendum A). A checklist is a questionnaire

consisting of a series of items. The teacher must indicate which of these items are most applicable to the child behaviour (Delport 2002: 184).

The second component of the data collection is the qualitative (less – dominant) aspect, for this the researcher used participant observation as a method of data collection. Participant observation is used to describe and study the natural setup of the child with Fetal alcohol syndrome. In participant observation the researcher become part of the play therapy sessions, allowing the researcher to fulfill a dual role of data collection and to interpret the data (Strydom 2002: 278). Participating observation explains the natural behaviour of the child with Fetal alcohol syndrome and this finding can contribute to compile the profile. In chapter four a full description of data collection used in the study is given.

In chapter two the researcher conceptualizes the child with Fetal alcohol syndrome and in chapter three the researcher explains Gestalt theory (gestalt play therapy). In Chapter four research methodology and empirical results are discussed and in chapter five guidelines and the profile are discussed. In chapter six the researcher makes recommendations of the study and come to a conclusion.

Chapter Two

Conceptualization: The child with Fetal alcohol syndrome

Keywords in this chapter

- *Fetal alcohol syndrome*
- *Behavioural effects of alcohol*
- *Developmental aspects*

2.1 Introduction

Fetal alcohol syndrome can be described as a birth defect that has its primary effect on the brain. It is caused by prenatal alcohol exposure and is characterized by growth deficiency, specific patterns of facial features as described in the study and some signs of central nervous system dysfunctions (Streissguth 1997: 26).

In this chapter the researcher will focus on main concepts of the study, namely Fetal alcohol syndrome, Attention Deficiency Hyperactive Disorder (as a related condition), Child development and Gestalt Play Therapy

2.2 Understanding the effect of alcohol

Since the first documentation of Fetal alcohol syndrome, literally hundreds of research and articles have been published on the syndrome. Smith & Jones (in Soby 1994:15; Accardo, Blondis, Whitman & Stein 2000:359) first recognized fetal alcohol syndrome in 1973. The reason for this interest level is that Fetal alcohol syndrome is a totally preventable syndrome. Concerns about the possibility of alcohol use causing problems during pregnancy can be traced back into ancient times. In 1834 a report to the British House of Commons indicated that infants born to alcohol mothers had an “imperfect and starved look” (Davies 1994:170).

The probability of having a child with Fetal alcohol syndrome increases with the amount and frequency of alcohol consumed. Intrauterine exposure of the human fetus to alcohol causes a neurotoxic syndrome termed Fetal alcohol syndrome (Ikanomidou, Bittigau, Ishimaru, Wozniak, Koch, Genz, Price, Stefovaska, Horster, Terkova, Dikranian & Olney 2000:1056). Fetal alcohol syndrome refers to a pattern of abnormalities observed in children born to mothers using alcohol excessively during pregnancy. It is caused by maternal alcohol abuse during pregnancy and is a birth defect. Prenatal alcohol affects the neural circuitry of the brain, resulting in an imbalance in both neurochemical and electrophysiological functions (Zevenbergen & Ferraro 2001: 127). Thus alcohol delivered prenatally to the fetus causes brain damage of varying magnitude.

According to Streissguth 1997: 4; Viljoen 1997: 3; Russell 1991: 207; Little, Snell, Rosenfeld, Gilstrap & Gant 1990: 1142; SA medical research council 2002: 5) children suffering from Fetal alcohol syndrome would suffer from growth retardation, central nervous system defects, moderate mental retardation, behavioral disturbances and distinctive facial features.

Epidemiological studies undertaken in rural setting in the Western Province (South Africa) in 1997 and 1999 have found rates of forty-eight out of every thousand and sixty four out of every thousand fetal alcohol syndrome cases are children entering the school system in South Africa. Thus the prevalence of Fetal alcohol syndrome among school – entry children of South – African population is the highest in the world (Krause & Viljoen 2001: 450). In the

wineland region of South Africa nearly one in every fifteen children suffers from Fetal alcohol syndrome, that is fifty two times the rate in the United States (Glasser 2002: 26).

The stage of fetal development during which exposure to drugs occurs determines which system is affected. Both developing and existing structures can be disrupted by teratogens (alcohol). Few developing systems escape damage when the mother drinks alcohol throughout the pregnancy. From about the second to eight week, major structural malformations to the brain and vital organs results. According to Soby (1994: 14) and Streissguth (1997: 56 – 60) alcohol exposure during the third week has the most harmful effect on the central nervous system and the heart. Driscoll, Streissguth & Riley (1990: 233) demonstrated the remarkable similarities in animal behavioral, teratology literature and the human studies of children who were prenatally exposed to alcohol.

Experiments with laboratory animals have shown conclusively that alcohol can cause birth defects in almost any specie. Many behavioral effects have been demonstrated in both children and animals effected by prenatal alcohol exposure. This will be listed in Table 2.1 (Streissguth 1997: 65).

Table 2.1 Behavioural effects in children and animals effected by prenatal alcohol exposure

Humans	Animals
<ul style="list-style-type: none"> •Hyperactivity •Attention deficits •Lack of inhibition •Learning disabilities •Feeding difficulty •Gait abnormalities •Poor fine and gross motor skills •Development delays •Hearing abnormalities •Poor state regulation 	<ul style="list-style-type: none"> •Increased activity and reactivity •Decreased attention •Inhibition deficits •Impaired associative learning •Feeding difficulties •Altered gait •Poor coordination •Development delays •Altered auditory evoked potentials •Poor state regulation

From the above mentioned it is clear that alcohol has a negative effect on both children and animals prenatally exposed to alcohol. Drawn from research on these negative effects of alcohol, there are six main aspects on teratogenic effects of alcohol (Streissguth 1997: 49). These aspects are indicated in table 2.2.

Table 2.2 Aspects of the teratogenic effects of alcohol

1. Alcohol is a teratogenic drug	<p>□Animal research have demonstrated that alcohol disrupt the developing embryo and the fetus</p>
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<p>2.Dose, timing and pattern of exposure modify the prenatal affects of alcohol</p>	<p>□Research has demonstrated that teratogenic effects of alcohol are not limited to chronic exposure. Moderate and episodic exposure produce effects as do early and late in gestation</p>
<p>3.Individual differences in the child and mother modify the effect of prenatal exposure in the individual</p>	<p>□Alcohol causes a variety of central nervous system effects in offspring that are manifest at various ages. Alcohol causes the damage, genes modify the effect</p>
<p>4.Brain damage caused from prenatal alcohol can occur without accompanying physical manifestations and from lower doses and frequency of exposure</p>	<p>□Children with Fetal alcohol syndrome are not the only ones damaged by prenatal alcohol. Children with Fetal alcohol effects can have brain damage caused by alcohol</p>
<p>5.Brain behavior relationships have been well established in animal studies</p>	<p>□Disrupted brain development caused by prenatal alcohol can cause aberrant behaviour in the individual. Prenatal alcohol can cause hyperactivity, impulsivity, difficult learning from</p>

	<p>experience and perseverative problem – solving approaches. Many of the bizarre behaviours that people with Fetal alcohol syndrome show may be caused by their brain damage. This has implications on their daily lives and their social interactions.</p>
<p>6.The effects of prenatal alcohol exposure last into adulthood</p>	<p>□Aberrant behaviour in children, Can be caused by prenatal exposure to alcohol. A diagnosis of Fetal alcohol syndrome can be an important link to understand the aberrant behaviour .</p>

From the above mentioned it is clear that the teratogenic effects of alcohol have a negative effect on individuals and children suffering from Fetal alcohol syndrome. It is thus important to be specific in the diagnosis of Fetal alcohol syndrome.

2.3 Diagnosis of Fetal alcohol syndrome

Diagnostic information about Fetal alcohol syndrome can help families; teachers and people working with the child with Fetal alcohol syndrome set realistic expectations and build on a network of support. According to

Zevenbergen & Ferraro (2001:124) this information not only helps people to understand the syndrome's challenges but also facilitates appropriate treatment, intervention and planning.

The researcher is of opinion that the advantages of a diagnosis and a profile of Fetal alcohol syndrome can be a catalyst to parents and teachers to:

- Seek additional education and information
- Begin a process of personal recovery and healing for the mother and her family
- Give information to the school and get more help with education.

Fetal alcohol syndrome can be diagnosed by the presence of abnormalities in each of the following three categories (Russell 1991: 207, Zevenbergen & Ferraro 2001: 124).

- Central nervous system damage, hyperactivity, fine and / or gross motor problems, attention deficits, learning disabilities, intellectual and / or cognitive impairment or seizures;
- Prenatal and / or postnatal growth retardation, growth deficiency;
- Specific pattern of minor anomalies that includes a characteristic face, generally defined as short palpebral fissures (eye openings), flat midface, thin upper lip, short upturned nose and long philtrum (ridges between nose and the lips).

Drawn from these abnormalities children with Fetal alcohol syndrome portrait certain characteristics.

Before the researcher discuss the characteristics of Fetal alcohol syndrome it is important to make the reader aware of the following traits that indicate that a child needs to be evaluated for Fetal alcohol syndrome (Streissguth 1997: 10). Fetal alcohol syndrome manifests differently in every developmental stage of the child. In Table 2.3 the developmental stages and important traits that might indicate Fetal alcohol syndrome is stated (Davies 1994:9 – 12). It is important to note that some of these traits can be portrayed by children developing normally, thus the reader must keep in mind that the child with Fetal alcohol syndrome exhibites specific facial characteristics, growth deficiency and damage to the central nervous system. The child with Fetal alcohol syndrome is born with this syndrome and defects associated with this syndrome are noticeable from birth.

Table 2.3 Traits that might indicate Fetal alcohol syndrome

Developmental stage	Traits indicating that a child needs to be evaluated for fetal alcohol syndrome
Infants (0 – two years)	<ul style="list-style-type: none"> •May smell like alcohol at birth •Irritable •Poor sucking ability •Cant tolerate stimulation •Lack of development

Toddlers (two - four years)	<ul style="list-style-type: none"> •Hyperactive •Needs one on one attention •The child has no sense of boundaries •Trouble to learn right from wrong •Wants lots of physical contact •Poor memory •No fear
Preprimary School (four - six years)	<ul style="list-style-type: none"> •Needs one on one attention •Poor coordination and judgment •Gets easily distracted •Slow in reading and writing •Social skills are low and inappropriate •Easily distracted •Poor anger control
Primary School (six - twelve years)	<ul style="list-style-type: none"> •Low self – esteem, due to this they will fall in with the wrong crowd for example steal etc •Need to be accepted •Lack in academically and socially progress •No or little concept between right and wrong

	<ul style="list-style-type: none"> •Lack of fear
High School (twelve - eighteen years)	<ul style="list-style-type: none"> •Low impulse control •Needs a caretaker has low ability to take care of own needs •Gets into trouble

It is important for the reader to remember that some the above mentioned traits can also be found in the behaviour of children who have developed normally, but in the Fetal alcohol syndrome child, these traits are more prominent and problematic. If a child is diagnosed with Fetal alcohol syndrome it is important to be aware of the following characteristics they portrait.

2.4 Characteristics of Fetal Alcohol syndrome

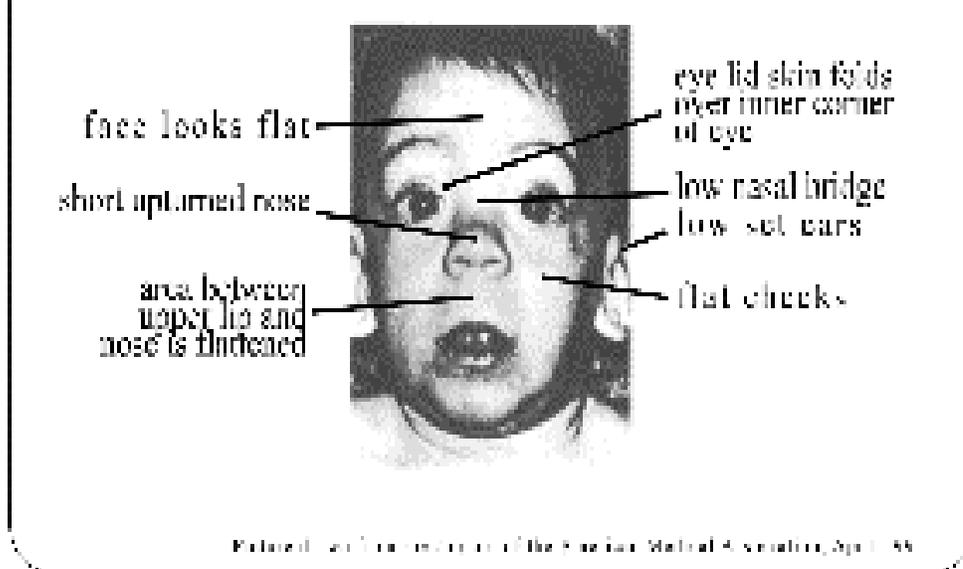
This information is very important to construct a profile of the child with Fetal alcohol syndrome. If individuals are aware of these characteristics it will help them to recognize a child with fetal alcohol syndrome. The researcher will focus on facial and behavioural characteristics.

2.4.1 Facial Characteristics

According to Church (1996: 85 – 111) the facial characteristic of the child with Fetal alcohol syndrome has become a hallmark of this syndrome and is the most distinctive part of the condition. It is important to know that the child with Fetal alcohol syndrome has specific characteristics of which these facial characteristics are one. These facial characteristics of Fetal alcohol syndrome can be listed as follow (Davies 1994: 5 – 10; Streissguth 1997: 23 – 25):

- Small head circumference
- Low set ears
- Short upturned nose
- Sunken / low nasal bridge
- Area between the nose and upper lip is flattened or missing
- Eyelid skin folds over the inner corner of the eye
- Short eye slits
- Flat cheeks
- Face looks flat

Figure 1. Facial characteristics
of Fetal Alcohol Syndrome



These facial characteristics become less visible as children reach adolescence (Spohr, Willms, & Steinhausen 1994: 21, Accardo, Blondis, Whitman, & Stein 2000: 362). Other physical problems that have been identified with Fetal alcohol syndrome are: additional eye anomalies, nearsightedness, under-development of the optic nerve, hearing disorders, skeletal anomalies (e.g. crooked fingers, shortened little finger), limitation in movement of joints (Streissguth 1997: 24).

Growth deficiency does occur with alcohol teratogenesis and has been demonstrated in a large number of studies. Research has demonstrated that growth deficiency is related to alcohol exposure in the second half of pregnancy (Weiner, Morse, & Garrido 1989: 387). As the child with Fetal

alcohol syndrome reach puberty they often gain an unexpected amount of body weight. Further characteristics in this syndrome can be listed as follows.

Table 2.4 Other characteristics in Fetal alcohol syndrome

A: Premature Birth

B: Prenatal and postnatal growth retardation

C: Facial abnormalities

D: Renal abnormalities

F: Respiratory dysfunction

G: Immune system dysfunction

K: Neurological problems

- Mental retardation
- Disorganized play
- Speech and language disorder
- Learning disabilities
- Decreased attention span
- Clumsiness
- Poor eye contact
- Poor hand – eye coordination
- Head and body rocking
- Sleep disturbance
- Hearing impairment and visual impairment

Behaviour

- Insecure attachment patterns
- Irritability in infancy
- Hyperactivity in childhood and conduct disorder in adolescence

2.4.2 Intellectual functioning

Alcohol alters the development of the brain structure at any number of ways. Various studies done on humans with Fetal alcohol syndrome reflect that, ethanol,

- Reduce neuronal numbers in the cerebral cortex and in the cell layer of the cerebellum
- Neuronal migration can be disrupted and
- Drive neurotransmitter levels up and down

The child with Fetal alcohol syndrome has impairment in abstract reasoning, inability to generalize, limited ability to concentrate on a single task, problems with academic achievement, language and attentional difficulties (Soby 1994: 17, Accardo, Blondis, Whitman, & Stein 2000: 363). The IQ mean of the child with Fetal alcohol syndrome is 68 with a range from 83 to below 58 (Streissguth, Randels & Smith 1991: 585). The demands that pupils with Fetal alcohol syndrome presents to teachers, service providers, play therapists and families are unrelenting. The child with Fetal alcohol syndrome has poor memory, limited ability to generalize, sporadic skill mastery and impairment in abstract reasoning. The above-mentioned impairments can lead to variable

degree of learning disabilities and difficulty coping within the school and or learning environment.

Prenatal drug intake may interfere with development of behaviour patterns necessary for normal development. Physiological effects of alcohol exposure may extend into emotional development affecting social relationships and cognitive development (as explain above).

The development of the Fetal alcohol syndrome child, as discussed below, is a very important part of the research as to enable people to understand the difficulties facing these children.

2.5 Development of the Fetal alcohol syndrome child

In this section of the literature review the researcher will explain the development of the child with Fetal alcohol syndrome. The reference framework used in this research is based on Erikson and Piaget's developmental stages and important to remember that cultural diversity can influence this framework. Due to the sample group used, the main focus of this section will be on childhood and early adolescence. Human development can be defined as a progressive series of changes and continuities in a individual that occur in a predictable pattern as the result of an interaction between biological and environmental factors (Salkind 1985:2, Wait, Meyer, Loxton 2003:1).

Recent research suggested that exposure to alcohol during the third trimester (last 3 months of pregnancy) affects fetal growth, intellect and behaviour (Coles 1994: 24).

2.5.1 Newborn and Infancy (0 – 2 years)

It is often difficult to identify Fetal alcohol syndrome in the newborn period because of the lack of development of specific facial features characterised by this syndrome. The newborn with Fetal alcohol syndrome is usually small and below normal length. Babies often display behaviour patterns associated with withdrawal, refer to Table 2.3 (McCreight 1997: 52). During the first week of life infants exposed to high levels of alcohol throughout pregnancy, may show sleeping disorders, excessive arousal states and hyperactive reflexes. These symptoms persist throughout the first month of life but may continue longer. According to Randels, & Streissguth (1992: 3) about 75 percent of infants with Fetal alcohol syndrome are irritable and “jittery”. At this age developmental delays and motor dysfunction become apparent (Gardner 1997: 320).

Infants may show the following behaviours:

- Impulsiveness
- Hyperactive - rolls around a lot in bed
- Short attention span the child cannot play with toy for more than a couple of minutes, loses interest quickly (may differ from child to child)
- Emotionally labile - quick change in emotions (crying to laughter)

2.5.2 Toddlers (2 – 4 years)

Preschoolers with Fetal alcohol syndrome are usually of a small posture and experience development delays, attention deficits and fine motor difficulties. Toddlers with Fetal alcohol syndrome show the following behaviour (Gardner 1997:320).

- Hyperactive
- Overly sensitive to touch and other types of stimulation
- Difficulty making transitions from one activity to another
- Display severe temper tantrums
- Attention deficits
- Talkative

2.5.3 Childhood (6 – 12 years)

The main goal for the child with Fetal alcohol syndrome in this age group 6 – 12 years is to gain a sense of capability or industry rather than developing a sense of inferiority (McCreight 1997: 89). It is also important in this life stage to help the child retain his confidence and have courage to keep trying despite his Fetal alcohol syndrome. If the child doesn't succeed he feels inferior to others and becomes vulnerable to depression and secondary behavioural problems (McCreight 1997: 91).

A major focus in this age group is peer relationships. Children social and academic skills take on a new importance and play are bounded by rules and become complicated (Wait, Meyer, & Loxton 2003: 135). Games provide a

forum for group bonding and the interaction gives children an opportunity to develop interpersonal skills.

The child with Fetal alcohol syndrome has difficulty with unstructured play and games, because they cannot always meet the social expectations of their peers (McCreight 1997: 89). Their peer group may shy away from them because the child with Fetal alcohol syndrome are unpredictable and often in trouble. To a child with Fetal alcohol syndrome this rejection is hurtful, because he doesn't understand the implications of his actions. According to Gardner (1997: 320) in this stage of life the child with Fetal alcohol syndrome are described as hyperactive, impulsive and distractible. This child is diagnosed with Attention Deficit Hyperactive Disorder, because of their high energy level, poor short-term memory and short attention span. Positive characteristics showed by Fetal alcohol syndrome children are being socially engaging, interested in others, talkative and affectionate (Osion, 1994: 14).

Effective communication with the child with Fetal alcohol syndrome, especially instructions, rules and explanations, must be short and simple, because they express themselves in this manner and process information in the way it is given to them (short and simple).

In this life stage the child enters puberty. The child with Fetal alcohol syndrome has an understanding of how the body works and how it is related to sexuality (McCreight 1997: 46).

They have few boundaries and struggle with social cues. The child with Fetal alcohol syndrome, due to varied levels of mental retardation that may occur, are at greater risks of negative forms of exposure such as abuse, substance abuse and sexual abuse i.e. can be easily influenced by other people. The child with Fetal alcohol syndrome has a full range of feelings and emotions despite the fact that they may not always display them (Gardner 1997: 320). Thus the child with Fetal alcohol syndrome may have difficulty expressing complex feelings.

2.5.4 Adolescence (12 – 18 years)

Adolescence is the transition between childhood and early adulthood and in this phase sexual maturation takes place. According to Louw (1994: 212) the main goal of this age (twelve – eighteen) is to learn to associate and identify with the community. To do this successfully the youngster must develop his sense of self in relation to others and learn all the rules of the community in general that will make him more acceptable. However the adolescent with Fetal alcohol syndrome lacks necessary social skills and as a result becomes vulnerable to social isolation (McCreight 1997: 108). Adolescents with Fetal alcohol syndrome have a lack of boundaries, impulse control, inability to link behaviours to consequences and a need for acceptance. Dating often leads to overt sexual behaviour long before the adolescent is emotionally and or intellectually prepared for it. Due to the lack of impulse control and intense need for peer approval the Fetal alcohol syndrome adolescents are highly vulnerable to drug and alcohol abuse (McCreight 1997: 224).

School attendance is an area of severe stress for most adolescents with Fetal alcohol syndrome. Social and academic pressure is too great for adolescents. Adolescents with Fetal alcohol syndrome may experience social, emotional, cognitive and psychosocial needs. The following are difficulties / problems associated with Fetal alcohol syndrome; in the next chapter the researcher will give recommendations on how to deal with difficulties. (Streissguth, et al 1991: 585).

Table 2.5 Difficulties needs associated with Fetal alcohol syndrome

Age	Problems and Concerns
Latency Period Age 6 – eleven years	Easily Influence Difficulty understanding consequences Inappropriate sexual behavior Difficulty separating fantasy from fact Temper tantrums, lying, stealing, disobedience, defiance of authority Delayed physical and cognitive development Hyperactive, impulsivity Poor comprehension of social rules and expectations
Adolescence	Lying, vandalism, stealing, trouble with

Age twelve – seventeen years	<p>the law</p> <p>Faulty logic</p> <p>Egocentricity</p> <p>Difficulty comprehending and / or responding appropriately to other's feelings, needs and desires</p> <p>Impulsivity and low self esteem</p> <p>Aggressive and motivation</p> <p>Unpredictable behaviour</p>
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For further information regarding normal child development, please refer to Wait, Meyer & Loxton. 2003. Lecture notes in Human Development.

McCreight (1997:13) is of the opinion that although these behavioural problems are always present they may go unnoticed until the child enters school. Once the child enters school the learning and behavioural problems becomes apparent as the normal social and academic expectations become. Streissguth, Davies and McCreight have noted the following compilation of behaviour characteristics. According to McCreight (1997: 14) it is important to note that these secondary disabilities are consistent throughout the life of the individual. The secondary disabilities that will be discussed are as follows:

2.6 Behavioural Characteristics

2.6.1 Learning disability

2.6.2 Attention deficiency hyperactive disorder

2.6.3 Speech and Language disorder

2.6.4 Information process deficit

2.6.5 Patterning problems

2.6.1 Learning disability

According to Nevid, Rathus & Greene (1997: 592) learning disability can be defined as a noted deficiency in a specific learning ability, which is remarkable because of the individuals' general intelligence and exposure to learning opportunities. The child with Fetal alcohol syndrome experience learning disabilities in all areas of schoolwork, especially language, arts and mathematics. A child with Fetal alcohol syndrome impaired executive function does not allow any process to take place. Once the child gets started the ability to do the work may be blocked by the child's problem with dyslexia and spatial disorders (McCreight 1997:16).

2.6.2 Attention Deficit Hyperactive disorder as a related condition

Attention Deficit Hyperactive disorder can be defined as a medical diagnosis that is applied to children and adults who are experiencing significant behavioural and cognitive difficulties in important aspects of their lives namely school, personal and relationships (Cooper & Ideus 1996:1).

Neurobehavioral deficits in the child with Fetal alcohol syndrome and related conditions as Attention Deficit Hyperactive disorder are clearly the most disabling concerns.

Research found that 60 percent of subjects aged six – twelve years with Fetal alcohol syndrome reported attention deficit problems. Characteristics seen in both children with Fetal alcohol syndrome and Attention Deficit Hyperactive disorder include trouble-sustaining attention, hyperactivity and impulsivity. Attention problems appear to be a common disability in the child with Fetal alcohol syndrome (Streissguth, & O' Malley 2000:181).

Symptoms of Attention Deficit Hyperactive Disorder can be listed under three broad clusters (Green 1995:41, Cooper & Ideus 1996:2).

- Inattention - refers to errors either in selecting what to attend to or in keeping attention focused for as long as necessary to perform a task.
- Hyperactivity - Hyperactivity relates to excesses in physical movement, especially excesses that have a purposeless poorly directed or driven quality.

- Impulsivity - means that the child has difficulty properly controlling / regulating impulses.

According to the DSM – IV (Kaplan & Sadock 1998: 495) six or more of the following symptoms of inattention, hyperactivity and impulsivity have persisted for at least 6 months to a degree that is maladaptive and inconsistent with developmental level.

Table 2.6 Symptoms of inattention, hyperactivity and impulsivity according to the DSM IV

Inattention

- Often fails to give close attention to details, makes careless mistakes in schoolwork or other activities
- Often has difficulty sustaining attention in tasks / play activities
- Often does not seem to listen when spoken to directly
- Often does not follow through on instructions and fails to finish schoolwork or duties
- Often has difficulty organizing tasks and activities
- Often avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort
- Often loses things necessary for tasks and activities
- Is often easily distracted by extraneous stimuli
- Is often forgetful in daily activities

Hyperactivity

Although the terms hyperactivity and impulsivity imply two distinct problems, their basic characters are so similar, they represent one dimension Attention deficit hyperactive disorder (Cooper, & Ideus 1996, Green, & Chee 1995, Wodrich 2000: 1 – 8). Studies have found that hyperactivity is present in over 70 % of children with Fetal alcohol syndrome (Majewski & Majewski 1988: 839).

- Often fidgets with hands or feet
- Often leaves seat in classroom
- Often runs about or climbs excessively in situations in which it is inappropriate
- Often has difficulty playing or engaging in leisure activities quietly
- Often 'on the go'
- Often talks excessively

Impulsivity

- Often blurts out answers before questions have been completed
- Often has difficulty awaiting turn
- Often interrupts or intrudes on others

The child with Fetal alcohol syndrome demonstrates many of the same behaviours found in children with Attention Deficit Hyperactivity Disorder. The child with Fetal alcohol syndrome also experiences some difficulty with speech and language.

2.6.3 Speech / Language Disorders

Speech and language disorders involve difficulties in understanding and or using language (Nevid, Rathus & Greene 1997: 469). The child with Fetal alcohol syndrome has problems with opposites and speech patterns are consistently wrong. Children don't always outgrow these common grammatical errors shown by all young children.

2.6.4 Information Processing Deficit

Information processing deficit can be described as the problem individuals experience with the storage, retrieval, manipulation and output of information (Nevid, Rathus & Greene 1997: 53). This deficit has three components:

- Inability to translate information into appropriate actions
- Difficulty in perceiving similarities and differences between events
- Failure to generalize information from one situation to another

These disabilities may also manifest in children diagnosed with various other disorders, e.g. communication disorder. This means that although a child with Fetal alcohol syndrome understands a rule for a particular situation and manages to remember it, the child will not be able to perceive when the same rule should be used in similar situations (McCreight 1997: 18).

2.6.5 Patterning Problems

Patterning is used to denote ability to perceive the patterns, on common threads,

ways in which people relate to each other (Grobler 2003: 68). The child with Fetal alcohol syndrome, due to the fact of their underdeveloped social skills, are not always likely to notice or care about the fact. The development of the Fetal alcohol syndrome child is a very important part of the research. The researcher will discuss this.

At this level of the research the researcher explain the development of the fetal alcohol syndrome child and knows that the child do experience hyperactivity and impulsivity and understand the facial characteristics of the child with fetal alcohol syndrome. With this knowledge the researcher can focus on the emotional imbalance the child with fetal alcohol syndrome experience. The next section of the research will help the reader understand gestalt therapy because it is the approach used in the study during the play sessions with the child with Fetal alcohol syndrome. Gestalt therapy will be discussed in the next chapter.

Chapter Three

Gestalt Therapy: Process of Becoming

Keywords in this chapter:

- *Gestalt therapy (introduction)*
 - *Awareness*
 - *Contact boundaries*
 - *Self regulation and*
 - *The gestalt therapist*

3.1 Introduction

In Chapter two a background in the child with Fetal alcohol syndrome was given. It is important for the reader to understand gestalt therapy. By using gestalt therapy the researcher can explain the child with Fetal alcohol syndrome in a holistic manner. According to Carroll & Oaklander in Thompson & Rudolph (2000: 201), Gestalt therapy is a humanistic and process orientated approach. The concern of the therapy is the integrated functioning of all aspects of the child with Fetal alcohol syndrome so that senses, body, emotions and intellect are well coordinated in a creative adjustment. The concept of integration aids the Fetal alcohol syndrome child to live a

systematic lifestyle, meaning that the child is a whole organism whose inner states and behaviour match (Ludick 1995: 73). As mentioned by Perls in Thompson and Rudolph (1992: 113) the main aim of Gestalt therapy is to help the child, in this case the child with Fetal alcohol syndrome to mature, learn acceptable social behaviours and take charge of his life and the central goal of awareness, helping the child with Fetal alcohol syndrome to live in the 'here – and – now'. Gestalt therapy's success is measured by the extent of how the child with Fetal alcohol syndrome will grow in awareness, take responsibility for his action, ability to be independent and to which extent the child can assimilate principles of gestalt into his life (Thompson & Rudolph 1992: 113). In this chapter the researcher will focus on the theoretical concepts of Gestalt theory namely:

- Awareness
- Contact boundaries
- Self –regulation
- Gestalt therapist to set a theoretical framework from where the child with Fetal alcohol syndrome will be assessed

The gestalt therapy as an approach will be integrated in this assessment by using gestalt play therapy as a medium to teach the child with Fetal alcohol syndrome mechanism's to cope with his behaviour he experience. It is important that the reader is aware of the fact that gestalt play therapy is grounded in Gestalt theory and that all the theoretical concepts is manifested in gestalt play therapy. Before the researcher discusses the theoretical

concepts of gestalt therapy a description on gestalt play therapy will be discussed.

3.2 Gestalt play therapy

Today there are an increasing number of children who function in a manner, which we can describe as mentally retarded, or as mentally subnormal (Streissguth 1997: 27). Mentally retarded refers to a generalized impairment or delay in the development of intellectual and adaptive abilities. The IQ of a mentally retarded child is seventy or below (Nevid, Rathus & Greene 1997: 593).

Due to the fact that the child with Fetal alcohol syndrome function within his framework he can be described as subnormal child and are unable to function at a level consistent with the needs of the community.

According to Oaklander (1999:65) healthy uninterrupted development of a child's senses, body, emotions and intellect is the underlying basis for the child's sense of self. A strong sense of self leads to good contact with his environment and the people in it. The goals of gestalt play therapy with the subnormal child are varied but center around attempts to raise the child's level of functioning and to help the child learn to control his behaviour in such a manner that will help him cope in the education / school mainstream. It is thus important to explain gestalt therapy concepts and to define the importance of play in a child's life.

Play can be described as a driving force in human development. According to Schaefer and Reid (2001: 1) play has a key role in infancy and early childhood promoting exploration and mastering, exercising muscles and the mind; and relating to other people. According to Oaklander (1999: 47) the child entering therapy has two basic malfunctions: A faulty sense of self and an inability to make good contact with others. In Chapter two the researcher came to the conclusion that the child with Fetal alcohol syndrome has an inability to make contact with others.

Oaklander compares the process of Gestalt play therapy to a dance where sometimes the counselor leads and other times the child leads. Oaklander (1988: 61 - 62) explains the goal of play therapy to help the child to believe in himself and to help the child to see the world as it really is. According to Oaklander (1996:66) the child has a powerful thrust for life and growth. Contact is a very important concept in Gestalt play therapy. It is having the ability to be completely present in a situation by using ones senses that connect with the environment such as looking, listening and smelling. Being aware of feelings and using the intellect are also part of making contact (Thompson & Rudolph 2000:144). As the child with Fetal alcohol syndrome develops he may show a process of interrupting or constricting contact with the environment. This process can be described as “shuts down his senses”, withhold his expression of feelings and shuts of his mind.

The main goal of Gestalt (play) therapy is to make the child with Fetal alcohol syndrome totally aware of the 'here and now' or present and to integrate it in his life. Thus the goal of therapy is to restore the child's natural functioning and self – regulatory process. Experiencing the contact process leads to integration, choice and changes in the 'here and now' or present (Thompson & Rudolph 2000:145). According to Schoeman & Van der Merwe in Grobler (2003: 100) contact making is a continuous process and includes the following:

3.2.1 Contact making process

•Awareness

The Fetal alcohol syndrome child becomes aware of the need for making contact;

The awareness intensifies and influences his behaviour and thoughts;

The Fetal alcohol syndrome child integrates his total life experience and becomes a unified whole

The child with Fetal alcohol syndrome is motivated to take action

•Action

The Fetal alcohol syndrome child mobilizes his energy and considers alternatives and makes choices. The child then moves forward to fulfillment of needs.

•Experimental contact making

The Fetal alcohol syndrome child develops a sense of self, boundaries and clarifies the content of meaningful material.

•**Making contact**

Interaction takes place between the child with Fetal alcohol syndrome and his environment and exchange of sensory information becomes prominent.

•**Assimilation**

The fetal alcohol syndrome allows new energy sensation to take place freely.

According to Zinker in Grobler (2003: 101) the above mentioned outlines the contact awareness cycle as: withdrawal, sensation, awareness, mobilization of energy, action contact and withdrawal. The child with Fetal alcohol syndrome can now attribute meaning to stimuli and potentials exists for development of new perceptions

According to Axline (1974: 71) play is an important part of a child's world where the child can express himself through this medium. According to Landreth in Thompson, & Rudolph (2000: 120) play is children's symbolic language and provides a way for them to express their experiences and emotions in a natural, self – healing process. Play, as a medium is flexible, non – literal, make believe quality and has the power to enhance normal

development and alleviate abnormal behaviour (Schaefer 1993: 38). According to Albon in Thompson & Rudolph (2000: 89) facilitating play into therapy, powerfully facilitates development even with minimal verbal interactions. Incorporating play into counseling has several other advantages, thus the use of play therapy with children seems to be a helping aid in the therapeutic process.

Working with the child with Fetal alcohol syndrome common emotions / behaviours seen in these children must be taken into consideration. By using play with the fetal alcohol syndrome child will help the child with the imbalance in his life. As mentioned previously, impulsivity, hyperactivity and inattention are common in children with Fetal alcohol syndrome.

Specific techniques for helping children express feeling through play are endless. Oaklander (1998) stated that regardless of what she and the child choose to do the goal is to help the child become aware of himself and his existence in his world. It is important to note that each therapist will use his own style in achieving that balance between directing and guiding the session on the one hand and following the child's lead on the other. The researcher will use gestalt play therapy, but it will change the techniques to suite the Fetal alcohol syndrome child's need. The researcher used play therapy primarily to help the child with unresolved issues in his live and to teach the child.

It is important to know that the child with Fetal alcohol syndrome shows a disrupted development process. Besides the disrupted developmental process the child's sense of self is not fully develop and the goal of using this specific method as mentioned above is to work on the child's sense of self, strengthen contact functions and renew the child's contact with his body feelings, senses and to express himself. The child with fetal alcohol syndrome experience disequilibria, leaving the child without a sense of self due to unfulfilled needs. The researcher will focus on the theoretical concepts of gestalt therapy.

3.3 Theoretical Concepts of Gestalt as a theory

The theoretical concepts of the Gestalt perspective will enable the reader to understand Gestalt therapy and emphasize the importance of a theoretical framework regarding the child with Fetal alcohol syndrome. The key component of this theory is the awareness continuum. All the other concepts of this study are based on and influenced by this continuum (Ludick 1995: 75).

3.3.1 Awareness

According to Clarkson & Mackewin (1993: 44) awareness can be described as the child's capacity to be in touch with his own existence, to note what is happening around or inside him, to connect with the environment, other people and the self. Awareness is the process of thinking, feeling, sensing,

doing and being in contact with full sensory – motor, emotional, cognitive and energetic support (Ludick 1995: 75).

Through awareness the child with Fetal alcohol syndrome is able to identify his most dominant need and make contact with his environment in order to meet his need. According to Schoeman & Van der Merwe (1996: 30) there are three characteristics of awareness that must be maintained. Firstly, awareness must be grounded, motivated and dominated by present need. The child with Fetal alcohol syndrome should be aware of his experience and life space for instance if the child has suppressed angry feelings, though he may not be aware of this suppression, the child finds a way to express this feeling without awareness of anger the child cannot choose a direct healthy form of expression. The child with Fetal alcohol syndrome then finds his own way through hyperactivity and impulsivity to express his feelings. Helping the child become aware of what he needs is the first vital step towards overcoming fragmentation and achieving integration. Secondly the child must accept responsibility with regard to his own situation and behavioural responses and thirdly awareness is always connected to the here and now. The researcher can come to the conclusion that awareness is one of the cornerstones of Gestalt theory. The focus point is that everything is based in the here and now with the child taking responsibility for his behaviour. A second important concept relating with the process of awareness is the contact of “I” boundaries.

3.3.2 Contact boundaries

Healthy organism's is always in contact with the environment, however he requires permeable ego – boundaries between himself and the environment, to ensure that his identity is not lost (Ludick 1995: 80). These boundaries are not fixed or rigid, if these boundaries are fixed they inhibit growth it forces the child with Fetal alcohol syndrome to develop and react in one manner.

Two fundamental characteristics of ego – boundaries are identified and estrangement. Identification can be defined as the process by which the child distinguishes between what is his own and part of him and what is strange and not part of himself. Feelings of cohesion and co – operation exist within boundaries and outside ego – boundaries the child experience the situation as strange (Ludick 1995: 80). If the child has contact without acknowledging and differentiating between ego – boundaries can result in the loss of autonomy within the child and confluence. According to Polster & Polster (1973: 99 – 107) five types of contact boundaries of which cognizance should be taken. This is a prerequisite for making good contact with others and the environment.

- 1.Body: The five senses (seeing, hearing, touching, tasting and smelling) form the essential contact function, which enhance awareness.
- 2.Expressive: The way in which the child express or does not express himself
- 3.Exposure: Uncovering what is hidden
- 4.Familiarity: Identifying factors which prevents the child to explore the unfamiliar

5.Value: If children possess different value systems, to which extend is interaction possible.

If a child with Fetal alcohol syndrome's contact boundaries are impaired the child portrays the manners such as hyperactivity and impulsivity.

As the above mentioned indicates contact boundaries and awareness form an integral part of a child's total functioning. A third important concept is self – regulation.

3.3.3 Self – regulation

With the constriction of senses, body, feelings and intellect the child's boundaries become diffused and his sense of self becomes greatly impaired. According to Oaklander (1999: 67) all growing children struggle constantly for self – identification and skills of self – support. Impairment of the sense of self exacerbates the struggle.

The researcher comes to the conclusion that how the child with Fetal alcohol syndrome makes use of his contact functions is evidence of the relative strengths or weakness he is feeling about his 'self'. If the child is unsure of his boundaries he cannot make contact with anybody else in his environment.

Regulation can take place externally and internally. Self – regulation (internal) is an inherent characteristic of the child, which takes place spontaneously, and primary focuses on satisfying the needs of him (Ludick 1995: 78). External regulation is a spontaneous process of gestalt – forming within the

child, as well as disruption between the child and his environment. Regulation takes place through the process of homeostasis.

According to Perls in Aronstam (1989: 633) homeostasis can be defined as the process by which the organism maintains its equilibrium and is therefore healthy under varying conditions. According to Perls in Oaklander (1999: 5) all life and all behaviour are governed by the process which scientists call homeostasis and which the layman calls adaptation. The homeostatic process is the process by which the organism maintains its equilibrium and it is thus the process by which the organism satisfies its needs. Since its needs are many and each need upsets the equilibrium, the homeostatic process goes on all the time. Through homeostasis the child with Fetal alcohol syndrome is able to identify the psychological and physiological imbalances being experience. When concentration and attention are divided between several events fragmentation may occur (Ludick 1995: 78). These fragmentations refer to the process where the contact function is impaired and are refer to by Perls (1951) as the layers of neurosis. Perls developed a theoretical construct of the five neurotic layers to illustrate how fragmentation and resistance to contact prevents the experience of growth. The five layers of neuroses are as follow:

- Phony layer – this layer is characterized by conflicts that are never solved.
- Phobic layer – The child become aware of his phony games which leads to an awareness of fears that maintain these games.

- Impasse layer – According to Perls in (Grobler 2003: 88) this layer is also called “nothingness”, “emptiness” or “the feeling of being stuck and lost”. It is marked by an attitude, namely avoidance. Resistance is always present in this phase.
- Implosive layer – The child become aware of how he limits himself and he begins to experiment with new behaviour
- Explosive layer – When the child is successful with experimenting with his new behaviour, his able to discover much unused energy that has been tied up in maintaining a phony existence

In order to make a progress through these layers the therapist should observe the body language of the child during the gestalt play therapy. Through the gestalt play therapy used with the child with Fetal alcohol syndrome, the child may be capable to become self – regulating, achieving a sense of unity and integration in his life. The child with Fetal alcohol syndrome may adjust his behaviour successfully to meet his needs and portrait a healthy behaviour that will be evident when the child acts and reacts as a total organism.

3.3.4 The Gestalt therapist

The role of the Gestalt therapist when working with the child with Fetal alcohol syndrome is to create an atmosphere in which the child can discover himself. Direct experiences in Gestalt therapy with the child with Fetal alcohol syndrome is the only successful method of learning. The gestalt (play) therapist has to encourage and assist the child and provides a special place

for the child, which allows the child to discover how to relate to himself (Schoeman & van der Merwe 1996). To work with children the therapist needs to be in touch with her own 'child within'. Being in touch with her 'child within' will help the therapist to understand the feelings of the child. It is important that the therapist has tolerance of ambiguity that will enable the therapist to enter the child's world of experience (Ludick 1995: 101).

According to the researcher the gestalt therapy perspective as discussed, which underwrites the kind of relationship in which children can develop provides a suitable context within which treatment is to take place.

3.4 Conclusion

This chapter provided the reader with a thorough yet practical overview of the gestalt perspective. The gestalt approach has been presented as the theoretic orientation, which will be used in gestalt play therapy to gather and address the behaviour characteristics such as hyperactivity experienced by the child with Fetal alcohol syndrome.

In the next chapter the researcher will explain the research methodology of the study and will discuss the empirical results and demonstrate how gestalt (play) therapy is used in the sessions with the children.

Chapter Four

Research Methodology and Empirical Results

Keywords to this chapter:

- *Connor's symptom checklist*
- *Gestalt play therapy techniques*

4.1 Introduction

This chapter documents the research methodology followed during the study and it will focus on the empirical results. In Chapter one it was outlined that the Conner symptom checklist was suited to obtain information about the child with Fetal alcohol syndrome's behaviour characteristics and that gestalt play therapy was a strategy to facilitate the child to change his behaviour. The methodology for this study was structured around the aims and objectives introduced in Chapter one (Chapter one: 6). The research in this study is two –

fold, to gather information and the utilization of gestalt with the child with Fetal alcohol syndrome. To clarify the research goal it will be stated once again.

The problem formulated by the researcher is that teachers, parents and people who works with the child with Fetal alcohol syndrome has no guide that can serve as a form of assistance for them. The researcher's goal of this study is to formulate a profile that focuses on specific characteristics and emotional awareness by integrating the gestalt helping strategy as a tool that can assisted professionals working with the child with Fetal alcohol syndrome to recognize his emotional imbalance and emotional unawareness. The profile will help teachers and play therapists and other professionals to work successfully with the child with Fetal alcohol syndrome and through Gestalt play therapy facilitate the child to change his behaviour.

The instruments used in this study to help the researcher construct a profile are the Conner's' symptom checklist questionnaire only handed to teachers and gestalt play therapy techniques. The researcher will discuss the measurement instruments used in this study.

4.2 Conner's symptom checklist questionnaire

Checklists are designed to evaluate a wider rage of attributes possessed by people, objects and events. The use of the Conner symptom checklist is normally used to indicate if children experience Attention Deficit Hyperactive disorder. In this study the Conner symptom checklist will be used to indicate if

the child with Fetal alcohol syndrome experiences the same behaviour. By recognising these behavioural characteristics a structured helping strategy will be available and with Gestalt play therapy methods helping this child, the child's holistic functioning will be improved.

The Conner's scale is widely used in school settings. The researcher only included the teachers to complete this questionnaire, due to the fact that the parents of the children in this study have a low level of education and some of them cannot read or write. Teachers are among the most important individuals in a child's life and are in a unique position to observe the behaviour of the child over an extended period of time. Teachers are less biased in their ratings of children than parents and the checklist completed by the teachers is useful in identifying factors as hyperactivity and impulsivity that influence the child's learning and behaviour patterns.

According to Aiken (1996: 12) a checklist such as the Conner scale is a cost effective and reliable method of describing a child, person or event. Answering the eighteen items on the Conner's questionnaire is simply a matter of checking and indicating acceptance of those items pertaining to the subject of the checklist (refer to Addendum A). The teachers make a yes or no decision indicating if the behaviour is problematic and indicates on a scale the severity of this behavioural characteristic. Thus the Conner scale has components of a numerical rating scale. The purpose of this checklist is to rate the child on behavioral criteria, which focuses on inattention, impulsivity and hyperactivity.

4.3 Gestalt Play therapy techniques

For the purpose of this study Gestalt play therapy techniques was used to observe how the child with Fetal alcohol syndrome function in the classroom. In Chapter Two the researcher discussed Gestalt Play therapy as a method of understanding of understanding the child with Fetal alcohol syndrome.

The main goal of the researcher is to observe the children in a playful environment and through play gather information on aspects of emotional functioning.

With the help of these measurements and play therapy techniques the researcher is able to construct a behavioural profile of the child with Fetal alcohol syndrome. In the next section of this Chapter the methodology and empirical results will be discussed with an emphasis on sampling, data collection, data analysis, results and shortcomings in data.

4.4 Methodology and Empirical results

Research activities that were carried out are summarized by means of the data collection cycle below, followed by a brief description of each step.

(a) Locate site and identifying the selection criteria

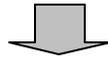
(b) Access to site



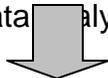
(c) Purposive sampling



(d) Data capture – checklist



(e) Data analysis



(f) Resolving field issues as they arise during the process



4.4.1 Locating site and identifying the selection criteria

The sample used is of a purposive nature. This sample is entirely based on the judgement of the researcher because it is composed out of a Fetal alcohol syndrome population (de Vos 2002: 334). The sample composes of 20 children aged between eight – twelve years (n = 20) from the Stellenbosch

area that have been diagnosed with Fetal alcohol syndrome by a medical doctor. Ten of these children were randomly selected to participate in five Gestalt play therapy sessions.

The researcher got the necessary permission from the parents to work with these children and to gain access to their medical files, so that it can be confirmed that these children were diagnosed with Fetal alcohol syndrome. The parents were informed of the nature and the structure of the study and the parents had to complete a form where they granted the researcher permission to work with the children (refer to Addendum B). To protect the identities of children used in this study, the name of institution they attend will be withheld. The reason for choosing children aged between eight – twelve years, is that it is an easy age group to work with and as mentioned in this document, parents were left out of the study due to illiteracy and in some cases the inability to read and write. The researcher got permission from the institute to work with the children and the researcher worked with one of the teacher's (Occupational Therapist) during the research. Arrangements were made with the institution regarding meetings and the duration of the study.

4.4.2 Data Capture

Before data collection took place all ethical aspects of the research was cleared with the Academic institutions ethical committee. Data capture was conducted in two stages, stage one the completion of the Conner symptom

checklist by teachers and stage two the data capture during gestalt play therapeutic sessions.

4.4.2.1 The completion of the Conner symptom checklist by teachers

The Conner Symptom Checklist was handed to the participating teachers to complete. This was a once off survey. The researcher explained to the teachers how important this questionnaire is to the study and that they must answer the questions as honestly as possible. The researcher was present while this questionnaire was answered.

4.4.2.2 Data capture during gestalt play therapeutic sessions

Arrangements were made to see the children during school hours. Ten of the participating children diagnosed with Fetal alcohol syndrome were randomly assigned to be part of the Gestalt Play therapy sessions. During this stage of data capture the researcher dealt with the objective of identifying the child with Fetal alcohol syndromes responses. The gestalt play therapeutic sessions followed the same format in each of the five sessions and the participants' reactions to the facilitative process was analyzed. These sessions held in an hourly format over a period of five days. This process could therefore easily be replicated and thereby enhanced trustworthiness. To ensure credibility in this qualitative process, different sources of data

capturing and different methods of recording thereof were used. The following strategies were employed to capture and record information.

- Field notes were kept of what had occurred and what had been observed during the sessions. This information was used to compile the guidelines
- The researcher reflected on what had happened in each session, evaluated her own responses and planned for the next session
- The data from the field notes was analyzed to identify traits and characteristics according to the Gestalt view on the child's unique process, in order to make comparisons with the Conner symptom checklist and the literature

4.4.2.3 Intervention applied

The process of Gestalt play therapy as discussed in Chapter three, a theoretical perspective formed the basis for the intervention sessions. In dealing with the objectives of the study namely to compile a profile for helping the child with Fetal alcohol syndrome, the session findings informed clinical reasoning around selection of suitable strategies for determining the profile of the child.

4.4.2.4 The child's process as assessment tool

When referring to the child's personality functioning, Schoeman (1996: 29) refers to use the term "process". The word process implies continual reconfiguration, in this case of ego – function within the context of a constant reshaping of the self – structure, each child has an inherent base - pattern of personality function. Schoeman (2000) proposes that the child's underlying base – pattern or process should be assessed through a projection. During this projection a metaphoric scenario is offered, suited to the child's developmental context. In this scenario the child projects his personality traits, which will be triangulated with the Conner symptom checklist.

4.4.2.5 Handling projections

The data from the Conner Symptom checklist informed the researcher of projective tasks to be implemented from session two onwards. When selecting the projective tasks to be utilized during the sessions the following factors needed consideration. The child limited attention span, can't sit still and complete a projection and the child's limited use of imagination and cognitive functioning. The sessions were adapted to suite the child's process by keeping the child busy with activities. In each of the sessions the play techniques are indicated. Each of these sessions will be discussed. These sessions were held to help the children learn behaviour that is accepted in the social setting.

4.5 Description of sessions

4.5.1 Session One – “Contact making” (Monday)

Goal of session: To establish sensory contact

Technique used: sensory experience – drawing technique

This was the first session with the group of children (age 8 – 12 years). The researcher (play therapist) explained to the children what they would be doing over the following five days. In this session the researcher used awareness exercises as an icebreaker. The goal of this session was to observe the children and to make them feel safe with the group activity. The children were blindfolded and each of them had to use their smell, taste, feel and listening senses and had to draw what they had experience with this exercise (refer to Addendum C). Each child had the opportunity to tell the researcher what he had drawn. The researcher observed that the children couldn't sit still, jumped up and down during the session, had low concentration and some of them were aggressive towards each other and didn't finish the task. This session was ended on a positive note with a game they liked to play. Teacher's completed the questionnaire on the same day as this session.

Planning for the next session: The assessment of the child's process.

4.5.2 Session Two – The assessment of the child's process (Tuesday)

Goal of session: Determining the child's process

Technique used: music

The questionnaires completed by the teachers gave the researcher a basis to work from. From the questionnaires the researcher was aware of the fact that teacher struggled with the fact that these children showed hyperactivity, impulsivity and engaged in behaviour that is problematic in the classroom setup. With this knowledge the researcher could use gestalt play therapy techniques to help the children with their behaviour. In this session different music styles classical, hip – hop and instrumental pieces were used, the children were asked to comment verbally on what emotions they experience while listening to these music pieces. The children had to sit in a circle with their eyes closed and listen to the music. If the children couldn't express themselves through language, they could demonstrate the emotions they feel by acting it out or dancing. Each child was asked to demonstrate or tell the group how the music made him feel.

Feelings that they felt were:

- Anger – “ this music makes me feel cross and I want to hit anything in my way”
- Happiness – “ My hart feels warm and happy, makes me think of the sea and friends”
- Free – “ I feel like a bird in the bush, I can go where I want to”
- Relaxed – “ This music makes me feel sleepy and calm”

The session was ended on a positive note with a game they enjoyed playing, hide and seek and this gave the researcher more time to observe the child in his daily activities. Once again the researcher observed that these children

- Has difficulty in sustaining attention in play activities and in tasks (contact boundaries are broken)
- Does not seem to listen when spoken to (unaware)
- Easily distracted (unaware)
- Runs about in the room (sensory unbalanced)
- Some of them talks excessively (sensory over stimulated)
- Difficulty in awaiting turn (contact boundaries are broken)

From a gestalt view the researcher observed that the child with Fetal alcohol syndrome is unaware, breaks contact boundaries easily and over stimulated and unbalanced.

Planning for next session: Help the child deal with emotions in an appropriate way.

4.5.3 Session Three – Helping the child deal with emotions to become emotional balanced (Wednesday)

Goal of session: to handle aggression in an appropriate way

Technique used: Firecracker technique and expressing anger with crayons



In this session the researcher used techniques to help the Fetal alcohol syndrome child deal with and express his anger in an appropriate manner. It is important to remember that play therapy is used to teach the child and not in a therapeutic way.

Children with Fetal alcohol syndrome are prone to anger outbursts because they easily become frustrated and have little impulse control (Davies 1994:

76). The following techniques teach children with Fetal alcohol syndrome how to understand their anger and deal with it in ways that won't hurt themselves and others.

The technique used to help children deal with their anger is the **Firecracker technique** (Davies 1994: 80). The goal of this exercise is to illustrate to the children that people, just like firecrackers can have a short temper (short fuse) or are slow to anger (long fuse). Because the children struggle to visualize objects the researcher made two firecrackers for each child one with a short fuse and one with a long fuse. Children were asked to identify with one of these firecrackers and to explain to the researcher what makes him explode (angry), Consequences of this type of fuse were discussed.

In the group we discussed appropriate manners for releasing / expressing their anger and demonstrated it with the next technique – **Expressing anger with crayons**. The researcher used unprinted newspaper taped to a table. The researcher encouraged the children to choose a colour crayon for each hand and to scribble over the paper and to release his anger out. The children enjoyed this exercise and were encouraged to release this anger by saying things like “good, get those feelings out”.

After these exercises the researcher recapped what they had learned in this session and ended the session with a piece of music, where the children were free to do what they wanted to do.

Planning for next session: Help the child to release energy

4.5.4 Session Four – Helping the child to release energy to become

emotional balanced (Thursday)

Goal of session: Help the child to release energy

Technique used: Physical exercise – Obstacle course

In this session the main goal was to release energy of the children. As the questionnaires and the direct observation indicated children with Fetal alcohol syndrome are hyperactive.

An obstacle course was used to release energy. The group of children (n=10) was divided into two groups. Each group consisting out of five children had to choose a leader and a name for their group. The obstacle course had the following obstacles to help the children release their energy. Each group member has to complete all the obstacles before the next member can start the obstacle course. It is important to have an adult at each obstacle to remind the child what he must do.

- Obstacle 1: Blowing up a balloon and hanging it on a string. (the group members can help those members that struggle with this task)
- Obstacle 2: To bounce on a Physio ball (big ball Physiotherapist use) from one point to the other
- Obstacle 3: To ride on a tricycle between obstacles
- Obstacle 4: Hitting a ball with a bat
- Obstacle 5: Jumping rope up to the end of the obstacle course and touching the next member's hand to begin his round.

After this exercise each child was rewarded with a sweet and discussed how they felt when doing the exercise. At the end of this session the children were informed that the following session will be the last session.

4.5.5 Session Five – Recap of all the sessions (Friday)

Goal of session: To recap what they learned in all the sessions



This session was used to work through everything they learned during the week. The opportunity was given to the children to express the feelings throughout the the week. This session was ended of with an energy releasing game, hoola hoop competition. Each child had a hoola hoop and the child who hoola hooped the longest was the winner. Music was used during this game.

All of these sessions focused on the 'here and now' and used Gestalt therapy as the basis for these sessions. These sessions were enjoyed by the children and had a positive effect on them.

4.6 Data analysis

Data analysis dealt with the processing of data in accordance with the research objectives, stage by stage in a manner aspiring to establish thematic and chronological meaning.

4.6.1 Stage One: Analysis of the Conner Symptom checklist data

Data is drawn from the Conner symptom checklist (see Addendum B). The purpose of the Conner scale in this study is to indicate if a child with Fetal alcohol syndrome is hyperactive, inattentive and impulsive and if these behaviours are problematic to the teachers. This data helped the researcher to compile a profile of the child with fetal alcohol syndrome. Data is drawn from whether the teachers indicated it as problematic or not.

4.6.2 Presentation of results

Eighteen questions were asked. The researcher will name the eighteen questions and indicate the frequency of the behaviour as indicated by the Conner checklist.

Table 4.1 Frequency of behaviour as indicated by the Conner checklist

Questionnaire	Behaviour shown by how many children	Percentage
1 Fails to give close attention to details or makes careless mistakes in schoolwork or other activities	14	70 percent

2 Has difficulty sustaining attention in tasks or play activities	14	70 percent
3 Does not seem to listen when spoken to directly	15	75 percent
4 Does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace	12	60 percent
5 Has difficulty organizing tasks and activities	10	50 percent
6 Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort	7	35 percent
7 Loses things necessary for tasks or activities	5	25 percent
8 Is easily distracted by extraneous stimuli	17	85 percent
9 Forgetful in daily activities	11	55 percent
10 Fidgets with hands or feet or squirms in seat	11	55 percent
11 Leaves seat in classroom or in other situations in which remaining seated is expected	9	45 percent
12 Runs about or climbs	12	60 percent

excessively in situations in which it is inappropriate		
13 Has difficulty playing or engaging in leisure activities quietly	10	50 percent
14 Is “on the go” or acts as if “driven by a motor”	10	50 percent
15 Talks excessively	14	70 percent
16 Blurts out answers before questions have been completed	9	45 percent
17 Has difficulty awaiting turn	10	50 percent
18 Interrupts or intrudes on others	9	45 percent

This data is drawn in the following graph to show the frequency per question.

The graph can be drawn from the Conner symptom checklist. This graph is constructed from the results from the Conner checklist that can be seen as a behaviour portrait by the fetal alcohol syndrome children in this study. Each 'yes' answer indicated if the behaviour was problematic scored 1 point and a 'no' answer score 0.

The sample size is $n = 20$ children and the following behaviours were seen as problematic. Seventeen children out of the sample group ($n = 20$), 85 percent, are easily distracted by extraneous stimuli (Question 8). Fifteen children out of the sample group ($n = 20$), 75 percent, do not seem to listen when spoken to directly (question 3). 70 percent (fourteen children out of the sample group, $n = 20$), fails to give close attention to details or makes careless mistakes in school work or other activities (question 1), has difficulty sustaining attention in tasks or play activities (question 2) and talks excessively (question 15). 60 percent (twelve children) of the sample group do not follow through on instructions and fails to finish schoolwork (question 4) and runs about or climbs excessively in situations in which it is inappropriate (question 12). 55 percent of the sample group are forgetful in daily activities (question 9) and fidgets with hands or feet or squirms in seat (question 10). 50 percent of the sample has difficulty organizing tasks and activities (question 5), has difficulty playing or engaging in leisure activities quietly (question 13), is on the go (question 14) and has difficulty awaiting his turn (question 17).

Only 45 percent (nine children) leaves their seat in the classroom or in other situations in which remaining seated is expected and blurts out answers

before questions have been completed (question 16). Only 35 percent (seven children) avoids, dislikes or is reluctant to engage in tasks that require mental effort and 25 percent loses things necessary for tasks or activities.

4.6.3 Stage Two: Analysis of the Gestalt intervention sessions

The analysis of the sessions was done by means of completing an assessment for each child regarding his process. From this form specific characteristics were identified and listed as subcategories. A comparison between this subcategories and the Conner symptom checklist was drawn to determine the profile. The assessment form that was used for each child is as follow.

Table 4.2 Assessment form

1	Name of client	
2	Goal of session	<ul style="list-style-type: none"> • •
3	Technique used during session	<ul style="list-style-type: none"> • •
4	The child's reaction on the play therapy used in the session	
5	Temper / State of mind	

6	Willingness to participate	
7	Spontaneity	
8	Behaviour characteristics according to the Conner symptom checklist <ul style="list-style-type: none">•is the child easily distracted•does the child fail to give attention to details•has difficulty sustaining attention•Talks excessively•Can't sit still during play therapy sessions•Is on the go the all the time General behaviour characteristics shown during play therapy session	
9	General findings	
10	Planning for next session	
11	Goals and aims of next session	

In the play therapy sessions the researcher experienced that the children couldn't sit still, jumped up during the session, had low concentration and some of them were aggressive towards each other, didn't finish the task and has difficulty in sustaining attention in play activities and in tasks. In gestalt terms the researcher can say that the child is unaware, sensory over stimulated and that contact boundaries are broken easily. The following behaviour was portrayed by the children during sessions.

- Does not seem to listen when spoken to
- Easily distracted
- Runs about in the room
- Some of them talks excessively
- Difficulty in awaiting turn

4.7 Trustworthiness and Rigour

In qualitative research the truth-value is ensured through different sources of data around the same issue. To ensure trustworthiness in this study the guidelines set in De Vos (1998) for a case study was followed. Rigour was enhanced through credibility, transferability, consistency and neutrality.

4.7.1 Credibility

Confidence in the truth of the findings was enhanced as follows: The truth - value of the stage one assessment was ensured by using a standardized

procedure. The Conner symptom checklist is an updated procedure and is generally used by professionals to determine behavioural characteristics.

4.7.2 Repetitive field entry

Five sessions were held in stage two over a period of five days adhering to the same procedural guidelines – stepwise replication.

4.7.3 Triangulation

Crosschecking of data required the use of three different sources to verify the data. Triangulation was achieved through the Conner symptom checklist assessment, the Gestalt projective assessment and through literature research on Fetal alcohol syndrome and gestalt personality formation.

4.7.4 Applicability / Transferability

Findings can be applied to many contexts to where professionals work with the Fetal alcohol syndrome child. It was pertinent to ensure that the selection criteria accommodated characteristics of Fetal alcohol syndrome.

4.7.5 Neutrality

Establishing personal biases upfront by rigorously adhering to the methodology and using strategies, which can be easily replicated, enhanced the degree of objectiveness, which was adhered during the research process.

4.8 Conclusion

The quality of the data is very relevant to the study and reliability of the checklist is good. A shortcoming of the data collected is that parents could not partake in the study due to their incompetence and that the teachers didn't indicate other behavioural characteristics they experienced with the child as the researcher requested them to do.

From this data interpretation the researcher can come to the conclusion that Fetal alcohol syndrome children portrait behavioural problems such as hyperactivity, inattentional and impulsivity. In chapter five the profile will be drawn to give guidelines for the professionals working with the Fetal alcohol syndrome child.

Chapter Five

Profile and guidelines for professionals working with the child with Fetal alcohol syndrome

Keywords in this chapter:

- *A profile on the child with Fetal alcohol syndrome*
- *Guidelines for professionals*

5.1 Introduction

Findings represented in Chapter four relate to a general set of characteristics for children with Fetal alcohol syndrome, as well as to findings pertaining to the explication of the Gestalt process of the child, which was used to assess the child's process. From the symptom checklist used in this study the researcher can construct the following profile for the child with Fetal alcohol syndrome

5.2 Conner Profile constructed from the study

- The Fetal alcohol syndrome child is easily distracted by extraneous stimuli
- The Fetal alcohol syndrome child does not seem to listen when spoken to directly
- The Fetal alcohol syndrome child fails to give close attention to details / makes careless mistakes in schoolwork
- The Fetal alcohol syndrome child talks excessively
- The Fetal alcohol syndrome child does not follow through on instructions and fails to finish schoolwork
- The Fetal alcohol syndrome child runs about / climbs excessively
- The Fetal alcohol syndrome child fidgets with hands / feet/ squirms in seat

5.2.1 The school setting

Drawn from these behaviours, the Fetal alcohol syndrome child shows hyperactive, impulsive and inattentive behaviour and this may lead to that

teachers often struggle to work effectively with Fetal alcohol syndrome children.

Teachers experience these behaviours as problematic. The school is most advantageously situated to influence the lives of children with Fetal alcohol syndrome. The primary challenge that these children with Fetal alcohol syndrome present at school is their disruptive, hyperactive and impulsive behaviour. Noticing this behaviour profile of Fetal alcohol syndrome children helps individuals to understand and interpret the behaviours Fetal alcohol syndrome children portrait.

5.2.2 The Gestalt process assessment profile

Drawn from the play therapy sessions and the assessments forms completed for each child the Fetal alcohol syndrome child portrait hyperactivity, impulsivity, unawareness and emotional imbalance. Gestalt play therapy facilitated the child to cope with his emotional behaviour.

5.2.3 Conclusion

To assist individuals (especially teachers) working with the fetal alcohol syndrome child this study provides guidelines for handling these children. Teachers who might feel overwhelmed that they have to worry about the child with Fetal alcohol syndrome in their classroom should consider that they are

already spending lots of time and energy on these children without any satisfactory results. It is important to start in the preschool setting working and implementing some of the strategies (as mentioned in the guidelines) with children and parents. These guidelines are useful for better understanding and working with the child with Fetal alcohol syndrome, but should never replace the value of responding to individuals on their own particular needs, strengths and weaknesses.

5.3 Non - academic guidelines for professionals working with the Fetal alcohol syndrome child between the ages eight to twelve years

- 1.The Fetal alcohol syndrome child has difficulty with abstract concepts – keep instructions short and to the point
- 2.To help the child understand use concrete examples (use songs to learn them important concepts). This does not only make learning more fun, but helps the child to cope in the classroom
- 3.To learn the child new skills break it down into small segments. It is important to keep these children actively involved in the learning process, ask the child what he is learning and to show you as teacher what he learned
- 4.Stick to a routine and structure in activities. This will help the child through the school day
- 5.Between the ages eight – twelve, the Fetal alcohol syndrome child becomes alienated from his peer groups because of poor social skills.

Help the child to engage in activities in which he can succeed in and make him feel part of a group (use classroom activities)

6. Show the child how his behaviour affects others at school or at home and make him take responsibility for his behaviour

7. Aggressive behaviour can be problematic. Use play therapy techniques so that the child can express his anger. It is important that the child learn to express his anger in an appropriate way. Techniques that the teacher can use are

- Boxing gloves and boxing sack
- Express his / her anger by drawing

It is important to work with the child through his aggression. Use a play therapist to handle this aspect

8. Use positive communication styles

9. Review basics that is learn in class

10. Place the child near to the teacher, away from distractions

11. Alternate activities in the class, involving movement

12. Make sure the child know that help is available with school work

13. Keep the child's motor skills / development in mind, so that you as the teacher can choose appropriate tasks and set realistic goals

14. Be sympathetic

15. Encourage the child to verbalize needs

16. Look at the child's nonverbal communication – in order to help defuse situations

17. The child with Fetal alcohol syndrome needs more help in maintaining emotional control because of his problems with impulsivity. The child

with Fetal alcohol syndrome will benefit from a calm and structured setting

18. Provide a limited number of toys in the classroom to avoid this child from feeling frustrated and confused
19. Avoid hyper stimulation, because these children are hyperactive
20. Encourage the child
21. Guide the child, let him understand what is expected from him
22. Coordinate with parents / caregivers, help the parents and caregivers understand Fetal alcohol syndrome and what their role is in the child's life
23. Give the child responsibility – as much as each individual can handle
let the child open and close the windows of the classroom
24. Establish clear and consistent rules
25. Teach functional and social skills in class

Children with Fetal alcohol syndrome experience hyperactive and impulsive behaviour; these guidelines can be successfully used with these children in a school setting. In a classroom environment where a teacher teaches systematically and monitors organizational and time management, Children with Fetal alcohol syndrome have a chance to succeed. By using the following guidelines teachers can guide these children to use simple methods that can enhance their concentration, decrease their frustration and increase their patience (Lazear 1991: 25).

5.4 Guidelines for awareness of the Fetal alcohol syndrome child in the classroom

1. Get whole – body involvement. Include all sensory channels, this increase the child's level of communication
2. Keep his hands busy. Use drawing and building activities, this will keep the child's attention focused
3. Allow for postures other than sitting. Create opportunities for the child to work while standing up. This will help with their concentration. Dunn and Dunn (1992: 68) mentioned that standing up, pacing around, chewing gum, fiddling with a rubber band and pointing at words as they read can act to engage attention.
4. Provide strong visual input
 - Teach by showing rather by telling
 - Use maps and visual aids to demonstrate and to explain
 - Write keywords on overhead
5. Use of colour can make information easier to remember
6. Use visual language when speaking
7. Create mental pictures – this enhance both concentration and recalling
8. Use colour coded files in classroom, this will improve the child's organization skills
9. Establish a structured classroom environment, this will help the Fetal alcohol syndrome child with his attentional and hyperactivity in schoolwork
10. Build a team spirit within the classroom

To help the child with his hyperactivity use the following guidelines:

(Sensory Integration)

- 11.Exercise before class – make this interesting for the child, use a game they enjoy playing
- 12.Use movement as a reward. If a child is still and quiet for a period of time, reward the child with an activity to do in the class
- 13.Rotate active periods with inactive periods
- 14.Use music in the classroom, this will have a calming effect on the child. Make this a fun activity. This will make the child less impulsive and better focused
- 15.Allow chewing gum, this might be a problem in the school setting, but studies have found that if the child's mouth is moving there is less talking and body movement. Maybe this can be used as a reward.
- 16.Use brainstorming – using techniques to innovate ways of expelling energy
- 17.Be a coach to the child

Some play therapy techniques can be used to release energy (hyperactivity) and to modify behaviour of the Fetal alcohol syndrome child (Davis 1994: 86). These games such as bats and balloons are enjoyable to the child with Fetal alcohol syndrome.

5.5 Techniques for releasing energy

- Bats and Balloons:** (Plastic bats and one balloon)

This technique helps the child to release energy and to get the child talking. Talk to the child while playing ask him how he is feeling now and tell the child that he is allowed to take his energy or emotions out on the balloon. It is important to work with the child. Encourage the child to hit the balloon. Discuss with the child how energy can be released in a positive way. This technique helps the child to work through his anger in a non – disruptive way.

- The trampoline**

This technique will help the child with Fetal alcohol syndrome to release some energy. It is important to discuss with the child what the energy he is experiencing is about. Remember to encourage the child to release his energy.

- Squeeze Toy** (you will need a balloon, flour 1/3 per child, measuring cup, funnel and a spoon)

This is an enjoyable exercise for the child. Each child makes their own squeeze toy and can be used to release energy / agitation. Discuss with the child when this toy will come in handy.

5.6 Techniques for behaviour modification

The child with Fetal alcohol syndrome can become easily frustrated and can lead to an outburst in class. Have a place like a special corner outside the classroom where the child can cool down. Use items such as pillows, blankets, books, teddy bears, music etc in this special corner. Encourage the

child to calm down. It is important that the child has someone (play therapist) to talk to, once he is under control.

•**Sticker board:** (you will need a tag board, colourful stickers)

The child with Fetal alcohol syndrome responds well to this technique. Don't list too much goals on the board. Remember to keep the child's cognitive development in mind. Acknowledge good behaviour with a sticker on the board. This will encourage the child to portrait good behaviour.

Example of a sticker board

Day	Did homework	Listened in class	Was quiet and still in class	Didn't move around in class
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				

These techniques empower the child and assist the teacher in a positive way. It is important that teachers see this as guidelines to assist them in working with the child with Fetal alcohol syndrome.

Within the privacy of each classroom the teacher can use these guidelines as he sees fit. Teachers have the power to create a structured environment and to adjust their teaching techniques so that the child with Fetal alcohol syndrome can stay actively engaged in learning. By taking control teachers can create an atmosphere where every class member feels totally confident to try and that it is possible to succeed

6. Conclusion

These techniques empower the child and assist the teacher in a positive way. It is important that teachers see this as guidelines to assist them in working with the child with Fetal alcohol syndrome.

Within the privacy of each classroom the teacher use these guidelines as he sees fit. Teachers have the power to create a structured environment and to adjust their teaching techniques so that the child with Fetal alcohol syndrome can stay actively engaged in learning. By taking control teachers can create an atmosphere where every class member feels totally confident to try and that is possible to succeed.

Chapter Six

Conclusion and Recommendations

Keywords in this chapter:

- *Limitations of the research methodology*
- *Significance of the results*
- *Other Recommendations*

6.1 Introduction

This study illustrates a profile of a group of children suffering from Fetal alcohol syndrome. The case data enlightens play therapist and educators on how the profile can be utilized in guidelines.

Before it can be concluded whether the goals, objectives and research question was answered, it is necessary to identify the limitations and strengths of this study in relation to Chapter one.

6.2 Limitations of the research methodology

The major limitation of the research methodology is that the results of a relatively small sample case cannot readily be generalized. Acknowledging this as a shortcoming, it is the researcher's opinion that this study is offering a starting point to understand the world of the child with Fetal alcohol syndrome. The important of clearly defining the roles of the researcher and therapist is emphasized by Strydom in De Vos (1998) as it can be difficult for the same person to represent both roles objectively. When establishing the researcher's bias for this study it was clear that this aspect was handled with circumspection. By adhering strictly to the methodology it was attempted to link theory and practice in ways, which enslaved a high degree of neutrality.

6.3 Considerations on how representative the sample was of children with Fetal alcohol syndrome

The sample used in this study was small, but representative of Fetal alcohol syndrome because a medical practitioner diagnosed all the participating children in the study as children with Fetal alcohol syndrome. The sample group is all children from the Western Cape area but did not include other provinces due to financial and time limits. In a sense this study is representative of Fetal alcohol syndrome but not representative of the South African population of Fetal alcohol syndrome, due to the fact that other provinces didn't form part of this research study. This research can be seen as a starting point in research of Fetal alcohol syndrome children from other provinces and countries.

6.4 Advantages of the Study

The main advantages of this study is that it can make a contribution to all children suffering from Fetal alcohol syndrome and assist individuals working with Fetal alcohol syndrome children. Other advantages can be listed as follow:

- This study will help individuals to better understand the child with Fetal alcohol syndrome
- This study can be the stepping stone for further indept research on children with Fetal alcohol syndrome

- The guidelines given in this study will assist teachers in the classroom to help the child with Fetal alcohol syndrome cope in the classroom environment

6.5 Recommendations for future research

To further help the Fetal alcohol syndrome child in the educational mainstream, a study must be conducted on if the merits of a curriculum is put in place for children diagnosed with Fetal alcohol syndrome; will this curriculum help the child with Fetal alcohol syndrome to complete his education. Secondly a questionnaire must be develop to identify women at risk of having an alcohol – exposed pregnancy to prevent Fetal alcohol syndrome in children.

6.6 Reflection on the research question

In this study there wasn't a specific research question but the researcher wanted to identify if the fetal alcohol syndrome child portrait characteristics such as hyperactivity and impulsivity. As proved in the study these characteristics are portrait by the child with Fetal alcohol syndrome.

6.7 Reflections on the goal and objectives of the study

The main goal of this research was to formulate a profile that focuses on specific characteristics of the child with fetal alcohol syndrome, focusing on his emotional awareness by integrating the gestalt helping strategy as a tool that can assist play therapists, parents and teachers working with the child with fetal alcohol syndrome to recognize emotional imbalance and emotional unawareness. This goal was reached by the following objectives that was met by the researcher

- A literature review by means of descriptive research was conducted to help the researcher understand the functioning and characteristics of the child with Fetal alcohol syndrome
- The child with Fetal alcohol syndrome in the Western Cap was identified by means of the research selection procedures and the Conner symptom checklist to indicate if the child with Fetal alcohol syndrome portrait hyperactivity, impulsivity and inattention
- A profile of children with fetal alcohol syndrome by means of a standardized symptom checklist and gestalt play therapy was described
- Play therapy was used as a method to gather information and to learn the child how to handle his behaviour appropriate
- A profile within the gestalt to be a guidance to people in contact with the child with fetal alcohol syndrome was conducted by means of integrating all relevant information

6.8 Conclusion

Although Fetal alcohol syndrome has been around for decades the need of children with Fetal alcohol syndrome are now only being addressed. As discussed in the research Fetal alcohol syndrome is caused by maternal alcohol use during pregnancy.

This study constructed a profile of the child with Fetal alcohol syndrome to enable people like teachers working with the Fetal alcohol syndrome child to better understand the characteristics the Fetal alcohol syndrome child portrait, which will support and assist them in their classrooms and working environment. Descriptive research and a dominant (Quantitative) – less dominant (Qualitative) research approach were used in this study. Twenty children diagnosed with Fetal alcohol syndrome between the ages eight - twelve years were used in the study. Gestalt therapy was used as a frame of reference for the research. During the research the researcher could observe the Fetal alcohol syndrome child and teach the child with Fetal alcohol syndrome more acceptable behaviours in social settings. The findings of this study indicated that children with Fetal alcohol syndrome do suffer from Hyperactivity, impulsivity and inattentional behaviour. The characteristics as mentioned above are experienced as problematic in the school – environment and teachers struggle to reach the child with Fetal alcohol syndrome. As discussed throughout the document, guidelines are provided for individuals working with Fetal alcohol syndrome children. These guidelines will help the teacher to better understand the child with Fetal alcohol syndrome and it will help the child to grow in himself and learn to take responsibility for his

behaviours and to learn more sociable acceptable behaviours. Teachers and children who formed part of this research seemed to have benefited from the study and its findings.

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Addendum A: Conner symptom checklist

Addendum B: Letter to parents

**Addendum C: Drawing of the child from the
first gestalt play therapy session**

