GUIDELINES FOR ALTERNATIVE CAREGIVERS TO ENHANCE ATTACHMENT WITH THE TRAUMATISED CHILD

By

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I hereby declare that **GUIDELINES FOR ALTERNATIVE CAREGIVERS TO ENHANCE ATTACHMENT WITH THE TRAUMATISED CHILD** is my own work and that all references used or quoted were indicated and acknowledged.

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SIGNATURE DATE

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“ I can do everything through Him who gives me strength.”

ABSTRACT

This thesis focuses on the development of Gestalt guidelines for alternative caregivers to enhance attachment with the traumatised child. The researcher made use of the intervention research process, consisting of six phases. For the purpose of this study of limited scope, the intervention research process was completed up to step one of the fourth phase. The target group in this study was alternative caregivers of traumatised children where attachment difficulties existed. 'Alternative caregivers' refers to people who provide care to these children, either on a voluntary basis or professionally. Focus groups, field notes and observation were used as data collection method, and Creswell's spiral was used to analyse data. Not all aspects regarding attachment were covered in this study and only relevant Gestalt principles were discussed. Gestalt guidelines with an observational system were finally developed. The views of the respondents, those of experts and a literature review were incorporated into the guidelines, as well as some functional elements of existing treatments.

KEY TERMS

Gestalt approach

Caring

Enhancing attachment

Traumatised child

Child in care

Secure and insecure attachment

Alternative care

Faith is to believe what you cannot see. The reward is to see what you believed.

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CHAPTER 1

PROBLEM ANALYSIS AND PROJECT PLANNING

1.1 INTRODUCTION

With this study, the researcher seeks to assist the alternative caregiver in enhancing the attachment relationship with the traumatised child by means of the development of guidelines from a Gestalt perspective. For the purpose of this study, the traumatised child refers to the child in care who, due to abuse and neglect at the hands of his* parents, no longer lives with his biological family and/ or has experienced a series of moves through the care system (Gray, 2002: 111). The alternative caregiver is the nonbiological parent, for example foster carer or alternative family member who is deemed appropriate to look after the needs of the child (The American Heritage Dictionary of the English Language).

The researcher has experienced the value of attachment work with adopted children and their new parents and has found that alternative caregivers themselves felt the need to enhance the attachment with the child in their care. There is some evidence that attachment helps to calm some of the overaroused parts of children's brains, which in turn helps them with trauma (Gray, 2002: 116). The child in care who has suffered trauma in their birth placement, would therefore benefit from an attachment relationship with the nonbiological caregiver. Gray (2002: 116) states that even though children are not as responsive after having been traumatised, attachment work still need to be done before trauma work.

Fahlberg(1999: 14) describes attachment as "… an affectionate bond between

* When "he," "him" or "his" instead of "he/she," "him/her" or " his/her" are being used in this study, the intention is by no means to be gender discriminatory, but simply to avoid a clumsy way of writing.

two individuals that endures through space and time and serves to join them emotionally." A strong attachment to a parent allows children to develop both trust for others and selfreliance. It influences both physical and intellectual development, as well as forming the foundation for psychological development. It also becomes the prototype for subsequent interpersonal relationships. Further positive effects of attachment are increasing feelings of selfworth, logical thinking, overcoming common fears and worries, developing social emotions, coping better with stress and frustration and developing a conscience (Fahlberg, 1999: 14).

Many children who enter alternative care are in jeopardy of losing some or all of these strengths. According to Fahlberg (1999: 15), studies of children raised in institutions have shown that adequate physical care is not enough to lead to the development of a physically and psychologically healthy child with optimal intellectual functioning. For normal development to occur, the child needs a primary attachment object, who'll respond to the child's needs and initiates positive activities with the child.

Unfortunately, many children in alternative care have moved from one family to another, never having experienced the continuity in relationships that enhance selfesteem and identity formation. Interrupted relationships have traumatic effects on the children and few receive adequate help in resolving the grief they experience when separated from birth and other families. Unresolved separations then interfere with their formation of new attachments (Fahlberg, 1999: 17).

According to Kagan (2004: 17–18), children could have either attachment difficulties or an attachment disorder. Children who are diagnosed with an attachment disorder, require intense therapeutic treatment over an extensive period of time. For the purpose of this study, the researcher only focused on children with attachment

difficulties. Attachment and attachment difficulties are discussed more in depth in Chapter 3.

Gestalt therapy is a phenomenological-existential therapy founded by Fritz and Laura Perls (Yontef, 1993: 123). Underlying the Gestalt phenomenological perspective is field theory. The field is a whole in which the parts are in immediate relationship and responsive to each other and no part is uninfluenced by what goes on elsewhere in the field (Yontef, 1993: 125). It is the researcher's opinion therefore, that the Gestalt approach would be most suitable for the development of guidelines to enhance the attachment between the child and alternative caregiver since the Gestalt approach and principles address the individual as a whole, including his interactions with others in the environment.

1.2 MOTIVATION FOR THE CHOICE OF SUBJECT

The researcher attended a course on the role that early attachments play in the traumatised child's later life where the child is placed in alternative care. Through the attendance of this course and further discussions with colleagues in the social work field, it became clear that no guidelines or training programmes exist to prepare alternative caregivers for this task. Alternative caregivers need help in knowing how to form attachments with the traumatised children placed in their care and guide them into adulthood in order to become healthy, independent individuals.

The need for more knowledge in understanding these children and guidance on how to meet their emotional needs was also expressed to the researcher by alternative caregivers themselves. This occurred while the researcher was working in the Northern Cape as a social worker at a welfare organisation, mainly involved with young children in play therapy. Most of the cases were those of children who have experienced severe trauma, either due to neglect or to some form of abuse, and as a result had to be placed in alternative care. In most of

these cases it has also been noted that alternative caregivers have not been given the necessary information and preparation in how to raise these children.

Fahlberg (1999: 15) highlights the importance of a strong, healthy attachment in early childhood to a primary figure in order to ensure a child's successful progress through the stages of child development. Wassell (2002: 31) also points out that where a child has never experienced attachment security, it is much more difficult to help the child to begin to trust and use attachment relationships as a secure base from which to recover developmental progress. Although there are lots of literature available on attachment and its importance, yet limited literature seems to be available that give practical advice on how attachment can be enhanced between the child and alternative caregiver from a Gestalt perspective (Social Sciences Citation Index, CSA, Proquest and Biblioline databases were explored). This knowledge, along with the researcher's awareness of the need of alternative caregivers for guidelines, has thus contributed to the motivation for this study.

1.3 PROBLEM FORMULATION

Mouton (2002: 91) states that the problem formulation relates to the goal of the study. Strydom and Delport (2002a: 327) describe problem formulation as the researcher's broad conceptualisation of the problem that should be redefined. Bless and Higson-Smith (1995: 29) add to this by stating that the formulation of a problem introduces the necessity for defining clearly all the concepts used and determining the variables and their relationships.

In this study, the following problem areas could be identified:

- Adequate physical care given to children in alternative care situations is not enough to lead to the development of a physically and psychologically healthy child with optimum intellectual functioning. For normal

development to occur, the child needs a primary attachment object. This person, who'll respond to the child's needs and who initiate positive activities with the child, seems to be indispensable for normal development (Fahlberg, 1999: 15). Alternative caregivers are not always made aware of the potential of disturbances in attachment and development in the child. They are also not brought to an understanding of the effects of early trauma on these children. As a result, relationships between the alternative caregiver and the child are strained and become more and more strenuous, to the point where a child is once again moved to another placement, because the alternative caregiver could not cope with the child (Fahlberg, 1999: 168).

- There is a lack of relevant programmes to prepare and equip prospective alternative caregivers fully and on all levels.

From the researcher's experience in practice, it was therefore clear that a need exists to develop guidelines for alternative caregivers to enhance the attachment with the traumatised child. For the purpose of this study, the guidelines were specifically developed from a Gestalt perspective.

1.4 RESEARCH METHODOLOGY

When guidelines are being developed in research, intervention research would normally be conducted. In this study, the researcher made use of intervention research, since the aim was to develop guidelines for alternative caregivers to enhance attachment with the traumatised child. Intervention research, according to Fouché (2002: 112), is a concept that developed from the collaboration between two pioneers, Edwin J. Thomas and Jack Rothman in the field of developmental research. Developmental research refers to the development of a technological item that would be crucial to professions such as nursing, medicine and social work. Technology in this context refers to the technical means that are

used in such a profession to achieve its objectives. Since intervention research derived from developmental research, it is conceptualised as research that is targeted at addressing the application of research in practice.

Intervention research is applied research, and therefore applied research was used in this study. Fouché (2002: 108) defines applied research as "… the scientific planning of induced change in a troublesome situation." He continues to describe applied research as "… being focused on solving problems in practice." Applied research can be exploratory, descriptive, explanatory, correlational or evaluative. According to Fouché (2002: 109), exploratory research aims to answer a "what" question and gain insight into a situation. Descriptive research, on the other hand, focuses on "how" and "why" questions, thus presenting the specific details of a situation. This study sought to explore (viz., what are the needs of alternative caregivers regarding the enhancement of attachment in their relationship with the children in their care) ánd to describe (viz. the development and description of guidelines to enhance attachment between the alternative caregiver and traumatised child).

De Vos (2002: 397) explains that the design and development intervention research is a phase model consisting of six phases. Each of these phases has a series of steps or operations. For the purpose of this study of limited scope, this model was completed up to step one of the fourth phase, which is developing a prototype or preliminary intervention. These four phases with their different steps will subsequently be discussed.

1.5 WORK PROCEDURE

The first phase of the design and developmental model (D&D) of intervention research is problem analysis and project planning.

1.5.1 Problem analysis and project planning

In de Vos (2002: 397), a distinction is made between a personal problem and a social problem. If an individual cannot find a job, that is a personal problem, but if millions of people cannot find jobs and it leads to mass action because they are hungry and dying, it becomes a social problem. Hastings as quoted in de Vos (2002: 397) describes social problems as "… conditions of society that have negative effects on large numbers of people." It appeared that the problem identified in this study was the need of alternative caregivers for guidelines on how to enhance their attachment with traumatised children in their care. The first step of the problem analysis and project planning phase was to identify and involve clients.

1.5.1.1 Identifying and involving clients

As indicated in de Vos (2002: 398), it is important that a population is identified whose issues are current or of emerging interest to the researcher, society and the clients involved.

A **population** would be individuals in the universe who posses specific characteristics, while the **universe** refers to all potential subjects that have the attributes in which the researcher is interested (Arkava & Lane in Strydom & Venter, 2002: 198). It is important to clarify between a universe and a population before a sample is drawn. For the purpose of this study, the **universe** includes all alternative caregivers in South Africa with traumatised children in their care. The **population** denotes alternative caregivers referred by FAMSA Springbok, who had children in their care who have suffered trauma and with whom they were experiencing attachment problems.

Arkava and Lane, as quoted by Strydom and Venter (2002: 199), define a **sample** as "… comprising of the elements of the population considered for actual inclusion in the study", thus, it is a smaller version of the total set of persons or events and through the use of a sample, time, money and effort can be concentrated to produce better quality results.

The way in which sampling was done for this study, was through nonprobability sampling. Nonprobability sampling is done without randomisation and examples can be accidental, purposive, quota, dimensional, target, snowball or spatial samples (Strydom & Venter, 2002: 203). In this study, a purposive sample was used. The judgment of the individual researcher is a prominent factor in this regard, in that a sample is composed of elements containing the most characteristic, representative or typical attributes of the population (Singleton *et al*. in Strydom & Venter, 2002: 207).

For the purpose of this study, the sample identified consisted of alternative caregivers of children who have experienced some form of trauma. These alternative caregivers were referred to FAMSA Springbok for play therapy for the children and guidance for themselves on how to deal with these children and form an attachment with them. The sample consisted of five alternative caregivers. These were relatives of the children in their care, apart from one foster carer who wished to be part of the research study, since she felt that she shared the feelings and concerns of the other alternative caregivers.

1.5.1.2 Gaining entry and cooperation from settings

It is important to form a collaborative relationship with those who can facilitate access to the particular settings. By involving them in identifying problems, planning the project and implementing the intervention, researchers gain the

necessary support to conduct the intervention research (Fawcett *et al.* in de Vos, 2002: 399).

For the purpose of this study, it was not necessary for the researcher to obtain special permission to contact alternative caregivers, since the researcher worked for FAMSA Springbok and was known to the alternative caregivers as well as the personnel who have made the referrals. Information about the research objectives, process and development of guidelines was shared with the Director of FAMSA, as well as the professionals who had referred the families. All of them gave their verbal consent and support to the researcher for this study. The respondents were all thoroughly informed of the purpose and process of the research study by way of individual conversations. A consent form (see Addendum A1) was signed by all the respondents, in which they agreed to take part in the research.

1.5.1.3 Identifying concerns of the population

True to the Gestalt theory, it is important for researchers to understand the issues of importance to the population, without attempting to make interpretations of the information gained (cf. Fawcett *et al.* in de Vos, 2002: 402). In order to understand the issues of importance to the population, the researcher made use of a **qualitative approach,** since this approach mainly aims to understand social life and the meaning that people attach to everyday life (cf. McRoy in Fouché & Delport, 2002: 79). The issues of importance to the population were the difficulties that alternative caregivers experienced with regard to attachment and bonding in their relationship with the traumatised children in their care.

The researcher used focus groups as an interviewing method to collect data in order to identify issues and concerns of the population. Greeff (2002: 309) states that careful planning with respect to respondents, the environment and questions to be asked are keys to conducting effective focus group interviews. The researcher drafted an interview

schedule and tested the questions on a sample of three parents who did not form part of the research sample. This pilot test served to investigate the accuracy and appropriateness of the questions. Feedback was shared and a few questions were revised. The pilot testing also allowed the researcher to determine the respondents' likely response to the interview schedules. Questions were specifically formulated to identify what particular needs and areas the alternative caregivers wanted the guidelines to address in order to enhance attachment and their relationship with the children in their care. A dictaphone and video recording were used to record the information and field notes were kept. Greeff (2002: 318) views field notes as a written account of the things the researcher hears, sees, experiences and thinks in the course of the group sessions when information is obtained. The researcher jotted down as much of the conversation as possible. Field notes also included the seating arrangements of the group and the order in which the respondents spoke, in order to identify respondents on the dictaphone and video recording. Body language was also noted, as well as themes emerging.

Greeff (2002: 307) maintains that focus groups are useful when one is looking for a range of ideas or feelings that people have about something and one wants ideas to emerge from the group. Additionally, Greeff (2002: 306) states that this information can be obtained in a shorter period of time than through individual interviews.

1.5.1.4. Analysing concerns or problems identified

Analysing the concerns or problems identified was the next step of the problem analysis and project planning phase (see Chapter 2). It is mentioned by de Vos (2002: 339-341) that in order to bring structure and meaning to the mass of collected data, the concerns of the population identified and gathered, should be analysed. Fawcett *et al*. (in de Vos, 2002: 403) further states that in order to analyse concerns, some key questions should be used to guide this process. These questions include the following:

- For whom is the situation a problem?
- What are the negative consequences of the problem for affected individuals?
- Who (if anyone) benefits from conditions as they are now?

These questions might shed some light on who is being affected by the lack of attachment and relationship between caregiver and child and also the consequences for the affected persons while the problem exists. Other important questions would be the following:

- How would affected persons want things to change?
- What would need to happen?
- Who would have the responsibility to "solve" the problem?
- What aspects have respondents highlighted as necessary for the development of guidelines?

These questions were considered and addressed throughout the study in relation to the need of the alternative caregivers for attachment enhancement with the children in their care.

It is important that gathered information be organised into patterns, categories and basic descriptive units. Creswell (in de Vos, 2002: 340) suggests a data analysis spiral. The data analysis spiral consists of managing data, reading and memoing, describing, classifying and interpreting, and representing and visualising. The researcher used the field notes written down during the focus group sessions to reflect on the information gathered. Files containing the information gathered were organised into keywords and key sentences. The researcher repeatedly read through the information to get a sense of it as a whole, and information was highlighted in different colours, taken apart and sorted under the four main themes. The four main themes were further broken down into subcategories and presented in four schematic figures (Figure 2.1-2.4).

1.5.1.5 *Setting the goal and objectives*

It is believed that the better the problem analysis of identified problems and concerns, the better clarified are the potential targets for change. In terms of goals and objectives, de Vos (2002: 404) states that broad goals and specific objectives would best clarify the

proposed ends and means of the intervention research project. This ensures that the next phase of information gathering and synthesis is more structured**.** The **goal** for this study was the development of guidelines for alternative caregivers to enhance the attachment relationship with the traumatised child in their care. The specific **objectives** for this study were:

- An in depth empirical study, using an interview schedule to collect data, in order to analyse what the concerns and problems are as identified by the respondents;
- to undertake a thorough literature study on attachment and how it can be enhanced through the utilisation of applicable Gestalt principles with the traumatised child in alternative care;
- to determine functional elements of existing guidelines for alternative caregivers to be used when establishing Gestalt guidelines for alternative caregivers to assist them in enhancing their relationship and attachment with the child;
- to establish guidelines from a Gestalt perspective to assist alternative caregivers to enhance their relationship and attachment with the child;
- to draw conclusions and make recommendations in order to assist alternative caregivers and field social workers and contribute to further research.

1.5.2 Information gathering and synthesis

The second phase of the design and development model is the gathering of information and synthesis. Acquiring knowledge means that the relevant types of knowledge should be identified and selected and appropriate sources of information be integrated and used (de Vos, 2002: 405). A discussion on how existing information sources were used and natural examples were studied, now follows.

1.5.2.1 Using existing information sources

According to de Vos (2002: 405), a literature review can be done by examining selected empirical research reports, reported practice and other existing information relevant to the particular topic being studied. For this study, a literature review was undertaken to discover what others have done in regard to the research problem. Literature was studied that related to the following: attachment and attachment theory; Gestalt concepts and the Gestalt approach; children in alternative care; and various treatments to enhance attachment between caregiver and child (see Chapters 3 and 4). An extensive internet search was also launched and various subject databases on social sciences, psychology, sociology and clinical social work were explored.

It was important that the literature not only related to the particular field of the topic being studied, but also included other fields that could be related to this particular topic. This included information gathered from books, journals and dissertations in the fields of psychology, education, social work and health. In this way through intervention research new knowledge was generated and new links between concepts and methods of various disciplines were established (cf. Fawcett *et al*. in de Vos, 2002: 406).

The researcher used some references in this study that is more than ten years old. These include books by Zinker (1978), Latner (1986), Yontef's book (1993) on Gestalt therapy and a book by Violet Oaklander (1988) that gives some parental advice from a Gestalt perspective.

1.5.2.2 Studying natural examples

According to de Vos (2002: 406), studying natural examples can also generate new knowledge. Interviews with those who have first-hand experience of the problem can be a particular useful source of information. Their sharing of information could provide insight into which interventions might or might not succeed and which variables may have an influence.

Experts in the field of attachment and treatment to enhance attachment, and in the field of play therapy, trauma and alternative care were consulted. These consultations provided valuable insights and information.

The following experts were consulted:

Dr Petro van Zyl, social worker in private practice, Springbok
Dr van Zyl is a trained social worker and play therapist who has worked in the field for 32 years. She is especially interested in the early attachments of the child and conducts courses on the impact of early attachments on the traumatised child. Dr Van Zyl agreed that there was a need for this research and was helpful in providing useful information.

Lindie Nell, social worker and play therapist, Pretoria
Ms Nell is a former therapist at the RP Clinic in Pretoria. She now works privately where she assesses children who have been traumatised and specialises in attachment therapy. She has been working with children, locally and internationally, for the past 12 years. Ms Nell was particularly helpful in providing information from her own experience on the value of attachment therapy with children and alternative caregivers who have experienced difficulties in their relationship. She agreed that although there was quite a bit of information

available on attachment and adoption, information on attachment and alternative caregivers were limited.

David Howe, professor in social work at the University of East Anglia, UK

Professor Howe is one of the UK's leading figures in academic social work. His main research interests are in developmental attachment theory, adoption, theory and practice in child and family social work, child abuse and neglect, and disorders of attachment. The researcher consulted with professor Howe via e-mail. He was excited about the research topic and provided useful information on attachment (see Chapter 4).

Dr Terry Levy, Director, Evergreen Consultants in Human Behavior, Colorado, USA

Previously president of the Board of Directors of ATTACh (Association for Treatment and Training in the Attachment of Children), Dr Levy has been providing psychotherapy treatment and training for over 25 years. He has taught seminars for the American Psychological Association, American Professional Society on the Abuse of Children, and many other organisations. Dr Levy responded to e-mails from the researcher and referred her to his book *Healing Parents: Helping Wounded Children Learn to Trust and Love*, which was particularly useful. His corrective attachment parenting model is discussed in Chapter 4.

1.5.2.3 Identifying functional elements of successful models

According to de Vos (2002: 407), it is useful to look at programmes and practices that have previously addressed a problem in order to analyse whether the critical features of these programmes and practices have indeed contributed to solving the problem. Questions to be considered would be: Has there been a programme

implemented that has successfully addressed and changed targeted behaviours? What has made a particular programme effective? Has there been an unsuccessful programme and what has caused it to fail?

In terms of this study, the researcher looked at the functional elements of the following treatments which are discussed in Chapter 4: Corrective attachment parenting; and the dyadic developmental psychotherapy treatment model. In addition, elements of the arousal-relaxation cycle, the positive interaction cycle and positive claiming used in conjunction to enhance attachment received attention, and particular functional elements in attachment-based intervention used with foster caregivers were considered.

Although not practised from a Gestalt perspective, these treatments contain elements that were useful in establishing Gestalt guidelines for alternative caregivers.

1.5.3 Design

The design phase in intervention research is called “design and development”. Issues such as designing an observational system and specifying procedural elements of the intervention should be considered when the guidelines of the design and development model are followed (de Vos, 2002: 408).

1.5.3.1 Designing an observational system

According to de Vos (2002: 408), the observational system is closely linked to the process of designing an intervention. It is important that a method be developed which can measure the extent of the problem, that is, to establish what kind of attachment, if any, exists between the caregiver and child and what are the effects following intervention. Respondents should be involved in specifying the problems and conditions that need to be changed and observed. De Vos (2002:

408) continues, saying that once the focus of change has been identified, it is necessary to define these behavioural events in ways that can be observed. He explains that the purpose of the observational system is to measure the outcomes of intervention through direct observation, self-monitoring or self-reporting of events that may be difficult to observe directly.

The researcher developed observational tools to be used in conjunction with the established guidelines, as can be seen in Chapter 5, Tables 5.1, 5.2 and 5.3. These tools are used to evaluate or self-monitor whether there is an improvement in the behaviour and an enhancement in attachment security after intervention. The observational tools help to establish relationships between environment changes and behaviours related to the problem (cf. de Vos, 2002: 408).

1.5.3.2 Specifying procedural elements of the intervention

According to de Vos (2002: 409), by observing the problem and studying naturally occurring innovations and other prototypes, researchers can identify procedural elements for use in the intervention. Procedural elements in this study mean that the professional implementing the guidelines would have to possess the following qualities:

- A sound knowledge and understanding of the Gestalt approach as a phenomenological-existential therapy, and the particular concepts that are included in the guidelines, namely awareness, including sensory awareness, here and now, impasse, organismic self-regulation, dialogue and responsibility(see 5.4) ;
- a clear understanding of attachment and attachment related issues;
- the ability and experience of professional facilitation. This means that a professional person would share the guidelines with the alternative caregivers on their level and in an understandable way, and also assist

them in implementing the guidelines with the children. This would mean allowing the alternative caregivers to apply the guidelines themselves and refraining from taking action on behalf of the alternative caregivers;

- professional experience of alternative care, which involves making alternative caregivers fully aware of the needs of these traumatised children. The sharing of information needs to take place on a general basis during preparation, while training groups of caregivers about attachment problems and these children's histories, but also on an individual basis with regard to the history of a particular child. Alternative caregivers need to understand that children's early experiences with biological parents shaped their core beliefs about themselves, and that with negative core beliefs they perceive alternative caregivers as rejecting and untrustworthy. Negative attitudes and actions by the children should not be taken personally, as this is part of their coping strategy. Instead, alternative caregivers should give approval and praise for specific behaviour;
- the sincere wish to enhance attachment between alternative caregivers and the children in care;
- commitment to bring about change.

When implementing the guidelines, procedural elements also involve that two sets of copies of the recording sheets (observational tools) will be given to the alternative caregivers (see Chapter 5). One set will include the examples in the column "What you as alternative caregiver can do/ did to address the need", in order to guide alternative caregivers when completing the recording sheets. In the second set of copies, this particular column will be left blank. The first two columns, namely "Type of behaviour displayed" and "Possible underlying need" will be filled in, in both sets of copies.

These procedural elements of an intervention often become part of an eventual practice model, which is the final product of the research (de Vos, 2002: 409).

1.5.4 Early development

This phase includes the important operations of developing a prototype or preliminary intervention and conducting a pilot test (de Vos, 2002: 410). For the purpose of this study, preliminary guidelines were developed, but no pilot-testing of these proposed guidelines was carried out.

1.5.4.1 Developing a prototype or preliminary intervention

Reber and Reber (2001: 575) state that a prototype is the original, primitive type or form of a thing. For the purpose of this study, the development of a prototype or preliminary intervention consisted of outlining the elements of the guidelines aimed at assisting alternative caregivers to enhance attachment with children in their care. The respondents in this study, the experts in the fields of Gestalt and play therapy, the literature study that was undertaken, and functional elements as identified in existing alternative caregiver programmes all contributed to the development of the preliminary guidelines that are outlined and discussed in Chapter 5.

1.6 DEFINITION OF MAIN CONCEPTS

Bless and Higson- Smith (1995: 29) states that it is necessary to define clearly all the main concepts used and to determine the relationships between the concepts. Barnes-September as quoted by de Vos (2002: 410) agree that the description of the key elements and concepts of the research is helpful when developing a program of intervention. The main concepts of this study are briefly clarified below.

1.6.1 Attachment

Bowlby (1997: 371) defines attachment as follows:

> To say of a child that he is attached to, or has an attachment to, someone means that he is strongly disposed to seek proximity to and contact with a specific figure and to do so in certain situations, notably when he is frightened, tired or ill.

Reber and Reber (2001: 61) define attachment in terms of developmental psychology as:

> … an emotional bond formed between an infant and one or more adults such that the infant will: (a) approach them, especially in periods of distress; (b) show no fear of them, particularly during the stage when strangers evoke anxiety; (c) be highly receptive to being cared for by them and (d) display anxiety if separated from them.

It is important to have a clear knowledge and understanding of what attachment is. Understanding what a normal attachment between a parent and child entails, would provide a basis for an assessment of the strengths and weaknesses of the attachment relationship between alternative caregiver and child.

1.6.2 Traumatised child

According to the American Psychological Association (in Gray, 2002: 110), a traumatic event is "… an event that is outside the range of usual human experience and that would be markedly distressing to almost anyone."

Furthermore, trauma is followed by specific, high stress symptoms that have lasting effects on key areas of a person's functioning.

Gray (2002: 111) also mentions the changed patterns of thinking and specific behaviours that children demonstrate when they have been traumatised. Some symptoms are the following:

- Exaggerated startled response;
- emotional numbness;
- lowered control over regulation of their moods;
- physical symptoms such as stomach-ache.

Retief (2005: 17) states that a person has experienced trauma when he or she has been exposed to events in relation to their current life situation or stage in life that resulted in them not being able to cope any longer.

For the purpose of this study, the traumatised child is the child in alternative care that has experienced trauma such as abuse and/ or neglect and as a result have been placed in alternative care.

1.6.3 Gestalt guidelines

The researcher will firstly define **Gestalt** and then **guidelines.** Thompson and Rudolph (2000: 89) describe **Gestalt** as:

> … a form, a configuration or a totality that has, as a unified whole, properties which cannot be derived by summation from

> the parts and their relationships. It may refer to physical structures, to physiological and psychological functions or to symbolic units.

Corsini (2002: 413) defines **Gestalt** as "… a unitary, integrated, articulated perceptual structure or system whose parts are in dynamic interrelation with each other and with the whole."

Guidelines are defined as "… statements of principles giving practical guidance" (Hawkins, 1990: 358).

Gestalt guidelines, for the purpose of this study, therefore means that it is practical guidance being given on how to relate effectively and dynamically with each other and with the surrounding environment.

1.6.4 Alternative caregiver

A definition of **alternative** and **caregiver** will be given separately.

Hawkins (1990: 22) defines **alternative** as "… available in place of something else."

A **caregiver** is defined by The American Heritage Dictionary of the English Language as "… an individual, such as a parent, foster parent, or head of a household, who attends to the needs of a child or dependent adult."

The Merriam-Webster's Medical Dictionary defines **caregiver** as "… a person who provides direct care (as for children or the chronically ill)*."*

In this study an **alternative caregiver,** therefore, is someone who provides care to children, but in place of someone else, namely the parents.

1.7 ETHICAL ASPECTS

It is important to be aware of and identify the particular ethical issues in social research.

1.7.1 Harm to experimental respondents

According to Strydom (2002: 64), harm to respondents can be of a physical or emotional nature. This study had the potential to be invasive and bring to light personal underlying issues for the respondents. It was therefore important for respondents to be thoroughly informed beforehand about the potential impact of the investigation, in order to give them the opportunity to withdraw, should they wish to do so(cf. Strydom, 2002: 64). The respondents were assured that should any personal emotional issues arise during the research, they would have access to a professional social worker who could help them work through the problem.

1.7.2 Informed consent

Strydom (2002: 65) states that informed consent becomes a necessary condition, even where respondents will not be subjected to any harm or discomfort. It is important to communicate to them adequate information as to the goal of the investigation, the procedures that would be followed, the possible advantages and disadvantages and the demands the study would place on respondents in terms of time, activities and sharing of information, and then obtain their consent, even if no attention was paid (Strydom, 2002: 66).

Written consent for participation was obtained from all respondents after the necessary information was shared (see Addendum A1). Their consent was also obtained to make use of the dictaphone and video recordings for data collection.

1.7.3 Deception of respondents

Strydom (2002: 67) states that deception can occur deliberately or without the researcher's awareness. In this study, the possibility existed that, without the researcher being aware of it, the alternative caregivers could come to believe that, as a result of the study, attachment and the relationship between child and alternative caregiver would be 100% should the guidelines be implemented. The researcher discussed this possibility with the respondents at the beginning of the research, clarifying any misconceptions that the respondents may have had regarding the outcome of the research.

1.7.4 Violation of privacy/ anonymity/ confidentiality

The privacy of respondents should be protected by all possible means. In this study, anonymity and confidentiality were observed as far as possible. Information was treated with confidentiality at all times. Data was only used for the purpose of the research. Written consent forms were used to ensure all of the above (cf. Bless & Higson-Smith, 1995: 103).

1.7.5 Actions and competence of researcher

According to Strydom (2002: 69), researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake a particular study. In this case, the researcher has been working as a qualified social worker for quite a few years and was guided by the study leader in executing this study.

The researcher also had to be competent and skilled in dealing with cultural differences during the study, as the respondents' culture differed from that of the researcher. The researcher refrained from making value judgments with regard to caring since it differed in certain respects from the researcher's own personal value system.

1.7.6 Release or publication of findings

The ultimate goal of any research project should be to encourage the professional utilisation of the research findings. The researcher was therefore ethically obliged to ensure that the research would proceed correctly at all times and that no one was deceived by the findings. Strydom (2002: 72) believes that the researcher personally would know best what the shortcomings of his study would be and that they should be clearly mentioned in the report. This was discussed by the researcher in Chapter 6. Huysamen as quoted by Strydom (2002: 72) suggests that it would be desirable to present the findings to subjects as a form of recognition and to maintain future good relationships with the community concerned.

The respondents have asked the researcher for a copy of the final document once the findings have been released, and the researcher will also negotiate with welfare organisations about the possible implementation of the research as part of the training programme for alternative caregivers and foster parents.

1.7.7 Debriefing of respondents

As discussed under 1.7.3, it was important for the researcher to rectify any misconceptions that could arise in the minds of participants during the study. It did not appear as if the respondents cherished any such overly optimistic ideas

once the researcher had clarified the matter (cf. Strydom, 2002: 73.) Due to the intimate and close nature of the group, feelings and experiences were shared spontaneously throughout the group sessions, and this served as debriefing in itself.

1.8 CONCLUSION

In this chapter the project analysis and planning for this research was explained. Various aspects of the research, *inter alia* the definition of core concepts and the ethical aspects received attention. In the next chapter the empirical findings of this research will be discussed.

CHAPTER 2
IDENTIFYING AND ANALYSING CONCERNS OF THE POPULATION

2.1 INTRODUCTION

In this study, the researcher aimed to establish Gestalt guidelines for alternative caregivers in order to enhance attachment with the traumatised child. For this reason, the design and development model, which forms part of intervention research, was used. In the previous chapter, attention was given to the first part of the first phase of intervention research, namely project planning. Reference was also made to the following steps of the first phase, namely identifying and analysing the concerns of the population and setting goals and objectives (see 1.5.1.3-1.5.1.5). Identifying and analysing the concerns of the population as discussed in this chapter, form part of the empirical findings of this research. These steps were important in order to determine the problems experienced by alternative caregivers with the children in their care. Although most of the problems identified in this chapter relate to the attachment relationship between the alternative caregiver and the traumatised child, many other frustrations were also highlighted by alternative caregivers which organisations need to take note of.

Focus groups were used as an interviewing method. Alternative caregivers were selected by means of purposive sampling (see 1.5.1.1) and empirical data was obtained from the alternative caregivers who formed the focus groups. The researcher will refer to this sample group as the respondents.

2.2 IDENTIFYING AND ANALYSING CONCERNS OF THE POPULATION

The researcher used the qualitative approach in order to understand the issues of the population and to gain a first-hand and holistic understanding of the areas of interest. Information was gathered from the focus group interviews and recorded on video and dictaphone. Field notes were also used in order to reflect on the information obtained. Information was organised into key words and key sentences, and further analysed by reading repeatedly through the data to get a sense of the information as a whole. The information was then classified by taking the information apart and sorting them under four main themes. The researcher presents the four main themes with their subthemes and categories in four schematic figures in this chapter (see Figures 2.1-2.4).

2.3 IDENTIFICATION OF CONCERNS UNDER MAIN AND SUBTHEMES

The following main themes were identified from the collected data:

- Respondents' opinion of the **personal problems** experienced with traumatised children in their care;
- respondents' opinion of the **individual problems** experienced by the children in their care;
- respondents' opinion of **environmental attitudes** affecting their care of these children;
- respondents' opinion of the **needs** that arise when caring for traumatised children.

Next each main theme with its subthemes and categories will be presented and separately discussed.

FIGURE 2.1: SCHEMATIC PRESENTATION OF MAIN THEME, SUBTHEMES AND CATEGORIES AS IDENTIFIED FROM EMPIRICAL DATA: MAIN THEME 1

MAIN THEME	SUBTHEMES	CATEGORIES
Respondents' opinion of the **personal problems** experienced with traumatised children in their care	Uncertainty	• Lack of caring skills
	Challenges	• Responsibility of the respondent • Demanding behaviour • Biological parents
	Guilt feelings	• Conflict in respondents' household • Lacking resources to meet the child's needs
	Hurt	• Disrespect for respondents' feelings

		• Nonacceptance by child in care

2.3.1 Main theme 1: Respondents' opinion of the personal problems experienced with traumatised children in their care.

The first main theme identified from the empirical data is the personal problems the respondents have experienced with the traumatised children in their care. It is the researcher's experience in working with alternative caregivers that because of a lack of knowledge, training and experience in caring for traumatised children, alternative caregivers often come face to face with a series of personal problems regarding their care of these children. According to the ACVV's Manual for Foster Caregivers ([sa]:65), the alternative caregiver should have the following three basic characteristics, namely knowledge, skills and attitude in order to know how to handle the children in their care. The right attitude towards the child in care is very important, whilst knowledge and skills need to be updated and developed on a regular basis. Where this does not happen, alternative caregivers seem to feel unsure and ill-equipped for their task as alternative caregiver. In this regard, respondents participating in this study experienced and identified certain personal problems. These were identified as subthemes (see Figure 2.1) and will subsequently be discussed.

2.3.1.1 Uncertainty

From the empirical data it was found that respondents seem to experience uncertainty in their ability to take care of traumatised children due to a lack of caring skills. They were unsure how to handle these children who came into their care and found it stressful, especially in situations where children were seriously traumatised. They empathized with the hurt and pain of these children, but felt

helpless as they did not know what was expected of them and how to deal with the child's hurt.

Temple-Plotz *et al.* (2002: 34) highlight the fact that alternative caregivers should acquire specific skills during initial training in preparation of placements. These skills include teaching children life-skills they may need help with, and using positive and negative consequences as discipline method. It is also important for trainers to discuss with alternative caregivers the policies and procedures relating to caring, as part of the preparation training provided. All of this preparation should empower the alternative caregiver and create the necessary self-confidence in taking on a child in care.

In the South African context (cf. Review of the Child Care Act Executive Summary, 2002, Chapter 16), there appears to be very little in place to ensure this kind of preparation for the alternative caregiver. In the researcher's opinion, that is the main reason why alternative caregivers are left feeling uncertain about their capabilities. Amendments to sections of the Children's Act are still being made, including sections on foster care and alternative care. It is, for instance, only now being recognised that "… all forms of foster care should be seen as having a professional dimension and that financing of this service should take into account the need for training and support of caregivers" (Review of the Child Care Act Executive Summary, 2002, Chapter 16). It is further being proposed that the Department of Social Development embarks on a consultative process of developing broad minimum standards for the selection and training of substitute family caregivers in various categories. Attention is therefore given to the training needs of alternative caregivers in the South African context, although very little detail is specified as yet in terms of how these needs will be addressed, whilst detailed information is given on how alternative caregivers will be financially supported (Review of the Child Care Act Executive Summary, 2002, Chapter 16).

From the empirical data, it became clear to the researcher that the lack of proper initial training for prospective alternative caregivers, as well as a lack of clear policies and procedures do exist, and that this is very important in order to ensure self-confidence of the alternative caregivers, as pointed out by Temple-Plotz *et al.* (2002: 35).

2.3.1.2 Challenges

Respondents seemed to experience a variety of challenges in their role as alternative caregivers of traumatised children. The responsibility of the alternative caregiver, children's demanding behaviour and the biological parents' interfering were the challenges that were identified. It is the researcher's opinion that these can prove especially challenging where procedures are not clear and support is limited.

- **Responsibility of the respondent**

The respondents felt that it is a huge responsibility and sometimes overwhelming task to care for someone else's child. One respondent stated that "… social workers and the biological parents are constantly watching you to see whether you are providing good enough care!" Temple-Plotz *et al. (*2002: 35) agree that the responsibility of the alternative caregivers towards the children in their care can be a huge challenge in that they have to be role models to the children, as well as to others watching them. For instance, it is expected of the alternative caregiver to teach and model new skills to the child. Temple-Plotz *et al. (*2002: 37) continue, saying that it is a further part of the alternative caregivers' responsibility to model dressing appropriately, using correct grammar, exercising good listening skills, being on time for meetings and completing tasks as promised.

The researcher agrees that the alternative caregiver carries a big responsibility in caring for other people's children. It is also of the utmost importance, since the alternative caregiver's home may be the only place that a much-needed positive image of family and care is experienced.

- **Demanding behaviour**

The respondents were of the view that children's behaviour can become extremely demanding. One respondent mentioned: "I would be totally exhausted after a day, because of the child's need for my love and attention." Another respondent shared the following:

> I have an adolescent in my care whose father had died and whose mother committed suicide. I feel quite discouraged at this stage since the child shows no cooperation and would not listen to me at all. I did not expect it to be this hard to care for a child. I realise there is a lot more for him going on than what I feel I am able to deal with.

Fahlberg (1999: 140) explains that adolescents who feel that they have lost all control over their lives, is likely to act up. If the family does not meet the adolescent's needs, he or she will become totally dependent on their peers to meet all their desires. Adolescents who have experienced parental separation or loss often do not feel secure in their current sense of belonging. The issues they struggle with would often centre around where they should live, as they really belong to another family than the one with whom they are currently living. Again, this creates conflicting loyalties and demanding behaviour for the alternative caregiver.

The demanding behaviour of these children often gives rise to feelings of anger towards the child, guilt and inadequacy in the alternative caregiver. The

challenge is to enhance alternative caregivers' positive emotions, instill hope, increase their motivation and create a more effective model by which to view their caring role and understanding of the child (Attachment parenting, 2001: "Parenting is an art, not a science … ").

The researcher agrees that by educating and training alternative caregivers as well as possible and by providing a supportive structure, many of them would feel less overwhelmed by the demands of the children. Joyce and Sills (2001: 173) explain how new ways of being and behaving can be experimented with in groups. Alternative caregivers can, for instance, be prepared in how to deal with these children and their demands by means of group discussions and experimenting with new ways in handling the situation, simultaneously receiving feedback from other group members about their handling of the situation.

- **Biological parents**

The respondents agreed that they found it quite a challenge to have the biological parents as part of their families, explaining that the biological parents of the children in care would often phone the respondent or even arrive unexpectedly at the respondent's home. What the respondents found especially challenging and even upsetting at times, was when the biological parents would accuse them of untruths or suddenly interfere in the child's life, upsetting the child after they have been absent from his life, showing no interest.

Fahlberg (1999: 161) states that it is often the biological parents who have the greatest difficulty accepting that the child has two sets of parents. They have difficulty accepting that children can love more than one mother or father. The child may love each in different ways, but it does not have to be one instead of the other. Fahlberg (1999: 161) agrees that the attitudes or behaviour of parents who feel threatened by the importance of alternative caregivers in their child's life may pose the biggest obstacle. Decreasing loyalty conflicts is an important task

for all adults involved in the child's life. Alternative caregivers can help the child by accepting the child's feelings, both positive and negative, towards biological parents, and by being supportive of contact with the biological family, even if such contact is painful. It becomes easier for both the child and the biological parents to accept the situation, when alternative caregivers behave as though it is acceptable for the child to love two sets of parents. Encouraging the child to have pictures of the biological family, and not discouraging them from talking about them, are ways to allow the biological family into the alternative caregiver's family without necessarily having them physically present (Fahlberg, 1999: 161).

In the opinion of the researcher, the biological parents of the child in care cannot be left out or uninvolved. The researcher supports Fahlberg's (1999: 181) statement that by involving the biological parents in the decision-making process about placement, their opinions and views are being acknowledged. This may make a difference in the parent being able to support the child's feelings at the time of placement and not pose so much of a threat to alternative caregivers. Guidelines on contact between the child and biological parents should also be clear and appropriate. The time, venue and frequency of the meetings, for instance, should be contracted.

2.3.1.3 Guilt feelings

From the empirical data it became clear that respondents struggle with guilt feelings because of a number of factors, as discussed below.

- **Conflict in respondents' household**

Many traumatised children with attachment problems are cared for by well-meaning adults who are, however, ill-prepared to handle the child's severe emotional and behavioural problems. This creates ongoing stress and turmoil in the family and can lead to families and marriages suffering (Attachment

parenting, 2001: “Parenting is an art, not a science …”). Respondents seemed to identify with this by sharing that with additional members in the household they were often unable to give the necessary love and attention to their own biological children. This would often lead to disharmony between the various children, which in turn would create a lot of tension in the house. One respondent described the situation in her house by saying:”I may often behave differently towards the children in my care. This causes upset with my own children as they struggle to understand why everyone is not treated the same.” Due to this kind of situation, the respondents seemed to carry a lot of guilt feelings, as they feel that they were not living up to their own set of standards as parents.

Temple-Plotz *et al. (*2002: 66) explain that many of the children in care may have been victims of physical, sexual or emotional abuse and therefore have different backgrounds and experiences than those of the alternative caregivers’ own children. It is therefore likely that the alternative caregivers would have to treat the children differently in certain situations in order to keep them safe. For instance, a child that has been sexually abused will not be allowed to visit anyone on his own.

The researcher is of the opinion that proper preparation of and open communication between the alternative caregivers and their families before placement is crucial. This might prevent any potential misunderstandings and deal with certain feelings, in particular those experienced by the caregivers’ own children. Openness in the family should also alleviate guilt feelings for the alternative caregiver.

- **Lacking resources to meet the child’s needs**

Temple-Plotz *et al.* (2002: 80) state that every child in care has a right to basic clothing necessities. They should be provided with appropriate dress and leisure clothing in keeping with their age and sex. A child’s preference in clothing should

be strongly taken in consideration by alternative caregivers, as long as the personal preference is not extremely deviant in style or overly expensive.

Even though alternative caregivers receive a foster care grant for the children in their care, respondents complained that it was still not enough to meet the needs of the children in full. Respondents felt that due to all the financial demands placed on them it was not always possible to meet even the basic demands. In this regard, one respondent said the following:

> Sometimes the children would ask for clothing with a specific brand name, also wanting to be fashionable and fit in with the current trends. It breaks my heart, because I know it is impossible to grant them their wish since I just don't have the money.

These circumstances often led to arguments between the respondents and children, because the children could not or didn't want to understand, which left the respondents feeling sorry for the child in care and guilty that they were unable to provide more.

In the view of the researcher, the problem regarding finances lies with the government, who needs to realise that foster care grants must be adjusted to meet the needs of the child in care. It was recently recommended that all alternative care placements should be supported through a nonmeans-tested foster care grant. Should a universal grant be introduced, this would be an additional source of support for alternative caregivers. A further recommendation was that an allowance be paid to alternative caregivers in addition to the foster care grant, should the children have special needs. Special needs include emotional and behavioural problems (Review of the Child Care Act Executive Summary, 2002, Chapter 17). If this would be the case, the children in care of the respondents who participated in this study would also benefit from this.

2.3.1.4 Hurt

The empirical data showed that respondents struggled with feelings of hurt and pain. The following were identified as causes for these hurt feelings experienced:

- **Disrespect for respondents' feelings**

Respondents mentioned that children in their care would often deliberately hurt them by being ungrateful, accusing them falsely and comparing them to their own parents, telling the respondents that their care of them is useless. This would leave the respondent feeling hurt and rejected.

In the researcher's experience, this behaviour is a typical reflection of children with attachment problems. In this regard, Fahlberg (1999: 299) explains that many children in the child placement system have not developed normal healthy attachments to parental figures due to a lack of attunement between parent and child. Signs and symptoms of attachment problems that a particular child exhibits are the result of: the way biological parents had behaved towards the child; the environment; and the child's own particular psychological traits. Hughes (1998: 3) supports this view by pointing out that when an infant experiences too little attunement from the parent in the initial eighteen months of his life, the infant develops a sense of worthlessness and shame. As a result, the child will not communicate well verbally or nonverbally. Smiles, physical contact, eye contact and verbal expression of thoughts and feelings will be very difficult for them. Furthermore, their way of communication will be to try and manipulate adults into meeting their needs, either through charm or aggression, and they have difficulty accepting the possibility that adults would naturally want to keep them safe and meet their needs.

These feelings of hurt and rejection experienced by the respondents, are also discussed by Fahlberg (1999:288). This author suggests that although

alternative caregivers are feeling hurt by the child's words and actions, their goal should rather be to provide a relearning experience about the acceptability of feelings, but the unacceptability of certain ways of behaviour. Children in care have frequently been exposed to negative modelling by adults and thus have difficulty to vent their feelings in ways that help, rather than hinder them.

Hughes (1998: 4) explains that for alternative caregivers to have a meaningful chance to form an attachment with these children, they must use the early mother-infant bond and the young child's first developmental stages as a guide. This means that the attitude and behaviour that a new mother would display towards her infant should be re-enacted by the alternative caregiver with the child in care. The alternative caregiver should also socialise with this child the way a new mother would do with her infant. By using the young child's first developmental stages as a guide, experiences should be created that the child would have had as an infant, in order to maximise the child's overall development. A parent attuned with her infant, manifests an attitude of acceptance, empathy, love, curiosity and playfulness. The same attitude is crucial in convincing the poorly attached child that forming a reciprocal relationship with the child's alternative caregiver does elicit varied and rich pleasurable feelings (Hughes, 1998: 4).

- **Nonacceptance by child in care**

Another experience that left the respondents feeling hurt was the fact that they felt unaccepted by the child in their care and as a result felt no attachment between them. According to Attachment Parenting (2001), children in care are extremely self-centred and lack the desire for intimacy. They have developed these personality traits as a defence mechanism against their early life traumas, designed to avoid being hurt further either emotionally or physically.

Randolph (2002: 11) further explains by saying that among neglected children, in particular, the attachment that forms with the neglectful birth mother is highly dysfunctional. Most neglected children seem to spend the rest of their lives trying to re-create this highly dysfunctional attachment with their alternative caregiver, with the result that the alternative caregiver and child are unable to form a healthy attachment. In actual fact, it seems as if children in alternative care go out of their way to push their alternative caregivers to treat them abusively, often seeming desperate to drive their alternative caregivers to the point of behaving just like their abusive biological parents did.

The researcher is of the opinion that it would be important for alternative caregivers to help children let go of their defence mechanisms where they constantly feel a need to control their environment. The ideal situation would be if alternative caregivers could create an environment that allows the child to relax by learning to trust the alternative caregivers in their lives and experience the alternative caregivers' acceptance.

FIGURE 2.2: SCHEMATIC PRESENTATION OF MAIN THEME, SUBTHEMES AND CATEGORIES AS IDENTIFIED FROM EMPIRICAL DATA: MAIN THEME 2

MAIN THEME	SUBTHEMES	CATEGORIES
Respondents' opinion of the **individual problems experienced** by the children in their care.	Emotional problems	• Insecurity • Trust • Fears • Rejection • Conflict of emotions
	Behavioural problems	• Lying, stealing, destroying own and other's belongings, exhibiting cruelty towards siblings and other children, wetting their beds, smearing of faeces, having problems developing friendships with other children, overly clinging and demanding of

		attention, overly affectionate with strangers, showing developmental lags and cruelty towards animals

2.3.2 Main theme 2: Respondents' opinion of the individual problems experienced by the children in their care.

The second main theme that emerged from the research was respondents' opinion of the individual problems the children in their care experience. The two subthemes presented in Figure 2.2 are emotional problems and behavioural problems. These are discussed below.

2.3.2.1 Emotional problems

The empirical data showed that children in care seem to struggle with various emotional problems. In the empirical research, the following five problems were identified by the respondents:

- **Insecurity**

Respondents shared that the children coming into their care often presented as shy, uncertain and vulnerable. One respondent was of the opinion that "… coming into care was a whole new experience and adjustment that these children had to make, and a frightening one as the new home was often different to the home environment they were used to." Respondents further commented

that although these children also seemed insecure, they were often difficult to manage and did not attach easily.

Other signs of insecurity mentioned by the respondents were the worrisome nature of the children in care. They would worry about little things and display clinging and dependant behaviour towards their alternative caregivers. They would also have many questions, especially about their biological parents, their actions and whereabouts.

According to Fahlberg (1999: 134), children respond in many different ways when separated from their parents. This could be due to the fact that during the toddler years, separation interferes with the development of a healthy balance between dependency and autonomy. The nature of the separation could be so severe that the children eventually do not trust that adults will be there when they need them and thus insist on constantly keeping adults in sight by demanding attention or clinging to their alternative caregivers. When the child has not been given the emotional support necessary for completion of the grief process, the reactions may persist for years.

Fahlberg (1999: 142) further explains that children who have experienced multiple moves might less likely show marked reactions and appear to show no sign of discomfort or grief. In situations like these, children eventually tend to develop defences against the pain. The most common one is a hesitation to become emotionally close to others, thereby protecting themselves from a recurrence of the psychological pain of separation.

It is the researcher's experience that these children first of all need to learn again to trust and form attachments with significant people in their lives before they can begin developing and building healthy relationships and feeling secure within themselves.

- **Trust**

The traumatised child who has been seriously traumatised in an earlier relationship, is reluctant to trust or hope again (Gray, 2002: 115). Respondents confirmed that it has been difficult to develop new interpersonal relationships with children where they have experienced physical, sexual and/or emotional abuse or death. In these instances it was particularly difficult for the children to trust the alternative caregivers.

Fahlberg (1999: 40) explains that children in alternative care have great difficulty in learning to build and maintain relationships of any sort, since their experience of adults have been that they are unreliable in terms of availability and affection. Because these children, as a result, do not trust others, many of the forms of behaviour they exhibit are aimed at keeping people at an emotional distance.

It would therefore be important for the alternative caregiver to recognise that when there have been disruptions in children's care during the toddler years, later experiences should emphasise opportunities for increasing both trust for others and age-appropriate autonomy (Fahlberg, 1999: 136). Gray (2002: 116) explains that attachment work with the child is very important since evidence shows that attachment helps to calm some of the overaroused parts of the brain, which in turn will help the child dealing with trauma. In this regard, Perry (2001: 9) suggests a few different ways for alternative caregivers that can enhance attachment with the child. One of the suggestions is to nurture the child by being caring and loving towards them, especially by way of physical contact. In this way, the alternative caregiver is providing replacement experiences for those that should have taken place during their infancy. The alternative caregiver could, for instance, touch the child, mess up their hair, play with them outside and read them stories (Hughes, 1998: 4).

It is the researcher's opinion that even though children in care have suffered many losses and have trust issues as a result, the experience of a secure primary attachment relationship with an alternative caregiver could allow children to again develop trust in others and ultimately in themselves.

- **Fears**

Respondents explained how children showed great fear in conjunction with the lack of trust and insecurity as described earlier. One respondent mentioned that the biological parents of the children in her care simply stayed away, leaving the children in fear of what might have happened to their parents, and at the same time afraid that the alternative caregiver would one day disappear in the same way. Another respondent spoke about a child in her care whose mother had died. As a result, the child became very anxious and scared, distanced herself and did not want to love and attach again, as she was afraid that the alternative caregiver might also die.

Fahlberg (1999: 133) highlights the importance for alternative caregivers involved with these children to recognise that separation involves fear, which needs to be mastered, and that loss involves grief that needs to be expressed.

The researcher is of the opinion that when children who have had these kinds of experiences are placed in care, alternative caregivers need to be well-informed about the backgrounds of these children, and well-prepared in how to handle the fear and grief that accompany separation and loss.

- **Rejection**

Respondents mentioned that many of the children in their care suffered feelings of rejection. One respondent stated: "The child in my care will often say that no one cares about him and that he was thrown away by his biological parents."

Since the children often did not know how to deal with these feelings of rejection, they would also reject the respondents as a defence mechanism, because they believed the respondents would also reject them. The respondents felt that this affected the relationship between them and the child in a negative way.

Fahlberg(1999: 286) states that feeling rejected also means that the child experiences a lack of trust, and therefore the researcher is convinced that, once again, trust should be established first and foremost, before a secure relationship where the child feels accepted, can be formed.

- **Conflict of emotions**

Respondents agreed that the conflict of emotions in the adolescents in their care was quite clear. According to the respondents, these adolescents seemed to find it difficult to attach to a new alternative caregiver, since they have already formed a bond with their biological parent and were accustomed to their ways. The respondents further found that adolescents who have lost their parents through death, find it especially hard to accept someone new into their life and adjust to their set of rules. These feelings of confusion and disruption often lead to differences between the respondents and the child, which makes it very difficult for the respondents to look after the child in the way they would want to.

Levy and Orlans (1998: 23) agree that moves during early adolescence (12-14 years) are more difficult than in later adolescence, because individuation is a major developmental task of this early stage. It is difficult to encourage attachment to new alternative caregivers when the child is still in the process of emotionally separating from his family. Alternative caregivers therefore need to be sensitive to these development issues. It is suggested that adolescents need to have input into making decisions about their lives and future, consistent with their need to have increasing control over life events in general. They should be a part of the process of deciding where to live. However, exceptions should be

made in situations where the adolescent often displays poor judgement and cannot be counted on for realistic input.

It is the researcher's view that commitments ("contracts") could be helpful in clarifying and attaining goals. In this way, alternative caregivers and adolescents will be clear on the current and future plans. At the same time, alternative caregivers can assist the adolescent in coming to terms with prior losses and trauma, and encourage a healthy balance of dependence and independence (Levy & Orlans, 1998: 23).

2.3.2.2 Behavioural problems

According to Fahlberg (1999: 275), children being looked after show evidence of underlying problems through their behaviour. The behavioural problems that the children in care of the respondents presented with involved: Lying, stealing, destroying their own and other's belongings, exhibiting cruelty towards siblings and other children, wetting their beds, smearing of faeces, having problems developing friendships with other children, overly clinging and demanding of attention, overly affectionate with strangers, showing developmental lags and cruelty towards animals.

Respondents spoke about how the children in their care would lie, because they did not know otherwise. They would also steal money and destroy their own and others' belongings. When they are angry or frustrated, these children would show cruel behaviour towards their siblings and other children. Some of the younger children would keep on wetting their beds. One respondent spoke of a girl in her care who smeared faeces all over the walls. Another respondent mentioned that the child in her care who had lost her parents, found it particularly difficult to develop friendships with other children. She was overly clinging and demanding of attention and showed developmental lags, by being interested in games and toys for younger children and throwing tantrums like a much younger child.

Another respondent spoke about a girl in her care who was overly affectionate with strangers but extremely cruel to animals. She battered the family's pet tortoise to death with a brick. These forms of behaviour, according to Temple-Plotz *et al. (*2002: 11) are commonly seen in children with attachment difficulties.

Levy and Orlans (1998: 5), however, make a distinction between secure and insecure attachment. Where children have experienced a secure attachment since birth, they would present with the following:
Self: I am good, wanted, worthwhile, competent, lovable.
Caregivers: They are appropriately responsive to my needs, sensitive, caring, trustworthy.
Life: The world is safe, life is worth living.

On the other hand, where children began their lives with compromised and disrupted attachment, they would experience the following:
Self: I am bad, unwanted, worthless, helpless, unlovable.
Caregivers: They are unresponsive to my needs, insensitive, hurtful, untrustworthy.
Life: The world is unsafe, life is not worth living.

Kagan (2004: 17) alleges that this lack of attachment leads to social aggression, disruptive behaviour disorder and deficits in social skills, self-control and frustration tolerance, which include the forms of behaviour as described in the first paragraph of this section. Placement away from home can confirm a child's sense of being worthless or abandoned, leading to increased rejection and increased behavioural problems (Attachment parenting, 2001: "Parenting is an art, not a science …").

Nowadays, children enter care with more exposure to violence, higher rates of abuse and traumatic levels of neglect than previously (Gray, 2002: 111). Due to these factors, they have almost automatically suffered a lack of attachment. As

a result, children demonstrate changed patterns of thinking and specific form of behaviour as described earlier. They organise their world as if it were inevitably hostile, and act in ways as described in order to survive and be in control of their environment.

It is the researcher's belief that the behavioural problems displayed are a result of the trauma and emotional problems these children have experienced. It also became clear from the empirical data that alternative caregivers urgently need guidance on how to manage these behavioural problems that go hand-in-hand with deficient attachment. Dealing with these problems would basically entail the building of trust and attachment between the child and the parental figures.

FIGURE 2.3: SCHEMATIC PRESENTATION OF MAIN THEME, SUBTHEMES AND CATEGORIES AS IDENTIFIED FROM EMPIRICAL DATA: MAIN THEME 3

MAIN THEME	SUBTHEMES	CATEGORIES
Respondents' opinion of **environmental attitudes** affecting their care of the children	Government Local community	• Welfare systems not sufficiently functional • Lack of support • Lack of understanding • Lack of involvement

2.3.3 Main theme 3: Respondents' opinion of environmental attitudes affecting their care of the children

The third main theme identified in this research was the environmental attitudes affecting the respondents' care of the traumatised children. Yontef (1993: 125) states that human beings are inextricably linked to their environment. They constantly impact on and interact with their environment. It is therefore understandable that the environment would also impact on alternative caregivers as they care for the traumatised child.

The two subthemes identified under the main theme are government and local community. These subthemes will subsequently be discussed.

2.3.3.1 Government

Respondents pointed out that the government forms part of the environment demonstrating certain attitudes towards the care system and alternative caregivers. These attitudes are often not supportive, or not sufficiently supportive, according to the respondents. The following issues relating to the government's attitude were identified:

- **Welfare systems not sufficiently functional**

Respondents felt that up till now, policies and procedures within the welfare system regarding the care of children have not been very clear. Respondents often felt unsure of their task as alternative caregivers and had no concrete procedures to follow for certain difficult situations. One of the respondents, for instance, had to deal with biological parents that arrived at her door and wanted to take their child from the respondent's house. Due to the fact that she had no clear guidelines to follow, she was unsure how to handle the situation.

Foster care and kinship care, both falling under alternative care, have been under review as part of the Review of the Child Care Act of 1983 that is still in process. Several recommendations have been made regarding alternative care, which hopefully will be accepted and included in the new Act. Should these recommendations be implemented in the care system, the researcher believes that alternative caregivers, for one, would have far less problems with the biological parents.

Another problem that the respondents experienced was the lack of a placement and follow-up plan implemented with them by the social worker before the child

was placed in their care. This lack of clarity on the part of the welfare system has been leaving the respondents and children with a great deal of uncertainty. The Review of the Child Care Act of 1983 does not address the issue of a placement and follow-up plan, although this is part of practice in countries like the United Kingdom (Fahlberg, 1999: 244).

In general, the respondents' opinion of the government was that they had an attitude of "… who cares? What does it matter?" The respondents believed that the government did not really care about them or the welfare of the child in care, and this left them feeling very discouraged about their task as alternative caregiver.

When systems are properly in place, according to Fahlberg (1999: 176), children, ideally speaking, will be prepared for the move from the biological family to alternative care. This would involve a discussion about placement procedures and goals with both the parents and the child by the social worker. Roles of the alternative caregiver and social worker in facilitating change would also be identified in situations like these, emphasising the fact that for a successful outcome everyone needs to work together. Furthermore, prior to the placement a schedule and arrangement for postplacement contacts would be set up, as well as fixed times for re-evaluation of the follow-up plan and the progress towards goal achievement. Photo albums may, according to Fahlberg (1999: 176), also be used to first introduce the child to the prospective alternative caregiver's family.

The researcher feels that the government needs to put more effort into ensuring that existing systems are functioning effectively, thereby showing that they do have the alternative caregivers' and children's best interests at heart. This will instill faith in the government's support and create more confidence in the alternative caregiver's own ability. Precisely the lack of support was another issue identified as one of the government's attitudes and will be discussed next.

- **Lack of support**

As already mentioned, respondents felt insufficiently supported by the welfare system. Respondents gave a number of reasons that, in their opinion, contributed to this feeling of no or too little support. Firstly, respondents identified the fact that social workers are completely overworked and consequently unable to provide the necessary support and input needed by the alternative caregiver. They also felt that there was no mechanism in place to ensure that alternative caregivers are being listened to and heard. Respondents need a structure enabling them to voice their complaints and suggestions, knowing that these are being seriously considered. Finally, respondents felt that the government and welfare system which are supposed to support them financially and materially, were placing excessive demands on them which they were unable to meet.

In the Review of the Child Care Act of 1983 many positive comments and recommendations have been made with regard to some of the issues mentioned by the respondents. Firstly the commission who reviewed the Act acknowledged that provision should be made for the necessary support of both foster care and kinship care (care by relatives). More specifically, this commission proposed that relatives caring for children who have been abandoned or orphaned or, for some or other reason, are in need of their assistance but not necessarily in need of formal protective services, should have access to a simple procedure whereby the necessary parental responsibilities can be passed onto them. These should include consent to medical treatment and the capacity to apply for statutory financial assistance on behalf of the children. The commission further proposed that all forms of foster care should be seen as having a professional dimension, since the majority of children placed in care nowadays have behavioural problems and therefore do not only need care, but also therapy. As a result, financing of the care service should take into account the need for training and support of alternative caregivers. As mentioned earlier, an additional allowance is recommended by the commission to be paid to alternative caregivers caring for

children with special needs, including behavioural and emotional problems, in addition to the current foster care grant (Review of the Child Care Act Executive Summary, 2002, Chapter 17).

Temple-Plotz *et al.* (2002: 41) emphasises the importance of all the systems working together as a team, in order for a child to receive proper care. Having good relationships with the schools, medical facilities and welfare systems are crucial in meeting the child's needs and providing support to the alternative caregiver.

It is encouraging that recommendations have been made to update the Child Care Act of 1983 in order to provide better support for alternative caregivers. Unfortunately, these proposals have still to be accepted and confirmed in the new Act. As a result, the researcher has found very little resources available in terms of actual support for alternative caregivers in the Northern Cape.

2.3.3.2 Local community

According to the respondents, the local community also demonstrated certain attitudes towards them as alternative caregivers and to the care system as such. The following issues relating to communities' attitude were identified:

- **Lack of understanding**

Respondents felt that there was a lack in sharing information and educating communities on topics such as "the child in care" and "the care system". According to the respondents, communities seem to lack understanding of the issues experienced by them. A lot of insensitivity is shown by the community to the respondents and children in care. Children, and even adults, would often make insensitive remarks about a child in care and his biological family, or bully or tease the child. Respondents are often accused falsely, for example, that they

are misusing the child care grant. They further experience no sympathy, gratitude or understanding from the community for their role and task as alternative caregivers, purely because the community does not understand the process of caring and the challenges involved in caring for someone else's child.

According to the respondents, even schools have little understanding of the needs of the child in care and the role and tasks of the alternative caregiver. This lack of awareness by the school sometimes results in situations, which make it difficult for the alternative caregiver to manage with the child. In this regard, Fahlberg (1999: 338) highlights how teachers can sometimes assign certain projects regarding the biological family as homework, for example, asking the children to include events such as their christening or the first time they lost a tooth. This creates unsettling emotions for the child in care who do not have information about these events in his life. Often, these feelings once again result in demanding behaviour displayed by the child.

It is clear to the researcher that the broad community has to be properly educated and informed about the care system, the nature and needs of the child in care and the tasks and roles of the alternative caregiver. By being informed and having a better understanding of the care system, the community would fulfil an important task by providing support to these families and helping the child heal and lead a normal life.

- **Lack of involvement**

Respondents felt that the local community has been uninvolved with alternative caregivers due to their lack of interest in the role and task of the alternative caregiver. As a result, alternative caregivers have to struggle alone, receiving no concrete, physical or financial support from the community.

The researcher believes that the alternative caregivers and communities need to reach out to one another in order to provide help and support where necessary.

Bronfenbrenner's model (in Finlay, 2006: 69) displays the interconnectedness of the social systems in the environment within which alternative caregivers exist. Within the Gestalt approach, these systems refer to the field within which individuals function. The field is seen as a whole in which the parts are in immediate relationship and responsive to each other, and where no single part is uninfluenced by what goes on elsewhere in the field (Yontef, 1993: 125). The researcher is of the opinion that it would be important for alternative caregivers to have an awareness of the field within which they exist as part of the whole. By having this awareness, alternative caregivers will be more conscious of resistance as well as support within the field.

FIGURE 2.4: SCHEMATIC PRESENTATION OF MAIN THEME, SUBTHEMES AND CATEGORIES AS IDENTIFIED FROM EMPIRICAL DATA: MAIN THEME 4

MAIN THEME	SUBTHEMES	CATEGORIES
Respondents' opinion of **the needs that arise** when caring for traumatised children	Skills development	• Skills development in how to care for the traumatised child
	Greater awareness	• Raising communities' awareness of the child in care, the alternative caregiver and the care system • Need for concrete help
	Open communication	• Alternative caregiver vs systems • Biological parents

2.3.4 Main theme 4: Respondents' opinion of the needs that arise when caring for traumatised children

The fourth main theme identified in this research was the needs that arise when caring for traumatised children, namely skills development, greater awareness and open communication. These subthemes will subsequently be discussed.

2.3.4.1 Skills development

According to the empirical data respondents have a specific need for skills development when it comes to care of the traumatised child.

- **Skills development in how to care for the traumatised child**

Through the process of caring for the children, respondents have become aware of their own limitations. They experience a lack of knowledge in how to parent a child who have been traumatised and also feel inadequately informed about the histories that these children may have. They experience the signs and symptoms of attachment problems, but do not have the practical knowledge of how to build trust again and form a new attachment. They also have to deal with the bereaved child, but have no knowledge of the grieving process and how they should support the grieving child emotionally. Respondents also mentioned that they have some understanding of the reasons why the adolescent have angry outbursts, but once again they have a strong desire to develop skills in handling angry adolescents as well as younger children. Respondents would like to develop these skills by attending further courses and basic counselling training.

Fahlberg (1999: 154) states that alternative caregivers deserve to have both knowledge and emotional support, enabling them to help the child through the various stages and processes, whether it is the grief process or a traumatic process. At the same time, healthy new relationships are being built. Without this,

the likelihood of long-term attachment problems occurring is great. Fahlberg (1999: 163) continues, saying that alternative caregivers have the responsibility to help children and their parents cope with pain and loss, not to protect them from the reality of life. It is the researcher's view that alternative caregivers can only fulfil these tasks if they have received proper skills development training.

2.3.4.2 Greater awareness

According to the empirical data, alternative caregivers feel the need for creating greater awareness amongst the communities about the child in care, the alternative caregiver and the care system. Specific categories identified by the respondents were the following:

- **Raising communities' awareness of the child in care, the alternative caregiver and the care system**

Respondents felt that the community needs to be educated about the care system and especially the role and tasks of the alternative caregiver. One respondent stated: "The people and places like the schools and churches need to be informed about our rights and duties as alternative caregivers. They place expectations on us and the children that cannot be met."

In order for alternative caregivers to experience support and understanding from the community in this role they fulfil, the need to inform and educate the community is as clear as it is important. In the South African Child Gauge (2006:6) the following is stated:

> It should be the priority of government, business, civil society and indeed every individual to understand and combat the conditions that children often live in. Even in alternative care poverty is experienced, including a lack of

access to services, infrastructure and opportunities. It is therefore imperative that intersectoral collaboration between all government departments that impact on child well-being is required to ensure integrated development and service delivery.

- **Need for concrete help**

Apart from the fact that a greater awareness amongst the communities about the caring system and all involved needs to be created, the respondents have felt that the need for concrete and bigger financial help must also be expressed. The foster carer who was one of the respondents in this study (see 1.5.1.1), shared the view with the other caregivers, although the amount she received for a foster child was R620. Despite this sum being higher than what an alternative caregiver receives, she said it did not cover all the financial needs of the child in foster care.

According to the South African Child Gauge (2006: 39), the child support grant (CSG) was introduced in 1998 to provide the poorest parents or alternative caregivers with a small monthly cash amount to cover some of their children's basic needs. The cash value is currently R200 per child per month. According to the conditions of the CSG, the primary caregiver does not have to be related to the child or children to receive the grant, but has to be the person who looks after them and takes responsibility for their everyday needs such as food, clothing, schooling and health care. The primary caregiver, in other words, can be a sister or brother, a grandparent, a friend or a neighbour (The Child Support Grant, 2005-2007). This grant is available for children under 14 years. A means test is applied to the income of the child's primary caregiver and spouse if they are married, and do not take into consideration the number of children in their care. Despite inflation, the means test has remained the same since its introduction in 1998. Failure to adjust the means test excludes more children each year from

receiving the CSG. Other obstacles preventing children from receiving the CSG, appear to be difficulties in acquiring the right documentation and gaining access to the relevant offices to apply. Furthermore, the current social assistance system only provides social security for children younger than 14 years and for adults over 60 (females) or 65 years (males). Thus, there is no protection for people between the ages of 14 and 60/65 years, unless they are disabled or sick (The Child Support Grant, 2005-2007).

Research has shown that social assistance grants do help in lifting households out of the deepest poverty. Research has also shown that even grants that are not targeted at children – such as the old age pension – are often used for the benefit of children in that household. Most of the grants targeted at children and their alternative caregivers are much lower than even what people working in the informal economy are likely to earn (South African Child Gauge, 2006: 29).

It is the opinion of the researcher that care grants in the South African welfare system compare very poorly with grants in other countries and is not nearly enough to meet even the most basic needs of a child in care. In the UK the government's national minimum allowance for alternative caregivers relates to the basic core allowance which alternative caregivers receive to cover the basic costs involved in looking after any child in alternative care. The actual level of allowance that an alternative caregiver receives, depends on a number of factors, in particular the specific needs of an individual child. Allowances are increased annually on a par with the rate inflation (Foster Care, 1995-2007). As discussed earlier in the chapter, every child has the right to basic clothing necessities and his own possessions, but the grants in South Africa do not allow for even these basic rights to be exercised. Respondents in this research were single caregivers with no other means of income and would therefore appreciate any other form of support.

2.3.4.3 Open communication

The third subtheme identified from the empirical data is respondents' need for open communication with other systems and the biological parents. The following categories were distinguished under open communication:

- **Alternative caregiver vs systems**

Respondents felt that there was not enough openness between alternative caregivers and the social services department. They would like to be fully informed about a child before placement. They would also value feedback on the standard of their care, and they expressed the desire to be able to access these services whenever they need to do so. Respondents felt that there is very limited access to the government system and very little way to lodge complaints and/ or suggestions. One respondent expressed the following: "I often do not feel listened to by the social worker or government. I mostly feel pressured and under attack instead of supported. There is seldom a 'thank you'". Respondents expressed the need for open communication between all the systems in order for policies and procedures to be properly implemented.

The lack of open communication between alternative caregivers and the departments create misunderstandings, distrust and great uncertainty on the part of alternative caregivers. Levy and Orlans (1998: 25) therefore are of the opinion that everyone involved with a child's care should work together as a team. They should create a secure base for the child, develop and maintain a support system and improve problem-solving skills. The researcher believes that this would only be possible once open communication has been established.

- **Biological parents**

Respondents expressed the wish to have open communication with the biological family of the children in their care, although they believed that it might be difficult. To them it was important to make sure that the parents are being rehabilitated and undergoing a parent guidance programme in preparation of the return of their children. Respondents felt that they needed to be sure that the situation with the biological parents have changed and improved before the child is returned home.

Temple-Plotz *et al.* (2002: 53) is of the opinion that it is an important part of the alternative caregiver's responsibility to help the parents learn the necessary parenting skills and support other professionals who are helping the child's parents. In this regard, Fahlberg (1999: 181) describes alternative care as shared parenting and feels that biological parent involvement is beneficial to everyone involved – the child, parents, alternative caregivers and social workers.

According to the Children's Amendment Bill, 2005 (Act No. 38 of 2005), the main purpose of alternative care in the South African context is the reunification of the child with his birth family. Relationships between children and their parents and other family members should therefore be supported, encouraged and facilitated, and families and family relationships are to be strengthened and preserved whenever it is in the best interest of the child. The goals of permanency planning towards family reunification as a priority option should be promoted. Otherwise children should be connected to other safe and nurturing family relationships intended to last a lifetime.

The researcher agrees with the respondents that it might be difficult for them to have openness between them and the biological parents, but believes that in spite of this fear it should be encouraged since it could have many benefits. The system in South Africa is perhaps not fully developed yet, but systems in other

countries have shown the benefits of working together as a team that includes the biological parents (Fahlberg, 1999: 185). Fahlberg goes on to say that regular visits between the child and the biological parents would help alternative caregivers to better understand the child's background and perceptions of the child's parents. Such visits would also help the goal of assessing what changes need to take place for the child to return home. The involvement of the alternative caregivers with contact sessions between the children and their biological families also decrease the likelihood of alternative caregivers having fantasies of rescuing these children from their "terrible home circumstances". Direct contact between biological parents and alternative caregivers also provide opportunities for the alternative caregivers to model healthy family relationships, which may help the biological parents in their process of change (Fahlberg, 1999: 185).

The purposes of alternative care as stated in the Children's Amendment Bill, 2005 (Act No. 38 of 2005) need to be structured and applied thoroughly. While the respondents have identified the need for openness between alternative caregiver and biological parents, they have not yet experienced the implementation of the Act's purposes practically.

2.4 CONCLUSION

The focus of the empirical study was to determine the perspectives of alternative caregivers on the existing extent of the need for guidelines for alternative caregivers to enhance the attachment relationship with the children in their care. From the empirical data and the relevant literature a number of suggestions were made that could be helpful for caregivers in encouraging the attachment relationship between the caregiver and child. A specific goal and objectives were also formulated.

The researcher presented the four main themes, subthemes and categories in four schematic figures (Figures 2.1-2.4).These different steps in the method of

analysis helped the researcher to understand the concerns and needs of the respondents, with a view to establish Gestalt guidelines to assist alternative caregivers in enhancing attachment with the traumatised child.

2.5 SETTING THE GOAL AND OBJECTIVES

After the concerns of the population were identified and analysed, the researcher was able to set the goals and objectives for this study. The goal of this research study was to establish guidelines from a Gestalt perspective to assist alternative caregivers in enhancing attachment with traumatised children in their care. The objectives for this study are:

- To undertake a thorough literature study on attachment and how it can be enhanced through the utilisation of applicable Gestalt principles with the traumatised child in alternative care;
- to determine functional elements of existing guidelines for alternative caregivers to be used when establishing Gestalt guidelines for alternative caregivers to assist them in enhancing their relationship and attachment with the child;
- to establish guidelines from a Gestalt perspective to assist alternative caregivers to enhance their relationship and attachment with the child;
- conclusions and recommendations to be made to assist alternative caregivers and field social workers and contribute to further research.

These objectives will be discussed in Chapter 3, 4, 5 and 6.

CHAPTER 3
GATHERING INFORMATION

3.1 INTRODUCTION

This research study sought to develop Gestalt guidelines for alternative caregivers to enhance attachment with the traumatised child. The focus of the empirical data in Chapter 2 was to complete the steps of the first phase of intervention research. From the perspectives of the alternative caregivers involved, the extent of the existing problems and the need for such attachment guidelines were established. Several problems relating to the relationship between the alternative caregiver and child were identified, as discussed in Chapter 2.

In this chapter the second phase of the design and developmental model of intervention research was carried out, which was to gather information from relevant literature. Information on attachment is therefore presented below, while attention is also given to the Gestalt concepts relating to attachment, and how attachment in the relationship between the alternative caregiver and child can be enhanced through the use of these concepts.

3.2 DEFINITION OF ATTACHMENT

Fahlberg (1999: 14) defines attachment as "… an affectionate bond between two individuals that endures through space and time and serves to join them emotionally." Archer (1999: 36) further describes attachment as "… a relationship that develops between two or more organisms as their behavioural and physiological systems become attuned to each other."

Attachment, for the purpose of this study, is the deep and enduring connection established between a child and alternative caregiver in the first several years of life, allowing the child to develop both trust for others and self-reliance. It affects all components of the human condition, namely mind, body, emotions, relationships and values (What is attachment? 2001). The child's earliest attachments, according to Fahlberg (1999: 14), become the prototype for subsequent interpersonal relationships.

It is important to have a clear knowledge and understanding of what attachment is. An understanding of what a normal attachment between a parent and child is, would further provide a basis for an assessment of the strengths and weaknesses of the attachment relationship between alternative caregiver and child. The researcher will subsequently discuss the attachment theory and secure attachment, followed by a discussion of the various types of attachment as part of an insecure attachment, which manifests with many of the traumatised children in care.

3.3 ATTACHMENT THEORY

Hughes (2004: 264) states that attachment theory and research has evolved into a primary model of child development. It serves as a foundation for affective, social, cognitive and behavioural development throughout the life cycle. The development of attachment security in the child therefore seems crucial for all subsequent development. Several authors (cf. Howe, 2006: 128; Hughes, 2004: 264; Smith, [sa]) agree that once infants feel safe, much of their energy is expended in becoming engaged with others, especially their primary attachment figure. Their cerebral activities focus on learning and responding to the social and emotional signals of their alternative caregivers and neuropsychological development takes place. Maintaining the bonds of trust, attaining full intellectual potential, acquiring a conscience, developing relationships with others,

developing an identity and self-esteem, learning to regulate feelings, language development, brain structures and the organisation of the nervous system are all results of a healthy attachment (Smith, [sa]). Howe (2006: 128) describes this as "… young minds forming in the context of close relationships." Howe (2006: 128) continues, saying that a secure attachment between alternative caregivers and children therefore exist where alternative caregivers are responsive and available at times of need, sensitive and emotionally attuned to children.

Perry (2001: 5) refers to a simple process called the strange situation procedure developed by Dr Mary Ainsworth, to examine the nature of a child's attachment. According to this procedure, the mother and infant are observed in a sequence of "situations". Following this process, four categories of attachment were identified, namely secure, insecure avoidant, insecure ambivalent and insecure disorganised attachment. These four categories are discussed below.

3.3.1 Secure attachment

Gray (2002: 67) describes secure attachment as a "… relationship involving intimacy, exclusivity, mutual enjoyment, acceptance and recognition of the other's feelings." Secure attachments normally develop in the first year of life, when parents meet children's needs over and over again. The attachment cycle, or "season of the soul" (see Figure 3.1), describes the process that the infant goes through with the alternative caregiver in forming attachment. The interaction is initiated by the child's need and consequent expression of displeasure, and completed by the alternative caregiver's response. It is the relief of this displeasure which is an integral part of the attachment process. The alternative caregiver's role when the infant is venting his tension is to help the child return to a quiescent state. Repeated completion of this cycle helps the child to develop trust and security, and to become attached to his alternative caregiver (Fahlberg, 1999: 26).

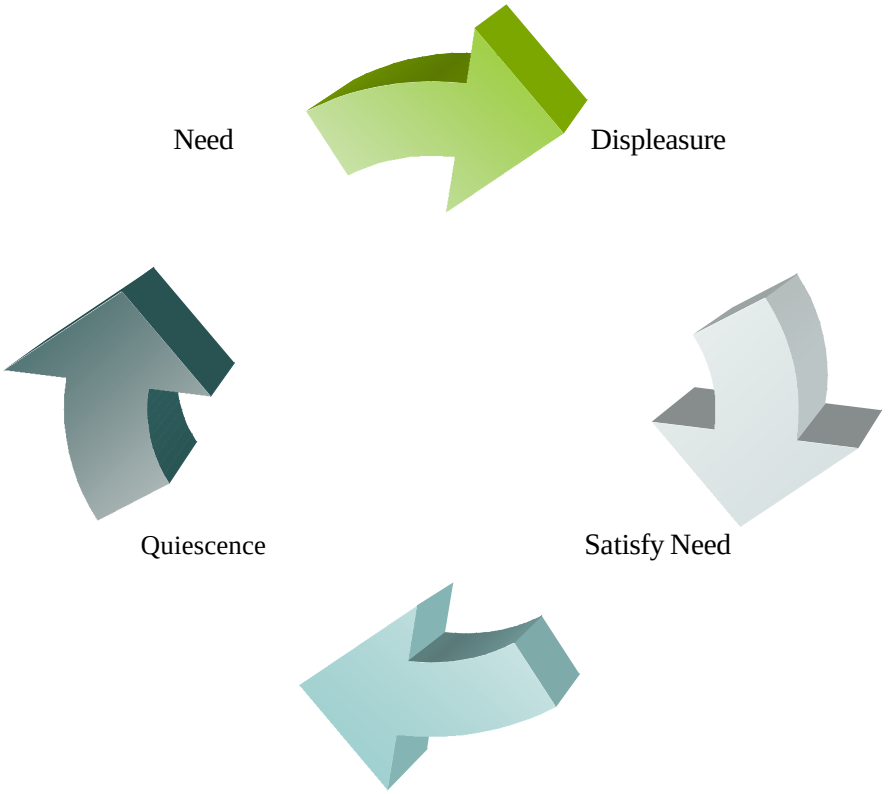

FIGURE 3.1 The attachment cycle

In secure attachments, children have formed what is called an "internal working model," or template, allowing children to believe that alternative caregivers will respond to them (cf. Gray, 2002: 68; Randolph, 2002: 5). Bowlby (in Randolph, 2002: 5) believes that this "internal working model for attachment" forms the basis for all social interactions throughout the remainder of the child's life and becomes a "fixed model" by the age of one year.

Ainsworth (in Randolph, 2002: 6) mentions seven **universal attachment behaviours** towards alternative caregivers, that were consistently seen in children across cultures. These universal attachment behaviours are:

- Making long-lasting and intense eye contact with the alternative caregiver;
- following the alternative caregiver, particularly in strange settings;
- protesting when the alternative caregiver is absent;

- engaging in reciprocal touch, speech and social interactions with the alternative caregiver;
- gently touching and playing with the alternative caregiver;
- refusing comfort from anyone other than the alternative caregiver;
- the child does what the child is asked to do, even when this is not what the child wants to do.

According to Ainsworth (in Randolph, 2002: 6), a healthy attachment could only be present when all of these behaviours were repeatedly shown to the alternative caregiver, but not shown to other adults other than the alternative caregiver. Should a child fail to consistently show these behaviours to the alternative caregiver, or show these behaviours to other adults other than the alternative caregiver, this is believed to indicate an attachment disruption for the child.

Kagan (2004: 21) discusses a few more indicators of a healthy attachment. Signs of attachment would include that a child spontaneously looks for a hug or affection from a significant adult, and that a child can be soothed by the alternative caregiver. A child's reaction of protest to the absence of the alternative caregiver is also believed to be a sign of attachment. Furthermore, attached children will recover quickly from minor hurts and insults when held by their alternative caregiver. Finally, they will spontaneously hug or put their arms around the alternative caregiver, will demonstrate confidence and have a positive view of their potential in the world.

In addition to Kagan's view that attached children demonstrate confidence and have a positive view of their potential in the world, Fahlberg (1999: 14) highlights the many positive long-term effects of children's strong, healthy attachment to their alternative caregivers. It can enable children to:

- Attain their full intellectual potential;
- sort out what they perceive;

- think logically;
- develop social emotions;
- develop a conscience;
- trust others;
- become self-reliant;
- cope better with stress and frustration;
- reduce feelings of jealousy;
- overcome common fears and worries;
- increase feelings of self-worth.

Several other important functions of a secure attachment in children are given by Levy (2000: 7). These include:

- Learning basic trust and reciprocity, which serve as a template for all future emotional relationships;
- exploring the environment with feelings of safety and security ("secure base"), which leads to healthy cognitive and social development;
- developing the ability to self-regulate, which results in effective management of impulses and emotions;
- creating a foundation for the formation of identity, which includes a sense of competency, self-worth and a balance between dependence and autonomy;
- establishing a prosocial moral framework, which involves empathy, compassion and conscience;
- generating the core belief system, which comprises cognitive appraisals of self, caregivers, others and life in general;
- providing a defence against stress and trauma, which incorporates resourcefulness and resilience.

Children who begin their lives with the essential foundation of secure attachment seem to fare better in all aspects of functioning as development unfolds. On the

other hand, Gray (2002: 20) states that children who miss the attachment cycle and never come to the comfort part of the cycle, will for the rest of their lives base all of their perceptions of and interactions with others upon this "fixed internal model for attachment" as mentioned earlier by Bowlby (in Randolph, 2002: 5). As a result, an insecure attachment is created. Insecure attachment and the number of subtypes will be discussed subsequently.

3.3.2 Insecure attachment

An insecure attachment describes the condition of children who cannot count on their alternative caregivers as constant, safe bases of nurture and caregiving (cf. Gray, 2002: 69; Howe, 2006: 128). Lack of a strong attachment between a child and alternative caregiver can result in failure to thrive, conduct disorder, anxiety and depression, poor social skills, borderline personality disorder, regulation and self-control problems, low frustration tolerance, short attention span, poor concentration and problem-solving skills, poor peer relations, limited ability to adapt to adversity, social aggression and disruptive behaviour disorders (Kagan, 2004: 12).

Gray (2002: 21) explains why children sometimes lose out on forming attachments. Some of these common reasons why children could experience attachment problems are preventable and some are not. They are the following:

- Separation from alternative caregivers through foster care moves;
- prenatal exposure to drugs and alcohol;
- traumas like sexual abuse, physical abuse and domestic violence;
- major depression, schizophrenia or manic-depressive illness in the parent figure;
- drug or alcohol addiction in the parent figure;
- orphanage care;

- hospitalisation of parent or child, during which children lose access to their parents;
- neglect.

Insecurely attached children seem to feel inconsistent, punishing, unresponsive emotions from their alternative caregivers and feel threatened during times of stress. Insecure attachment can be divided into the following categories, namely insecure avoidant, insecure ambivalent and insecure disorganised attachment.

3.3.2.1 Insecure avoidant attachment

In avoidant attachments, children still feel connected to the alternative caregivers, but cannot trust them to meet their needs in a reliable, pain-free or sensitive manner (Gray, 2002: 70).

- **Alternative caregivers' behaviour**

Avoidant attachment arises when alternative caregivers are indifferent towards or even rejecting the children. They show a lack of interest in the children's needs and emotional state (Howe, 1995: 12). According to Howe *et al.* (1999: 27), children with this form of attachment pattern experience their alternative caregivers as rejecting, interfering and controlling. In situations like these, alternative caregivers seem to be annoyed or agitated when the children show distress. The result is a rebuff or an aggressive attempt to control or deny the children's attachment behaviour, which can consist in crying, clinging, being demanding or distressed. The child's behaviour therefore seems to bring forward the opposite of what the behaviour is designed to achieve, namely proximity to and a feeling of security with the attachment figure. Levy and Orlans (1998: 15) add that these alternative caregivers are often not emotionally and physically connected and often have a critical view of the children. They are dismissive of

attachment, often have forgotten most of their own childhood and tend to deny unpleasant events.

- **Children's behaviour**

Children with an insecure avoidant attachment conclude that it is safer and better if they could be self-reliant, thus they do not seek comfort or ask for help. These children treat strangers in a similar way as their alternative caregivers and avoid any closeness. They show little apparent signs of distress when separated from their alternative caregivers and will either ignore or avoid their alternative caregivers upon reunion. Other people are viewed as a source of potential hurt and pain, and all trust in the adult world is lost (cf. Randolph, 2002: 26; Gray, 2002: 70; Howe, 1995: 12; Levy & Orlans, 1998: 15).

Randolph (2002: 26) highlights the following characteristics as typical of children with these attachment difficulties:

- They have no friends and do not care that they have no friends;
- they do not need others for anything;
- they push away all closeness with and touching from others;
- they can become explosively angry and destructive if closeness is pushed on them;
- passive-aggressive behaviour;
- they almost never do what they are asked to do;
- they ignore any orders;
- controlling behaviour;
- they argue constantly;
- bossy behaviour.

The primary emotion experienced by these children is unfathomable sadness, according to Randolph (2002: 27). They will therefore do whatever they have to

do to keep themselves from having to experience this feeling. To them the best defensive strategy seems to be to minimise attachment behaviour and affect. The downplaying of feelings and expressions of distress might be defined as a *flight* from a display of attachment needs (Howe *et al.,* 1999: 28).

3.3.2.2 Insecure ambivalent attachment

An ambivalent attachment is a style in which children alternately push alternative caregivers away and cling to them (Gray, 2002: 72).

- **Alternative caregivers' behaviour**

In this category, care tends to be inconsistent, unreliable and unpredictable. Alternative caregivers are not necessarily unloving, but are erratic and insensitive in their care of the children. Children's signals are not always observed or read correctly, and alternative caregivers struggle to put themselves in the children's shoes. Misunderstandings are also common in this category (Howe, 1995: 10).

- **Children's behaviour**

Children who show an ambivalent attachment style often have to maximise their attachment behaviour. They have to break through their alternative caregivers' emotional neglect, unavailability and lack of responsivity in order to increase their chances of getting noticed. Their greatest anxiety is being ignored, abandoned and left alone with needs unmet. They have little confidence in their own abilities to bring about change and get the things they need, and would therefore make use of an aggressive approach, for instance showing distress, whining, clinging, shouting and threatening. They act as if always in a crisis, which produce children who are demanding yet never satisfied or reassured (cf. Howe, 2006: 129; Howe *et al.,* 1999: 28.) To the child, the other person is both emotionally desired and emotionally unreliable, which is deeply frustrating. At any one time,

children's relationships with their alternative caregivers are guided by strong feelings of either love or anger. These children's maximised attachment behaviour, also seen as attention-seeking strategies, might be defined as ones of *fight* – demands for attention and protection (Howe *et al.,* 1999: 28).

3.3.2.3 Insecure disorganised attachment

Children who cannot develop ways to organise information about their alternative caregivers, along with consistent approaches to get needs met, are in the disorganised attachment category (Gray, 2002: 74). This occurs within very disturbed caregiving relationships, where children find it difficult to organise their attachment behaviour in order to feel safe and cared for (Howe *et al.,* 1999: 29).

- **Alternative caregivers' behaviour**

Alternative caregivers of children who have disorganised attachment have been frightening or alarming to their children and are often the actual cause of the initial distress (cf. Gray, 2002: 74; Kagan, 2004: 15; Howe *et al.,* 1999: 29). They could be alternative caregivers who are either dangerous (abusive) or emotionally unreachable, for instance psychotic, depressed or heavy drug or alcohol abusers (Howe *et al.,* 1999: 29*).* These alternative caregivers have been described as often failing to protect the children and often feeling helpless in their roles as alternative caregivers. The alternative caregiver is not necessarily consistently rejecting, but occasionally hostile or scary. Displays of love and affection may be dispersed amongst the aggression and violence (Howe, 1995: 13). When they have lost attachment figures in their own lives, alternative caregivers are especially vulnerable to problems in raising children. The children's attachment-seeking behaviour may trigger painful memories of their parents that have not been resolved. As a result they may become disorientated and unable to care for or comfort their children. Alternative caregivers who remain traumatised from violence suffered at the hands of their siblings or

spouse, may react with detachment, rage or ambivalence towards the children when triggered by the developing images, gestures, tone of voice or other nonverbal behaviours of the children (cf. Kagan, 2004:16; Levy & Orlans, 1998: 17).

- **Children's behaviour**

Children who cannot organise their behaviour, or develop a defence strategy to achieve proximity or security, find that their distress and arousal remain heightened and unregulated (Howe *et al.,* 1999: 29). They find it difficult to maintain a functional and positive relationship with their alternative caregiver, because the alternative caregiver who should be the source of comfort and safety is the one triggering the child's anxieties. In situations like these, the child is presented with an irresolvable conflict (Howe, 1995: 13).

Gray (2002: 74) mentions that these children show levels of extreme rage. They seem to be either unable to play, or only able to play out violent themes that include separation. Children tend to have a sense of helplessness about their relationship with their alternative caregivers. As a result, they use aggression or dissociation in order to cope.

Howe (2006: 129) reasons that, developmentally, abused and neglected children with disorganised attachment suffer more complex and profound impairments, as they experience the worst elements of both avoidant and ambivalent caregiving environments. Emotional arousal and attachment systems remain activated, and much mental time is spent on issues of safety and security, leaving less time for exploration and pleasurable interaction with their alternative caregiver. Children fail to develop coherent models and, as a result, are most at risk of developing behavioural problems, psychopathology and being placed in foster or adoptive care.

Randolph (2002:32) concurs with Howe in saying that children with disorganised attachment often suffer from neurological impairments as a result. This may include low average or borderline intelligence, learning disabilities and/ or sensory integration problems. These children will talk, hum or sing to themselves all day long, primarily as a defence against being overwhelmed by their primary emotion, which is poorly controlled and overwhelming anxiety. They will chatter nonstop and sometimes invent tales of abuse against their foster or adoptive caregivers. This would be as a result of losing track of which parents did what, rather than from a desire to cause trouble for the alternative caregivers. These children are driven by their impulses and unable to stop themselves from being impulsive. They will also do very destructive or dangerous things, but this tend to occur more often at times when they are threatened with traumatic memories, as they have no coping skills to manage intense emotions of any kind (Randolph, 2002: 33).

Howe (1995: 13) and Howe *et al.* (1999: 29) conclude that children with a disorganised attachment pattern are constantly confused in the presence of their alternative caregivers and without an organised attachment strategy, they literally or emotionally *freeze.* This is their instinctive way of trying to cope.

3.3.3 Behaviours reflecting attachment problems

Many traumatised children placed with alternative caregivers seem to have not developed normal healthy attachments to parental figures. Consequently, they display behaviour reflecting one or some of the attachment patterns described above. Unstable foster home placements and the multiple moves that many of these children experience have added to their difficulties in developing trust for and attachment with others.

Hughes (in Kagan, 2004: 17) has compiled a list based on research and clinical experience, of behavioural symptoms of children with significant attachment difficulties. These symptoms include:

- A compulsive need to control others, including teachers and alternative caregivers;
- intense lying;
- poor response to discipline: aggressive or oppositional-defiant;
- lack of comfort with eye-contact (except when lying!);
- physical contact (wanting too much or too little);
- interactions lack mutual enjoyment and spontaneity;
- body functioning disturbances (eating, urinating, defecating);
- indiscriminately friendly and charming; easily replaced relationships;
- poor communication; many nonsensical questions and chatter;
- difficulty learning cause and effect, poor planning and/ or problem-solving;
- lack of empathy;
- increased attachment produces discomfort and resistance.

Fahlberg (1999: 301) adds the following signs and symptoms of attachment problems, namely:

- Withdrawal from interaction;
- aggressive and hyperactive behaviour;
- overcompetency or self-parenting;
- lack of self-awareness.

Temple-Plotz *et al.* (2002: 11) give a list of some warning signs that may indicate that a child in care has an attachment problem. These include:

- Destroying own and/ or others' belongings;
- exhibiting cruelty towards siblings, other children in care or classmates;
- being cruel towards animals;

- having problems developing friendships with other children;
- hoarding or gorging food;
- stealing;
- having poor impulse control.

In this section, the researcher has stated the various forms of behaviour that are symptomatic of attachment problems, as reflected in the literature. Against this backdrop, when looking at the behaviour problems identified by the respondents in the children in their care (see Chapter 2), it is clear to the researcher that these children have some form of insecure attachment.

Whether guided by primary or secondary strategies, children exhibiting secure, avoidant or ambivalent attachment have developed a set of coherent and organised rules based on experience, that predict and guide their future behaviour. They have methods of developing a relationship, even if it reflects dilemmas that are unresolved (cf. Gray, 2002: 74; George in Howe *et al.,* 1999: 29*).*

In the next section, the researcher will reflect on how the Gestalt approach could be used in establishing Gestalt guidelines to enhance attachment between the alternative caregiver and the child in care, and subsequently minimise behaviour problems. Attention is given to the definition of Gestalt and Gestalt approach, to the concepts of Gestalt, and how this perspective relates to attachment in the care relationship.

3.4 THE DEFINITION OF GESTALT

The German word Gestalt is explained by Clarkson (1999: 1) as "… the shape, the pattern, the whole form, the configuration. It connotes the structural entity, which are both different from and much more than the sum of its parts." This aspect is related to holism and is one of the theoretical concepts of Gestalt

theory. Latner (1986: 18) expands on the above by stating that Gestalt is also a cohesive entity, a form that cannot be broken down without destroying it. The parts themselves may change, but as long as the relationships stay the same, the Gestalt will remain intact.

In the context of this study, the children in care as well as their alternative caregivers are being viewed as whole entities where the totality of their beings is more than the components of problematic behaviour and the attachment problems experienced.

3.5 GESTALT APPROACH

The Gestalt approach is a phenomenological-existential therapy founded by Fritz and Laura Perls (Yontef, 1993: 123). In this humanist and process- orientated form of therapy, which is also an existential approach, the emphasis lies on awareness of the present and immediate experience (Blom, 2004: 2). Latner (1986: 7) believes that because people are constantly interacting with and form part of their environment, they have to be aware of themselves. The aim is for individuals to become aware of what they are doing, how they are doing it and how they can change what they are doing (Yontef, 1993: 142). Blom (2004: 4) further states that the existential, phenomenological and holistic approach of Gestalt emphasises awareness in the here and now, as well as the interdependence between people and their environment. This improves organismic self-regulation (see 3.6.5), in that individuals become aware of choices they can make in respect of their relationship with others. It focuses on the phenomenological method of awareness, in which perceiving, feeling and acting are distinguished from interpreting and reshuffling preexisting attitudes. Awareness or insight is seen as the goal of Gestalt phenomenological exploration (Yontef, 1993: 124).

The following summary of the philosophy of the Gestalt approach is given by Passons (in Clarkson, 1999: 14-17):

- A person is part of his environment and cannot be understood apart from it;
- people are capable of being aware of their sensations, thought, emotions and perceptions;
- people are proactive rather than reactive. They determine their own response to the world;
- a person is a whole and is a body, emotions, thoughts, sensations and perceptions – all of which function interrelatedly;
- people can experience themselves only in the present;
- people, through self-awareness, are capable of choice and therefore responsible for their behaviour;
- people possess the potential and resources to live effectively and to satisfy their needs;
- people are neither intrinsically good or bad;
- the past and the future can be experienced only in the now through remembering and anticipating.

It is clear that the basis of the Gestalt approach is awareness. For one to function healthily, it is most important to have this awareness in order to know what one is doing, how one is doing it and how one can change what one is doing.

3.6 GESTALT CONCEPTS

There exist many worthwhile concepts within the Gestalt approach, all of which would probably apply in some way or other to this research study. The researcher is of the opinion, however, that the following concepts identified within the Gestalt approach would be most appropriate in developing guidelines to enhance attachment between the alternative caregiver and the child. These

involve awareness, here and now, unfinished business, impasse, organismic self-regulation, contact, contact boundary disturbances, dialogue and responsibility.

3.6.1 Awareness

Yontef (1993: 139) describes awareness as a form of experience that may be loosely defined as being in touch with one's own existence, with what is. Laura Perls (in Yontef, 1993: 139) supports this view when she states:

> The aim of Gestalt therapy is the awareness continuum, the freely ongoing Gestalt formation where what is of greatest concern and interest to the organism, the relationship, the group or society becomes Gestalt, comes into the foreground where it can be fully experienced and coped with (acknowledged, worked through, sorted out, changed, disposed of, etc.), so that then it can melt into the background (be forgotten or assimilated and integrated) and leave the foreground free for the next relevant Gestalt.

In this study, this would mean that alternative caregivers address the attachment relationship between them and the child as the Gestalt, acknowledging it and working through the issues, for it to melt into the background, leaving the foreground free for the next problem.

Yontef (1993: 139) continues, saying that effective awareness is grounded in and energised by the dominant and present need of the organism. In this study, this would be the need of the alternative caregiver for closer attachment with the child in care. It involves not only self-knowledge, but knowing the current situation and how the self (alternative caregiver) is in this situation. In other words, any denial of the situation and its demands of the alternative caregiver's wants and chosen responses would be a disturbance of awareness.

According to Yontef (1993: 140), “Awareness is accompanied by owning. This means that one is aware of one’s control over, choice of and responsibility for one’s own behaviour and feelings.” The researcher believes that by owning their situation of caring for a child, alternative caregivers will increase their awareness. Increasing their awareness will include choosing how they want to react towards the child in care and will allow themselves to feel in the situation and taking responsibility for their actions and feelings and not blame the child. Some respondents gave the impression that they did not have any control over their situation and were the victims of their circumstances. Yontef is of the opinion that people have to “become aware of what they are doing, how they are doing it and how they can change themselves, and at the same time, learn to accept and value themselves” (Yontef, 1993:124).

The researcher therefore believes that once alternative caregivers become more aware of how they are acting as alternative caregivers, and the reasons for it, they will also be more aware of what changes need to be made. Once changes have been made and alternative caregivers have also learned to value and accept themselves, they may begin to feel more in control of their situation and more confident in their caring of the child, as well as more willing to work on a closer relationship with the child.

According to Schoeman and van der Merwe (1996: 41 -53), traumatised children often block their awareness through their sensory modalities, as a result of the abuse or neglect they have suffered. This leaves them with little awareness of their feelings and needs. It would be important for alternative caregivers to be made aware of the above-mentioned aspect. Since people experience awareness of situations through their five senses (hearing, touch, smell, taste and sight), it is essential that these children’s sensory skills be developed in order for them to make meaning of their surroundings and relationships. As the child’s awareness develops, he can start to explore the options and choices available, experiment with new ways of interacting with the world, or deal with

fears that he has thus far hidden to prevent him from improving his behaviour/ choices (Oaklander, 1988: 58).

Clarkson (1999: 78) believes that the client's awareness of unfulfilled needs or experiences is a process of discovery and development. The amount of change regarding awareness and attachment in the alternative caregiver-child relationship will depend on the individual child and alternative caregiver.

3.6.2 Here and now

Experiencing the here and now begins with sensation. One's sensory exploration enlivens one in the moment (Zinker, 1978: 78-79). Sensory exploration can be seen as a direct experience which is used as a primary tool and always focuses on the here and now (Yontef & Jacobs, 2000: 321). According to Yontef (1993: 149), "now" starts with the present awareness of the individual.

Lewin (in Clarkson, 1999:9) states:

> Behaviour is determined by the psychological present (here and now) more than by the past or the future. People can experience themselves only in the present. The role of the past and expectations about the future can be experienced in the now only through remembering and anticipating.

In setting guidelines for alternative caregivers to enhance attachment with the children, it would be important to look at alternative caregivers' experience of past events or similar caring situations with children, in the context of the question how those experiences affect both alternative caregivers and children in their current functioning. Similarly, alternative caregivers would need to be aware of the fact that children's past experiences might have an effect on their current behaviour and the relationship between alternative caregiver and child. More

importantly though, it should be determined what meaning these experiences and any unfinished business from the past have for the children in the here and now, and how it affect their current functioning (cf. Blom, 2004: 58). Through her experience with children in alternative care placements, the researcher has found that the problem behaviour displayed in the here and now often appeared to be linked to attachment difficulties experienced in the past.

3.6.3 Unfinished business

Yontef (1993: 78) views unfinished business as unexpressed feelings or concerns and unsatisfied needs. Joyce and Sills (2001: 130) expands on this by saying that unfinished business are "… situations in the past, especially traumatic or difficult ones, which have not achieved satisfactory resolution or closure for the individual." These authors (2001: 130) speak of introjects or beliefs that prevent closure. Introjects are where individuals allow others to impose their views or values on them and act accordingly, although the individual does not own it. For example, as discussed in 3.3.2.1, children with attachment problems may harbour the belief that they do not deserve to be loved, because of the way their primary caregivers have acted towards them. The original need for love is then denied and pushed out of awareness and this creates a situation where certain needs are unmet.

Sometimes, the individual just seems to be stuck and that which is unfinished or unresolved is unclear and may only show as a certain behaviour without an obvious cause (Joyce & Sills, 2001: 130). The child with an insecure avoidant attachment may push away all closeness with others (behaviour) as a defence strategy. The "unfinished business" is then the experience of unfathomable sadness that was experienced in their original relationship with their parents, because their attachment needs were not met. The reluctance to face this feeling of sadness is an example of what is called a stuck point or an impasse, which will subsequently be discussed.

3.6.4 Impasse

Yontef (1993: 144) views an impasse as a situation in which external support is not forthcoming and the individual believes he cannot support himself. The most frequent method then of trying to cope with the situation is to manipulate others. According to Joyce and Sills (2001: 131), old patterns are safe and familiar, albeit painful or uncomfortable. They are tried and tested ways of getting needs met sufficiently or to a certain degree when there seem no other way of managing the difficulty. As shown in this study, traumatised children with attachment problems will display typical controlling behaviour in order to get their needs met, since there was no support for them originally when needs arose, so that alternative measures had to be put into operation.

In order for attachment to be enhanced between the alternative caregiver and child it would be important for the child to break through this impasse barrier. The researcher agrees with Joyce and Sills (2001: 131) who state that it is hard for a person to abandon a practiced response that may at some time have felt life-saving. Abandoning a familiar response creates a sense of danger and feels unsafe. This is, however often the occasion for the most potential change and growth. For example, the child experiencing a deep sense of unfathomable sadness as an impasse, can be helped and supported by the alternative caregiver and professional to get fully in contact with these feelings and their cause. This can then lead to a cathartic experience where the child can begin to work through and finish situations from the past, setting himself free to start trusting and building attachment again (Thompson & Rudolph, 2000: 166).

Alternative caregivers, with the help of a professional with a Gestalt background, need to assist these children to become unstuck and finish their unfinished business. This process forms part of organismic self-regulation which will now be discussed.

3.6.5 Organismic self-regulation

Aronstam (in Blom, 2004: 11) views organismic self-regulation as a way in which individuals satisfy their needs both within the individual and from the environment. In order to grow and develop, people strive to maintain a balance between gratification and tension elimination (cf. Clarkson, 1999: 21; Blom, 2004: 11.) MacKewn, as quoted by Brink (2006: 86), finds it important for every person to be aware of his own pattern of meeting these needs and to learn how to deal with them effectively, if they are not met in a healthy and balanced way.

In order to enhance attachment between the alternative caregiver and the child in care, it must be considered that the child has formed part of a family and community called the unified field (Parlett, 1997: 1). How the child's needs were met and how the child went about meeting his needs, have to be considered within the "unified field". With most of the children in alternative care, their need for attachment has not been met in their original families and a disturbance in their organismic self-regulation has occurred. It would be important for the alternative caregiver to explore the needs of the child and help him find ways to meet these needs. The child's awareness would have to be raised of how past issues impact on the child's relationship with others now. The child should then be empowered to take responsibility for changing his reality as a whole, including the child's relationship with others in the new unified field consisting of a new family and new community. These changes will affect the child's equilibrium and may require him to take risks and try something different in his relationship with the alternative caregiver. Building new ways of dealing with the world is the function of disequilibrium. Eventually, "old" information can be reorganised and new views and behaviour can develop. This is called integration. Old elements such as wrong beliefs regarding caregivers (not trustworthy) can be transformed into something new (adults can be trusted), and this new information can become part of the self. This integration makes new attitudes, behaviour and emotional

responses possible, such as trusting and attaching to caregivers (Hoosain, 2003: 5).

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3.6.6 Contact

According to Yontef and Jacobs (2000: 305), contact refers to "… being in touch with what is emerging here and now, moment to moment." Contact is further seen as an integral part of all experience; therefore no experience can exist without contact (Yontef & Jacobs, 2000: 313).

Contact takes place as soon as the organism uses the environment to meet his needs (Blom, 2004: 19). Healthy contact occurs when the individual is aware, with all his senses intact. That is when the senses are being used to look, listen, taste, touch and smell with. The use of the intellect (thoughts, ideas, wants), as well as the ability to express emotions are both also important in making healthy contact (Oaklander, 2003: 144). Contact-making therefore implies that the environment is used for satisfying needs. Through contact-making and satisfying their needs appropriately, children and alternative caregivers will grow in their relationship. In the researcher's experience, most children in care unfortunately have experiences of where contact was made with their environment (primary caregivers) in order to meet their needs, but their needs were left unsatisfied, or answered in an inappropriate manner, for instance by sexual abuse where children were seeking pure love and affection.

When senses and modalities that are used for contact-making are being blocked or restricted in any part of the process for the individual, contact suffers and is interrupted. The formation of new Gestalten becomes blocked by unmet needs that form an incomplete Gestalt and therefore demand attention (Yontef, 1993: 52). This is called contact boundary disturbances, that will subsequently be discussed.

3.6.7 Contact boundary disturbances

When the boundary between self and others becomes unclear, lost or impermeable, this results in a disturbance (Latner, 1993: 137). Oaklander (1994b: 144) describes contact boundary disturbances in the child as follows:

> The child, in his quest for survival, will inhibit, block, repress and restrict various aspects of the organism: the senses, the body, the emotions, the intellect. These restrictions become contact boundary disturbances and cause interruptions of the natural, healthy process of organismic self-regulation.

Children with contact boundary disturbances do not have an awareness of their needs and are incapable of having healthy contact with the environment. Their holistic functioning of body, senses, emotions and intellect is fragmented by these contact boundary disturbances (Blom, 2004: 22).

From the researcher's experience, children in care also experience some form of contact boundary disturbance in their contact-making. The need for love, care and nurture, for instance, has often not been met by the parents, or met in a disorganised way. As a result, certain defence strategies were developed by the child in order to cope, leaving an incomplete Gestalt formation.

Alternative caregivers and the children in their care need to become aware of any contact disturbances that may have impacted on meaningful contact in the past or in the here and now, affecting their current behaviour and relationships.

3.6.8 Dialogue

Dialogue is more than communication, it is allowing contact to happen without trying to control the outcome. MacKewn (in Brink, 2006: 79) states that the person communicating must in the same manner know himself, be aware of who he is and choose to show his real responses. It is through this form of contact that a relationship grows and individual growth and identity formation take place (Yontef, 1993:126).

Good contact during dialogue is the main focus of Gestalt, as it provides the medium for the growth of awareness, learning problem-solving and self-development. According to Yontef (1993: 127), dialogue as part of the therapeutic relationship in Gestalt therapy consists of four characteristics:

- *Inclusion* – this is putting oneself as fully as possible into the experience of the other person, without judging, analysing or interpreting, while at the same time retaining a sense of one's separate self. Inclusion is an extension or broader form of empathy.
- *Presence* – this means knowing oneself as one is, rather than pretending to oneself that one is something one is not. It implies "being real."
- *Commitment to dialogue* – this is allowing contact to happen rather than making contact and controlling the outcome.
- *Dialogue is* lived – dialogue is something done, rather than talked about. Relating to another person can take place in silence or laughter. Schoeman and van der Merwe (1996: 180) are of the opinion that an established, warm, trusting and supportive relationship can be used as a tool to empower people to change and take responsibility for themselves.

The researcher agrees that children can only change and become more attached to their alternative caregiver once an accepting, caring and warm relationship exists where dialogue and awareness flourish. Good contact needs to take place

between alternative caregiver and child, where all sensory and motor functions are used and trust develops as a result. Attachment will be enhanced once trust is established.

3.6.9 Responsibility

According to the Gestalt therapy approach, people are responsible; that is, they are the primary agents in determining their own behaviour (Yontef, 1993: 141). People are responsible for what they choose to do. Yontef (1993: 141) states that blaming outside forces (e.g. genetics or parents) for what one chooses is self-deception. Taking responsibility for what one did not choose, a typical shame reaction, is also a deception. Individuals are responsible for the minute-to-minute choices they make to act or not to act in a specific way (Clarkson, 1999: 27-28). The importance of responsibility is also emphasised by Frankl (in Clarkson, 1999: 28). He states that even when a person is not responsible for his circumstances, he remains responsible for the meaning he gives to his life, since he chooses his attitude towards and his behaviour in such situations.

It would be important for the alternative caregiver to help the child in care understand the importance of taking responsibility for one's actions. Children in care also have choices. They can blame their unfortunate circumstances for their behaviour or choose to act differently and take responsibility for their new behaviour and attitude with support from the alternative caregivers.

3.7 CONCLUSION

In this chapter, literature on attachment as well as on Gestalt and the various Gestalt concepts was discussed. In applying the insights gained to the research problem of this study, the researcher has also given attention to the use of the Gestalt concepts in the enhancement of attachment between the alternative caregiver and traumatised child.

From these discussions it became clear how insecure attachment patterns in the behaviour of traumatised children form part of their impasse, contact and contact boundary disturbances, unfinished business and organismic self-regulation. It also became clear that awareness, dialogue, the here and now, and taking responsibility are essential in establishing Gestalt guidelines for alternative caregivers to enhance attachment with the traumatised child. In the next chapter, functional elements of existing attachment treatment models that could be utilised for the purpose of this study will be discussed.

CHAPTER 4

IDENTIFYING FUNCTIONAL ELEMENTS OF SUCCESSFUL MODELS

4.1 INTRODUCTION

Chapter 4 forms part of the third and final step of the second phase of the design and development model. Information has been gathered from literature in the first two steps of this phase, and in this step of the design and development model functional elements of existing models or programmes will be identified (see 1.5.2.3). Consulting relevant literature on attachment treatment, the researcher discovered some functional elements in various treatments that could be useful in establishing Gestalt guidelines for alternative caregivers, even though these treatments are not designed from a Gestalt perspective. The treatments identified were not necessarily put together in a model or programme, but had useful suggestions and information that were identified as functional elements. The functional elements of the following treatments will be discussed in this chapter: Corrective attachment parenting, and the dyadic developmental psychotherapy treatment model. Elements of the arousal-relaxation cycle, the positive interaction cycle and positive claiming used in conjunction to enhance attachment, will also receive attention in this chapter. In addition, the researcher will briefly refer to particular functional elements in attachment-based intervention used with foster caregivers.

4.2 CORRECTIVE ATTACHMENT PARENTING

Corrective attachment parenting (CAP) consists of specific skills, strategies and solutions for alternative caregivers of children with disrupted and compromised

attachment, aimed at creating a healing environment. It enables alternative caregivers to help children learn to trust, be emotionally sensitive and to really connect with another human being in a safe and satisfying way again. The goal for the alternative caregiver in using CAP is connection with the child and not control over the child. Firstly, the basic principles of CAP will be discussed, followed by a discussion of the skills, strategies and solutions which form part of the functional elements identified (Orlans & Levy, 2006: 3).

4.2.1 Basic principles

CAP includes principles of change and creating a healing environment. Principles of change will subsequently be discussed, but due to the limited scope of this study, the elements for creating a healing environment will only be mentioned, without expanding on them.

4.2.1.1 Principles of change

Orlans and Levy (2006: 121-123) outline the following principles of change:

- **You can only change yourself**

As alternative caregiver you cannot change others. It is only through knowing oneself and striving for personal growth and having a positive attitude that one can start influencing and impacting on others to change.

- **Information and skills**

Knowledge is power. By fully knowing and understanding the child in care, one is able to help him in a positive way. Teaching the child life-skills, such as communication and anger management, also creates good self-esteem and future success in all realms of life.

- **Focus on change**

Have a positive attitude and believe that things can change. Be a role model of change. Focus on what is right, and validate any change for the better, no matter how small. Focus on the present and future and not just the past.

- **Learning through experience**

Learning is the basis of change. People learn and change through real-life experiences. Positive experiences between alternative caregiver and child are helpful and healing. Children should be provided with new relationship experiences as these often create new expectations (“I can trust you”) and positive feelings (“I feel love, security and self-worth”).

- **Motivation is essential**

Alternative caregivers often become burnt-out, feeling hopeless, because they lack information, skills, support and the confidence in their role as alternative caregiver. By having the skills, information, support and confidence that comes from success, the child’s motivation to change will increase as the alternative caregiver-child relationship improves.

- **Have a plan with specific goals**

Alternative caregivers should have a clear picture of what changes they want to see in their relationship with the children in their care. Have specific and realistic goals that are small at first. Notice and celebrate any small achievements.

- **Partnerships for change**

Change is a team effort, something both the alternative caregiver and the child work on together. The relationship is the primary vehicle for change, and with empathy, nurture, support, limits and hope, children will be guided towards growth and health.

- **Risk and protective factors**

Risk factors are abuse, neglect, and multiple caregivers. All of these would increase fearfulness and stagnation. Protective factors are safety, support and consistency from a sensitive caregiver. These would increase motivation, exploration and positive change. Alternative caregivers should reduce risk factors and enhance growth producing protective factors. Under the right conditions, growth and change occur naturally.

- **Change is not easy**

Change evolves gradually, and resistance and regression are natural parts of change. Children must learn that unhealthy choices or actions are not the end of the world. Correcting the situation is possible, requiring the individual to take personal responsibility.

- **Have hope**

Hope is associated with positive feelings and the ability to convey an optimistic and encouraging attitude. Having hope and positive expectations of change for oneself and the child are crucial for the alternative caregiver. This will have to be communicated verbally and nonverbally to the child, for instance: “I believe in you and me. This will work out. We will succeed” (Orlans & Levy, 2006: 123).

4.2.1.2 Creating a healing environment

Orlans and Levy (2006: 144) believe that healing alternative caregivers would create a healing environment. The "ingredients" for creating a healing environment by the alternative caregivers are the following: do not try to "fix" the child; face and resolve own past issues; avoid labels as it affect solutions; understand the family system and interchange of family dynamics; strive to balance love and limits; have an opportunity mindset rather than a crisis one; be proactive, not reactive; always be a positive role model.

4.2.2 Functional elements of corrective attachment parenting

Orlans and Levy (2006: 145) offer skills and solutions as part of CAP to help parents increase their confidence and to enable them to convey a healing attitude, thus leading to positive changes in the relationship with the children in their care.

4.2.2.1 Guidelines for alternative caregivers

For the purpose of this study, the following functional elements of corrective attachment parenting, specifically for alternative caregivers to facilitate secure attachment, were identified and will subsequently be discussed (Orlans & Levy, 2006: 273-275).

- **Understand core beliefs**

Alternative caregivers should look beyond children's behaviour. They should understand that children's early experiences with caregivers have shaped their core beliefs about themselves, and that with negative core beliefs they would perceive alternative caregivers as rejecting and untrustworthy. Rejection and resistance by children should therefore be seen as their strategy to cope with

prior loss and maltreatment. Instead of criticising in turn, give approval and praise for specific behaviour and do not take children's negative attitudes and actions personally.

- **Provide a balance of connection and structure**

It is important to have a balance between rendering support, nurture and empathy and providing structure to engender respect, security and trust. Alternative caregivers should model caring, nonjudgmental, sensitive and positive emotions and behaviour by means of nonpunitive responses and lots of hugs. At the same time, alternative caregivers should be clear and consistent regarding limits and consequences. Alternative caregivers should also maintain consistent routines and rituals and give children choices rather than commands. Alternative caregivers who want to control situations, would often find themselves involved in power struggles with these children.

- **Teach reciprocity**

Alternative caregivers should encourage children to ask for help and the fulfilment of specific needs. As a result of their histories of insecure attachment, lack of trust and the belief that they are unworthy of love and caring, they have become self- centred and demanding and avoid needing others. By giving children chores to do, they become part of the family through their contributions. This creates a feeling of accomplishment and their receiving praise and appreciation. Alternative caregivers should make conscious efforts to engage with the children in reciprocal interactions through play, homework and other activities done cooperatively.

- **Meet individual needs**

Alternative caregiver attunement to the needs and signals of children facilitates secure attachment. Alternative caregivers should know and understand the child's unique needs, core beliefs and attachment pattern. By responding to the child's deep emotional needs with love, empathy and support, attachment is enhanced. Alternative caregivers can build trust by successful completion of the attachment cycle (see 3.3.1).

- **Look in the mirror**

Alternative caregivers must be aware of their own histories and issues. They should also be aware of common reactions such as anger, depression and helplessness. Having good self-awareness of one's own mindset and emotional baggage, contributes to a healthy caring relationship with the child. Alternative caregivers should take good care of themselves and be aware of stress levels and personal needs.

- **Managing emotions**

Children in care would often mask pain and fear, due to unresolved loss and maltreatment, behind a response of anger in order to reduce vulnerability. It is therefore imperative that when conflicts arise, alternative caregivers should remain emotionally neutral so that conflict does not escalate. Alternative caregivers should encourage communication about feelings and show pleasure and excitement in response to positive behaviour. As far as possible, alternative caregivers should try to model healthy emotional management and communication, and promote positive emotions such as joy, fun, pride and a sense of accomplishment.

- **Sense of belonging**

Helping the child in care to feel a sense of belonging, has a stabilising and reassuring effect on the child. Alternative caregivers should encourage children to participate as members of the family and community through ongoing routines and rituals in order to feel part of something again. Children's cultural and ethnic backgrounds, as well as prior relationships, should also be respected as part of their sense of belonging.

4.3 DYADIC DEVELOPMENTAL PSYCHOTHERAPY

Dyadic developmental psychotherapy (DDP), also known as attachment-focused family therapy was developed by Daniel Hughes for the treatment of abused and neglected children in alternative care. This model of family therapy consists of attachment-focused interventions that aim to facilitate the development of patterns of secure attachments with alternative caregivers (Hughes, 2007: 7).

4.3.1 Philosophy of the treatment

Hughes (2005: 3) believes that attachment security and intersubjective experiences are core features of stable family relationships. Hughes (2007: 14) explains intersubjectivity as "… those moments when the parent and child are in sync: When they are affectively and cognitively present to each other." In order for children in care to be able to begin a new life within their new families, attachment security and intersubjective experiences need to be developed. In using the treatment model of DDP, these experiences are facilitated and the functioning of the family strengthened by the therapist. This leads to attachment security for the child and enables the child to pursue optimal development.

4.3.2 Process of the treatment

Dyadic developmental psychotherapy uses two-hour sessions involving one therapist, alternative caregiver(s) and the child. Two offices are used. The structure of a session involves three components. Firstly, the therapist meets with the alternative caregivers in one office, while the child waits in the treatment room. Secondly, the therapist will meet with the child in the treatment room, with the alternative caregivers present. This usually takes one to one and a half hour. Thirdly, the therapist meets with the alternative caregivers again without the child. DDP focuses extensively on the nonverbal experiential level of interaction, rather than on verbal content in order to facilitate attachment. Key elements of the treatment will subsequently be discussed (Becker-Weidman, 2006: 158).

4.3.3 Key elements of the treatment

According to Becker-Weidman (2006: 160), treatment interventions are designed to create experiences of safety and affective attunement to facilitate attachment. Affective attunement involves eye contact, tone of voice, touch and movement. Treatment involves multiple repetitions of the caregiver-child attachment cycle. The cycle consists of the following:

- Shared affective experiences;
- breach in the relationship;
- re-attunement of affective states.

A certain structure that forms part of the above-mentioned cycle is often used in the second part of the treatment. This is pictured in Figure 4.1 below.

- **Shared affective experiences**

During the second part of the treatment process, the alternative caregivers and child will identify and explore certain behaviour through affective shared experiences. This behaviour may have occurred in the immediate interaction or some time in the past. Through the use of curiosity and acceptance the behaviour is explored and the meaning begins to emerge to the child.

- **Breach in the relationship**

Empathy is used to reduce the child's sense of shame as the child becomes aware of behavioural disturbances. At the same time, empathy helps to increase the child's sense of being accepted and understood.

- **Re-attunement of affective states**

The child's behaviour is then normalised, in other words, the child becomes able to understand the meaning of the behaviour and its basis in past trauma, and to communicate this understanding to the alternative caregiver. Finally, a new meaning is found for the behaviour, and the child's actions are integrated into an autobiographical narrative for the child. Cognitive restructuring and psychodramatic re-enactment allows the child to integrate the past traumas and understand past and present experiences generating the feelings and thoughts associated with the child's behaviour. As a result, the child's capacity to engage affectively in a trusting relationship is enhanced.

This part of the treatment process requires the alternative caregivers to maintain a high degree of structure and consistency along with an affective milieu that demonstrates playfulness, love, acceptance, curiosity and empathy. Alternative caregivers also receive lots of support from the therapist during this part of the treatment as they often feel incompetent, blamed and depleted. That is why

alternative caregivers are also instructed in the first part of the treatment in attachment parenting methods. Personal issues of the alternative caregivers that may create difficulties in engaging with the child in the above-mentioned manner, may indicate treatment of the alternative caregiver first (Becker- Weidman, 2006: 159-162).

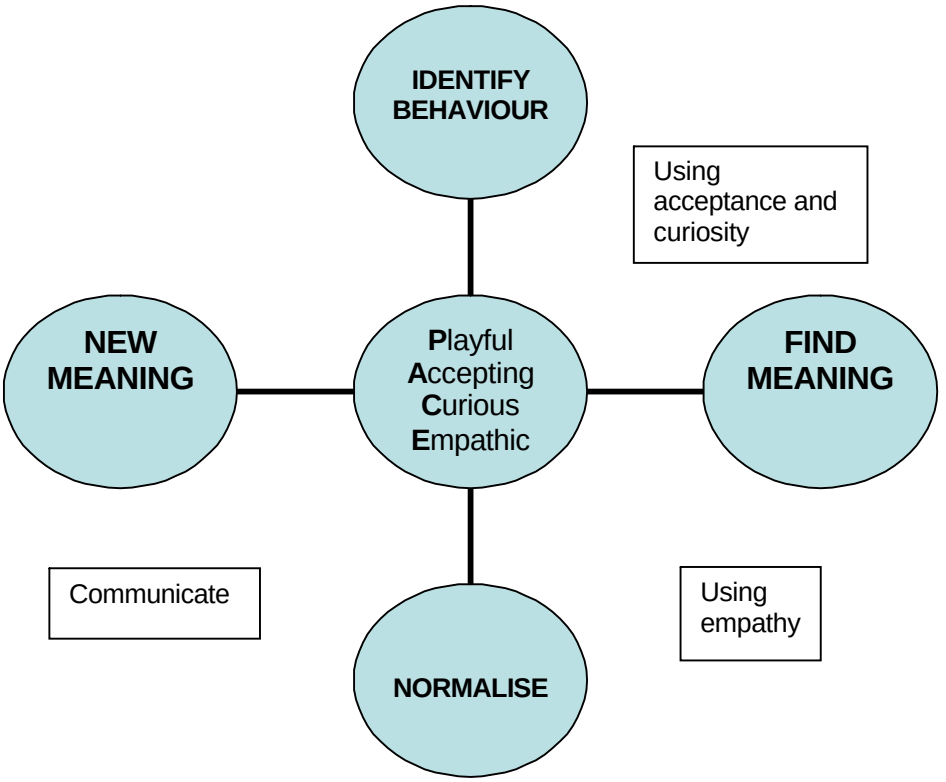

FIGURE 4.1 Dyadic developmental psychotherapy

4.4 AROUSAL-RELAXATION CYCLE, POSITIVE INTERACTION CYCLE AND CLAIMING

In Fahlberg (1999: 45), the arousal-relaxation cycle, the positive interaction cycle and claiming were identified as three useful ways to enhance attachment between the adoptive parent and children beyond infancy. The researcher found functional elements in these three ways that can appropriately be used in guidelines to enhance attachment between the alternative caregiver and children in care. A summary is given in Table 4.1 below of how the functional elements could practically be implemented.

TABLE 4.1

Ways to encourage attachment		
Responding to the arousal-relaxation cycle	**Initiating positive interactions**	**Claiming behaviour**
Using the child's tantrums to encourage attachment. Responding to the child when he is ill. Accompanying the child to dentist or doctor appointments. Helping the child express and cope with feelings of anger and frustration. Sharing the child's extreme excitement over his achievements. Helping the child cope with feelings about moving. Helping the child cope with ambivalent feelings about his biological family. Responding to a child who is hurt or injured. Educating the child about sexual issues.	Making affectionate overtures: hugs, kisses, physical closeness. Reading to the child. Playing games. Go shopping together for clothes or toys for the child. Going on special outings, e.g. circus, lake. Supporting the child's outside activities by providing transport or being a group leader. Helping the child with homework when needed. Teaching the child to cook or bake. Saying "I love you". Teaching the child to participate in family activities such as picnicking, going to church.	Hanging pictures of child on the wall. Including the child in family rituals. Buying new clothes for the child as a way of becoming acquainted with child's size, colour and style preference.

4.4.1 Arousal-relaxation cycle

The arousal-relaxation cycle or attachment cycle (see Figure 3.1) depicts the child's need and the alternative caregiver's response that meets that need in a way that alleviates any discomfort. In this way, the cycle is completed. The repeated successful completion of this cycle helps the child to develop trust and security and become attached to the alternative caregiver (Fahlberg, 1999: 27).

4.4.1.1 Functional elements of the arousal-relaxation cycle

According to Fahlberg (1999: 47), functional elements of the arousal- relaxation cycle are the following:

- The children in care may have particular physical or psychological needs which initiate the arousal-relaxation cycle. Because of this, discomfort is experienced which leads to high arousal. Emotions that accompany the discomfort and high arousal could be either negative (anxiety, rage) or positive (extreme joy or excitement). The alternative caregiver's role is to be supportive and empathic during the expression of the emotion until the body tension accompanying the intense feeling subsides. At the point of relaxation, the child is most open to attachment. The child also develops trust in the alternative caregiver at this point if the alternative caregiver is present and available (Fahlberg, 1999: 47).
- When a child is ill and faces a trip to the doctor, with the accompanying fear of what is going to happen, the child is likely to be highly aroused. According to Fahlberg (1999: 48), attachment is then encouraged when the alternative caregiver is emotionally available throughout this visit to the doctor, allowing expression of feeling and providing physical comfort to the child after the visit.
- When children in care feel overcome by emotion they need to have immediate adult physical comfort and psychological support by the

alternative caregiver being empathic. That is when trusting relationships develop (Fahlberg, 1999: 47).

4.4.2 Positive interaction cycle

Apart from the successful completion of the arousal-relaxation cycle, the extent to which the alternative caregiver initiates interactions with the child, also influences the connection between them (Fahlberg, 1999: 29). Social interactions include a rich variety of stimulation involving any of the senses. Ainsworth (in Fahlberg, 1999: 30) states that the more positive social interactions a child has with someone, the more strongly attached the child will become to that person (see Figure 4.2). Positive self-esteem will also be experienced by feeling loveable and worthwhile.

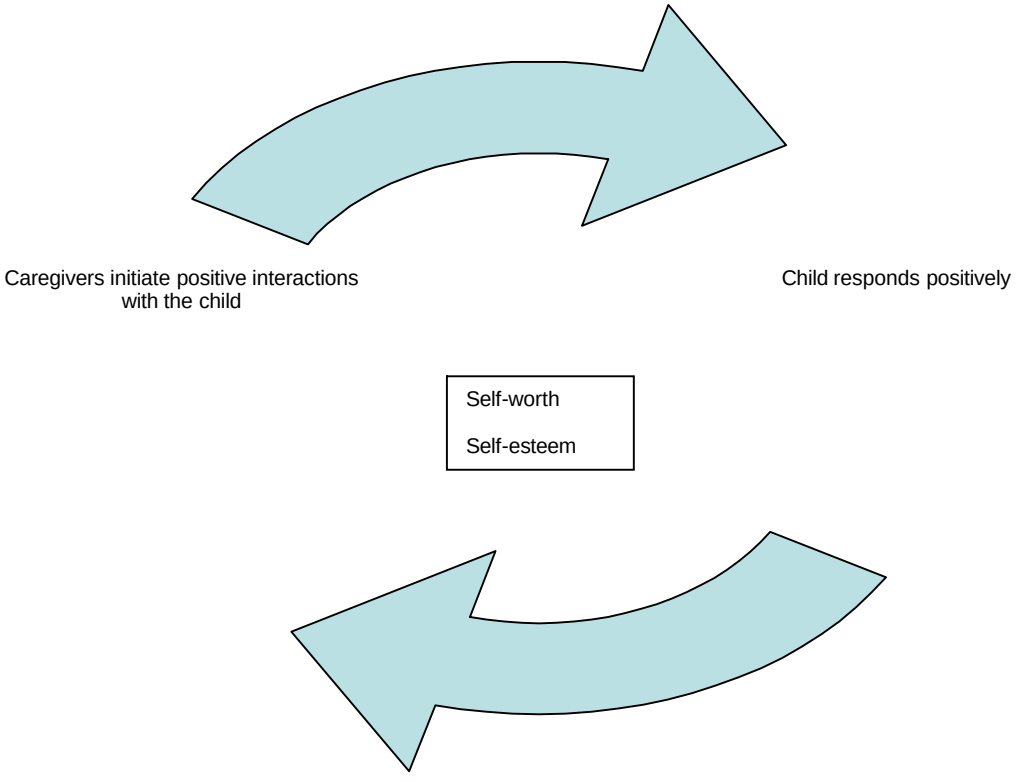

FIGURE 4.2 Positive interaction cycle

4.4.2.1 Functional elements of the positive interaction cycle

The following are functional elements of the positive interaction cycle as stated by Fahlberg (1999: 49):

- Alternative caregivers should initiate positive interchanges with a child and maintain a positive focus.
- Interchanges can be low key and not emotionally charged, for instance, “Good morning,” or “How was your day?”
- Interchanges can also include activities such as playing a game, helping with a chore, reading a story or giving a hug.
- The alternative caregiver should be proactive rather than reactive in initiating positive interchanges as soon as the child moves in. A “bank account” of positive memories and experiences should be built up. Having this positive memories and experiences as a family will help them stand together and get through crisis times (Fahlberg, 1999: 49).

4.4.3 Claiming

Claiming is another way of building attachment, according to Fahlberg (1999: 30). Claiming behaviour separates the we’s and the they’s from each other. The focus is on similarities rather than differences. There is a difference, however, in terms of claiming with an adoptive placement and an alternative care placement. Alternative caregivers do not have the same legal entitlement to parent the child as the biological or adoptive parents have. Nevertheless, strategies can be developed for utilising varying degrees of claiming to differentiate between adopted children and children in care (Fahlberg, 1999: 50).

4.4.3.1 Functional elements of claiming

According to Fahlberg (1999: 50), the following can be viewed as functional elements of claiming:

- Children in care can be encouraged to "practise" getting close to new alternative caregivers. The child can, for instance, practise having fun with the alternative caregivers by playing games or sitting close while reading a story.
- Alternative caregivers should also from their side make the effort to get close to the child, so that the child understands that learning to be close involves both children and adults working at it. This can take place through family members sharing their histories or photo albums. Knowing the more intimate details of each person's personality and of life within a particular family, helps someone joining the family feel like an insider, as opposed to being an outsider.
- Alternative caregivers can have individual pictures taken of the children in care and display it in their home.
- Claiming strategies are individual to each child in care. Strategies developed can be based on family composition, the child in care's relationship and contact with the biological family and the long-term plans for the child in care (Fahlberg, 1999: 51).

4.5 ATTACHMENT-BASED INTERVENTION WITH FOSTER CAREGIVERS

Dozier (2003: 255) supports an intervention that challenges children in care to change their expectations regarding their alternative caregivers and their situation. This intervention seeks to create an environment in which children feel nurtured and loved, even when that is contrary to their expectations. This intervention has the following functional elements that will be useful when establishing Gestalt guidelines.

4.5.1 Functional elements of attachment-based intervention with foster caregivers

Dozier (2003: 255) states that through therapeutic intervention foster caregivers are helped to behave in nurturing ways to the children, even when children send out the message that they do not want their nurturing. The alternative caregivers' ability to provide a nurturing relationship is enhanced by overriding the natural tendency to respond in a complementary fashion to a child's behavioural signals, that is, when children in care push their alternative caregivers away and the alternative caregivers respond by submitting to being pushed away. Rather, when a child turns away from an alternative caregiver when hurt, the alternative caregiver is encouraged to respond in a nurturing way to the child by going to him and giving him a hug or expressing words of comfort (Dozier, 2003: 255-256).

According to Dozier (2003: 256), this form of intervention holds the belief that children need their alternative caregivers even though they may not appear to need them. This challenge is a key component of treatment for individuals who have not experienced good enough caring. However, it is important that this challenge of nurturing these children even though the children are behaving in ways that suggest they do not want or need nurturing, be executed in a gentle way and for the sake of helping a child feel loved and worthwhile (Dozier, 2003: 256).

4.6 CONCLUSION

In this chapter, elements of existing attachment treatments that have been identified as being functional for the purpose of this study, have been discussed. The researcher is of the opinion that these elements are all useful in establishing Gestalt guidelines to enhance attachment between the alternative caregiver and the traumatised child. Although none of these treatments have a Gestalt

approach, most of them have something in common with the principles of Gestalt. By looking at these other suggestions and solutions to improve the relationship between alternative caregiver and child and enhance the attachment between them, new perspectives and insights were gained which was helpful in the formation of Gestalt guidelines. In Chapter 5 the researcher will describe the process of designing and developing Gestalt guidelines to enhance attachment between the alternative caregiver and the traumatised child.

CHAPTER 5

DESIGN AND EARLY DEVELOPMENT

5.1 INTRODUCTION

In Chapter 4 functional elements of various treatments that could be useful in establishing Gestalt guidelines have been discussed. Chapter 5 will focus on the last two phases of the design and developmental model, namely the design phase and the phase of the early development of preliminary guidelines from a Gestalt perspective. The design phase will subsequently be discussed. The steps to be followed in this phase are to design an observational system and to specify procedural elements of the intervention.

5.2 OBSERVATIONAL SYSTEM

De Vos (2002: 408) states that the researcher has to design a method of detecting the effects following the intervention. De Vos further explains that the purpose of the observational system is to measure the outcomes of intervention through direct observation, or self-monitoring and/or the self-reporting of events that may be difficult to observe directly.

Respondents have been able to identify certain behavioural problems characteristic of a particular insecure attachment. It is, however, the underlying needs of these forms of behaviour that have to be addressed in order to enhance the attachment relationship between alternative caregiver and child (see 2.3.2 and 3.3.2). The researcher has used this information to create observational tools to be used in conjunction with the established guidelines. These tools can be used to evaluate or self-monitor whether there is an improvement in the behaviour of the child and an enhancement in attachment security after

intervention. The use of these tools as an observational system is subsequently discussed.

5.2.1 Recording sheet – targeted needs to be addressed

The purpose of these observational sheets (see Tables 5.1-5.3) is for the alternative caregivers to record what they have done to address the needs underlying a specific type of insecure attachment, in order to measure any changes in the behaviour of and attachment with the child. The three different sheets outline the typical forms of behaviour associated with each type of insecure attachment, as well as the possible underlying needs. According to the types of behaviour displayed, alternative caregivers choose the appropriate recording sheet. Alternative caregivers are then able to record what they did or could do to address the underlying needs and subsequent behaviour, and to monitor any change. The use of intervention to enhance attachment is a long-term process, thus recording sheets will be used over a period of time. The recording sheets will act as a visible encouragement once alternative caregivers begin to see an improvement in the attachment between them and the child.

Table 5.1 RECORDING SHEET NO.1 – TARGETED NEEDS TO BE ADDRESSED
Insecure avoidant attachment

Type of behaviour displayed	**Possible underlying need**	**What you as alternative caregiver did/ could do to address the need**	**Other possible resources/ help** E.g. teachers at school, adults at church and Sunday school, adults at children's leisure activities, social workers, doctors.	**Evaluation of possible change** Has the child's behaviour changed and attachment been enhanced or not, after using the guidelines? If so, in what way did it change?
Does not ask for help	Need for help	*E.g. help the child dress without saying anything when you see that he struggles.*		
Does not seek comfort, e.g. when ill, upset or frightened	Need for comfort	*E.g. give child a hug when you see that he is not feeling well.*		
Avoids closeness	Need for acceptance	*E.g. show acceptance by listening to the child, valuing his opinion and giving him your time.*		
Withdraws	Need for acceptance	*See example on acceptance*		
Ignores caregiver	Need for trust	*As alternative caregiver you should ALWAYS be consistent and do as you have said, e.g. bring back a surprise from the shop as you have promised.*		
Has no friends	Need for acceptance	*Provide experiences for the child, e.g. by*		

		inviting a friend over or taking them to a soccer game so that the child can allow himself to feel valued and accepted by you and the friend. Make sure the friend is a child who will be a good friend to the child in care and will have insight and understanding of the reasons for the child in care's behaviour at times.		
Do not do what they are asked to do	Need for trust	*See example on trust*		
Controlling	Need to feel safe	*Make sure that child is safe in every situation and give explanations, e.g. why he should put on his safety belt. ALWAYS be reliable, e.g. pick him up from school or contact with biological parents at the precise time as promised.*		
Argue	Need for communication around feelings	*E.g. the alternative caregiver can use stories that are similar to the child's own story, or drawings to explore the feelings of the child. By discussing the*		

		feelings, the alternative caregiver can establish whether there is any link with the child's constant need to argue. The help and guidance of a play therapist can be obtained in this instance.		
Bossy	Need for trust	*See example on trust*		

Table 5.2 RECORDING SHEET NO.2 – TARGETED NEEDS TO BE ADDRESSED
Insecure ambivalent attachment

Type of behaviour displayed	**Possible underlying need**	**What you as alternative caregiver did/ could do to address the need**	**Other possible resources/ help** E.g. teachers at school, adults at church and Sunday school, adults at children's leisure activities, social workers, doctors.	**Evaluation of possible change** Has the child's behaviour changed and attachment been enhanced or not, after using the guidelines? If so, in what way did it change?
Shows distress	Need for predictability, e.g. routine, structure	*E.g. have routine times for eating, bathing and bedtime, and explain in advance if there will be a deviation from the normal routine.*		
Whining	Need for recognition	*E.g. acknowledge the fact that the child is tired because he had a long day at school, and do a nice activity together like swinging in the park to combat the tiredness and the whining!*		
Clinging	Needs constant reassurance	*Always be consistent and reliable in every situation. Always give explanations for where you are going and why and when you will be back. Re-create experiences for*		

		the child, e.g. leaving him in the car when you pop out to buy a bread and return swiftly for the child to come to realise that you are trustworthy and he will be okay on his own at times.		
Shouting	Need to feel acknowledged	*See example on need for recognition.*		
Threatening	Need for predictability, e.g. routine, structure	*See previous example.*		
Demanding	Need to feel valued	*Lay down the boundaries, but still show that you value and love the child as person and appreciate anything never mind how small, that he contributes to the household. Give him your time and a listening ear. Involve the child in laying down the rules and the consequences when breaking them.*		
Constant attention seeking	Need to feel acknowledged	*See example on need for recognition.*		

Table 5.3 RECORDING SHEET NO.3 – TARGETED NEEDS TO BE ADDRESSED
Insecure disorganised attachment

Type of behaviour displayed	**Possible underlying need**	**What you as alternative caregiver did/could do to address the need**	**Other possible resources/ help** E.g. teachers at school, adults at church and Sunday school, adults at children's leisure activities, social workers, doctors.	**Evaluation of possible change** Has the child's behaviour changed and attachment been enhanced or not, after using the guidelines? If so, in what way did it change?
Aggressive	Need for safety	*Alternative caregivers should act consistently in the same calm and loving manner, e.g. read the child a bedtime story at night and leave a light on. React swiftly when the child calls and don't become angry if it is for something small or the tenth time. If this does become a problem, the alternative caregiver should explore the child's feelings with him.*		
Dissociation	Need for security	*Create experiences for the child where he can feel secure, e.g. sitting in the park while he plays on the*		

		equipment, or sitting with him when he is at the dentist.		
Sensory integration problems	Need for protection	*Do various sensory exercises with the child, including touch, taste, smell, hearing and seeing. Do this in a safe environment and be available for any outlet of emotions.*		
Talking, humming or singing to self	Need for predictability	*See Table 5.2, need for predictability.*		
Impulsive	Need to process emotions in safe environment	*See need for protection.*		
No coping skills	Need for predictability	*See Table 5.2, need for predictability.*		
Anxious and alert	Need for security	*See need for security.*		
Helpless	Need for safety	*Make sure that child is safe in every situation and give explanations, e.g. why he should put on his safety belt. ALWAYS be reliable, e.g. pick him up from school or contact with biological parents at the precise time as promised.*		
Controlling	Need for safety	*Make sure that child is safe in every situation and give explanations, e.g. why he should put on his safety belt. ALWAYS*		

		be reliable, e.g. pick him up from school or contact with biological parents at the precise time as promised.		

5.3 PROCEDURAL ELEMENTS OF THE INTERVENTION

According to de Vos (2002: 409), researchers can identify procedural elements for use in the intervention by observing the problem and studying naturally occurring innovations and other prototypes. These procedural elements of an intervention often become part of an eventual practice model, which is the final product of the research. In order to implement the developed guidelines in this study, the following procedural elements would apply. First of all, the person implementing the guidelines would have to possess the following qualities:

- A sound knowledge and understanding of the Gestalt approach as a phenomenological-existential therapy, and of the particular concepts that are included in the guidelines, namely awareness, including sensory awareness, here and now, impasse, organismic self-regulation, dialogue and responsibility (see 5.4).
- A clear understanding of attachment and attachment related issues.
- The ability and experience of professional facilitation. This means that a professional person would share the guidelines with the alternative caregivers on their level and in an understandable way, and also assist them in implementing the guidelines with the children. This would mean allowing the alternative caregivers to apply the guidelines themselves and not take action on their behalf.
- Professional experience of alternative care, which is making alternative caregivers fully aware of the needs of these traumatised children. Information sharing needs to take place on a general basis during preparation, training groups about attachment problems and these children's histories, but also on an individual basis with regard to the history of a particular child. Alternative caregivers need to understand that children's early experiences with alternative caregivers have shaped their core beliefs about themselves, and that with negative core beliefs they

would perceive alternative caregivers as rejecting and untrustworthy. Negative attitudes and actions by the children should not be taken personally, as this is their coping strategy. Instead, alternative caregivers should give approval and praise for specific behaviour.

- The wish to enhance attachment between alternative caregivers and the children in care.
- Commitment to bring about change.

Another procedural element would be that two sets of copies be given to respondents of the recording sheets (observational tools). The first set will include examples in the column “What you as alternative caregiver did/ could do to address the need”, in order to guide alternative caregivers when completing the sheets. In the second set of copies of the recording sheets, the particular column will be left blank. The first two columns, namely “Type of behaviour displayed” and “Possible underlying need” will be filled in, in both sets of copies.

5.4 GUIDELINES FOR ALTERNATIVE CAREGIVERS TO ENHANCE ATTACHMENT WITH THE TRAUMATISED CHILD

The Gestalt guidelines for alternative caregivers to enhance attachment with traumatised children are developed for a professional person to:

- implement with individual families consisting of alternative caregivers and children in care who are experiencing attachment problems in their relationship;
- discuss as part of the preparation training that alternative caregivers undergo before they take children into their care;
- discuss with support groups for alternative caregivers with children in care who are experiencing attachment problems and who have not discussed the guidelines as part of the preparation training.

The following guidelines were compiled from various sources. Suggestions were made by the respondents in this study and by experts in the fields of Gestalt play therapy. Aspects and insights from the literature review, as well as functional elements of existing alternative caregiver programmes were also used.

5.4.1 Awareness

Yontef (1993: 139) states that effective awareness is grounded in and energised by the dominant and present need of the organism. In this case, it would be the need of the alternative caregiver for closer attachment with the child in care. In order to address this need, the following aspects of awareness should be kept in mind:

- First of all, it would be important for alternative caregivers to be aware and acknowledge that there are certain issues in the alternative caregiver-child relationship that prevent an instant attachment. For instance, children who have experienced multiple placement moves, might be reluctant to form a close relationship again.
- Alternative caregivers should be aware of their motivation for caring and of their own feelings. They should be aware of their own histories and issues and how these impact on their responses and reactions to the children. Having good self-awareness of one's own mindset and emotional baggage contributes to a healthy caring relationship with the child (see 4.2.2.1).
- Alternative caregivers should be aware that they cannot change these children. Only through having good self-awareness and a positive attitude can they start influencing and impacting on these children.
- Alternative caregivers need to be aware that children in care would often mask pain and fear, due to unresolved loss and maltreatment, behind a response of anger, in order to reduce vulnerability. Alternative caregivers should encourage communication about feelings and show pleasure and

excitement in response to positive behaviour, but remain emotionally neutral when conflict arises. Alternative caregivers can identify and name emotions that they themselves may have. By doing this, they will help the child to become more aware of his own emotions, and that it is all right to share feelings and emotions.

- Alternative caregivers should have awareness for children's need to belong. Alternative caregivers can help children experience a sense of belonging by encouraging them to participate as members of the family and community through ongoing routines and rituals, for instance helping to decorate the Christmas tree. Alternative caregivers should also remain aware and respectful of children's cultural and ethnic backgrounds as part of their sense of belonging. This could, for instance, be done through regularly preparing typical dishes characteristic of the particular culture.
- Alternative caregivers can help children become aware of their own needs and feelings, since these children's self-awareness are often not very strong. Children may become more aware of their feelings and emotions by encouraging their sensory awareness. Conducting fun activities in a playful manner that includes touch, smell, taste, seeing and hearing, will enhance sensory awareness and establish a warm, trusting and caring relationship that can eventually lead to open communication between the caregiver and child about emotions experienced. Caregivers would have to be aware that such activities should be age appropriate.

5.4.2 Here and now

The alternative caregiver and child are "thrown together" in the here and now, each with their own backgrounds. The following guidelines could be helpful in overcoming the differences between the child and alternative caregiver:

- It would be important for alternative caregivers who have previously cared for children to reflect on how past experiences affects both

alternative caregiver and child in their current functioning. What have worked well with a previous child in a particular situation, may not be suitable with another child in the current situation.

- Similarly, children's past experiences might have an effect on their current behaviour and on the relationship between alternative caregiver and child. It would be necessary to look at what meaning these experiences and any unfinished business from the past have for the children in the here and now and how it affect their current functioning. For instance, children may have the experience that adults are unreliable and untrustworthy. As a result, children are trying to be totally self-reliant. In the here and now, it means that as adults, alternative caregivers need to prove the contrary, that is, being reliable and trustworthy in order to help children let go and allow adults to take care of them. In Table 5.1 it is said that alternative caregivers should ALWAYS be consistent and do as they have said, to bring back a surprise from the shop as promised, thus creating trust for the child in the alternative caregiver. It would be important for the alternative caregiver to remain positive and believe that things can change. In order to achieve this, the alternative caregiver and child should focus on the present, creating interpersonal experiences of fun and joy together and not dwell on the past or worry about the future.
- However, that doesn't mean that events in the child's history can not form part of a dialogue in the here and now between the alternative caregiver and the child. Past traumas can be revisited by the child, alternative caregiver and a therapist during play therapy sessions and be integrated to allow the child to understand the past and present experiences that create the feelings and thoughts associated with the child's problem behaviour. Having a better understanding of the child's behaviour and accepting past traumas as part of the child's life story, could help the child to deal with past

issues and eventually move on, leaving the child with a sense of completion.

5.4.3 Impasse

Yontef (1993: 144) views an impasse as a situation in which external support is not forthcoming and the individual believes he cannot support himself. The most frequent method then of coping with the situation is to manipulate others. According to Joyce and Sills (2001: 131), old patterns are safe and familiar, albeit painful or uncomfortable. They are tried and tested ways of getting needs sufficiently or partially met when there seem no other way of managing the difficulty.

The following guidelines were compiled to address the impasse:

- Alternative caregivers should assist children in breaking through old but dysfunctional attempts at self-support. Children in care often have the tendency to push their alternative caregivers away and the latter often respond in complementary fashion to these behaviours, that is, by submitting to being pushed away. Through therapeutic sessions, alternative caregivers and children, with the help of a trained therapist, can address this kind of resistance as manifested in their relationship. Alternative caregivers can then be helped, for instance to provide nurturing to these children, even though the children are behaving in ways that suggest that they do not want or need nurturing. Rather than responding to children's signals directly, alternative caregivers are urged to see that children need them, even though they may do their utmost to deny this need. For example, if a child turns away from an alternative caregiver when hurt, the alternative caregiver is encouraged to respond in a

nurturing way to the child by going to him and giving him a hug or expressing words of comfort.

- Alternative caregivers should also show great empathy when children do become aware of their dysfunctional ways of operating and the reasons for it, and help them feel understood and accepted in spite of the behaviour they have shown. Children may, for instance, become aware of their clinging behaviour and that this is due to the fact that they have never experienced consistency or predictability from adults in their life. By understanding the reason for their difficult behaviour, cognitive restructuring is taking place and the child is given the opportunity to start experimenting with new responses and behaviour, namely of trusting the alternative caregiver and behaving less clingy. It is important that alternative caregivers form part of this process and show acceptance and empathy throughout. In this case, it would also be important for alternative caregivers to remain consistent and predictable as the child begins to behave differently.

5.4.4 Organismic self-regulation

In Chapter 3, the researcher referred to Aronstam (in Blom, 2004: 11), who views organismic self-regulation as a way in which individuals satisfy their needs both within the individual and from the environment. In order to grow and develop, people strive to maintain a balance between gratification and tension elimination (cf. Clarkson, 1999: 21; Blom, 2004: 11).

Organismic self-regulation could be achieved as follows:

- Alternative caregivers should be aware that the need for attachment in most of the children in their care have not been met

in their original families. It would be important for the alternative caregiver to explore the needs of the child and help him find ways to meet these needs.

- Through alternative caregivers' attunement to the needs and signals of children, organismic self-regulation is achieved and secure attachment facilitated. It would therefore be important for the alternative caregiver to have full knowledge of children's histories in order to understand their attachment pattern, underlying needs and core beliefs. Having this knowledge, would also enable the alternative caregiver to respond appropriately to the child's needs. In order to "connect", alternative caregivers may have to interact on the level of the developmental age of the child and not on that of the chronological age, particularly at times of distress and high arousal. Particular attention should be given to this aspect during the preparation training that alternative caregivers undergo before they take children into their care. It would require a heightened degree of sensitivity, accurate, repeated and slightly exaggerated feedback about the child's emotional condition (as one would do with a baby or toddler). The caregiving environment should be structured, warm and predictable, and particularly responsive to the child's signals. This would promote children's ability to self- regulate.
- Creating experiences of safety and affective attunement will facilitate attachment. Affective attunement involves eye contact, tone of voice, touch and movement, while the alternative caregiver and child repeatedly go through the attachment cycle (see Figure 3.1). Needs expressed by the child are met by the alternative caregiver in a way that alleviates any discomfort. Children in care experience high emotions when in physical or psychological pain (see 4.4.1.1). It is important that the alternative caregiver is then present and available, providing physical comfort and support.

Typical examples of displeasure as component of the attachment cycle are when children are ill, have to go to the doctor or dentist, experience frustration or anger, are emotional about moving, are hurt or injured, and experience ambivalent feelings about their biological family. By being available and providing comfort and support, the alternative caregiver satisfy the children's needs, and the attachment cycle is completed, enhancing trust and attachment between the alternative caregiver and child.

- Alternative caregivers should encourage children to ask for help and specific need fulfilment. Since this does not come naturally for these children, special efforts should be made by alternative caregivers to engage children in reciprocal interactions such as homework, play and other activities done cooperatively, like doing chores. In this way, children become part of the family through their contributions, and a feeling of accomplishment is achieved when they receive praise and appreciation.

5.4.5 Dialogue

Good contact during dialogue is the core idea in Gestalt. It is allowing oneself to become wholeheartedly engaged in an experience or process without any pretence (Clarkson, 1999:39-40).

Dialogue is discussed as part of the following guidelines:

- Inclusion as part of dialogue means that alternative caregivers put themselves as fully as possible into the experience of the other person, the child in care, whilst retaining a sense of self. This means that the alternative caregiver shows a lot of empathy, acceptance and understanding, allowing the child to explore

behaviour that may have occurred in the past or the immediate interaction, and assigning meaning to it.

- Presence is another characteristic of dialogue which means that alternative caregivers be authentic, genuine, “real”. Alternative caregivers should know themselves, be aware of who they are and choose to show their real responses. Children appreciate the openness and vulnerability shown by the alternative caregivers, leading them to become more trusting of the alternative caregivers over time.
- Alternative caregivers should have intersubjective experiences with the children in their care, which can be achieved through affective attunement. Through eye contact, touch and active listening, the alternative caregiver and child experience “moments of meeting”. A poorly attached child has missed out on the early mother-infant bond. By using the child’s first developmental stages as a guide, experiences should be initiated that the child would have had as a young child, in order to maximise his overall development. The attitude and behaviour that a new mother would have towards her young child should be re-enacted by the alternative caregiver. This also includes socialising with the child in a spontaneous way, like messing up his hair, playing with him outside, reading him stories and cuddling him.
- Alternative caregivers should encourage positive interactions that include fun sensory experiences in order to establish a warm, trusting and supportive relationship. Alternative caregivers and children can for instance, blow bubbles together and reach out and touch them, telling each other how it feels on one’s skin. They can also share a sticky bun or feed each other different textures and tastes of food. Making a “child sandwich” using two duvets and squashing the child in the middle will be fun, and the child will experience deep pleasure. Other activities can include going to the

zoo together, cooking or baking together and teaching the child to participate in family activities, such as playing carpet bowls or camping.

5.4.6 Responsibility

It is one of the firm beliefs of the Gestalt approach that people are responsible for what they choose to do. Every moment, the individual makes choices to act or not to act in a certain manner, and he is fully responsible for these choices (Clarkson, 1999: 27- 28).

The following are important guidelines on responsibility:

- Change in terms of these children's behaviour and attachment to the alternative caregiver evolves gradually. Alternative caregivers should allow children to learn that unhealthy choices or actions are not the end of the world, but that there are definite consequences. Children should learn that correcting the situation is possible, but requires taking personal responsibility. A child can be helped to be more responsible, for instance by involving him in setting up the rules as well as outlining the consequences, for example of doing or not doing homework. If the rule says that homework should be finished before any television is watched, the child is responsible to act accordingly. If the child chooses to watch television without having completed his homework, the consequence is that he would not be allowed to watch television any further until his homework is finished. Children have to recognise that they are the agents of their own behaviour, and they have to accept this responsibility.
- It is important that alternative caregivers scrupulously strive to create a balance between rendering support, nurturing and being empathic, on the one hand, and setting clear and consistent

boundaries and consequences, on the other. In this way, children can gradually learn to be responsible. For instance, there can be consistent routines and rituals, such as making their beds in the morning or walking the dog after their homework is completed. These provide the children with opportunities to act responsibly by doing these chores, but also suffer the consequences if the rules are ignored.

- Alternative caregivers should model taking responsibility without blaming the environment, and also teach children not to blame outside factors for suffering the consequences of their own unacceptable behaviour. Traumatised children can easily blame their background, biological parents, previous placements or past abuse for their difficult behaviour. It would be important for alternative caregivers to make children aware that they have choices and that they can choose to act differently and take responsibility for themselves in the here and now, starting to change their attitude and behaviour with the support of the alternative caregivers and other professionals. For instance, if a child was previously exposed to an aggressive father, the child can choose not to act in the same way and walk away from situations where he is provoked, or he can ask someone for help.

5.5 CONCLUSION

In this chapter, the researcher has described the development of observational tools as part of the design phase of the design and development model. These tools are to be used by alternative caregivers for self-monitoring and self-recording of any change in behaviour and enhancement of attachment in the alternative caregiver-child relationship. In addition, the researcher has developed guidelines from a Gestalt perspective for alternative caregivers to enhance attachment with the traumatised child. Attention was given to awareness, the

here and now, impasse, organismic self-regulation, dialogue and responsibility as Gestalt concepts as they relate to the enhancement of attachment. In the final chapter recommendations will be made and conclusions drawn from this research study.

CHAPTER 6

RECOMMENDATIONS AND CONCLUSIONS

6.1 INTRODUCTION

In Chapter 5 the last two phases of the design and development model were discussed, namely the design phase and early development of guidelines for alternative caregivers from a Gestalt perspective to enhance attachment with the traumatised child. In this final chapter the extent to which the goal and objectives of this research study have been achieved, will be discussed first. Subsequently, recommendations will be made and conclusions drawn from the findings of the research study.

6.2 THE INTERVENTION RESEARCH PROCESS

The design and development model was followed as part of the intervention research process and all the steps of this intervention model was integrated into the research process to ensure continuity and for the study to form a unit. The intervention research process will now be reviewed in order to evaluate whether the goal and objectives for this study have been achieved. This process will be discussed according to the four different intervention phases that were followed.

6.2.1 Problem analysis and project planning phase

This phase consists of the various steps that will be evaluated in sequence.

6.2.1.1 Identifying and involving clients and gaining entry

Referrals of alternative caregivers and the children in their care were made to the researcher by professional social workers. These alternative caregivers were referred to for play therapy for the children and guidance for themselves on how to deal with these children and form a healthy attachment with the children in their care. Five of these alternative caregivers, of whom one was a foster carer, were identified and involved in the study. Since the researcher was known to the respondents as well as the professionals who had referred their clients, the researcher had no trouble in ensuring the cooperation and support necessary to conduct the intervention research. These steps of identifying and involving clients, as well as gaining entry into the community, were successfully completed as part of the first phase. This procedure is discussed under 1.5.1.1 and 1.5.1.2 in Chapter 1.

6.2.1.2 Identifying concerns and analysing identified problems

An in depth empirical study was carried out by the researcher. The researcher used focus groups as interviewing method to collect data, in order to identify pertinent issues and concerns of the population. Firstly, an interview schedule was drafted and tested on a sample of three parents who did not form part of the research sample. Feedback was shared and a few questions on the interview schedule were revised.

Information gathered from the focus group interviews was organised and analysed under the following four main themes:

- Respondents' opinion of the **personal problems** experienced with traumatised children in their care;
- respondents' opinion of the **individual problems** experienced by the children in their care;
- respondents' opinion of **environmental attitudes** affecting their care of the children;

- respondents' opinion of the **needs** that arise when caring for traumatised children.

When the intended guidelines were eventually compiled, the various concerns and needs identified under these four categories were taken into consideration. This procedure is discussed under 1.5.1.3 and 1.5.1.4.

6.2.1.3 Setting the goal and objectives

The goal of this study was:

To develop guidelines for alternative caregivers in order to enhance attachment with the traumatised child in their care.

The goal was achieved through the successful completion of the following objectives.

- *To undertake an in depth empirical study, using an interview schedule to collect data, in order to analyse what the concerns and problems are as identified by the respondents* (this objective is discussed under 6.2.1.2);
- *to undertake a thorough literature study on attachment and how it can be enhanced through the utilisation of applicable Gestalt principles with the traumatised child in alternative care* (this objective is discussed under 6.2.2.1) ;
- *to determine functional elements of existing guidelines for alternative caregivers to be used when establishing Gestalt guidelines for alternative caregivers to assist them in enhancing their relationship and attachment with the child* (this objective is discussed under 6.2.2.3);
- *to establish guidelines from a Gestalt perspective to assist alternative caregivers to enhance their relationship and attachment with the child* (this objective is discussed under 6.2.4.1)*;*
- *conclusions to be drawn and recommendations made to assist alternative*

caregivers and field social workers and contribute to further research (this objective is discussed under 6.3 and 6.6).

These objectives were achieved in the course of completing the intervention research process.

6.2.2 Information gathering and synthesis phase

This second phase of the intervention research process consists of the following steps, which will subsequently be evaluated.

6.2.2.1 Using existing information sources

The objective was to undertake a thorough literature study on attachment and how the latter can be enhanced through the utilisation of applicable Gestalt principles with the traumatised child in alternative care. This objective was achieved, since the researcher gathered the necessary information with the help of the literature study. Information was gathered from books, journals and other dissertations in other fields like psychology, education and health.

An extensive literature study was done on attachment as well as the Gestalt approach and presented in Chapter 3. Firstly, attention was given to the definition of attachment and attachment theory. The various categories of attachment were then discussed, namely secure attachment, insecure avoidant attachment, insecure ambivalent attachment and insecure disorganised attachment. The forms of behaviour reflecting various attachment problems were also covered. The definition of attachment and attachment theory provided a good explanation of what a positive attachment between an alternative caregiver and child should entail. An explanation of the behaviour of the biological parents and that of the children associated with the various insecure attachment patterns, enables alternative caregivers to identify in which category the child falls and to have a

better understanding of the reasons for a particular form of behaviour. From the empirical research and the literature study on attachment it became clear that the children in alternative care that formed part of this study, had attachment problems, as reflected in their behaviour and described in the literature.

In Chapter 3, attention was also given to the definition of Gestalt, the philosophy of the Gestalt approach and the Gestalt concepts as they relate to the guidelines to enhance attachment between the child and alternative caregiver. Various sources of experts on Gestalt were consulted and used to explain the Gestalt concepts, before making it applicable to the attachment relationship between the alternative caregiver and child.

6.2.2.2 Studying natural examples

In this step of the second phase, professionals who are experts in the fields of attachment, traumatised children, attachment therapy and psychotherapy treatment were consulted. Valuable insights were gained and information gathered through face to face discussions, telephone conversations and e-mail correspondence with these professionals. Parents who did not form part of the study were consulted in order to test the questions for the focus group interviews and to enquire how they would address the needs in question. Existing information sources as discussed under 1.5.2.1, and functional elements of successful models as discussed under 1.5.2.3, were also helpful in eventually establishing guidelines to enhance attachment between the alternative caregiver and the traumatised child.

6.2.2.3 Identifying functional elements of successful models

In Chapter 4 functional elements of successful models were identified and discussed as part of the third and final step of the second phase of the design

and development model. Functional elements were found in various existing treatment programmes, and were integrated into the Gestalt guidelines for alternative caregivers to enhance attachment with the child in care. Although these treatments have not been designed from a Gestalt perspective, they were found to contain useful suggestions and information that were identified as functional elements for the purpose of this study.

6.2.3 Design

In this third phase, the steps in designing an observational system and specifying procedural elements of the intervention will be evaluated.

6.2.3.1 Designing an observational system

As part of this step of the third phase of the intervention research process, three observational systems in the form of self-recording sheets were compiled. These sheets are to be used in conjunction with the preliminary Gestalt guidelines. The three different sheets outline the typical forms of behaviour associated with each type of insecure attachment, as well as the possible underlying needs. By using these recording sheets, alternative caregivers are able to record what they did or could do to address the underlying needs and subsequent behaviour, and to monitor any change or improvement. This information is discussed under 5.2 in Chapter 5.

6.2.3.2 Specifying procedural elements of the intervention

By establishing procedural elements for the intervention, the second step of the design phase of the intervention research process was completed. Procedural elements outlined in Chapter 5, pertained in particular to the person implementing the guidelines. Some of the details were that the person implementing the guidelines must be a professional with a sound knowledge and

understanding of the theory, concepts and principles of the Gestalt approach. This person must also have a clear understanding of attachment and attachment related issues, as well as experience in working with alternative caregivers and their needs. Procedural elements also included that two sets of recording sheets (observational tools) be given to respondents (see Chapter 5). One set included examples in all columns, in order to guide respondents when completing the sheets. The second set was left blank, apart from the first two columns, namely "Type of behaviour displayed" and "Possible underlying need", for the respondents to fill in. This information is discussed under 5.3.

6.2.4 Early development

The fourth phase includes the important operations of developing a prototype or preliminary intervention and conducting a pilot test. For the purpose of this study, only preliminary guidelines were developed. These will be evaluated subsequently.

6.2.4.1 Developing a prototype or preliminary intervention

In the final phase of the intervention research process, preliminary Gestalt guidelines were developed for alternative caregivers to enhance attachment with the traumatised child. Information was gathered through the empirical research, the literature study, the opinions expressed by experts, and through identifying functional elements of other treatment models. In developing the preliminary intervention, attention was firstly given to the conditions under which the guidelines must be implemented, and secondly to various Gestalt concepts, namely awareness, the here and now, impasse, organismic self-regulation, dialogue and responsibility. This information was discussed under 5.4.

6.3 RECOMMENDATIONS FROM THIS STUDY

The researcher would like to make the following recommendations from the research, especially in relation to the guidelines. Firstly, it would be important for alternative caregivers to be well-informed about the task of caring for children who have been traumatised. Sharing of information should take place regarding the histories of the children and the difficulties that can be expected. Proper preparation should also be done in terms of handling the children and addressing their needs. This should include a thorough explanation of attachment issues and how the guidelines would apply.

Secondly the guidelines as such, as well as their application should be thoroughly explained to the potential users (alternative caregivers), mainly during the preparation training of the alternative caregivers.

The third recommendation the researcher would like to make, is that alternative caregivers as well as the professionals involved should have a genuine commitment to implementing and upholding these guidelines for assisting alternative caregivers to enhance attachment with the children in their care. Perseverance in applying these guidelines would be especially important, as they cannot be expected to bring about instant change.

Fourthly, the researcher would like to recommend that assistance and support from professionals be readily available at all times. For instance, alternative caregivers should have free and unlimited access to help when uncertainty exists about the use of the guidelines, or a particular aspect thereof.

Lastly, in conjunction with the previous recommendation, the researcher would like to recommend that regular support group meetings for alternative caregivers be initiated. The aim of such group meetings would be twofold. On the one hand, alternative caregivers can encourage and motivate each other to persevere with

the guidelines, by giving feedback on how the guidelines have made a difference. On the other hand, the professionals involved can join in with some of these meetings and, through evaluation and in consultation with the alternative caregivers, make certain adjustments to these guidelines that might make them more user friendly.

6.4 LIMITATIONS EXPERIENCED DURING THE RESEARCH

The number of respondents used for the research was limited due to time and transport constraints. The Northern Cape is a vast area and respondents did not always have access to transport which in turn had time implications. The findings of the research will therefore also be limited. In spite of the fact that respondents contributed as best they could, the researcher sometimes felt that the alternative caregivers lacked insight and understanding of the research subject. The researcher had difficulty at times to shift the focus to other issues in caring and not, for instance, discuss the lack of financial support every time.

Literature obtained regarding attachment and programmes to enhance attachment was mainly written for adopters or birth parents themselves. The programmes suggested were also mainly therapeutic in its nature, requiring a therapist to implement. Information for alternative caregivers who are not professionally qualified, was therefore quite limited, as were practical suggestions, for instance, what type of exercises and activities can be done to enhance attachment. In the course of the study, the researcher also realised that enhancing attachment between a child and alternative caregiver is actually a more difficult issue to deal with than in the case of an adopted or a birth child. A child in care does not necessarily stay with an alternative caregiver indefinitely, and may therefore question the need for real attachment with the alternative caregiver.

The researcher did not investigate the full extent of attachment and everything that plays a role, since this study was particularly focussed on how to address the lack of

attachment once this was identified. For this reason, only a small part of attachment and attachment related issues were actually covered in this study.

The Gestalt guidelines that were drawn up, only provide a basic background explanation of what the Gestalt approach entails. It would therefore be imperative that a professional facilitator, well-acquainted with the Gestalt approach, be involved in instructing the alternative caregivers in these guidelines and the implementation thereof, and be available for help in case of uncertainty (cf. fourth recommendation above). This could be a limitation, especially in areas where professionals do not have knowledge of Gestalt and are therefore unable to implement the guidelines.

6.5 ASPECTS FOR FURTHER RESEARCH

Since attachment issues were only addressed in part during this study, the researcher would recommend that, in future research, more attention be given to specific attachment disorders and how these can be addressed.

The researcher also believes that other aspects, such as the motivation of the alternative caregiver for caring, or the history of the child in care should receive further attention in future research. Such further research may provide new information on how factors such as long-term abuse or neglect of the children may impact on the attachment relationship between alternative caregiver and child. Furthermore, children in care can be involved in future research and become the focus of a study investigating how they themselves can contribute towards enhancing the attachment relationship with their alternative caregiver. Recording sheets (observational tools) can be adjusted accordingly, for instance to include a column showing the child's contribution towards enhancing the attachment in the relationship.

The fact that a person implementing these guidelines should have a sound knowledge and understanding of the Gestalt approach, as well as professional experience in facilitation, is in truth a limitation to the study. In future research, perhaps guidelines could

be developed that are not specifically based on Gestalt, making the guidelines more accessible to any person.

There is a need for further research where these Gestalt guidelines are being tested in practice, evaluated and adjusted through group discussions between alternative caregivers and professionals. The self-reporting recording sheets also need to be tested as to its functionality. In future research, it could then be determined how effective these guidelines really are.

6.6 CONCLUSIONS FROM THE RESEARCH

The researcher concludes that attachment between the alternative caregiver and child can indeed be enhanced, but only on the following conditions:

- Alternative caregivers should be well-informed, in general being prepared for the task of caring, and individually for the specific needs of each individual child with his particular history.
- Specific preparation with regard to attachment problems and the associated behaviour should take place with alternative caregivers in order to ensure more profound understanding and knowledge of the child and his circumstances.
- The need for closer attachment should be expressed, ideally on the part of both the alternative caregiver and child's.
- Alternative caregivers should be fully committed to the implementation of these guidelines and persevere with application thereof.

6.7 CONCLUSIVE SUMMARY

The application of Gestalt guidelines to enhance attachment between the alternative caregiver and the child will only be successful if these are applied consistently over a long period of time. This includes the relevant Gestalt concepts, namely awareness, dialogue, the here and now, responsibility, organismic self-regulation and impasse.

This research study has not only focused on the enhancement of attachment between alternative caregiver and child, but also on creating a deeper understanding of the child in care and the behaviour displayed, in order to help the child move on from the past and allow the formation of new meaningful relationships. By having a better understanding of the reasons for attachment problems and the underlying needs, alternative caregivers would be able to address these needs much more effectively by using the Gestalt guidelines, thus enhancing their relationship with the child.

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