

A phenomenology study of clinicians' perspectives on dissociation while working with traumatised children in the South African context.

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Dedication:

This work is dedicated to all the children who have developed dissociation to survive their trauma and especially to the children who presented with dissociative symptoms that I worked with as they inspired this study.

Acknowledgements

I would like to thank and honour my husband who supported me throughout the journey of completing this master's degree. Thank you for being my biggest cheerleader, making sacrifices and making the completion of this dissertation your priority as well.

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Abstract:

The statistics of children experiencing trauma is extremely high in South Africa, with the expectation of 1 in 3 children experiencing sexual abuse before eighteen years of age. Trauma is defined as experiences which overwhelm the internal resources of a child and changes their perception of their lives and environment. Dissociation is a protective mechanism functioning to shield the conscious from trauma by preventing the processing of these experiences. The researcher was interested in whether dissociation is a phenomenon which is present in children living in South Africa who have a history of trauma. To determine this, the researcher applied a qualitative approach and phenomenological design to the research. The researcher used a purposive sample of sixteen clinicians practicing in the Western Cape metropole, to determine whether dissociation is present and how it appears in children who have a history of trauma.

The findings showed that dissociation was found to be present in children who have experienced trauma living in the Western Cape metropole. Furthermore, the data indicated that between 60 and 80% of children who had experienced trauma present with dissociation. The dissociative symptoms and features identified were misbehaviour and daydreaming. Predisposing and precipitating factors were found to be risk factors for the development of dissociation after a trauma is experienced. These factors were the younger the child when the trauma happened the more likely the development of dissociation. Secondly, the type of trauma experienced and a disorganised attachment style with the caregiver. A protective factor identified was the presence of a secure attachment between the child and caregiver before trauma is experienced. The therapeutic treatment of dissociation was described as holistic in nature by involving the child's caregivers. The main therapy used by the participants with children who present with dissociation were based on play therapy techniques and recreating a sense of safety for the child needs to be a primary goal of treatment.

Recommendations for further study was given due to the impression of limited understanding and knowledge of dissociation. The findings emphasised the importance of the caregiver being involved in the therapeutic process and therefore it is recommended that clinicians who render therapeutic services to children include the caregivers in the therapeutic process. The data showed that trauma informed policies and interventions need to be developed to further assist children who have a history of trauma and present with dissociation.

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CHAPTER 1:

PROBLEM FORMULATION

1.1. Introduction

This chapter introduces the topic chosen for this research project and the rationale of the study is described. Concepts used throughout the research report are defined and clarified. The ethical considerations applied throughout the study are discussed. The research questions which the research project is designed to answer are presented. In this chapter the structure of this research report is described.

1.2. Statement of the Problem

Dissociation is described as a defensive response of the self to a traumatic event that is experienced (Wieland 2015). Dissociation is a psychobiological and mental process that allows the self to manage and cope with traumatic experiences by separating the psychobiological system of the personality that contains the traumatic experience from the conscious self (Schimmenti 2018). Dissociation develops into the main and long-lasting coping mechanisms of the self when traumatic experiences become repetitive resulting in pathological forms of functioning (van der Hart, Nijenhuis & Steele 2006). The mind compartmentalizes the traumatic experiences on an unconscious level, however the body still lives in a heightened state of arousal and, due to the internalisation of the experience, there is a continuous need to re-enact the experience for psychological relief (van der Kolk 2014). There is difficulty in being present within their selves and daily lives as an unconscious part of the self is continuously suppressed (van der Hart et al 2006). The amount of psychological energy that goes into keeping the experience separated prevents the self from being able to integrate the traumatic experience. This leads to complex pathological symptoms as well as not being able to fully engage in life (van der Hart et al 2006). Thus, living in a state of dissociation is compared to being simultaneously aware and unaware of an experience (van der Kolk 2014). This is disconcerting for a child who already has very little control and power over their daily lives while experiencing continuous trauma. This perpetuates the need for the child to dissociate from their experiences (Schimmenti 2018).

Research has found that dissociation which develops into pathological emotional and somatic symptoms in adulthood are caused by childhood trauma (Schimmenti 2018; van der Hart et al 2006). These symptoms range on a spectrum from mild, to moderate to extreme dissociation (Wieland 2015; Bovin, Ratchford & Marx 2014). It has been found that dissociation can be linked

to traumatic stress disorders and a contributing factor for the development of other psychiatric disorders (Chui, Tollenaar, Yang, Elzinga, Zhang & Ho 2019; Hagan, Hulette & Lieberman 2015) and co-morbidity with other psychiatric disorders with dissociative symptoms (Wieland 2015).

There has been very limited study on dissociation within the context of high-risk populations such as children exposed to trauma living in South Africa (Makhubela 2020; van der Merwe & Swartz 2015). South Africa has a unique history and current socio-economic climate resulting in many persons exposed to trauma throughout their lives (Atwoli, Stein, Williams, McLaughlin, Petukhova, Kessler & Koenen 2013). The Optimus Study (2016) further illustrated this by identifying that 1 in 3 children are exposed to sexual abuse, which is defined as one of the traumatic events that result in Post-Traumatic Stress Syndrome and dissociation (DSM5 2013). Therefore, in South Africa, the effects of childhood trauma are one of the most important areas of concern for clinicians.

Therefore, treatment requires that the effects be fully understood and studied in the unique society of South Africa.

Trauma during childhood results in widespread psychological difficulties which one cannot clinically refine to one type of pathology (Wamser-Nanney & Campell 2020). However, one of the main coping mechanisms of trauma which a child uses that may result in pathology is dissociation (Wieland 2015). A child has very limited control over their own lives as they look to their caregiver to regulate and create a safe environment. Neurological systems are developing and not yet able to process traumatic experiences (Schimmenti 2018). Dissociation is used by a child to be able to escape from their surroundings and at times caregivers are unable to recognise that a child is displaying dissociative symptoms of a pathological nature (Wieland 2015).

Most studies completed on dissociation focus on the experience of an adult and whether there is a connection between childhood abuse and dissociative symptoms and how these symptoms are displayed in adulthood (Hagan, Hulette & Lieberman 2015). Internationally there is little research on how children express dissociation and best practice interventions may be used to assist the child to deal with the initial experience that leads to the development of dissociation (da Silva & Fritz 2012). Indeed Silberg (2013) states that it was only in 2011 that the first book was written that was entirely dedicated to the topic of children and adolescents who experience dissociation.

The purpose of this study is to investigate the perspectives of South African clinicians on dissociation and how dissociation presents in children and determining clinicians' best therapeutic interventions in treating dissociation in children. The hope is that this study will contribute to developing therapeutic interventions for children to assist in integration of trauma to prevent dissociation developing into sustained psychopathology.

1.3. Rationale of the Study

Dissociation is a very complex and understudied phenomenon that needs more understanding if clinicians are to assist the self of the client to integrate traumatic experiences (van der Hart et al 2006). Dissociation is a term that is used by many clinicians when describing the outcomes of trauma. However, there is little clarity and agreement on the mental process of dissociation (van der Hart et al 2006). More research into dissociation, especially in underdeveloped countries, will further assist in creating consensus on understanding the mental process associated with dissociation.

Dissociation and hyperarousal are the two responses that a person has to trauma (da Silva & Fritz 2015). It is therefore important that clinicians understand the process of dissociation and apply best formulated practices and modalities to assist the child client (Wieland 2015). Most South African children live in circumstances that are trauma inducive (da Silva & Fritz 2015). Considering South Africa's political background of the apartheid regime which only ended in 1994, and which was followed by an increase of interpersonal violence, there is a high level of trauma in society. Studies showing 80% of the population has experienced a traumatic event (Atwoli et al 2013). Thus, to fully be able to reduce trauma related disorders, a deeper understanding of how dissociation affects the self in childhood is needed and the development of interventions to prevent psychopathology in childhood and adulthood.

1.4. Significance of the Study

This study has the potential to create dialogues between clinicians in South Africa for further development of therapeutic techniques for traumatised children who display dissociative symptoms. By gathering South African clinicians' first-hand experiences when working with traumatised children who display dissociation, the researcher hopes to assist in the development of a deeper understanding between trauma and the impact of coping mechanisms to the self-structure in childhood. This information has the potential to assist clinicians to improve support to parents in raising healthy children to become the best versions of themselves, and to develop effective interventions in treating children who have experienced trauma thus preventing the long-term effects of dissociation as a pathological coping mechanism. A study on this topic can contribute to the international dialogue on childhood dissociation and how clinicians can intervene therapeutically with children who dissociate.

1.5. Research Topic

The aim of this study was to investigate South African clinicians' perspectives on dissociation and traumatised children and their approaches to treatment. The researcher investigated clinicians' views on dissociation, based on their practice experience with traumatised children in the context of South Africa and whether relational trauma is a factor that results in the development of dissociative symptoms and eventually psychopathology. Furthermore, the researcher wanted to investigate clinicians' perspectives on whether traumatic dissociative disorders are misdiagnosed as other pathologies in childhood.

1.6. Main Research Questions

1. Do South African clinicians commonly observe dissociation among their child clients with a history of trauma?
2. What are the common symptoms and features of dissociation that South African clinicians observe during assessment among the children who have experienced trauma?
3. Which theoretical explanations of dissociation inform South African clinicians' clinical understanding of dissociation among traumatised children?
4. What therapeutic approaches do South African clinicians utilise and find effective when treating children experiencing dissociative symptoms due to trauma?

1.7. Research Objectives

1. To explore whether South African clinicians commonly observe dissociative features among the children they treat who have a history of trauma.
2. To investigate the most common features and symptoms of dissociation South African clinicians identify during assessment of children who have experienced trauma.
3. To determine the theoretical underpinnings that inform South African clinician's understanding of dissociation as it pertains to children who have experienced trauma.
4. To determine the therapeutic approaches that South African clinicians find to be most effective when treating dissociation among children who have experienced trauma

1.8. Main Assumptions

1. Considering South Africa's history of violence and trauma as well as the extreme statistics of physical and sexual abuse of children it is assumed that South African clinicians would have cases of dissociation among the children they treat.

2. South African clinicians, based on their particular experience of practice in the context of South Africa, will have experienced common features and symptoms of dissociation manifesting in children who have experienced trauma.
3. Clinicians in South Africa would have trained in various professional programmes and would draw from particular theoretical and clinical literature informing their understanding of dissociation and its manifestation in children who have experienced trauma.
4. South African clinicians would have developed their particular practice approaches with children who present with dissociation as a feature of their experience of trauma.

1.9. Clarification of Terms

De Vos, Strydom, Fouche & Delpont (2011) indicates that the clarifying and defining of terms allows for better communication and bringing across the data that is collected in a research project. The researcher has chosen key concepts for which a universal meaning is required to ensure that the reader is able to comprehend what it is that the researcher means when reporting on the collected data.

Trauma - Trauma is witnessing, experiencing, or becoming aware of a loved one experiencing a traumatic event (DSM 5 2013). A traumatic event is described (DSM 5 2013) as either being exposed to possible or actual death, serious injury or sexual violence. However, clinicians have noticed that trauma can be any overwhelming event that is beyond the resources of the individual and as a result imprints the experience in the psyche, brain, and body of the individual (van der Kolk 2014). The impact of trauma on the mind and body directly affects the perceptions of the individual and their responses to life, ultimately changing the individual's sense of self and ability to be present in their daily lives (van der Kolk 2014).

Children – The Children's Act (2005) and UNICEF (1989) classifies children to be anyone between the ages of 0 and 18 years. These ages can be split up between adolescence, from 10 to 19 years of age (UNICEF 1989) and a young child, between the ages of 0 and 10 years. For this study the researcher relies on this definition and has focused this study on children under the age of 11.

Dissociation - The DSM 5 (2013) classifies dissociation as a disruption or discontinuity of the integration of memories, experiences, identity, emotion, perception, body representation, motor control, behaviour, and consciousness. These disruptions result in dissociative symptoms which interfere with daily life and develop after a traumatic event (DSM5 2013). Dissociation has been described as a coping mechanism for overwhelming experiences especially for children who are

unable to physically get away from the experiences but by dissociating, they can psychologically escape (Wieland 2015). Dissociation is further explained as the process of the personality holding traumatic experiences so that the “rest” of the personality can continue with life and not be affected by the trauma – pushing all psychological and physical reminders of the trauma out of consciousness (van der Hart et al 2006).

Dissociation can result in psychopathy in the form of derealization and/or depersonalisation or dissociative amnesia (DSM5 2013). Dissociative derealization is the sensation of not experiencing oneself as being part of the surrounding environment or experiences of unreality (DSM5 2013). Dissociative depersonalisation is the experience of not being attached to one’s mind, body or self (DSM5 2013). Dissociative amnesia is the experience of part of the personality holding the experience of the person and the taking over of the current functioning (van der Hart et al 2006; DSM5 2013). Dissociative identify disorder has symptoms of amnesia as the personality develops part(s) that take over the consciousness (DSM5 2013).

For the sake of this study, the researcher as taken into consideration the DSM 5’s (2013) definition along with the concept of dissociation being a coping mechanism of trauma used as a form of protection for the mind, self and body (Wieland 2015; van der Hart et al 2006). The researcher has used these definitions cautiously to avoid influencing the clinicians’ personal understanding of the term, dissociation.

Clinician – Clinician is a term that refers to a subgroup of practising professionals consisting of mental health professionals (Austin 2017). To be included in this subgroup, the professional must have training which enables them to observe and evaluate a client who can be a child, adolescent, or adult, to determine whether there is a mental health issue that is presenting as problematic and to implement treatment plans (Austin 2017). A clinician is a professional that has had training in a school of psychology (Sue, Sue, Sue & Sue 2016). There are many different professionals that fall under the term of clinician, as is described by Howarth, Freeston, Reichelt & James (2014). These professionals include psychology, psychiatry, social work, and behavioural analyst (Howarth et al 2014; Sue et al 2016). For the sake of this study the researcher interviewed professionals that fall within the following professions: clinical, educational and counselling psychology, psychiatric nursing, social work and psychiatry.

1.10. Ethical Considerations

Research in social sciences is complex as it involves the observation and study of people (de Vos et al 2011). The ethical guidelines for research for the Humanities Department which are

described in the University of Cape Town's guidebook (2016) was considered throughout the process of this study.

1.10.1. Avoidance of Harm

One of the fundamental aspects of research is that no harm should come to the participants, be this emotional or physical and if there are any risks these need to be communicated to the participants beforehand (de Vos et al 2011). It is up to the researcher to be able to identify whether interviewing could lead to the participant experiencing a form of harm and assess whether the participant would be a good candidate to the study. The research explored the experiences and observations of clinicians who have worked with traumatised children who display dissociative symptoms. Once this information was gathered, the researcher was able to compile evidence of practice techniques of treatment for dissociation in children. The clinicians, as the participants, were not required to share personal information regarding themselves for the sake of the research study. Therefore, the participants did not experience any harm in the process of this research project. However, the researcher did take time after the interviews to debrief the participants.

1.10.2. Informed Consent

Requiring informed consent means that the participants are given all the information about the study and understand all the risks involved before agreeing to partake in the study (Babbie 2016). The information to be shared with participants includes the goal, the duration and procedure of the interview, possible advantages and disadvantages of involvement, whether involvement may result in any form of harm and the credibility of the researcher (de Vos et al 2011). Informed consent from the participant should be given voluntarily and the participants should be informed that they are free to withdraw from participating at any point in the process of the research project (de Vos et al 2011). The researcher informed the clinicians that the focus of the study was on their professional experience and perception of dissociation as a phenomenon in their work with children who have experienced trauma. The researcher obtained informed consent from the clinicians who participated in the research project.

1.10.3. Deception of Participants

Deception is the intentional withholding or misrepresenting information to the participants to ensure participation within the research project (de Vos et al 2011). No deception with regards to the nature or intent of the study was communicated to potential respondents and no misrepresentation of any information.

1.10.4. Privacy /Anonymity/ Confidentiality

De Vos et al (2011) describes privacy as the person's right to withhold or share information about their lives. Anonymity is not being able to distinguish who the participants are within a study. True Anonymity is when the researcher and the reader is unable to identify the participant (de Vos et al 2011). However, in qualitative research it is impossible for true anonymity to be assured as should the researcher need to determine the identity of the interviewee for clarification, it is important to be able to do so (Babbie 2001). The difference between anonymity and confidentiality is that only the researcher will be able to determine who the participants are but promises not to share this publicly (Babbie 2001). The researcher ensured that the interview took place in a setting that only the researcher was privy to what was shared by the participants. The researcher respected the participant's right to privacy by not forcing the sharing of information. True anonymity was not obtainable as the researcher interviewed the participants. However the researcher did not publish any identifying details that could possibly jeopardise anonymity and the participants were given pseudonyms in the study. The researcher is the only person who knows the identity of the participants and has access to the recordings of the interviews and transcripts, storage is in a confidential and secure place.

1.10.5. Voluntary Participation

No participant should feel forced nor obliged to partake in a research project (de Vos et al 2011). This is vital as participation in the research project may interfere with the participants' daily lives and require them to share personal experiences (Babbie 2001). The researcher did not force any participant to be part of the research project and allowed the participants to choose whether to voluntarily participate in the research and be a part of the study. The researcher informed the participants that they can choose to withdraw from the study at any point without any negative consequence to them.

1.10.6. Debriefing Respondents

The debriefing of participants after the involvement in a research project is to allow the participant to be able to share how they experienced their involvement and to ask questions or clear up any misconceptions of the project (de Vos et al 2011). The research topic is not of any sensitive nature to the participants personally, however the researcher did debrief every participant after the interview for reflection on their experience of the interview and their participation. During the debriefing there were no respondents who expressed a need for clarification or any degree of distress. Furthermore, the researcher offered to make available the final mini dissertation to the clinicians for them to read.

1.10.7. Publication of Findings

All research projects' findings should be summarised in a written report so that the findings can be shared in the scientific world (de Vos et al 2011). The researcher commits to ensuring that all information presented in this report is clear, free of manipulation for specific results to be formulated and free of language bias (de Vos et al 2011). This report, in the form of a minor dissertation, will be submitted to the University of Cape Town as well as to all the participants who were involved.

1.10.8. Actions and Competence of Researcher

It is of the utmost importance that the researcher of a research project has the competency of conducting a study on the determined topic (de Vos et al 2011). The researcher who has undertaken this study is a qualified social worker who has 3 and a half years' experience in the field of work with children, of which two and a half years was working as a therapist with sexually abused children in the Helderberg area. The researcher is also undergoing training as a clinical social worker which has a central focus in psychiatry and mental health. The researcher has successfully completed past courses in research methodology and the implementation of a past research project. This study was undertaken with the supervision of an experienced academic. A researcher needs to be open and accepting of different cultural norms and values when interviewing participants (de Vos et al 2011). The researcher who conducted this research project has worked in many different communities within the Cape Town area and is respectful of different cultures.

1.11. Outline of Research Report

This dissertation consists of five chapters aiming to determine clinicians' perspectives of dissociation while working with traumatised children in the South African context. The first chapter focusses on the topic and problem that was studied. The second chapter describes the relevant theoretical framework which was used throughout the study, namely psychodynamic theory, object relations and resource therapy. The second chapter consists of a review of existing literature on the chosen topic. The third chapter explores the applicable research methodology that was used to complete the study. The fourth chapter presents the data collected and the last chapter consists of the conclusions and recommendations developed from the data collected.

1.12. Conclusion

This chapter has given the overview of the occurrence of dissociation in response to childhood trauma and possible psychopathology that may develop if not treated in children. This section highlighted the importance of this research study in South Africa that focused on the broadening of clinicians' understanding and treatment of dissociation in children. The objectives of the study have been determined within this section and guided the research study to ensure that the objectives of the study were met. By indicating the ethical considerations that were taken into consideration for this research study, the researcher investigated clinicians' perceptions of dissociation while working with traumatised children in the South African context.

CHAPTER 2:

LITERATURE REVIEW

2.1. Introduction

The literature review gives the reader and the researcher the theoretical context of the topic chosen. In this chapter the researcher discusses the three theoretical frameworks which offer theoretical context to this research. The researcher will specify the legislation and policy frameworks taken into consideration that informed and guided the researcher while researching the topic. Finally, the researcher will go deeper into the existing literature on the topic within the four main questions that the researcher aims to answer from the process of this research. The aim of the literature review is to give a thorough background to the topic and present the existing research.

2.2. Theoretical Frameworks Contextualising the Study

Theory is a set of interrelated concepts that describe and present a systematic view of a phenomena which aims to explain and give substance to the phenomena (de Vos et al 2018). Babbie (2016) states that theory provides a methodical explanation for a phenomenon that is observed. Theory gives a phenomenon substance so that it can be understood as it is encountered. This study aims to understand, explain, and address treatment and the manifestation of dissociation in traumatised children. Three theoretical frameworks are identified to conceptualise dissociation. The three theoretical frameworks chosen are Psychodynamic theory, Object Relations theory, and Resource Therapy as they inform each other. These theories highlight how the self develops and fragments when using dissociation to cope with traumatic experiences.

2.2.1. Psychodynamic Theory

Psychodynamic theory and therapy focus on the unconscious forces in the mind that influence the individual's thought, relationships and life and the development of the self (Cabaniss, Cherry, Douglas & Schwartz 2017). Psychodynamic theory began with Sigmund Freud when he noticed the mind is not a static entity but rather full of energized elements that form a system from which the individual lives (Cabaniss et al 2017). Psychodynamic theory states that the mind is continuously working and processing matters outside of awareness and identifies this as the unconscious realm of the psyche (Cabaniss et al 2017). Psychodynamic theory focuses on the

unconscious drives, feelings and thoughts that drive the behaviour of the individual which causes pathology and distress. The unconscious can produce internal mechanisms to be used as a defence against overstimulating or frightening feelings, thoughts, or drives (Cabaniss et al 2017). The researcher connects the process of the psyche, placing these frightening experiences into the unconscious as a form of dissociation. The conscious dissociates rather than giving meaning and organising these aspects by creating a space in the unconscious. Although these aspects are in the unconscious they still push and influence the psyche by developing maladaptive thoughts and behaviours (Cabaniss et al 2017). Psychodynamic theory recognises the role of the clinician is to listen to the unconscious and to bring it into the awareness of the client. Psychodynamic theory focuses on how the unconscious is trying to push into the conscious by assessing an individual's five areas of functioning, the self, relationships, adapting, cognition, and work and play (Cabaniss et al 2017).

Psychodynamic theory describes dissociation as originating from the conflict within the unconscious drives and fantasies which results from trauma (Gullestad 2005). Psychodynamic theory defines trauma as overwhelming internal or external experiences uniquely interpreted by the psyche. The process of dissociation is portrayed as a defensive mechanism as the psyche changes to protect the conscious against the realisation of the internal conflict initiated by the trauma (Gullestad 2005). Psychodynamic theory observes dissociation to be the strengthening of defences within the psyche to repress the internal conflict (Gullestad 2005). Gullestad (2005) describes dissociation to be a form of present unconsciousness which creates a sense of safety for the person by denying the conscious realisation of the conflict between their desires, drives and affects. In childhood dissociation is seen as a regulatory coping mechanism for uncontrollable emotions (Gullestad 2005). Dissociation is described as a response that develops into an internal pattern used to defend against any experience or affect which triggers the original injury and conflict (Gullestad 2005).

When working with traumatised children it is important to understand how the self of the child develops and the different aspects that make up the self. Trauma affects the development of the self and has pathological consequences when experienced in childhood.

2.2.2. Object Relations

Object Relations develops away from the psychodynamic theory with the concept of the human object (relationships) being the most vital aspect that develops the structure of the self and that first and foremost humans desire relationships with others (Bodenheimer 2016). Object relations define the object as the symbolization of the internalization of the early relationships that are experienced. As an object is created by the internalization of how the self is defined and formed in

relation to the caregiver as well as an internalised object developing as a symbol of the other person, there can be many different internalised objects within the self (Bodenheimer 2016).

Object relations identifies the early stages of infancy and childhood to be the most formative period for the self (Hamlyn 2007). There are specific developmental phases that the child experiences that result in the development of the inner world of the self (Hamlyn 2007). The interaction and relationship that both the environment and the caregiver have with the child has consequences for how these developmental phases impact on the development of the self (Hamlyn 2007). Conflict and frustrations that are experienced within the self from the relationship with the caregiver or the environment creates disruptions within the self-structure that form fault lines (Hinshelwood & Fortuna 2018). These fault lines develop into patterns which the self uses to respond to similar and stressful experiences in both childhood and adulthood (Hinshelwood & Fortuna 2018).

There are many different object relations theorists that have different approaches to the phases of self-development, however Melanie Klein was the fundamental contributor to object relations in child psychoanalysis (Hinshelwood & Fortuna 2018). Klein (Hinshelwood and Fortuna 2018) states that there are two phases of self-development, these being the paranoid-schizoid and depressive positions. The paranoid-schizoid position is the process of self-development that the infant has from birth until 6 months, in this phase the infant is introduced to good and bad feelings from the interactions of the caregiver and the environment, both positioning as external to the self (Hamlyn 2007). The infant cannot comprehend that the same object can have both good and bad qualities (Hamlyn 2007). Therefore, these are split off and internalised into part objects within the self in the form of good and the bad objects. Pleasurable experiences are internalised as the good object and the feeling of annihilation anxiety is associated with the bad object (Hamlyn 2007). The bad object within the self evokes feelings of terror of annihilation and to protect the self from this, the self splits these experiences by internalising these feelings and projecting an idealised goodness onto the object (Hamlyn 2007). Should there be a healthy process of development the self will be able to experience that there is both good and bad in the caregiver. From the age of 6 months to two years the infant learns that they both love and hate the caregiver (Hamlyn 2007). During this phase of development of the self, the infant experiences feelings of separation anxiety and the fear of the loss of the other with the feelings of hatred towards the caregiver. The infant fears that these experiences of hate and rage will result in loss of the caregiver and compensates through expressions of love for reparation (Hamlyn 2007). The experience of early relationships with caregivers are internalized as templates for future relationships as well as the complex understanding of the self.

Object relations map out the self into two parts, the false and the true self (Ha Gu 2018). The false self develops to protect the consciousness from actualizing the true self. The true self is the part of the self that has developed in response to splitting the “badness” of the other and the environment as was described above. This is the part of the self that because of impingements and trauma experiences, experiences itself either as shameful, bad, guilty, fearful, rageful etc. The self cannot hold and process these emotions in an environment that is unsafe and where the self needs to maintain the relationship with the caregiver and their environment (Ha Gu 2018). The false self covers the true self, despite this the true self will at times push aspects into the consciousness through projecting it onto the other in their relationships as well as finding relationships that reflect aspects of the true self.

The researcher has realised that children who find themselves in traumatic situations have no power to be able to change the situation, they become victims to their circumstances (Herman 2015; Wastell 2005). To experience some control, the child’s self responds with splitting and creating a false self to interact with their caregivers and environments upon whom they are dependent for their basic needs (Ha Gu 2018). The child uses these defences to maintain the relationship with the caregiver as at times these relationships are what is causing their traumatic experiences. The child focuses their energy onto securing a form of an attachment with the unsafe caregiver by pushing away from their consciousness the traumatic experiences with their caregivers and environment (Quatman 2015; Ha Gu 2018). The researcher is of the opinion that the false self and splitting are structures of dissociation which the child’s self uses to cope with the traumatic environment and relationships (Ha Gu 2018). The child cannot cope with the realization of their caregivers wanting to hurt them or of their environment being unsafe, as this would mean the caregiver and their environment is bad. To make sense of this the child would rather accept the self as bad and develop a false self to protect the conscious from this and in turn creates the “façade” of a safe caring caregiver and environment. This becomes an unconscious precipitating cycle with the goal of ensuring the emotional survival of the child as the child relies on the false self for emotional protection, the deeper the fragmentation of the self occurs and the more the conscious needs to rely on the false self to be able to cope with the environment and the fragmented self.

2.2.3. Resource Therapy

Resource therapy is based on psychodynamic theory and the underlying concept of the personality having internalised experiences and emotions that develop, structure, and form the self. Resource Therapy stems from psychodynamic therapy and ego state theory (Emmerson

2014). Resource Therapy focuses on the development of different personality parts into resource states that are based on affects and experiences that the person has (Emmerson 2014).

Resource Therapy calls the different parts of the personality resources states which are first experienced as coping mechanisms for the self (Emmerson 2014). When the coping mechanism is repeatedly returned to, specific axon, dendrite growth and trained synaptic connections are created (Emmerson 2014). This neural network develops into a personality part that can be returned to when the function is needed. Resource Therapy, like psychodynamic theory, states that most of the formation of the self takes place in childhood and adolescence (Emmerson 2014)

Emmerson (2014) describes that the creation of resource states is a physiological process that is facilitated from the stimulation in childhood by the environment and caregivers. This results in the creation of different resource states that can be used by the self in different situations and circumstances. Emmerson (2014) describes the collection of the resource states which makes up the self as a resource map and any one person can have up to double digit resource states. These resource states can be in any one of these conditions: normal, conflicted, vaded, dissonant, or retro (Emmerson 2014). Resource states are divided into two types: surface (used regularly) and underlying (seldom used) and the resource state from which the person is in the moment is called the conscious state (Emmerson 2014).

Emmerson (2014) states that emotional memory is connected to the physiological process of the development of the resource states. However, resource states can enter dysfunctional roles if difficult emotions are not processed. Emmerson (2014) calls emotional memory “Sensory Experience Memory” (SEM) and describes this as the emotional remembering of experiences. The SEM can become separated to dissociate the difficult emotions that are provoked by the experience. Should these SEMs not be processed it may cause pathology for the individual as the SEM may become conscious or triggered but without the intellectual memory (Emmerson 2014). When the SEM is brought into the conscious in the inappropriate situation, the individual is affected by the emotions but does not know the source of the distress and thus is unable to remedy it. By the clinician applying the treatment process of Resource Therapy the self can connect the SEM with the initial sensitizing event which caused the emotion (Emmerson 2014). This allows the SEM to be processed and integrated into the intellectual memory and is no longer triggered by current situations. Resource therapy uses the concept of SEM to describe how resource states become dysfunctional and to explain how the resource states extend empathy towards each other for integration (Emmerson 2014).

2.3. Legislative and Policy Frameworks Contextualising the Study

There are several important legislative and policy frameworks that are relevant for this study. As the study's focus is to gain a better understanding of dissociation as it presents in traumatised children from the perspective of clinicians. The legislative and policy frameworks namely are the Children's Act no 38 of 2005, Mental Health Care Act no. 17 of 2002, the Department of Health's Policy Guidelines on Child and Adolescent Mental Health, 2002 and the United Nations Convention on the Rights of the Child on 16 June 1995.

2.3.1. Children's Act

The *Children's Act, No. 38 of 2005* (2005: section 8) indicates all children have the right to health services and this includes children who are struggling with their mental health. Dissociation is a pathology (DSM 5 2013) and can be extremely disruptive for the child and their family. It is the responsibility of the clinician to be able to identify and treat the symptoms of dissociation in children. The process of gathering information from clinicians on this topic is to better assist the child and the process of treatment of traumatised children. The aim is to empower clinicians to be able to discern if a child is presenting with dissociation from the traumatic experience and if the child is presenting with numbing in the therapeutic process when faced with a memory of the experience. Jamieson et al (2013) indicates the *Children's Act, No. 38 of 2005* encourages the clinician to write research publications for the further development of best practice evidence-based interventions that can be implemented in the best interests and treatment of children.

The *Children's Act no 38 of 2005 (2005: section 1)* defines a child as being under the age of 18 years. One of the important attitudes that a clinician can have when working with children is they are not mini-adults but rather children who differ developmentally and use a different manner to communicate as compared to adults. The overarching principle of the *Children's Act no 38 of 2005 (2005: section 9)* is the best interest of the child is paramount to any interaction and intervention with children. One of the key processes clinicians need to complete while working with children is to assess and develop interventions to better assist the child (Jamieson & Lake 2013). This can only be done by clinicians' sharing their experience of work with children in an under researched areas to develop new interventions and insights. Silberg (2013) noted, many interventions used with children who display dissociative symptoms are based mainly on adult based interventions and are adapted for children. Therapeutic intervention can have theory linked to adult based interventions however children need to have their own therapeutic interventions specified to their developmental needs and thus meet the imperative of the *Children's Act no 38 of 2005* of the best interest of the child being the guiding imperative.

2.3.2. Mental Health Act

The *Mental Health Care Act no. 17 of 2002* was designed to protect the interests and dignity of people who suffer from mental illnesses. People who suffer from mental illnesses are vulnerable and need to be treated with dignity and respect. This is especially true for children who display mental illness symptoms as pathology may already be present in childhood and adolescence (Jamieson et al 2013). Traumatized children are even more vulnerable as they have experienced an event or sequence of events beyond their control and may be struggling with PTSD as well as coming to terms with the experience.

The *Mental Health Care Act no. 17 of 2002* indicates people under the age of 18 may suffer from mental illnesses. This validates the suffering of children who display dissociative symptoms as this can be related to other mental health diagnoses.

Furthermore, the *Mental Health Care Act no. 17 of 2002* defines what mental health practitioners are. This assists with the definition of a clinician and who can partake in this research project. The *Mental Health Care Act no, 17 of 2002* identifies a mental health practitioner to be a psychologist, psychiatrist, registered medical practitioner or nurse, occupational therapist or social worker trained to administer mental health care or rehabilitation services. This definition informed the researcher about who renders therapeutic treatment to traumatized children who present with dissociation and who may be interviewed.

2.3.3. Relevant Policies or Charters which South Africa are Signatories to in Relation to Children.

The Department of Health (2003) released a policy guideline on the mental health for children and adolescents. This document informs how mental health can be addressed and emphasises a holistic approach for interventions with children. The Policy breaks down the ages of children into three categories and how the needs of children in these different phases of development must be addressed. The age categories are prenatal - conception to birth, childhood - birth to 9 years of age, and adolescence - 12 to 18 years of age (Department of Health 2003). The Policy highlights the need to contextualise the different phases of childhood as in each there are different developmental aspects of mental health needing to be addressed in treatment. The Policy highlights that success of treatment in preventing pathology is based on the consideration of the different phases of development while addressing the effects of trauma. The researcher has outlined the specific age group clinicians need to be treating to take part in the research project, namely being the childhood phase with the years 10 to 11 added.

South Africa ratified the United Nations Convention on the Rights of the Child on 16 June 1995, committing to protecting and promoting the rights of children. As a result, all Government agencies need to align with promoting the rights of the child by ensuring all necessary services are offered

to a child to enable good health and enable full realisation of potential. The Convention on the Rights of the Child (UNICEF 1989) protects the right of each child in South Africa to receive best practice and evidence-based mental health services.

2.4. Dissociation and Traumatized Children

The current psychiatric system does not have adequate categories to fully describe the impact of trauma and the intense difficulties experienced by traumatized children and adolescents as there is no valid formal epidemiological research completed on this area (National Child Traumatic Stress Network 2003). Although some difficulties and the impact of trauma on children and adolescents can be categorised into the aspects of PTSD there are areas of impairment missing (National Child Traumatic Stress Network 2003). Thus, the National Child Traumatic Stress Network (2003) developed a White Paper on complex trauma in children and adolescents outlining the six domains of impairment children and adolescents face after trauma. These being i) Attachment, ii) Biology, iii) Affect Regulation, iv) Dissociation, v) Behaviour Regulation, vi) Cognition, and vii) Self Concept. These domains are further broken down into the affected areas, however for the focus of this research will be dissociation.

The National Child Traumatic Stress Network (2003) states that dissociation results in impaired areas of functioning although it is a key resource that children use when faced with traumatic events. Traumatized children develop areas of impairment due to dissociation which prevents integration and processing of experiencing traumatic events on cognitive, somatic, affective areas of functioning or being consciously unaware of behavioural repetitions related to the trauma (National Child Traumatic Stress Network 2003). When dissociation is the child's primary psychological defence mechanism in response to chronic trauma it will eventually develop into a pathological disorder beginning in childhood and continuing into adulthood (Centre of Child Trauma Assessment, Services, and Interventions (CCTASI) 2017).

The National Child Traumatic Stress Network (2003) identifies three functions for dissociation when children experience trauma. Including the protection of the self by the automatization of behaviour, depersonalisation during the trauma, and splitting memories from feelings so that processing is limited. When children rely primarily on dissociation to cope with trauma then they begin to have difficulties managing their own behaviour, emotional regulation and a fragile self-concept is developed (National Child Traumatic Stress Network 2003).

2.4.1. Type of Traumas Prevalent in Children

There are two types of traumas that a child can experience, namely acute-type 1 trauma (Wastell 2005; Herman 2015) and complex-type 2 trauma (Wastell 2005; Herman 2015; National Child Traumatic Stress Network 2003; Potgieter Marks et al 2017). Acute-type 1 trauma is a single once off traumatic experience such as a car accident or natural disasters (Herman 2015; Wastell 2005). Although these can result in similar symptoms of complex-type 2 trauma, the key difference is that in complex-type 2 trauma the self-structure is altered and the child's sense of being in the world, their relationships and bodily connections are changed (Wastell 2005). Assistance and treatment after acute-type 1 traumatic experiences may be required but not to the same degree as the treatment needed for complex-type 2 trauma (Wastell 2005).

Complex-type 2 trauma is multiple traumatic experiences that are directly linked to the caregiving system that the child is in (National Child Traumatic Stress Network 2003). Complex-type 2 trauma is also described as prolonged and repeated traumatic experiences which result in Complex Post Traumatic Stress Syndrome and other circumstantial symptoms relating to the trauma (DSM 5 2013; Herman 2015). When complex trauma is experienced, it invades the sense of self and personality as survival becomes the focus rather than the development of the self (Wastell 2005). Both the neurobiological systems and the self of the child is impacted by complex trauma. The chronic traumatised child's neurobiological system is unable to develop a base line of safety and stabilisation, this results in the development of somatic symptoms and the child may sense that the body has betrayed them and is no longer safe (Herman 2015).

2.4.2. Trauma's Impact on the Developing Brain

Trauma has a severe impact on the development of a child's brain as instead of the biological energy being focused on growth, all resources are diverted to ensure survival (Harris 2020). Hart (2013) illustrates the neurological impact of trauma on a child, by describing the effect of long-term exposure of the stress hormone, cortisol, and adrenaline. Cortisol and adrenaline result in the reduction in size of the control and emotive structures in a child's brain which affects the development of one continuous narrative of self (Hart 2013). When the hyperarousal response to trauma is not efficient too much adrenaline is produced which triggers the Hypothalamic-Pituitary-Adrenal axis to produce cortisol (Hart 2013). Cortisol is the signalling hormone for the neurological systems that are not necessary for survival to shut down. As the increase of cortisol is stimulated the parasympathic nervous system responds by entering a state of hypoarousal, the freeze response primarily known as the dorsal vagal response (Paulsen & Lanius 2014; Hart 2013). The activation of the dorsal vagal in response to trauma is the neurobiological process of dissociation.

The neurobiological process of dissociation results in shutting down key memory processes which fragments the memory of the experience. Within this dissociative process the parasympathetic nervous system is stimulated resulting in fragments of the experience being stored physiologically (van der Kolk 2014). These fragments can be seen in a child's nightmares, re-enactment behaviour and flashbacks which re-establish the dissociation (Paulsen & Lanius 2014; van der Kolk 2014). The shutting down of neurological circuits contribute to the feeling of depersonalisation and derealisation that many experience in response to trauma and which are characteristics of dissociation. Due to infants and children being powerless to fight or flee from their environments, the freeze response is the only response they have for psychological survival (Hart 2013; Paulsen & Lanius 2014).

2.4.3. Risks Factors Contributing to the Development of Dissociation

The DSM 5 (2013) discusses underlying risk factors which need to be present before the experience of trauma for the development of dissociative disorders. These risk factors listed by the DSM 5 (2013) are environmental and temperamental aspects. The environmental risk factors are related to the traumatic event and not specific to acute or complex trauma, but rather to the nature of the trauma, the prevalence of other adverse childhood experiences and relational violence (DSM 5 2013). Hart (2013) states that the age of the child is a crucial component to the neurological impact of trauma as the younger the child is the less resources there are for the integration of the trauma. The younger the child is when the traumatic experience is experienced the more the child will use primitive ways of processing the trauma (Kaminer & Eagle 2010). Sexual, emotional and physical abuse, emotional neglect and the age of the child when the trauma was experienced are risk factors for the development of dissociative disorders (DSM 5 2013; Mate 2010).

Risk factors can develop from the self-structures that the person has before the traumatic event (DSM 5 2013). The severity of dissociation as a response to trauma depends on the individual's resources available to them in that moment of the traumatic experience (Bovin et al 2014). These include the structures within the self and particularly the presence of an impaired sense of dependency and vulnerability along with the fear of rejection from the discovery of any internal badness (Simeon, Guralnik, Knutelscka & Schmeidler 2002; Gusic, Malesevic, Cardena, Bengsston & Sondergaard 2017). The role of insecure attachment styles with a caregiver and strong harm avoidant drives within the personality are all predisposing factors (Simeon et al 2002; DSM 5 2013; Gusic et al 2017).

2.4.4. The Role of the Caregiver in Developing Dissociation

The response of a very young child to traumatic experiences are dependent on how the caregiver responds to the trauma, as it is the caregiver who regulates the child's nervous and emotional system with their own systems (Mate 2010; Kaminer & Eagle 2010). The quality of the relationship between a child and their caregivers determines the ability the child has to express their emotions and experiences related to a traumatic event. Should the caregiver be the source of the trauma, which is often the case in complex trauma, it results in an internal dilemma for the child (van der Kolk 2014). Van der Kolk (2014) describes this dilemma as the child experiencing a need to seek comfort and safety with the caregiver whilst the child is experiencing the caregiver as the source of fear. This experience of the caregiver results in a disorganised sense of self for the child. Due to limited internal resources within a disorganised sense of self, trauma and stressful events will likely trigger dissociation in assisting the child to cope with the experiences. A child can experience dissociation during and after the traumatic experience in the form of depersonalisation and derealisation, and the inability to recall the experience afterwards resulting in an inability to process and integrate the experience (Bovin et al 2014; Hart 2013).

Mate (2010) states that the attachment between the caregiver and the child is of the utmost importance as the sense of safety allows the child to be able to develop their sense of self, their body and brain (Gusic et al 2017). Should the caregiver not be able to create an attachment that facilitates the sense of safety for the child then dissociation develops. The child uses dissociation by creating a façade of safety by internalising the badness into themselves and creating a self that does not disrupt the environment via putting away their sense of self and needs and desires (van der Kolk 2014). The sense of badness within the self is established when young children experience chronic trauma as the self develops in the mirroring of experiences and relationships. Chronic trauma indicates to the child that the attachment they have with their caregivers is not a safe one and the child withdraws and arranges, even sacrificing the self, to try to protect the fragile attachment and securing love (van der Kolk 2014; Gumley & Liotti 2019; Gusic et al 2017). Furthermore Mate (2010) indicates that the worst trauma is inflicted by intergenerational trauma that is passed down from the mother to child as this impacting the child's ability to trust the caregiver and their world (Gumley & Loitti 2019).

2.5. Symptoms and Features of Dissociation Among Traumatized Children:

The literature points to different ways dissociation presents in children who have experienced trauma. Symptoms and features of dissociation is described as a spectrum among traumatized children. This spectrum of dissociation is identified as being mild to moderate to extreme or related to the different areas of functioning (Wieland 2015; Perry & Winfrey 2021). CCTASI (2017) has allocated the symptoms and features of dissociation as they are found to present in the different

age groups. Despite this there are behavioural symptoms and features which are often overlooked and as a result dissociation is generally misdiagnosed.

2.5.1 Dissociation in Different Age Groups of Children:

Dissociative symptoms between 0 – 6 years of age present mainly as behavioural indicators. These include unprovoked mood swings/extreme shifts in mood, uncontrollable crying/temper tantrums, rapid behavioural regression, loss of/not meeting developmental milestones and zoning out/staring off (CCTASI 2017).

CCTASI (2017) describes the behavioural indicators of dissociation in the age group of 7 – 18 years of age include the 0 – 6 years of age indicators. Other symptoms occurring within this age group include an inability to recall behaviour despite others witnessing it, flashbacks or unintentional thoughts or memories of trauma, emotional numbness or inability to describe internal states, seemingly unprovoked outbursts of anger or aggression, auditory hallucinations (not related to psychosis) and identity confusion.

2.5.2. Symptoms and Features of Dissociation

The ESTD (2017) lists and discusses many different symptoms of dissociation evident in children. Dissociative symptoms can be present in the form of imaginary friends, who are either characterised by having a helping role in the child's life, or the child is fearful of the imaginary friend, or the imaginary friend is giving messages or instructions and can be in conflict with each other (Diseth & Christie 2005). The child may hear voices which are instructing them to misbehave or hurt others or themselves (ESTD 2017). Children may have a history of self-harming, oversexualised and aggressive behaviour. As a form of amnesia the child may deny experiences or behaviour and will be accused of lying (ESTD 2017). Rapidly switching between different states of being is identified as a symptom of dissociation in children (ESTD 2017). During these incidents of switching, the child may display substantial changes vocally and facial expressions. The child may present with an inconsistent ability to perform previously mastered tasks. ESTD (2017) describe dissociation to present in children as the inability to be able to determine what is fantasy and reality. This negatively affects the child's ability to be present and function. Scholastically, dissociation presents as a child being unable to focus on their work and daydreaming, having major difference in IQ testing and different handwriting (ESTD 2017; Perry & Szalavitz 2017).

2.5.3. Dissociative Symptoms and Features on a Spectrum:

The symptoms and features of dissociation are discussed as a spectrum (Wieland 2015; Perry & Winfrey 2021; Gusic et al 2017). This concept of dissociation on a spectrum is based on worsening degrees of the symptoms and features. Perry & Winfrey (2021) describe the dissociative spectrum as correlating with the functioning states of being awake or sleep and heightened levels of arousal relating to experiences. Wieland (2015) places the symptoms and features of dissociation on levels of mild, moderate to severe.

Perry & Winfrey (2021) created a spectrum of dissociation which connects to the different areas of functioning and the states of being awake. These states of being awake are calm, alert, alarm, fear and terror. These areas of functioning relate to neurobiological areas, the arousal responses, dissociative responses, cognitive ability, and the IQ level available (Perry & Winfrey 2021). For the sake of this research the functioning area of dissociation will be discussed as it presents in the different states of being.

In the state of calm dissociation presents as daydreaming. The state of alert results in the dissociative symptoms of avoiding. In the state of alarm, dissociation presents as complying with the experience. The state of fear results in the dissociative symptom of paralysis or catatonia. The state of terror results in dissociation functioning as faint/collapse.

Mild dissociation presents as a form of spacing out experienced by the child which differs from other forms of retraction, such as lethargy in depression and anxiety withdrawal in childhood (Wieland 2015). The child spaces out as they become absorbed in their inner world to prevent them from engagement with a threatening external world and consequently is unaware that the world continues around them (Wieland 2015). This type of dissociative spacing out can happen unintentionally or intentionally but often without the awareness of the child.

Changes in a child's emotional expression and behaviour can be affected by mild dissociation (Wieland 2015). A child with mild dissociation can have extreme emotional dysregulation as there is no middle ground in their emotional experiences (Wieland 2015). When a child has mild dissociation, they can experience a distressing event and their emotions build up to the point where the child can no longer control their behaviour.

Moderate dissociation in children is when a sense of numbing of emotions, body sensations or experiences develops (Wieland 2015). Moderate dissociation in children presents as depersonalisation, derealisation and slight amnesia between self-states (Wieland 2015). This type of dissociation is when the child can block out anything threatening and dangerous within themselves or environment and as a result a child may react to situations in a manner which does not fit with the situation.

Severe dissociation takes the form of the unconscious mental process of fragmenting experiences, emotions, and bodily sensations from the consciousness into a subsystem within the self, forming its own separate identity outside of the child's awareness (Wieland 2015). The self-structure develops different parts of the self which main purpose is to hold the trauma and to ensure that the trauma does not come into the conscious self. These different parts form their own sense of identities, with their own memories and sense of time within the self-structure (Hart 2013). These parts can be experienced through unwanted emotions, voices urging the child to do something or a flash back of the trauma experienced (Wieland 2015). Although there can be some conscious awareness of these parts operating in the child's self, in others there is no awareness of these different parts. In severe cases, amnesia develops between these different parts of the self as they do not have any recollection of when the other parts are in the conscious (Wieland 2015). However, it has been noted that in most cases with children in clinical practice, there is a degree of an awareness of the presence of the different parts that are developed to help the child cope with the trauma (Silberg 2013). This mental process of the self protecting itself by the development of different and multiple identities is known as Dissociative Identity Disorder (DID). This is the most extreme form of dissociation manifesting in the mental process of preventing the traumatic event from actualisation.

2.5.4. Diagnosing Dissociation

When diagnosing dissociation there is a strong connection between PTSD and dissociation (DSM 5 2013). Morrison (2014) describes dissociative symptoms in childhood as also being part of other mental health disorder's symptoms and not necessarily a symptom of dissociation as indicated in the DSM 5 (2013). Bui, Ohye, Palitz, Olliac, Gontaudier, Raynaud, Kounou & Stoddard (2014) highlight the present of dissociative symptoms when making a diagnosis of Acute Stress Disorder in children after a stressful or traumatic experience. The use of dissociative symptoms is not only in the presence of dissociation disorders but are part of other diagnoses thus making a diagnosis of a dissociative disorder in children challenging.

2.6. Theoretical Positions in Understanding Dissociation among Traumatized Children

The different theoretical positions that are used in understanding dissociation in children are neurobiological aspects on how dissociation develops, the Discrete Behavioural State Model, the Disorganised Attachment Model, Affect Avoidance Model, Structural Dissociation, and the Ego-State Model (Wieland 2015; Silberg 2013; Lanius, Paulsen & Corrigan 2014; van der Hart et al 2006). Each theory will be briefly discussed to bring theoretical understanding of how dissociation develops in response to trauma as well as during the traumatic experience.

2.6.3. The Neurobiological Theory

The neurobiological theory of dissociation describes structural physiological indications and changes resulting from trauma which manifests as dissociation (Wieland 2015). Neurobiological theory of dissociation connects the effects of cortisol that is released in response to trauma, inhibiting the ability of the brain to recall the traumatic experience (Lanius, Paulsen & Corrigan 2014). The neurobiological theory describes the development of dissociation by the overstimulation of the sympathetic nervous system triggering the response of the parasympathetic nervous system (Wieland 2015). The sympathetic nervous system is the system in the brain that consists of the limbic structures and the brain stem that function together to respond in the flight or fight response when trauma is experienced (Wieland 2015). The parasympathetic nervous system triggers the freeze response when the brain shuts down from being present to prevent processing the experience (Lanius et al 2014). The response of the parasympathetic nervous system results in dissociation as the neurological structures that are unable to process and integrate the experience and regulate emotions (Wieland 2015; Lanius et al 2015).

2.6.4. The Discrete Behavioural Model Theory

The discrete behavioural model theory identifies different states of the self which develop in early infancy but are affected by traumatic experiences resulting in dissociation (Wieland 2015). There are different self states that begin to develop in early infancy when the child experiences behavioural states such as drowsiness, irregular sleep, regular sleep, crying, fussiness, feeding (Wieland 2015). The Discrete Behavioural model explains that in infancy there are limited neural pathways between these states as parts of the brain need to still develop (Wieland 2015). As the child develops the different self-states they become integrated into the perception of a self and a self structure develops. However, a traumatic experience disrupts the development of an integrated self by the development of fear based or trauma-based states of the self (Wieland 2015; Silberg 2013). These trauma or fear based selves take over the development of the potential self-states when there has not been a good enough experience with the caregivers and the environment (Wieland 2015). These different trauma states hold unprocessed experiences and emotions related to the trauma and are separated within the self as the bridging between the states is hindered and segregate even more as the child develops (Silberg 2013)

2.6.5. The Disorganised Attachment Model Theory

The disorganised attachment model describes that the process of the development of the self is created from the attachment style that the child has with the caregiver (Wieland 2015). The

disorganised attachment model describes the development of dissociation to protect the relationship with the unsafe caregiver (Silberg 2013). Disorganised attachment is created from inconsistent parenting, as at times the caregiver may frighten or harm the child and in the next interaction may demand comfort and caring from the child (Wieland 2015). This creates a disorganised self structure within the child. Uncertainty within the relationship with the caregiver is created as the child is never sure which part of the caregiver is going to be present or which role that they are required to be with the caregiver (Wieland 2015). Instead of the child developing their potential, three different roles develop into segments of the personality within the self, the persecutor, the victim and the rescuer. As the self develops these parts continue to grow and when trauma is experienced, they become more segregated and rejected parts of the self (Wieland 2015).

2.6.6. Affect Avoidance Model Theory

Affect avoidance model of dissociation identifies nine different biological effects that are experienced within the self which may facilitate the development of dissociation (Wieland 2015). These affects consist of six negative (anger-rage, fear-terror, distress-anguish, disgust, dismal and shame-humiliation), one neutral (surprise-startle) and two positive (interest-excitement and enjoyment-joy) and these affects are referred to by Silberg (2013) as being the psychic matter that keeps the self together. These affects are internal experiences of the infant/child that inform what experiences promote or endanger the wellbeing of the self (Silberg 2015). The affects develop into scripts within the self thus becoming the learnt responses to dealing with experiences that trigger specific affects (Silberg 2013). As these learnt responses become the main reactions in dealing with painful and negative affects, they become the unconsciously chosen coping mechanism of the self. Should the affect script develop avoidance as a coping mechanism then the pathology of dissociation develops as a manner of avoiding the affects that are triggered by traumatic experiences or the traumatic memory (Silberg 2013).

2.6.7. The Ego State Model Theory

The Ego State explanation model of dissociation is based on the Watkins & Watkins Ego State therapy model (Wieland 2015). The Ego State model indicates that there are different parts of the personality develops within the self to respond to specific roles within the child's life. Da Silva & Fitz (2012) state that new ego states are created in response to the trauma to assist the child in coping with the experiences and emotions related to the trauma. This ego state holds the experience and can be separated from the other ego states to prevent the traumatic experience from being actualised (Wieland 2015: da Silva & Fitz 2012). If there is little to no support from the

family or environment the boundaries between the ego states become inflexible and it is difficult for the self of the child to access the different ego states beginning the process of dissociation (da Silva & Fitz 2012).

2.6.8. The Structural Dissociation Theory

Structural Dissociation is a theory based on the structured characteristic concept of parts and systems that constitute the personality (van der Hart et al 2006). This understanding describes psychobiological states and systems that in cohesion presents as the personality and self (van der Hart et al 2006). Van der Hart et al (2006) describes dissociation as being a division that occurs between two psychobiological states and systems within the self and are known as action systems (van der Hart et al 2006). Action systems consist of two categories, one that assists with everyday life and another system which responds when threats to survival or the self is experienced (van der Hart 2006). When a trauma is experienced the two systems can no longer work cohesively as the action system known for dealing with threats within the self is spilt off from the action systems that are needed for everyday life (Wieland 2015; van der Hart 2006). The system containing the threat and traumatic experience is now termed the “Emotional part of the Personality (EP)” and the other part of the system that deals with everyday life is now referred to the “Apparently Normal part of the Personality (ANP)” (Wieland 2015; van der Hart 2006). As the personality is required to continue without processing the trauma the division between the two systems becomes more rigid as the ANP attempts to deal with everyday life (Wieland 2015).

These theories bring a deeper understanding of how dissociation develops within the personality and what causes the self to split into different segments in response to threatening and traumatic experiences. A vital aspect of all the theories is the importance of emotional support in the child’s relationships with their caregivers. The emotional support assists the child in not needing to separate the experience from the self and processing the underlying emotions related to the trauma, preventing dissociation.

2.7. Best Practice Interventions in Treating Dissociation among Traumatized Children

There are two main authors and clinicians (Wieland 2015; Silberg 2013) identified as being experts in the field of working with trauma related dissociation in children. There is not much research in the treatment of children who display dissociative symptoms (Diseth & Christie 2005). Thus, these two authors Wieland (2015) and Silberg (2013) are the main contributors in this area and are mainly referred to in this section.

There is very little research on the treatment of trauma-related dissociation in children (da Silva & Fritz 2012; Silberg 2013; Wieland 2015) however there have been a few adult treatment therapies adapted and used by clinicians working with children. These include Herman's three stages of trauma (Herman 2015; Wieland 2015; Silberg 2013), Silberg's (2013) modality of EDUCATE (Wieland 2015; Silberg 2013), and attachment-based therapy (Goodyear-Brown 2010).

Treating trauma-related pathology is complex and requires a holistic approach which at times may require a combination of treatments at any given moment in a therapeutic session (Wieland 2015; Herman 2015). While working with children, clinician's need to be aware that play is their language and that children use their behaviour and body expressions to communicate difficult experiences and emotions (Landreth 2012; Potgieter Marks 2015). Furthermore, the treatment of trauma-related dissociative disorders in children should be modified to the level of development of both their current age and when the trauma was experienced (Potgieter Marks 2015).

Throughout the research it points to the importance of understanding trauma and how it effects the child. When a child experiences a trauma their perception of life may completely shatter (Kagan 2004). Kagan (2004) compares the result of traumatic experiences to the self to the shattering of glass when broken. Likewise, the child's sense of self and relationships are shattered into pieces in response to traumatic experiences as the trauma may be unbearable. Therefore, when trauma related dissociation is developed by the child, both the processing of the trauma and the pathology of dissociation should be the focus of treatment for the aim of integration of the trauma into the self.

2.7.3. The Three Stages of Trauma Treatment

Herman's (2015) three stages of trauma treatment is referred to as the foundation of treating trauma-related dissociation in children (Wieland 2015; Silberg 2013). Herman (2015) three stages of trauma treatment is namely establishing a sense of safety, remembrance and mourning, and reconnection with ordinary life. To illustrate this Wieland (2015) places Silberg's (2013) model of treatment of dissociation within the three stages of Herman's stages of trauma treatment and refers to these stages throughout the course of treatment.

The first stage of establishing safety is reconstructing the child's perception of the world as an unsafe place (Herman 2015). This is the foundation of working with children who have experienced trauma and especially those presenting with trauma-related dissociation (Baita 2015; Kagan 2004). The traumatic event destroys the sense that there is good and safety in the world and replaces it with the feeling of being out of control and unremitting danger (Herman 2015).

The clinician needs to determine when there is enough safety that is established for the second stage of trauma treatment to begin (Herman 2015; Silberg 2013). The second stage of trauma treatment is remembrance and mourning which is described as the stage of bringing the memories of the trauma together and mourning the loss of self (Herman 2015). It is in this stage that specific therapeutic modalities can be used to assist the child to process the trauma and dissociation. The aim of this stage is for the client to be able to integrate their traumatic experience into their narrative of self. In most cases the child client will use play to communicate a scene or moment of trauma, the clinician will then assist the child client to be able to bring words and emotions to the experience for integration (Landreth 2012).

Stage three of trauma treatment is directly related to the child being able to rebuild their sense of self and sense of future (Herman 2015). Herman (2015) describes this as the process of the client reclaiming their life and becoming empowered after mourning the old self that was lost from the trauma. According to Herman (2015) trauma is never fully resolved and at different developmental phases different aspects of the trauma can be remembered and needs to be processed. This is especially true for children and Silberg (2013) states that the clinician is required to have a deep understanding of the developmental phases of a child.

2.7.4. EDUCATE Modality

Silberg (2013) identified 7 steps to treat trauma-related dissociation in children and adolescents and uses the acronym EDUCATE to outline these steps. Wieland (2015) places the “E,D,U,C,A” in the first stage of Herman’s Trauma treatment process and the “T” in the second stage of Herman’s trauma treatment process and lastly the “E” in the third stage of Herman’s trauma treatment process. The acronym of EDUCATE represents the following seven steps:

1. E – Educate about dissociation and traumatic processes

For treatment to begin the clinician needs to inform the child about how the body and the self responds to trauma and how and why dissociation develops (Silberg 2013). This helps the child to realise that what they are experiencing is not strange but is a physiological and mental process which their bodies and self-structure uses for protection from further harm (Silberg 2013). The clinician approaches this step with acceptance and gratitude towards the dissociative symptom for protecting the self and the child.

2. D – Dissociation Motivation

Initially the clinician needs to investigate what are the motivating factors that precipitate the dissociative symptoms and whether the child is still exposed to the precipitating factors that sustain the dissociative symptoms (Silberg 2013). These factors will continue to facilitate the use

of the dissociative symptoms until an environment is created where they are no longer needed. Thus, clinicians cannot facilitate the treatment of dissociative symptoms until the precipitating factors are dealt with and a safe environment is experienced by the child (Silberg 2013; Wieland 2015). At times the motivating factors may be revealed later in therapy when the child feels ready and safe to share these (Silberg 2013).

3. U – Understanding what is hidden

This step is the process of assisting the child to understand what underlies the dissociative symptoms and prevents healthy functioning (Silberg 2013). Silberg (2013) states that this is achieved by bridging the different aspects of the self together that have been separated by the dissociative symptom. The clinician facilitates the process of the child finding out what the meaning of the symptom is. The clinician needs to model acceptance, non-judgementalism and kindness towards the dissociative symptom as this helps the child to feel accepted and safe to explore their inner world (Silberg 2013).

4. C – Claim the hidden aspects of self as their own.

The aim of this step of the treatment is the acceptance of what the mind is trying to keep away from consciousness (Silberg 2013). These can be frightening experiences or intense emotions that children are unable to face on their own and thus it is important that the clinician shows empathy, acceptance and works at the pace of the child. The clinician helps the child to understand the purpose for the dissociative symptoms are (Silberg 2013). Once this is achieved the negative aspects of the dissociative symptoms are reframed into more positive and resource orientated characteristics.

5. A – Arousal Modulation/Affect Regulation/ Attachment

Trauma related dissociation is directly related to the avoidance of affects that represent the traumatic experience (Silberg 2013). Traumatic experiences are stored in non-cognitive areas of the brain. When triggered the brain and self is unable to cognitively process the affect thus resulting in dissociation (Silberg 2013). This results in hyperarousal or hypoarousal responses which the child is unable to regulate or modify. In these moments the child needs an external regulator who will be able to identify what is happening and to regulate. The child's caregivers need to be included by teaching arousal modulation and regulatory skills to help in these moments (Silberg 2013; Goodyear-Brown 2010). Before the traumatic experience can be told the clinician needs to facilitate the development of regulatory skills that the child can use when processing the trauma (van der Kolk 2014; Silberg 2013).

Poorly attached children are more susceptible to developing dissociative symptoms and trauma may destroy attachments children have with their caregivers (Silberg 2013; Kagan 2004).

Goodyear-Brown (2010) includes the child's caregiver in the therapeutic process both in the therapeutic sessions and at home to support the therapeutic process and rebuild attachments, naming the caregiver as a partner in the therapeutic process.

When different states within the self develop as a symptom of dissociation the clinician needs to explore the attachment that each part has with the caregiver (Silberg 2013). At times during traumatic experiences a part of the self develops from the betrayal and anger experienced from the lack of protection and safety the caregiver gave the child. This rage-filled dissociative part may not believe they are the child of the caregiver therefore strengthening the dissociation. The caregiver needs to directly and clearly show the child and the dissociative part that they are loved to try to re-establish the attachment (Silberg 2013).

6. T – Triggers and Trauma

Trauma strongly impacts a child, especially in their ability to imagine that their world is a safe and trustworthy along with effecting the development of the self (Silberg 2013). This results in the child believing that it is up to them to protect themselves and through this they develop self-protecting processes to prevent them from accessing the traumatic memory and emotions. It is in this step of the treatment process that the child's traumatic past needs to be processed for the integration of the self and to prevent the traumatic experience from hindering their growth. This does not necessary mean that the clinician needs to know every detail of what happened but rather to assess the impact of the trauma on the self (Silberg 2013).

Silberg (2013) highlights the use of specialised therapy modalities that focus on processing traumatic experiences such as Eye Movement Desensitization and Reprocessing (EMDR). According to Silberg (2013) this technique assists the child to integrate the trauma and regain a sense of power.

7. E – Ending stage of treatment

Silberg (2013) states the ending of the treatment of trauma related dissociation is when the child displays an integrated sense of self. The process of treatment does not always directly follow the 7 steps mapped out by the EDUCATE model but may move between the different steps. This is characteristic of therapy with children who have a history of trauma (Silberg 2013). In this step of the treatment of trauma-related dissociation the child begins to experience an integrated self as a new identity while able to have new challenges and life experiences (Silberg 2013). Although the goal of treatment is to end, it is important that this happens when the child is ready to leave the

support of the clinician (Silberg 2013). The child may begin to explore the thoughts and the meaning of their traumatic experiences in the stage of ending treatment.

2.7.5. Attachment Based Therapy

Goodyear-brown (2010) describes caregivers as the physiological regulators for the child and emphasises the important role, the caregiver has from before birth to early infancy in the process of the child developing the neurobiological systems to be able to self soothe during stressful and traumatic experiences (Goodyear-Brown 2010). It is the caregiver who emotionally contains and holds the child while the self makes sense of experiences until the child can internalise this (Goodyear-Brown 2010). Goodyear-Brown (2010) includes the caregiver in the therapeutic process when working with a child who has experienced trauma. The caregiver is included in the therapeutic activities to develop better attunement and relationship between the caregiver and the child. Goodyear-Brown (2010) focuses on improving the ability of the caregiver to identify what it is that the child needs when a trigger is experienced and how to fulfil these needs.

2.8. Conclusion:

The literature on dissociation in children who have experienced trauma is slowly gaining momentum in the international area of interventions with children. There is still much to be researched on the topic of recognising, addressing and treating trauma and dissociation. However, a few experts in the field of trauma have been able to integrate and modify a few adult based therapeutic modalities having noticed that many children suffer from dissociation. Research has shown that children display dissociation on a spectrum, and this ranges from misbehaviour to the development of different parts of their inner world. There is too little research on dissociation in children for clinicians to realise the importance of understanding and treating this complex response to trauma. This is especially the case in South Africa where many children grow up in traumatic and survival-based environments and whose only response to coping is dissociation.

CHAPTER 3:

METHODOLOGY

3.1 Introduction

This chapter focuses on outlining and describing the implementation of the research project. The research design that is most applicable to obtaining information for the research topic is discussed. The characteristic of the participants is outlined in the population and the sample. Furthermore, the tools and process of data collection are described as well as the process of verifying the data. The process of reflexivity is explored to ensure the quality of the data collected. Limitations of this research project are investigated and considered to ensure a successful outcome.

3.2. Research Design

There has not been substantial research on dissociation in children who have experienced trauma for treatment guidelines to develop (Potgieter Marks et al 2017). Some clinicians do not recognise that children can present with dissociation as a co-morbidity of PTSD making treatment challenging. More research on the process of dissociation will enable clinicians to treat dissociation (Makhubela 2020). The researcher has chosen the qualitative approach to gain more insight into how to identify, treat and understand dissociation in children who have experienced trauma in South Africa.

Pagdett (2017) describes qualitative research as being the approach to researching complex social processes. Qualitative research looks beyond the variables of measurements and rather to how processes unfold within the multifaceted lives of individuals. Dissociation is a complex phenomenon which is described as both a coping mechanism and a symptom of trauma. Dissociation presents differently in childhood as it does in adulthood. Taking this into consideration qualitative research design is the most applicable research approach to take when studying the phenomenon of dissociation. De Vos et al (2011) notes qualitative research to be used by researchers when studying a particular subject or phenomenon. The researcher is fascinated by how dissociation originates, presents and can be treated in children who have experienced trauma.

Qualitative research design is primarily based on the researcher's approach to the topic to be researched and the purpose of the study (de Vos et al 2011). There are five different types of research designs: namely narrative biography, ethnography, phenomenology, grounded theory

and case study (de Vos et al 2011). Each of these designs offer a unique perspective on how the subject will be researched. The qualitative researcher will use the design that is best suited to the purpose of the study. Narrative biography design aims to gather data on the story of the lives or first-hand lived experiences of the identified interviewees (de Vos et al 2011). Ethnography designs aim to describe and interpret cultural behaviour which is generally achieved through the researcher observing and interacting with the identified cultural group (de Vos et al 2011). The phenomenological research design is to describe a chosen phenomenon in accordance with lived experiences of individuals to gain better knowledge and understanding of the phenomenon (de Vos et al 2011). De Vos et al (2011) further describes phenomenological research design as an approach that aims to fully understand a phenomenon from the participants perceptions and first hand experiences resulting in knowing more about the concepts and structures which give meaning to the phenomenon experienced. Grounded theory design is used when the researcher aims to develop substantive theories. This is completed by the observation of individuals in social settings and based on these observations descriptions and abstractions are connected to formulate a substantive theory (de Vos et al 2011). De Vos et al (2011) describes case study research design as more of a process of identifying patterns and themes of interest through observation which develops into a research project.

The purpose of this research project is to understand by exploring and gaining more knowledge from clinician's first-hand experience and perceptions of the phenomenon of dissociation in children who they are working with who have experienced trauma. The researcher took into consideration the purpose for this research project and thus phenomenology research design was applied to the methodology of this project.

3.3. Population and Sampling

3.3.1. The Population

Population refers to a group of individuals that possess specific characteristics and attributes that are related to a particular research topic (de Vos et al 2011). The population is the frame that assists the researcher to determine which individuals can be chosen to take part in the research project and will be able to give their viewpoint on the research topic (de Vos et al 2011). Due to this research project being in the form of a minor dissertation which determines the sampling size, the most important aspect is to ensure that the correct population is determined to ensure that the individuals chosen can answer the research questions insightfully.

Therefore, the population considered for this minor dissertation are clinicians in the Western Cape who offer therapeutic services to children who have experienced trauma.

3.3.2. Sampling

Sampling is the process of choosing a specified number of subjects from the population that represents the population for comprehensive answers to the research questions (de Vos et al 2011). To achieve this the researcher has chosen nonprobability purposive and snowballing sampling technique as to best fit with the selected qualitative approach (de Vos et al 2011). Nonprobability sampling is used when the research project does not aim to investigate large-scale social phenomena that whole populations are represented by statistics, but rather when a description of a phenomenon that is experienced by a specified population is being researched (Babbie 2016). Purposive sampling is the main nonprobability sampling technique that is used in qualitative research as it gives the researcher the ability to choose the applicable sample (Padgett 2017). Purposive sampling is using selected elements which represent the population that is to be studied and snowballing sampling is asking identified subjects whether there are others that they are aware of that can contribute to the study (Babbie 2016).

The main element which characterises the participants are that the clinicians are professionals who render therapeutic services to traumatised children within South Africa. The researcher telephonically and electronically approached organisations and clinicians who are in private practice to participate in the research project. The clinician contacted the managers of organisations which render therapeutic services to children who have experienced trauma to request their clinician to participate in the research project. The researcher emailed as well as called the identified clinicians about the research project asking them if they were willing to participate. The researcher asked the participants to share whether they know other clinicians who were willing to participate. Once these contact details were shared the researcher made contact either through WhatsApp, email or calling the clinicians who were referred through the other clinicians. The researcher has previously been practising as a clinician and had developed a network of clinicians and contacted these clinicians to invite them to participate in the research project.

3.3.3. Sample characteristics

Identifying specific characteristics that determine the criteria for the sample enables researchers to be able to gather insightful knowledge to achieve the goals of the research project (Padgett 2017). A criteria is created which is used to identify the participants which assists a researcher to be able to choose the participants in the research project (Padgett 2017). Taking into consideration the research topic the participants needed to be clinicians who render therapeutic services to children. Therefore, the sampling criteria consisted of clinicians with a minimum of two years' practice

experience offering therapeutic interventions with children under the age of 11 years who have experienced trauma.

Padgett (2015) states that there are no specific rules as to what the sample size needs to be but highlights that the smaller the sample size the more in depth the exploration of the subject will need to be. This research project is taking the form of a mini dissertation and the sample size reflected this as the sample consisted of 16 clinicians. The maximum stipulated sample size for a minor dissertation is 20 participants when using the qualitative methodology at the institution where the researcher is registered.

3.3.4. Sampling procedure

The researcher made a list of what categories of clinicians work with traumatised children and from there began to isolate where these clinicians can be found. The researcher is aware of specialised non-profit organisations that employ clinicians who render therapeutic services to traumatised children in the Western Cape and used previously developed professional relationships to make telephonic or electronic contact with known clinicians and asked them to refer the researcher to clinicians that they knew would be able to contribute to the study. The known NGO and NPOs in the Western Cape that the researcher contacted for permission to interview their clinicians were, Jelly Beans, Childline, Patch and Community Keepers and community clinics along with clinicians in private practice. The researcher asked the clinicians telephonically and electronically whether they were interested in partaking in the research project and emailed the organisations the relevant information. Upon making contact, the researcher gave the participants the ethical clearance, the data collection tool, and a description of the study with an invitation to participate in the study, before the clinicians agreed to partake.

3.4. Data Collection

The method of data collection took the form of in-depth semi structured interviews with the clinicians. The method of data recording made use of was both Zoom and audio recordings. The researcher recorded and transcribed the interview. Using Zoom was helpful as South Africa was experiencing the COVID 19 pandemic.

3.4.1. Data Collection Method

Qualitative research focuses on gathering information about complex social phenomena and processes (de Vos et al 2011). This means that qualitative research projects aim to gather in depth knowledge from sources of information directly related to the research topic. Padgett (2017) describes three different methods that can be used to collect data for a qualitative research study,

these being interviews, observations, and documents. Interviews in the form of semi-structured interviews allow for the participants to share more about their own experiences and observations while the researcher ensures that all the research questions are answered (Padgett 2017). The researcher used semi-structured interviews either face to face or via Zoom, to collect data as the most appropriate for this research project. This method ensured that the participants were able to share and expand on the questions. Most of the interviews took 2 hours to complete.

3.4.2. Data Collection Instrument

Semi-structured interviews are conducted based on interview guides that consist of planned open-ended questions to guide the researcher to be able to gather information on identified areas of the topic that the research is about (Padgett 2017). The interview guide assisted the researcher to be able to probe into the answers of the interviewee to gather more in-depth research data about the topic studied.

3.4.3. Data Collection Tools

Audio recording was a reliable tool for collection of the data from interviews as it assisted the researcher in not missing any information from the interview as well as ensuring that the interview could be transcribed verbatim (Padgett 2017). Babbie (2016) states that observational notes should be taken after the interview to ensure that nothing is missed from the participant and the interview. The researcher obtained permission to record the interviewee either via Zoom or using a voice recorder. The researcher took field notes during the interviews which consisted of her observations and information that was of particular interest in relation to the respondent and the topic of the study.

3.5. Data Analysis

Qualitative data analysis focuses less on a structured manner of processing data and rather on inductive reasoning, forming interconnectedness and patterns of the data collected (de Vos et al 2011; Babbie 2016). Qualitative data analysis begins with developing codes and topics that can be applied to the data so that themes and patterns can begin to be formed (Babbie 2016). The data was analysed by categorizing the data into codes, the researcher documented what stood out and what ideas were forming during the categorizing to assist with the formulation of the final report. Babbie (2016) states that the researcher maps out the ideas and concepts that begin to develop from the data so that the interconnectivity, patterns and themes can be identified and conceptualised for the final process of data analysis. This process assisted the researcher to be

able to sieve out the most relevant information to best answer the research questions from the development of themes and patterns from the data collected.

This process was applied by the researcher to the data collected from the interviews. The researcher did not know what would be discovered and therefore did not have any predetermined concepts or theories to be proven.

3.6. Data Verification

Padgett (2017) applies the four categories of verifying the data collected to measure the quality of the data. These four categories are credibility, transferability, dependability and confirmability to ensure that the data collected results in a trustworthy research report. Credibility refers to the correspondence between what the interviewees said and what is recorded in the research paper (Padgett 2017). De Vos et al (2011) indicates 5 different aspects to ensure the credibility of qualitative research, namely enough interviews to gather substitutive data, the use of different methods, debriefing peers, applying a predetermined checklist to determining the participants as indicated above, and applying formal qualitative research methods. The researcher conducted 16 interviews to ensure the credibility of the data collected. The researcher applied the qualitative research method of phenomenology and selected participants by the process of snowballing and purposive selection. At the end of the interview the researcher debriefed the participants when it was required and queried how they experienced the interview and if they would like to include anything else.

Transferability is the ability to generalise the data that is collected to the population but in qualitative research this is a difficult concept to apply as qualitative research focuses on gathering data from an experiential viewpoint (de Vos et al 2011). However, de Vos et al (2011) indicates the researcher can apply transferability by ensuring the predetermined methods and design of the qualitative research project continuously guides the process. The researcher used the same predetermined data collection tool for each interview. Dependability is the procedure of assessing whether the research process is logical, documented well and inspected (de Vos et al 2011). The researcher continuously inspected the research project by reading through the document and asked other professionals to read through the document to ensure that the research project was logical and well documented.

The confirmability of the data is that the findings in the research report is clearly linked to the interviews and the literature that has been collected on the topic (Padgett 2017). The researcher intensively read the available literature on the topic which is summarised under the literature review chapter.

3.7. Limitations of the Study

The bulk of the data collected for the research project was by the qualitative method and this is derived from interviewing participants (de Vos et al 2011). De Vos et al (2011) explains that interviews have limitations that can influence the value of the data collected. These limitations are that participants may be unwilling to participate and can share untruthful information with the researcher (de Vos et al 2011). The researcher was aware that there may not be many participants willing to partake and due to this used previously developed professional relationships to approach participants. The researcher is aware that clinicians, the participants may not want to share unsuccessful experiences in therapy with children. To prevent this the researcher was non-judgemental about the clinician's approach to therapy with traumatised children which resulted in the clinicians sharing in depth experiences.

3.8. Reflexivity

Reflexivity is the ability of the researcher to be able to reflect on the process of the research project and how they may influence the research process (de Vos et al 2011). Implementing reflexivity is the continuous process of the researcher taking note of their thoughts about the research question and the data being collected for there to be balance between subjectivity and objectivity (Padgett 2017). Reflexivity is the ability of the researcher to be both the practitioner and the researcher so that a deeper understanding of the phenomena can be obtained (de Vos et al 2011). The researcher, as a clinician herself, has her own views and experiences as it pertains to traumatised children and dissociation. Due to this the researcher was aware of her own subjective position to the study which prevented compromising the objectivity of this study during the process of data collect and analysis of the data.

3.9. Conclusion

The research project was completed by the qualitative methodology and the data collection process through either a one-on-one or Zoom, semi-structured interviews with clinicians that render therapeutic services to children who have experienced trauma. The process of data capturing took place by recording the interviews, transcribing the interviews, coding the data collected and note taking of the themes that arose within the data. The researcher was continuously aware of applying reflexivity to the process of the research project so as to ensure the success of this project.

CHAPTER 4: FINDINGS

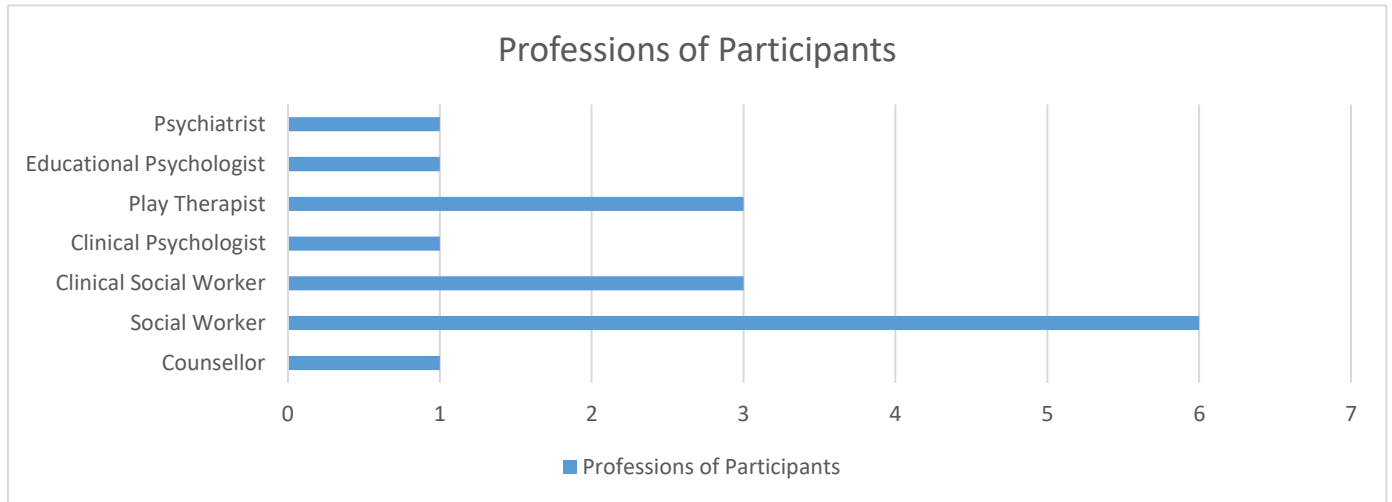
4.1. Introduction

The purpose of this research was to explore and identify whether children who have experienced trauma present with dissociation, particularly through the observations of clinicians rendering therapeutic services to children in the South African context. This chapter presents the findings from the data collection process of utilising semi-structured interviews with the identified participants. The chapter begins with the demographics of the participants and then the discussion of the analysed outcomes of the different themes that emerged from the data collected. The findings will be analysed and organised according to the identified themes based on the objectives of the research project. These namely are the observation of dissociation among child clientele who have experienced trauma, the common symptoms and features of dissociation that children who have experienced trauma present with, theoretical explanations of dissociation informing clinicians' understanding of dissociation amongst children who have experienced trauma and lastly, the therapeutic approaches used to effectively treat children who have experienced trauma and present with dissociation. These findings that emerged may consist of categories and subcategories. The researcher will arrange the findings in the format of an analysis framework based on the identified themes and emerged categories and subcategories (de Vos et al 2018). These will be discussed and compared to the literature presented in the literature review.

4.2. Demographics

The demographic data of the participants will give the reader an indication of the specific characteristics of the profile of the participants, giving context to the data collected and findings (Babbie 2016). Each demographic characteristic will be organised in a graph format based on the amount of the specific characteristics found in the 16 participants and discussed.

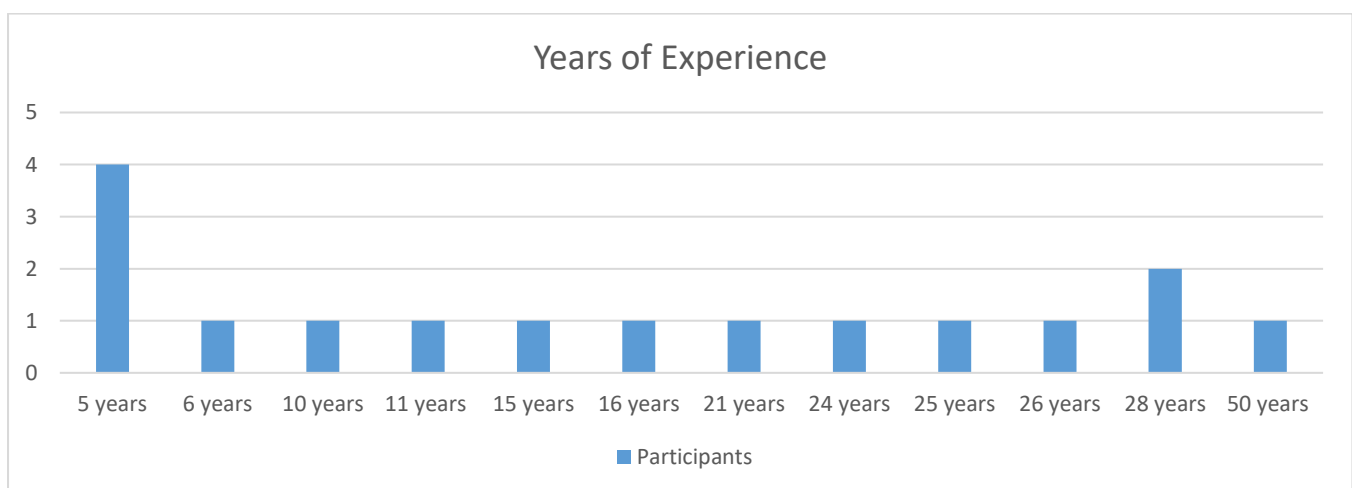
4.2.1. Professions of the Participants



This demographic shows that the profession of the participants in this study who mainly render therapeutic services to children are generic social workers (6 participants), clinical social workers (3 participants) and play therapists (3 participants) being the second most common and lastly, clinical psychologists (1 participant), educational psychologists (1 participant), psychiatrists (1 participant), and counsellors (1 participant).

The findings of this study are based on the perceptions and experiences of different professionals thus giving a variety of different viewpoints and information. However, notably the primary contribution of the findings is from generic social workers and clinical social workers.

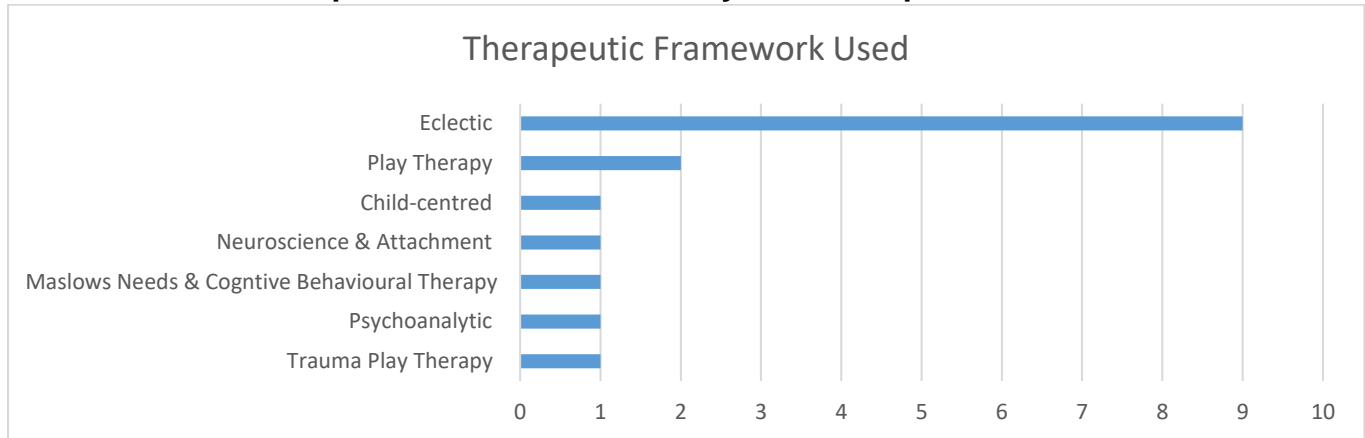
4.2.2 Years of Experience of the Participants:



Most of the participants (4 participants) that partook in the data collection process have 5 years of experience. The second most years of experience were 28 years (2 participants). Observing this demographic, it appears that over half of the participants have over 10 years of experience (10 participants), indicating a very experienced sample group.

The findings of the research reflect the perceptions of highly experienced clinicians with considerable number of years of practice experience.

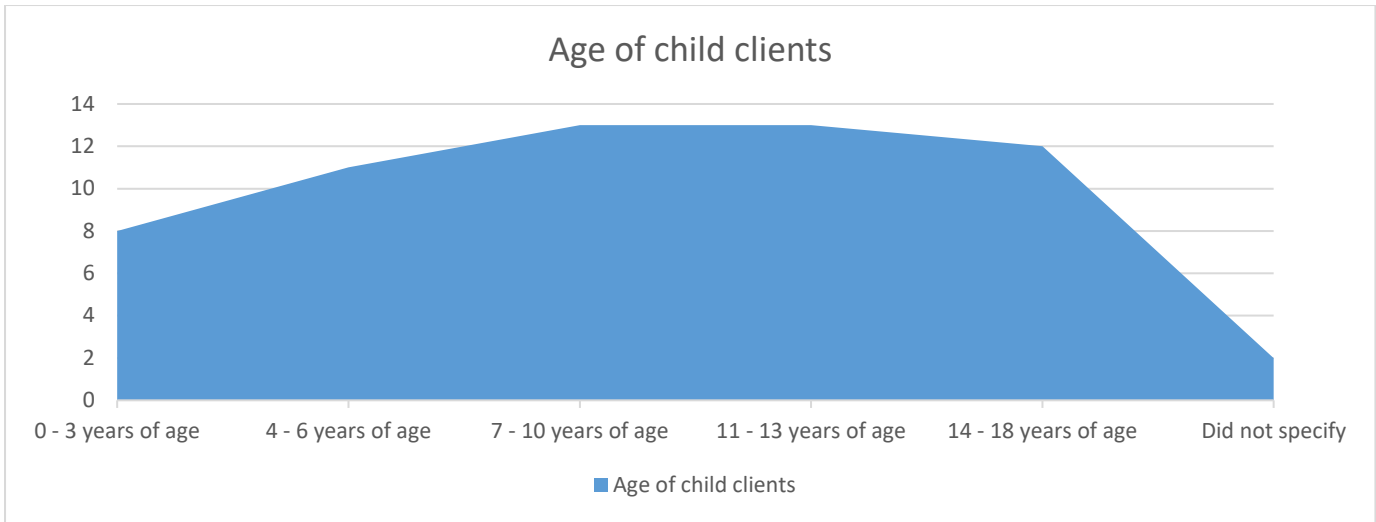
4.2.3. The Main Therapeutic Framework Used by the Participants



The participants involved in the study use different types of theoretical frameworks to guide their therapeutic interventions with children. There are seven identified therapeutic frameworks, the mostly applied framework by the participants is Eclectic (9 participants), Play Therapy (2 participants), Child Centred (1 participant), Neuroscience (1 participant), Maslows Needs and Cognitive Behavioural Therapy (1 participant), Psychoanalytic (1 participant) and Trauma Play Therapy (1 participant).

The results of this demographic indicate that the findings from the experience and perception of the participants are based on a range of theoretical frameworks the participants use.

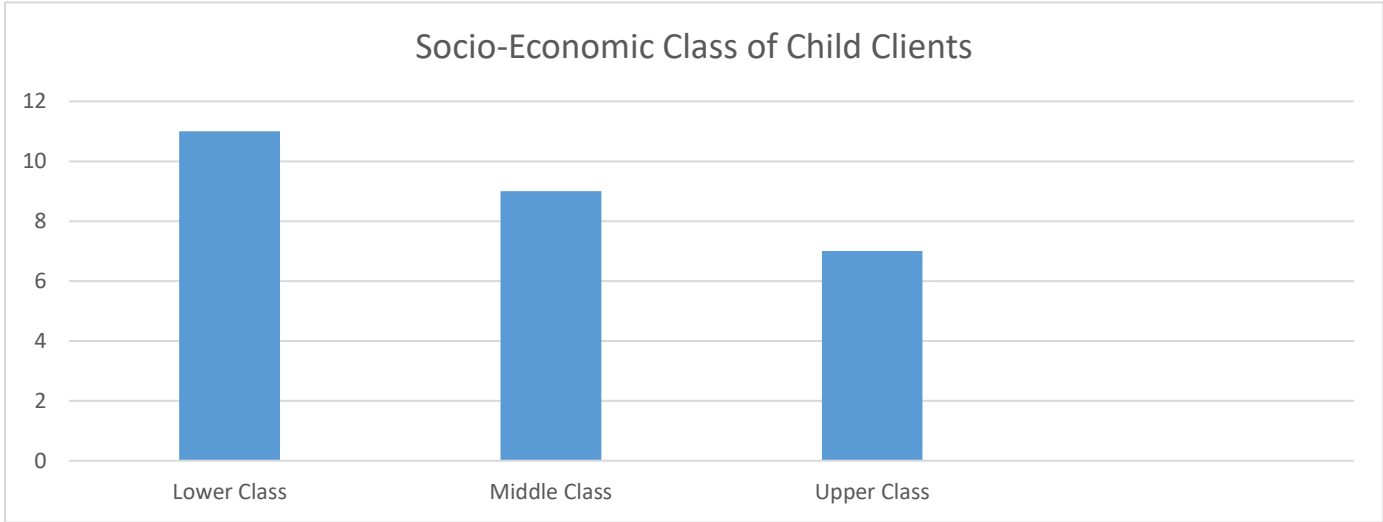
4.2.4. The Age Range of the Child Clients of the Participants



The information shown here illustrates that the average age range of the child clients of the participants is between seven and eighteen years, 13 of the participants work with this age group, 8 of the participants work with child clients between the ages of zero to 3 years and 12 of the participants work with child clients between the ages of four and six years.

The findings are thus based mainly on the observations of participants who render therapeutic services to children between the ages of seven and eighteen. This is not surprising as the age group this study focused on was up to the age of 11.

4.2.6. The Socio-Economic Class of the Child Clients of the Participants:



Most of the participants (11 participants) render therapeutic services to children living in low socio-economic circumstances, 8 of the participants render therapeutic services to children living in middle class economic circumstances and 7 of the participants render therapeutic services to children living in upper class economic circumstances.

This shows the findings of this study to be primarily based on the knowledge of participants who render therapeutic services to children living in low socio-economic circumstances.

4.3. Framework of Analysis:

This section presents the findings that emerged from the data collected. Below is the table where the data is divided into the themes, categories and sub-categories, thereafter each is presented and discussed in detail.

Themes	Categories	Sub-Categories
The observation of dissociation among child clientele who have experienced trauma.	<p>1 Prevalence of trauma among child clientele.</p> <p>2 Type of traumas:</p> <p>3 The prevalence of dissociation in children who have experienced trauma.</p> <p>4 Risk factors contributing to the development of dissociation:</p> <p>5 Attachment as a protective factor from dissociation.</p>	<p>2.1 Physical abuse & neglect.</p> <p>2.2 Sexual abuse.</p> <p>2.3 Death of a caregiver.</p> <p>4.1 Age of the child when the trauma is experienced.</p> <p>4.2 The type of trauma that is experienced.</p> <p>4.3 Sexual abuse.</p> <p>4.4 Disorganised attachment style with a caregiver.</p>
The common symptoms and features of dissociation that children who have experienced trauma present with	<p>1 Symptoms and features of dissociation:</p> <p>2 No awareness of the symptoms and features of dissociation.</p>	<p>1.1 Misbehaviour</p> <p>1.2 Day dreaming</p>

	<p>3 Symptoms and features of dissociation found to present on a spectrum.</p> <p>4 Diagnosis of dissociation in children.</p>	
Theoretical explanations of dissociation informing clinician's understanding of dissociation amongst children who have experienced trauma	<p>1 Dissociation creates a sense of safety.</p> <p>2 The Function of dissociation.</p> <p>3 Dissociation is disconnecting in nature.</p> <p>4 The neurobiological areas associated with dissociation.</p>	
The therapeutic approaches that are used to effectively treat children who have experienced trauma and present with dissociation	<p>1 Creating a sense of safety.</p> <p>2 Regulation techniques.</p> <p>3 Play therapy as the main therapeutic modality.</p> <p>4 The involvement of the caregiver in the therapeutic process.</p> <p>5 Psychoeducation</p>	<p>4.1 Developing attachment between the child and caregiver.</p> <p>4.2 Attachment based home activities.</p>

4.4. Theme 1: The Observation of Dissociation among Child Clientele who have Experienced Trauma.

In the analysis of the data for Theme 1 the following categories and subcategories were identified. Category one: The prevalence of trauma among child clientele. Category two: Type of traumas experienced by child clientele. Three subcategories for category two were identified, namely Subcategory one: Physical abuse and neglect, Subcategory two: Sexual abuse and Subcategory three: Death of a caregiver. Category three: The prevalence of dissociation in child clientele. Category four: The risk factors contributing to the development of dissociation. Four subcategories were also identified for category four, namely Subcategory one: The age of the child when the trauma was experienced, Subcategory two: Complex – Type 2 Trauma, Subcategory Three: Sexual abuse and Subcategory four: Disorganised attachment style with a caregiver. Category

Five: Attachment as a protective factor from dissociation. All these identified categories and their subcategories will be discussed below.

4.4.1. Category One: The Prevalence of Trauma in Child Clientele

Majority of the participants (10 participants) stated that most of their child clients under the age of 11 had experienced trauma, these participants described this as being 80 to 100%. One participant stated that all of their clients had experienced trauma, another stated that most of her child clients have experienced trauma, both are quoted below. Another participant is quoted as saying that very little of their child clients had experienced trauma.

"...mine would be 100% of my cases is trauma related..." Respondent 1

"...that 90% of the kids I see, um, have experienced some kind of trauma..." Respondent 3

"It's difficult. I would say, not more than 10%..." Respondent 15

There is no indication of the percentage of how many child clientele in South Africa are receiving therapeutic services that have experienced a trauma. The results of this study shows a new finding that most children who clinician's in this study render therapy to, have experienced trauma, described as 80 to 100% by the participants.

This finding supports the concern about the prevalence of children experiencing trauma and childhood trauma being a predominant phenomenon in South Africa (Atwoli et al 2013; da Silva et al 2015).

4.4.2. Category Two: Type of Traumas Experienced by Child Clientele

All the participants (16 participants) listed many different types of traumas that their child clientele had experienced. One participant stated trauma to be all situations where a child experiences a sense of being out of control and overwhelmed, along with a list of traumas observed in their child clientele. Another participant described trauma in their child clientele to be something that adults may not experience as traumatic. Most participants gave a list of traumas their child clientele have experienced, and one participant describes the trauma their child clientele experience as complex trauma.

"...I would count as trauma all situations, where children felt completely helpless, completely overwhelmed maybe by, by trauma..." Respondent 10

"...all of those things it's traumatizing to kids than to adults, but sometimes we think it wouldn't affect the child and then it does..." Respondent 1

“...sexual abuse, bullying, um, complex trauma family violence grief, the basic ones. They might be more than I'm just not thinking of.” Respondent 14

There are two categories of trauma children experience, being acute – type 1 traumas and complex – type 2 traumas (Wastell 2005; Herman 2015; National Child Traumatic Stress Network 2003; Potgieter Marks et al 2017). The participants describe the traumas of their child clientele to be many different experiences which mainly fall into the complex – type 2 trauma category. The findings concur with the National Child traumatic Stress Network (2003), Wastell (2005) and Herman (2015) that children experience complex traumas.

This finding further highlights complex – type 2 traumas as being the most common type of trauma child clientele experience. These findings affirm traumas experienced by children to comprise of repeated traumas relating to the caregiving system.

Category two: Type of Traumas experienced by child clientele

4.4.2.1. Sub-Category One: Physical Abuse and Neglect.

Nine out of the sixteen participants said that their child clientele had experienced physical abuse and neglect as trauma. One participant said neglect was a trauma their child clientele experience. Another participant described both physical abuse and neglect as trauma their child clientele experience.

“Um, I would say so, um, neglect, uh, neglect, physical abuse. Yeah. I think physical abuse, emotional abuse, uh, neglect abandonment. Um, death and loss especially now with COVID.” Respondent 4

“Sexual abuse, physical abuse, neglect, emotional abuse, um, emotional neglect, uh, grief. Yes, grief and also grief and loss.” Respondent 16

The National Child Traumatic Network (2003) and Herman (2015) describes complex trauma as being traumatic experiences that are directly linked to the caregiving system and relationships that the child finds themselves in. Physical abuse and neglect fall under the category of complex trauma (National Child Traumatic Network 2003) and according to the findings in this study it is one of the main traumas the participant's child clientele experience. This finding concurs with the National Child Traumatic Network (2003) which describes physical abuse and neglect as complex trauma children experience.

This finding confirms physical abuse and neglect as trauma children experience and further emphasises these to be the most prominent traumas children experience.

Category Two: Type of Traumas Experienced by Child Clientele

4.4.2.2. Sub-Category Two: Sexual Abuse

Eleven out of the sixteen participants described sexual abuse as being a trauma that most child clients have experienced. One participant stated she mainly renders therapeutic services to children who have experienced sexual abuse and this is the main trauma that she sees in children.

“...but I think I'm kind of known for, you know, kind of abuse and sexual abuse. So that's a lot of what gets referred to me.” Respondent 2

“Um, as you know I've seen mainly the kids who've been sexually abused...I saw a lot of complex trauma...” Respondent 7

“I would say sexual abuse was the majority of it.” Respondent 13

The Optimus Study (2016) indicated that in South Africa one in three children before the age of 18 have experienced sexual abuse and sexual abuse is classified as a form of complex trauma that children experience (National Child Trauma Network 2003). The results of this study have indicated that the child clients of most of the participants have experienced sexual abuse. This finding is in concert with both the Optimus Study (2016) and the National Child Trauma Network (2003) that sexual abuse is a significant trauma that children experience.

The finding highlights and confirms the extreme occurrences of sexual abuse in children and further strengthens the reality of sexual abuse being a significant traumatic experience for children.

Category Two: Type of Traumas Experienced by Child Clientele

4.4.2.3. Sub-Category Three: Death of a Caregiver

Half of the participants (8 participants) stated that their child clientele to have experienced the loss of a loved one as a trauma. A participant stated they had observed sudden death of a caregiver to be a traumatic experience that their child clientele have experienced.

“So, we saw lots of children traumatized through bereavement, um, especially sudden death, you know, where you have a child who, um, comes home and finds their mother dead in bed...”

Respondent 6

“Um, so domestic abuse, domestic violence, um, a parent passing away...” Respondent 12

During the early years of a person's life the self is developing in relation to their caregivers and their environment (Hamlyn 2007). In the early years of childhood, the loss of a loved one is not only a painful experience but also disruptive to their environment as a result it impacts on the development of the self (Hinshelwood & Fortuna 2018). The National Child Trauma Network

(2003) states that the loss of a safe base results in trauma for a child. Thus, this finding agrees with the psychodynamic theory as discussed by Hamlyn (2007), Hinshelwood & Fortuna (2018) as well as the National Child Trauma Network (2003) indicating the loss of a caregiver as being traumatic for a child and having a far-reaching impact on the self of the child.

This finding further emphasises the significant impact the loss of a caregiver has on the child's internal structures of the self. Further highlighting the connection of the psychodynamic understanding of the role of the caregiver and the development of the self and how the loss of the caregiver can be described as traumatic due to the impact this has on self-development.

4.4.3. Category Three: The Presence of Dissociation in Children who have Experienced Trauma

Most of the participants (11 participants) identified dissociation to be present in their child clientele who had experienced a trauma. Many participants chose to give the amount in a percentage of their child clientele who had experienced trauma who then presented with dissociation. One stated that 60% and another stated 80% of their child clientele who have experienced a trauma presented with dissociation. However, there was one participant who had not found dissociation to be present in their child clientele.

"...I don't know what the percentage is, but I would say approximately 60% or more..."

Respondent 16

"Not the disorder though, but definitely dissociation symptoms, um, about 80% of the 10 that I've seen. Um, now it was very prevalent, really big prevalent within, you know, the, uh, uh, um, child and youth care centre..." Respondent 8

"Yeah, for sure. I mean, I've just, I suppose I've not really encountered it to clinically, but reading in reading about it. Yeah. Yeah." Respondent 15

The National Child Traumatic Stress Network (2003) and Herman (2015) has indicated the presence of dissociation in children as a response to traumatic experiences. The findings clearly indicate that there is a strong connection between trauma and the presence of dissociative symptoms. Therefore, the findings concur with the National Child Traumatic Stress Network (2003) and Herman (2015) as the participants indicated that their child clientele who have experienced a trauma mostly presented with dissociative symptoms.

This finding further strengthens the theory of experiencing trauma to result in the development of dissociation both as a symptom and later as a pathology in childhood.

4.4.4. Category Four: Risk Factors Contributing to the Development of Dissociation

The participants identified different aspects which contribute to the development of dissociation. These aspects being predisposing and precipitating factors contributing to the development of dissociation. The findings show that although a trauma needs to be experienced for the development of dissociation to take place, dissociation is not an isolated phenomenon, there are other predisposing factors involved. The key factors identified by the participants were the age of the child when the trauma was experienced, the type of trauma, attachment style and one participant highlighted the personality as a factor.

“...but just like, depending on what the situation is, how bad it is, the, the, um, the severity, you know, like a lot of factors depends on how quickly that (dissociation) is triggered and based on the support that we have, how quickly we can regulate out of it. You know? So, I think a lot of kids, when they don't have support in place, then they get stuck.” Respondent 9

“Um, I, I think there's a lot of factors. I think there's multi. Trauma is trauma, but different people experience and deal and cope with it in different way.” Respondent 4

“...but I do think personality has a, a role to play. Just certain personality types I've seen has more of those symptoms for example than other ones.” Respondent 14

National Child Trauma Network (2003) and the CCTASI (2017) clearly indicate a traumatic event needs to be experienced for the development of dissociation. The DSM 5 (2013) lists temperamental and environmental risk factors which facilitate dissociation to develop. The findings of the participants describing that there are other predisposing and precipitating factors contributing to dissociation supports the literature (Mate 2010; van der Kolk 2014; CCTASI 2017; National Child Trauma Network 2003; Hart 2013; Bovin et al 2014; Paulsen & Lanius 2014; Kaminer & Eagle 2010; DSM 5 2013; Simeon et al 2002).

This finding reveals dissociation to be a complex and multifaceted phenomenon. Further showing there are predisposing risk factors required with the traumatic experience for the development of dissociation in children.

Category Four: Risk Factors Contributing to the Development of Dissociation:

4.4.4.1. Sub-category One: The Age of The Child When the Trauma is Experienced

Nine of the participants said that the younger the child experiences trauma the greater the possibility of the development of dissociation. This was further highlighted by a few participants in

discussing the younger the child is, the greater the sense of powerlessness the child has and the more reliance is developed on dissociation.

“Yes remember, but you all, your young brain will be go into your dorsal vagal a lot quicker because it's a fragile system. So, it will go quicker. You know, they will go into the freeze response a lot quicker than older children.” Respondent 9

“I speak under correction, but the way I see it, children often make use of the freeze response as opposed to fight or flight, because very often they can't actually fight or flee. Um, and dissociation is very much connected with that freeze response. It's a way for them to protect themselves while they are still in the situation that they can't get out of. Um, so I do think that younger children would probably experience dissociation more so than older children.” Respondent 7

Kaminer & Eagle (2010) indicates that the younger the child the more the child will rely on the development of dissociation to cope with the traumatic experience. Hart (2013) states younger children have limited internal resources and therefore rely on dissociation more than older children do. Quatman (2015) states that the younger the child is when traumatic events occur the more likely the development of defences within the self-structure such as dissociation. The finding clearly shows younger children who experience trauma have less resources to be able to make sense and cope with traumatic experiences. This finding concurs with both Kaminer & Eagle (2010), Hart (2013) and Quatman (2015) who state that the younger the child is, the more the child relies on primitive forms of defences and has limited resources to be able to integrate the trauma.

This confirms the finding of children who are exposed to trauma early in their lives are more susceptible to developing dissociation. Further affirming that when a coping mechanism is developed at a young age it becomes part of the defences used to protect the self and thus further strengthening the link between when dissociation develops in childhood and pathology in adulthood.

Category Four: Risk Factors Contributing to the Development of Dissociation:

4.4.4.2. Sub-Category Two: Complex – Type 2 Traumas as Risk Factors

Most of the participants (14 participants) said the trauma experienced by a child for dissociation to develop needs to be complex – type 2 trauma. A participant connected chronic traumatic experiences to result in long periods of feelings of helplessness and being unable to get away from the trauma. Another participant highlighted the child who experiences trauma repeatedly has very little choice besides to dissociate.

“Yeah. Um, yeah, I, I just, I just wonder about, um, about not so much what I suppose acute trauma definitely, but I think the kind of chronic trauma where, you know, eventually that just becomes a coping mechanism. Where traumas being inflicted on, uh, on a daily or on a regular basis.” Respondent 15

“...if it's very traumatic and it happened, it happens a few times, dissociation, if there's no other way, they, they, they simply just have this out of body experience” Respondent 5

The DSM 5 (2013) states traumatic experiences to be causal factors for the development of dissociation but does not determine whether acute – type 1 or complex – type 2 traumas will be a bigger risk. However, Wastell (2005) and Herman (2015) state that complex – type 2 trauma has a deeper impact on the self and the development of defences to ensure the psychological survival of the child. Therefore, this finding agrees with Wastell (2005) and Herman (2015) indicating that complex – type 2 traumas are more likely to result in the development of dissociation.

This finding strengthens the connection of complex – type 2 traumas as being a cause for dissociation to develop as the internal resources of the child cannot cope with constant recurring traumatic experiences without developing a form of psychological defence.

Category Four: Factors Contributing to the Development of Dissociation:

4.4.4.3. Sub-Category Three: Sexual Abuse

Ten out of the sixteen participants noted most child clients that had experienced sexual abuse develop dissociation. Participants connected the sense of the child being unable to do anything about the sexual abuse and the sense of being trapped in a power dynamic with the perpetrator. As two participants clearly state their perception of the experience of sexual abuse in children result in dissociation.

“And I would like, like, I would say almost ongoing sexual abuse was almost because then it makes sense. Like, you didn't just have a fight or flight response once you had it multiple, multiple times and it still didn't, you still didn't have control of the situation.” Respondent 13

“Okay. So, whilst I was working at (child and youth care centre), it was definitely sexual abuse.” Respondent 8

“Um, yeah, definitely sexual abuse. That's the major trauma where I've seen, um, dissociation come up quite a bit...” Respondent 7

The DSM 5 (2013) firmly connects sexual abuse as a risk factor with the development of Dissociative Identify Disorder however not so strongly with the other disorders and symptoms of

dissociation. On the other hand, the National Child Trauma Network (2003) classify sexual abuse as a complex – type 2 trauma and further states complex type 2 traumas to cause the development of dissociation. The findings show child clientele who have experienced sexual abuse to present with a form of dissociation. This finding agrees with the DSM 5 (2013) and National Child Trauma Network (2003) who indicate sexual abuse to be a factor for both the development of dissociative symptoms and pathology.

This finding strengthens the theory of sexual abuse in childhood to being a significant cause for dissociation as well as highlighting the long-term impact of sexual abuse on the self-defence structures of a child.

Category Four: Risk Factors Contributing to the Development of Dissociation:

4.4.4.4. Sub-Category Four: Disorganised Attachment Style with a Caregiver

Most participants (9 participants) identified that children with a disorganised attachment style and who experience trauma will develop dissociation. A participant stated that the lack of security and stability in the disorganised attachment style with a caregiver contributes to the development of dissociation in children.

“Well, certainly a disorganized attachment ya, um, I would think you see, and I suppose I would be thinking along the lines of, you know, life has been so chaotic and abusive and neglectful that, um, the way to deal with this would be, I'm not saying it's a conscious decision at all, but you know, that would be, um, aware of being able to manage the world, manage expectations of the world... but I think that it would perhaps be more pronounced in the disorganized form of attachment.”

Respondent 15

“...disorganized attachment, you know, that will present more with the dissociation I think rather than the avoidant avoidant, you know, they have in a pattern, but it doesn't cause you to be dissociative, you know, because you still get your physical needs being met, but your emotional needs are not met either.” Respondent 11

The disorganised attachment style theory of dissociation (Silberg 2013; Wieland 2015) directly implements the disorganised attachment style to be a major factor for the development of dissociation. The disorganised attachment style theory speaks to the internalisation of the different and unpredictable interactions children have with their caregivers which result in the disorganised attachment style (Silberg 2013; Wieland 2015). Silberg (2013) describes this theory as the result of internalisations developing states within the self-structure and as result should the child experience trauma, they are more susceptible to the development of dissociation. The finding connects the disorganised attachment style with the development of dissociation and particularly

due to the unpredictability of the caregiver children experience. This finding agrees with Silberg (2013) and Wieland (2015) that the disorganised attachment style is a risk factor for dissociation.

The finding prioritises the disorganised attachment style a child has with their caregiver as a risk factor for dissociation in children. This finding further highlights the impact the disorganised attachment style has on the child's development of defences and internal resources to deal with traumatic experiences.

4.4.5. Category Five: Attachment as a Protective Factor

Majority of the participants (15 participants) discussed the impact of a positive attachment the child has with a caregiver before the trauma is experienced on the development of dissociation. A participant identified that having a safe and secure attachment with a caregiver in a child's life acted as a protective factor towards preventing the development of dissociation. The type of attachment also indicated for the participants how the caregiver would respond to the child when they have experienced a trauma as maintaining a sense of safety and helping the child process the trauma therefore not needing dissociation to cope.

"...so secure attachment has its benefits because you have that feeling of safety and security, and you have that at least one adult that you can go to whenever you're feeling unsafe...But I think, I think dissociation comes out strong, stronger in people that don't feel that safety and security with any adults. So, I think there, there is a link, but it's hard to pinpoint if it goes a long way. If it's safety, a feeling of safety, just with one person that that'll really goes a long way in terms of healing." Respondent 1

"Your brain shuts down, your brain can't process it and you need an outside container to help you process it, you know? And, and the earliest container is your primary caregiving relationship. And if that's not facilitated for whatever reason, you know, your brain is left, you know, to deal with it on its own." Respondent 3

"You know, obviously the more securely attached a child is the better in general, their ability to process the trauma and pre trauma, they would probably be functioning better as so kind of so, I mean, I think it plays a very important role. I think also post-trauma, um, you know, having a secure attachment who is possibly also willing to kind of go to the dark places with you, or have insights and want to understand and want to really kind of help or learn how to help, um, would have a significant impact on, you know, on the child's ability to function and cope." Respondent 2

Mate (2010) states the relationship the child has with their caregiver will impact the internal resources a child develops to cope with traumatic experiences. Furthermore, van der Kolk (2014) states the relationship the child has with a caregiver determines the child's ability to integrate

trauma experiences. A safe and nurturing relationship creates the space where the child can make sense of their trauma and feel contained thus not needing dissociation to cope with the trauma (Kaminer & Eagle 2010). The findings connect a good attachment with a caregiver as being a protective factor to prevent the development of dissociation. This finding is in an agreement with Mate (2010), Kaminer & Eagle (2010) and van der Kolk (2014) that a positive attachment between a child and a caregiver inhibits the reliance the child has for dissociation.

These findings show the relationship between the caregiver and the child has a vital role in creating internal resources within the child to be able to cope with traumatic experiences and prevent dissociation from developing. Furthermore, this finding confirms and highlights the importance of a secure and positive attachment a child has with a caregiver as the relationship becomes the containing factor for the child after traumatic experiences and assisting the child to make sense of their traumatic experiences.

4.5. Theme 2: The Common Symptoms and Features of Dissociation that Children who have Experienced Trauma Present with

In the analysis of the data for Theme 2 the following categories and subcategories were identified. Category one: Common symptoms and features of dissociation. Two subcategories were identified for Category one, namely subcategory one; Misbehaviour and subcategory two: Daydreaming. Category two: No awareness of the symptoms of dissociation. Category Three: Symptoms and features of dissociation present on a spectrum. Category 4: Diagnosis of dissociation in children. All these identified categories and their subcategories will be discussed below.

4.5.1. Category One: Common Symptoms and Features of Dissociation

All the participants (16 participants) of this research project were able to identify many different symptoms of dissociation. Some of the symptoms identified were sleeping disruptions, masturbation, encopresis, and somatic symptoms. Despite this, only two primary symptoms of dissociation were identified by the participants, specifically misbehaviour and day dreaming. One participant described difficulty in identifying the symptoms of dissociation and as a result is often unidentified. The participants listed many different symptoms that they had seen in their child clientele.

“Um, and we do our own initial assessment. Um, you know, then I just wanted to run to the DSM 4 OR 5. So I just wanted run to the DSM. Um, and have the child assessed. And so often we miss

the symptoms. So often as therapists, as social workers, we often miss the symptoms.”

Respondent 8

“So, I would say all of those different you know over activity the somatization of symptoms and that numbing that you often see with children who dissociate...mutism, selective mutism...Enuresis and encopresis...” Respondent 10

“I've also seen some somatic forms of dissociation and things like encopresis um... Um, and I also see sudden regression sometimes. Um, and I've seen that, especially with the more, severe dissociation cases, um, and those mood switches as kids switch from one ego state to another.”

Respondent 7

Wieland (2015) and CCTASI (2017) list many different symptoms of dissociation. The CCTASI (2017) has divided the symptoms into age specific symptoms. The findings in the literature indicate there are many different symptoms and features of dissociation child clients present with. The findings show many different dissociative symptoms and features presenting in children. Therefore, these findings concur with Wieland (2015) and CCTASI (2017) that there are many different symptoms of dissociation which can be identified in children.

This finding shows different participants identify a range of different symptoms and features of dissociation in children. These findings highlight that not many clinicians are aware of or able to identify the different symptoms and features of dissociation which children can present with and as a result dissociation is often missed.

Category One: Common symptoms and features of dissociation:

4.5.1.1 Sub-Category One: Misbehaviour

Eight participants identified misbehaviour as a symptom of dissociation. One such participant stated misbehaviour to be an attempt of the child to feel something in the face of the numbing effect of dissociation. Another participant connected stealing, hiding things, and having weird behaviour with symptoms of dissociation.

“...weird behaviour reactions, seeming confused, mannerisms, going blank and not knowing afterwards what happened. Now those are symptoms of dissociation that you see sometimes stealing hiding things, stealing things...” Respondent 10

“... Um, I've seen some acting out...” Respondent 15

“...I don't want to say it's a symptom, but maybe it was what they saw was like a cure, a lot more trying to do things that would maybe make them feel something like, like more of like taking these

are the young kids in the lower communities, like stealing dad's beer and taking, you know, a couple of sips of it to see how it makes them feel and like going, you know, flashing themselves to the boys to go see like, if they get a reaction, like those kinds of things. But I don't know if that's a symptom. I think that's just more like an element of how they feel inside their bodies that they're disconnected.” Respondent 13

Misbehaviour, such as stealing and disobedience in children has been recognised to be a symptom of dissociation (Wieland 2015; CCTASI 2017). The ESTD (2017) indicates children may experience voices telling them to misbehave and the child being unable to remember acting out this misbehaviour. The findings connect misbehaviour as a symptom of dissociation in their child clientele. This finding agrees with Wieland (2015), CCTASI (2017) and ESTD (2017) that misbehaviour is a symptom of dissociation in children.

This finding highlights the externalising of symptoms in children as an attempt to make sense of their own internal processing. The finding further highlights misbehaviour in children can be linked to underlying causes such as dissociation, especially when the child denies any recollection of the behaviour.

Category one: Common symptoms and features of dissociation:

4.5.1.2 Subcategory Two: Daydreaming

Nine of the participants identified that daydreaming is a symptom of dissociation. The participants described the daydreaming as presenting in children as staring off into space and looking like they are not present. A participant stated spacing out as something seen as well as a sense of the child not being present as a symptom of dissociation.

*“So, it's definitely like, you know, the staring into space, daydreaming going blank, you know...”
Respondent 3*

“So, so they'll space out in some sort of, so you'll have them in a group and then a little, you know, you'll see, like you've seen something and they're not there.” Respondent 11

Daydreaming and zoning out are symptoms of dissociation (ESTD 2017; CCTASI 2017; Perry & Szalavitz 2017; Wieland 2015; Perry & Winfrey 2021). The participants have identified daydreaming, spacing out and zoning off as a symptom of dissociation. This finding agrees with ESTD (2017), CCTASI (2017), Perry & Szalavitz (2017), Wieland (2015) and Perry & Winfrey (2021) that daydreaming is a symptom of dissociation.

This finding emphasizes daydreaming and not being present through spacing and zoning out as a common symptom and feature of dissociation in children.

4.5.2. Category Two: No Awareness of the Symptoms and Features of Dissociation

Most of the participants (10 participants) stated children are unaware of their symptoms of dissociation. The presentation of dissociative symptoms and features were described as an unconscious process and experience that children are unaware of. One participant stated that the awareness of dissociation only comes in the process of therapeutic intervention by the clinician.

“I don't think that they are aware. They do know, like I said earlier, it's a form of, for me, I feel it's a form of defence mechanism. So, they are aware that they shutting people out. They're not necessarily aware that they doing it. I'm not, I'm not sure how to put it. Yeah. They don't do it to dissociate but they do it to defend themselves. So, it happens naturally. So, I don't think they are aware of it.” Respondent 16

“I would say it's unconscious unless they're in therapy and something brings that up to consciousness, but I would say unconscious.” Respondent 15

“I don't, I don't, no, not mostly I don't think that they do. I think it's, uh, I think a lot of times subconscious it's jumped in, comes up and it triggers them, they react, but I don't think that they always stop and say, oh, because it's happened I am acting, it's more like it happened and then they dissociate.” Respondent 4

Wieland (2015) states that the child is unaware of the process and presentation of their symptoms of dissociation. Wieland (2015) describes the process of responding in a dissociative manner to an experience or trigger as being unconscious. The findings explain dissociation to be a defence mechanism that develops and manifests unconsciously for the self and therefore outside of the awareness of the child. The findings indicate children as unaware of their symptoms of dissociation and their dissociative responses to trauma. These findings agree with Wieland (2015) that children are unaware of their presentation of dissociation and the internal process of dissociation.

This finding strengthens the concept of dissociation being an unconscious and uncontrollable response to trauma in children. The findings further show dissociation to be a phenomenon that is not thought about but rather an automatic unknown response to traumatic experiences.

4.5.3. Category Three: Symptoms and Features of Dissociation Present on a Spectrum

Almost all the participants (12 participants) said that dissociative symptoms present on a spectrum, ranging from normal to mild to severe symptoms. One participant describes the symptoms of dissociation to be on different levels. Two participants explained the spectrum to be

linked to how severe the fragmentation is of the self, leading to the pathology of Dissociative Identity Disorder.

“It's different levels of, um, disassociation, you know, like we have normal say like even daydreaming where I think it's also a protective function, um, you know, where if you think people that are very sensitive, they absorb more and things more deeply.” Respondent 9

“I think it is, I think it does present on the spectrum...So I would, I think I would describe it in, uh, in how fragmented the person becomes from up to the extreme of DID (Dissociative Identity Disorder) with parts that are quite malicious and violent and so forth.” Respondent 10

“I think it can range from very mild dissociation where it's just spacing out here and there, and then to moderate, where you experienced that, the derealization and depersonalization kind of moments. And then I think the severe dissociation would be the more disordered dissociation with the um, identity disorder or with the, um, dissociative disorder, not otherwise specified that one. Um, so that would be then I think, where there's that extreme splitting off of the different ego states, where children are almost not even aware of those ego states in themselves.” Respondent 7

Wieland (2015), Gusic et al (2017) and Perry & Winfrey (2021) all place symptoms of dissociation as being present on a spectrum. Wieland (2015) describes symptoms of dissociation to be on a spectrum of mild, moderate and severe symptoms, and relates specific symptoms within this spectrum. Perry & Winfrey (2021) places symptoms of dissociation on a spectrum based on the level of threat and the states of functioning. The findings in the literature clearly indicate dissociation to be present on a spectrum, mainly from normal to severe based on the level of fragmentation of the self. The findings of this study concur with Wieland (2015) and Perry & Winfrey (2021) that dissociative symptoms are found on a spectrum.

This finding emphasizes the symptoms of dissociation to be characterised as being on a spectrum from normal, mild to severe. This highlights that not all dissociative symptoms are pathological but rather have a healthy coping function.

4.5.4. Category Four: Diagnosis of Dissociation in Children

Nine of the participants either acknowledged they were uncomfortable with diagnosing children with dissociation or diagnosing was out of their scope of practise. Participants stated dissociation to be a normal response to trauma and rather than the dissociation being diagnosed that the traumatic experiences should be held above a diagnosis. The participants indicated to rather give a diagnosis of PTSD or a trauma related disorder.

“...I think in all honesty, I probably don't diagnose it as, you know, as it, you know, so, so I would say I probably, um, you know, what I use quite often is a total complex developmental trauma disorder, you know? So, so because this is something which as a concept makes most, most sense to me, you know, because it's basically just a description of, um, you know, a certain life experience combined with certain symptoms, you know, um, and, and presentations, you know, um, um, and, you know, because often these kids end up with a diagnosis of ADHD or diagnosis of oppositional defiant disorder or something like this, you know, and, and for me, it makes more sense to, to really put the trauma, trauma diagnosis at the forefront, you know, and you might still want to include, um, concentration difficulties or, um, mood lability, you know, but it's, it's trauma informed sort of, you know.” Respondent 3

“Um, so I think a lot of times they are wrongly diagnosed or even, um, oppositional defiance disorder because they seem like they're not listening or that they, they actively going against what you're saying that they're just trying to protect themselves. Um, but I would think more in the line of PTSD kind of diagnosis, that would make more sense or anxiety disorders. Hmm.” Respondent 1

The finding emphasises that the participants prefer to rather not give a diagnosis of a dissociative disorder but rather to identify the trauma as the cause of the dissociative symptom. The findings show that the participants, instead give a trauma related disorder diagnosis or focus on the trauma the child experienced. Morrison (2014) and Bui et al (2014) emphasis focusing on the traumatic event and how this impacted the self of the child rather than diagnosing a dissociative pathology. This finding agrees with Morrison (2014) and Bui et al (2014) that rather than diagnosing pathologies related to trauma clinicians' should assess the impact of the experience on the self of the child.

This finding focuses on the connection of traumatic experiences and the development of dissociation as a normal response to an abnormal experience. This finding rather emphasises for clinicians to assess the impact of the trauma on the child leading to a trauma related diagnosis, than focus on a dissociative related diagnosis.

4.6. Theme 3: Theoretical Explanations of Dissociation Informing Clinicians' Understanding of Dissociation Amongst Children who have Experienced Trauma

In the analysis of the data for Theme 3 the following categories and subcategories were identified. Category one: Dissociation creates a sense of safety. Category two: The function of dissociation. Category Three: Dissociation is disconnecting in nature. Category 4: The neurobiological areas associated with dissociation. All these identified categories will be discussed below.

4.6.1. Category One: Dissociation Creates a Sense of Safety

Most of the participants (8 participants) described dissociation to be an attempt to feel a sense of safety during and after a traumatic experience. One participant explained dissociation to help the child regain a sense of safety by creating a wall around themselves. Another participant states that dissociation creates a place within the child where a sense of safety can be felt.

“It's escaping an extreme threat and going to a place that feels a little bit more safe, but not, not in some ways, also not being present in that place. So, you're not present in this place, but in some ways, you're also not present in your safe space...” Respondent 2

“It makes them feel safe. Um, For the moment, you know, it makes them, it's like the survival of the fittest and they want to be the fittest, the fittest in society, because what our society tells us that we cannot be weak and we cannot be frail and we cannot be AB and C so we try not to be AB and C so we cope with it. We take all of those mechanisms that made us feel better. That made me feel safe, and it allows them to live in a world where there is no risk, um, where their lives are not at risk. So, they put up this wall around them and you, you all familiar with it as well? They've put up that wall around them... So, it allows the child that moment to feel safe.” Respondent 7

Psychodynamic theory describes dissociation to be a present unconsciousness which is created to form a sense of safety by denying conscious awareness of internal conflicts triggered by trauma (Gullestad 2005). This finding shows that dissociation creates a sense of safety within the child when traumatic events occur. The child needs to feel safe to be able to cope with their environment and experiences and when the surrounding support systems cannot do this the child then relies on dissociation. This finding agrees with the psychodynamic (Gullestad 2005) understanding of dissociation as a mechanism to create a sense of safety for the child who experienced trauma.

This finding emphasises that children need to feel a sense of safety and if their external environment cannot give them a sense of safety the child will create this through the development of dissociation.

4.6.2. Category Two: The Function of Dissociation:

All the participants (16 participants) stated dissociation's function within the self to be protective in nature when trauma is experienced, be this during or after the event. Some participants said the use of dissociation to be a protective function against trauma and often results in the development of dissociation becoming a defence mechanism within the self-structure of a child.

“Survival, it’s a way of surviving I mean, when it is a true freeze from the dorsal vagal system is literally the last option to survive...” Respondent 10

“I would definitely think that because I would, I think dissociation is a defence.” Respondent 15

“So, it’s something that happens to you. Trauma is something that happens to you and the dissociation is something that tries to protect your mind and body from what’s happening, on stopping the trauma from happening, but it’s trying to protect all your insides your, your psyche what’s happening. So it’s a protective reaction in the moment.” Respondent 1

Dissociation’s function is to be the protective mechanism of the self against trauma (National Child Traumatic Stress Network 2003). The CCTASI (2017) describes that should dissociation become the primary defence against the traumatic experience it will lead to pathology in adulthood. The participants stated that dissociation can further develop into defence structures within the self thus preventing a coherent and integrated self-structure which would likely result in pathology. The findings state that the function of dissociation to be a protection against trauma. The finding is concurrent with CCTASI (2017) and the National Child Traumatic Stress Network (2003) of dissociation’s function to be protective in nature.

The findings very much show the function of dissociation to be protective. This emphasises the role dissociation has in helping the self of the child be able to cope with traumatic experiences and ensure the psychological survival of the child.

4.6.3. Category Three: Dissociation is Disconnecting in Nature.

Many of the participants (9 participants) described dissociation to be a disconnecting occurrence from the reality of the child. One participant discussed the disconnecting happens between the child’s consciousness and their body and feelings during the traumatic experience. One participant states that the child disconnects from any external experiences to cope.

“...there’s just a disconnection from the, the child’s thoughts and feelings and sense of identity. And my explanation was when the child gets sexually abused they sometimes just disconnect. They, they have this outside, you know, sort of, um, they feel as if they are out of their own body, they completely and utterly dissociate. Yeah. So, I think that’s ya sort of, basically out of body experience. That’s, that’s what they have. They feel numb. They feel detach...” Respondent 5

“For me, my understanding is the disconnection of mental and physical actions to cope with an outside input so anything that comes my way, either physical or emotional, I’m just disconnecting from all of that.” Respondent 14

Wieland (2015) highlights the sense of disconnection that is experienced by children during traumatic experiences. Hart (2013) connects the hyperarousal effect of trauma on the child and the responding disconnecting aspect of dissociation when trauma is experienced. There is a disconnection within the self when dissociation develops and a separating within the self (Hart 2013; van der Hart 2006; Wieland 2015). Quatman (2015) describes the psychodynamic process of disconnection as splitting within the self as a form of self-defence from the external objects. The findings in the literature show that children experience disconnection from their self and the experience when they dissociate. The finding of this research indicates that children experience dissociation as disconnecting from any experience they deem traumatic. This finding concurs with Wieland (2015), Hart (2013) and Quatman (2015) that dissociation is disconnecting in nature and results in splitting within the self-structure.

The finding emphasises the disconnecting effect of dissociation that children experience. In particular validating the concept of an out of body experience that many describe dissociation to be in traumatic events. This finding further connects the psychodynamic concept of splitting and dissociation.

4.6.4. Category Four: The Neurobiological Areas Associated with Dissociation.

Eight out of the sixteen participants explained dissociation to take place within the brain stem as a response of the neurobiological survival system. All these participants indicated that dissociation is a primitive function of the brain and is found to take place in the structures of the brain that are linked to ensuring survival of the child, in particular the amygdala and the brain stem.

“It's the neuroscience part like, you know, experiencing stress that I live in the bottom of my brain. And then because of that the only way I can survive is dissociating or, you know, and my, and my, you know, sort of my nervous system, that's the only way I can cope.” Respondent 11

“...especially your, your fear centre, you know, your limbic system, your amygdala, you know the memory processing of it develops much later as your, your frontal cortex and your executive functioning. The ability to put things into words, to pause, to reflect, um, you know, but if you get triggered in your fear centre and your limbic system all the time, um, you know, it's, it's basically a message to your brain. It's too much...” Respondent 3

“So, dissociation sits into that whole thing of high alerts and being in your survival brain is like your primitive brain. So, it's either fight flight or freeze. And then the dissociation comes in with freeze.” Respondent 1

The neurobiological theory of dissociation (Wieland 2015) places the process of dissociation to take place within the survival part of the brain, consisting of the limbic system and the brain stem. The literature findings states that dissociation develops within the primitive and survival part of the brain, consisting of the limbic system and the fear centre (Wieland 2015). The participants describe their understanding to be that of the phenomena of dissociation takes place within the brain stem and the limbic system. This finding concurs with Wieland (2015) who states that the process of dissociation takes place within the parasympathetic nervous system when the sympathetic nervous system cannot cope with the overstimulation of the limbic system from traumatic experiences.

This finding further validates the process of dissociation stemming from an unconscious biological response to trauma for psychological survival resulting in children being unable to control symptoms of dissociation and biological changes. The findings highlight dissociation to be a process of different neurobiological systems within the survival-oriented part of the brain, namely the brain stem, the limbic system and the fear centre.

4.7. Theme 4: The Therapeutic Approaches that are Used to Effectively Treat Children who have Experienced Trauma and Present with Dissociation

In the analysis of the data for Theme Four the following categories and subcategories were identified. Category one: Creating a sense of safety. Category two: Regulation techniques. Category three: Play therapy as the main therapeutic modality. Category four: The involvement of the caregiver in the therapeutic process. Two subcategories were identified, namely Subcategory one: Developing attachment between the child and the caregiver and Subcategory two: Attachment focused home activities. Category five: Psychoeducation. All these identified categories and their subcategories will be discussed below.

4.7.1. Category One: Creating a Sense of Safety

Majority of the participants (9 participants) indicated that creating a sense of safety for children who dissociate is the most important part of the therapeutic process. Two participants state that it is within the therapeutic relationship where the child experiences safety. Another participant stated creating a sense of safety is the first aspect of the therapeutic process which needs to be established.

“I kind of bring that in I'm mostly work, play therapeutically with the kids. So, I think that that therapeutic relationship is very important. Um, so that a child can just feel safe enough to start accessing certain things.” Respondent 7

“...most first and most important thing...but it's being a safe person to be with. So, one therapist who wants to work with trauma and anyway a therapist, who wants to work with children should do their own work in order to have the own nervous system regulated in order to be a safe person for that person to heal.” Respondent 10

“And the whole model is based on your first thing that you do in therapy is creating a sense of safety because it's full of these getting through trauma.” Respondent 11

Herman (2015) emphasises recreating a sense of safety for the client as the foundation of therapeutic interventions after experiencing a traumatic event. The therapeutic process of creating a sense of safety in the child's relationships, body and environment assists the child to be able to process the trauma (Kagan 2004; Wieland 2015; Herman 2015). The findings state creating a sense of safety results in the child feeling contained enough to be able to process the trauma which resulted in the development of dissociative symptoms. The finding concurs with Herman (2015), Wieland (2015) and Kagan (2004) that a sense of safety within the therapeutic process is fundamental for the child to be able to access the trauma experienced which results in the dissociative symptoms.

The finding further connects the importance of a child client having a sense of safety in the therapeutic relationship with the therapist, within themselves and their environment before the processing of the trauma. Furthermore, this finding connects the lack of safety that children experience after trauma and this needing to be re-established for the child before the integration of the trauma in therapy.

4.7.2. Category Two: Regulation Techniques

Most of the participants (8 participants) shared that they teach the child client who presents with dissociation, regulation, and grounding techniques. One participant said she would ask the child to lay down and placing a book on their stomach would teach them how to breathe to assist with calming the nervous system. Another participant stated she will teach the child how to regulate themselves through grounding techniques and visualisations. Another participant shared she does sensory body-based activities with children.

“...obviously grounding do a lot of grounding visualization.” Respondent 14

“...I always taught children, how to breathe I remember I would put a book on their tummies when they lay down, they had to breathe so that, so that the book goes up and down, so that basic grounding techniques breathing for self-regulation.” Respondent 10

“Um, a lot of sensory activities. So, like more body-based activities, lots of like, but not telling them we are doing a sensory activity.” Respondent 13

Silberg (2015) emphasises the need for the therapist to teach the child and their caregiver regulatory skills to help regulate the child’s nervous system to prevent triggering the hyperarousal or hypoarousal response and entering a dissociative state. The findings indicate the clinicians teach their child clients how to regulate and ground themselves. The findings agree with Silberg (2015) that regulating techniques need to be taught to children who have experienced trauma and present with dissociation.

This finding shows teaching regulation skills to children is an important part of helping the child cope with triggers of the trauma which result in dissociative symptoms.

4.7.3. Category Three: Play Therapy as the Main Therapeutic Modality

Ten out of the 16 participants indicated that they use play therapy as their main therapeutic technique when working with children who have experienced trauma. One participant shared that she would use figurines as tools for the child’s projections and transference to assist the child to process their experiences. Another participant stated that she would interpret the play of the child to understand what the traumatic experience was for the child, as well as slowly moving the interpretation closer to the child for integration.

“Allow the child to tell the personas story. And it might become very repetitive. This is what happened. This is what happened. This is what happens for a number of sessions. Um, And then to kind of work at drawing the experience closer, and sometimes we can do that directly or indirectly. So, in other words, you might kind of, um, use the persona to, to discuss certain issues with the child. If the child is able to think abstractly. It obviously depends on the age of, let's say it's very difficult with children under the age of five or six. So, but you know, one would discuss the situation of that persona and what the child thinks and feels about that particular doll.” Respondent 6

“...through just interpreting through the play and then slowly getting closer and close to the child so that the child became conscious of, of what was happening. And I suppose in my own mind also having an idea. Of what the trauma was.” Respondent 15

Landreth (2012) and Marks (2015) clearly state that play therapy is the technique to be used when rendering therapy to children. Wieland (2015) writes that it is through the child’s play and drawings that therapist can interpret the presence of dissociative symptoms and the impact of trauma while helping the child to process the experience. The findings show that play therapy is a technique

used by the participants to interpret and integrate the trauma related to the dissociation. This finding agrees with Landreth (2012), Marks (2015) and Wieland (2015).

The findings validate play therapy as being the therapeutic modality for child clients and further highlights that children express their dissociative symptoms in their play. The finding also emphasises that clinicians can interpret the projections and transference in children's play for the integration of experiences, healing of the self and the treatment of dissociative symptoms. Furthermore, the findings connect the use of play therapy and psychodynamic techniques when treating dissociative symptoms and trauma in children.

4.7.4. Category Four: The Involvement of the Caregiver in the Therapeutic Process.

Most of the participants (11 participants) stated that they include the caregiver in the therapeutic process with children who present with dissociative symptoms and have experienced a trauma. One participant stated that trauma directly affects the relationship between the child and their caregiver and this is why beginning with the relationship is important. Another participant highlights therapy with children cannot be given without the support of the caregiver and their understanding of the child's dissociative symptoms.

"... even start with attachment therapy where I would work with the child and a parent who is able to offer a secure attachment because trauma sometimes impacts the attachment relationship as well because the child is so hypervigilant and then they miss those attachment cues that a parent gives." Respondent 7

"All the time. All the time, because you can't, my theory is, is that you can't be going to be working with the child and the caregiver knows has no idea about what's going on with the child... So it's, it's, it's vitally vitally important that, that a child, parent caregiver is involved in the treatment plan because sometimes parents don't understand the tummy aches, they don't understand the why does my child daydream or they don't understand why my child is not performing at school." Respondent 8

Silberg (2013) includes the family and the caregiver in the process of the therapeutic treatment of dissociation to assist with the integration of experiences. Both Silberg (2013) and Goodyear-Brown (2010) states that the caregiver is needed in assisting the child to regulate and integrate rather than using dissociation. Goodyear-Brown (2010) describes the caregiver as the emotional container for the child and by developing this in therapy the child will no longer need dissociation. Psychodynamic theory and in particular objects relations describe the importance of the caregiver in containing and helping the child to develop a sense of self. The findings show that the caregiver has an important role to play in the therapeutic process of the treatment of dissociation and trauma

in children. Therefore, the findings agree with Silberg (2013) and Goodyear-Brown (2010) in including the caregiver in the therapeutic process.

The findings emphasize the role of the caregiver in the therapeutic process and further highlights that therapy will be more effective when the caregiver is a partner to the therapist in the treatment process.

Category 4: The Involvement of the Caregiver in the Therapeutic Process.

4.7.4.1 Sub-Category One: Activities to Develop Attachment Between the Child and the Caregiver

Most of the participants (11 participants) emphasised developing the attachment between the caregiver and child through activities in the therapy process. One participant concluded strengthening the attachment relationship between the child and the caregiver as one of the best interventions of therapy. Another participant stated when attachment is developed in the therapeutic process between the child and the caregiver the therapy is more meaningful. Participants highlighted that healing happens in relationships and it is through the clinician modelling in the therapy sessions that new parenting skills are taught to caregivers and the attachment is strengthened.

“And there's a possibility of, um, integrating, uh, sessions with the caregiver and the child to, to build, um, attachment relationships between the two. I think that's one of the best working interventions to, to be able to nurture that the existing relationships that the child does have and strengthen those.” Respondent 16

“And then attachment, I'm a big person on attachment, big person on attachment And I see greater results when the mother and the child worked together, than when it's just the child by themselves.” Respondent 13

“But healing also happens within relationship...It's not like I'm going to tell them, oh, you need to watch their eyes you need to. It's not that at all, it's modelling that they actually are taught how to respond differently to the children, how to engage with the children, how to put like clear boundaries of, you know, creating some structure, predictability and all those different things.” Respondent 11

In Silberg's (2013) therapeutic process of addressing dissociative symptoms in children the caregiver is included to strengthen attachment. Not only this but Silberg (2013) goes so far as to assess the attachment that each part of the self has with the caregiver to ensure the best outcome for the relationship. The finding shows that clinicians who render therapy to children who have

experienced trauma and display dissociative symptoms use activities to strengthen the attachment between the child and the caregiver. These findings agree with Silberg (2013) that developing the attachment between the child and the caregiver is a vital aspect of therapy with children presenting with dissociative symptoms.

The finding emphasises that the development and establishment of a positive attachment between the child and the caregiver should be a focus of therapy. Furthermore, this finding validates psychodynamic therapy that the caregiver is the one who helps the child make sense of their experiences and integrate the meaning into the self-structure.

Category 4: The Involvement of the Caregiver in the Therapeutic Process:

4.7.4.2. Sub-Category Two: Attachment Based Home Activities

Most of the participants (8 participants) stated that they give home activities to the child and the caregiver which focuses on the development and sustainment of their attachment. Participants discussed the activities to be encouraging caregivers to play and spend time with the children at home.

“Yeah. So, playing teaching them to play together again, as I say that usually sometimes starts in the playroom just helping the parents to play with their children and really to play with them at their level.” Respondent 10

“I basically, for the parents I give them basically like those parenting skills kind of stuff active listening the coming down to the child's level, spending time with the child, entering the child's world, those types of things. And then obviously for the children. Then again, how to communicate my needs and wants to the parents. So, I kind of challenged them a little bit to have more interaction and communication with each other.” Respondent 14

Silberg (2013) describes the family as the driving force for healthy functioning in a child and that the responsibility of creating an environment for the child to heal is the families. Goodyear-Brown (2010) gives the family activities to do at home that assist the child with regulation as well as implementing daily play time. The findings show that clinicians' give activities to the caregivers to build better relationships between the child and the caregiver. The findings concur with Goodyear-Brown (2010) and Silberg (2013) that home activities should be given to the caregiver to facilitate the development of a secure attachment.

The findings emphasise establishing the relationship between the child and the caregiver outside of the therapeutic sessions through implementing play time and activities to be completed at home.

4.7.5 Category Five: Psychoeducation

Ten out of the sixteen participants stated that they psycho-educate both the child and the caregiver. One participant describes through psychoeducation that the shame of the child's trauma response shifts resulting in the child being able to process the experience. Another participant stated that through psycho-educating the caregiver, the teacher and the child there is more effective intervention as the dissociative symptoms are better understood.

“Ya, so, I think that that would be important. I think psycho education also for the child is extremely important too. I think in some ways also take the shame away from it, you know, then it's not something that's wrong with you. In fact, that it's something really clever that your brain has done, you know, so really trying to kind of shift that.” Respondent 2

“I think there, again, psychoeducation is the most important thing for the parents, the teacher, and the kid, because, you know, we don't have control over dissociation. It's like when your nervous system gets, is in any way, feels threatened and it's a coping mechanism to protect us.” Respondent 9

Silberg (2013) discusses that clinicians need to psycho-educate the child to develop a better understanding of the dissociative symptoms. Silberg (2013) starts the therapeutic process with psycho-educating the child and expressing gratitude for the dissociative symptom. The findings state that clinicians psycho-educate their child clients, parents and teachers on dissociation and trauma. The findings concur with Silberg (2013) that psychoeducation should be part of the therapeutic process with children who present with dissociative symptoms.

This finding emphasises the importance of psycho-educating children and their environment about dissociative symptoms to create understanding and appropriate responses to the child's dissociative symptoms.

4.8. Conclusion

This chapter discussed the findings based on the research questions and objectives from the participants in the study. The findings indicated a strong prevalence of dissociation and trauma in the participants' child clients. Factors relating to the development of dissociation were discussed and specific traumatic experiences were identified to result in the development of dissociation. The symptoms and features of dissociation which were identified in the participant's child clients were explored. Participants described that child clients experience dissociation to be a disconnecting in nature. The participants' theoretical explanations and understanding of dissociation in children was

strongly connected to protection and creating a sense of safety. The therapeutic interventions that the participants used were listed and described. The next chapter will present the conclusions and recommendations based on these findings.

CHAPTER 5: CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

This research aimed at exploring the connection between trauma and dissociation and the prevalence of this within children living in South Africa. The outcome of this research was to develop a better understanding of how dissociation presents in children who have a history of trauma and what are effective therapeutic interventions for clinicians rendering therapeutic services to children who present with dissociation. The findings of the research as presented in chapter four are concluded and discussed in this chapter. Furthermore, recommendations are given for future research, to clinicians, for the development of trauma informed policies and universities in this chapter.

5.2. Conclusions

There were many similarities between the findings and the literature on dissociation in children who have a history of trauma. Despite this there were new findings which emphasised the difference between children who present with dissociation who live in South Africa and other children living in other contexts. The findings from the data analysed are concluded and presented under the research objectives.

5.2.1. To Explore Whether South African Clinicians Commonly Observe Dissociative Features Among the Children They Treat who have a History of Trauma

The participant's indicated that they observe dissociative features among the children they treat who have a history of trauma. It was found that between 80 and 100% of the children being treated by the participants had experienced a traumatic event. The participants discussed three prominent traumas that child clients experience, namely physical abuse and neglect, sexual abuse, and the death of a caregiver. This finding highlighted that the participant's child clients mainly experience chronic, complex – type 2 trauma. There has been no literature indicating the numerical value of child clients who are in therapy with a history of trauma thus this is a new finding. The participants stated that amongst the child clients who have a history of trauma, 60% to 80% present with dissociative features. These findings concur with the literature which indicate a strong connection between trauma experiences and the development of dissociation.

The findings emphasize the correlation between trauma and dissociation. The participants further discussed other aspects within the child's environment which need to be present before experiencing trauma and specific trauma experiences which result in the development of dissociation. The participants identified these aspects as risk factors which contribute to the development of dissociation as well as a protective factor. These risk factors can be identified as predisposing and precipitating factors. The predisposing factors identified were the age of the child when the trauma is experienced and a disorganised attachment with the primary caregiver. The precipitating factors are experiencing complex – type 2 traumas and sexual abuse. The protective factor which was discussed is a secure attachment with the primary caregiver. Participants describe the secure attachment providing the child with a sense of safety and containment along with developing resilience to cope with traumatic experiences. Throughout the literature there was an emphasis on the relationship between the child and the caregiver in assisting with coping with traumatic and stressful experiences.

5.2.2. To Investigate the Most Common Features and Symptoms of Dissociation South African Clinicians Identify During Assessment of Children who have Experienced Trauma

The participants listed several symptoms and features of dissociation which present in children who have experienced trauma. However, the most identified were misbehaviour and daydreaming. The participants noted that misbehaviour in child clients is linked to dissociation and presents as stealing, lying and anger outbursts. Participants explained that the child may use the behaviour to feel something other than the numbing of dissociation. The research findings agree with the literature as misbehaviour is identified as a symptom of dissociation in children.

The participants identified daydreaming in children who have experienced a trauma as a symptom of dissociation. Daydreaming appears as zoning out, creating another sense of reality to cope with their experiences, appearing as if they are not present and blank. The participants stated that children who present with dissociative symptoms and features are unaware of the development as well as the symptom of dissociation. The findings show that dissociation is an unconscious process that children cannot control.

Symptoms and features of dissociation were characterised as a spectrum from normal, mild to severe. The findings described the spectrum to be related to the severity of the fragmentation of the self in response to the trauma experienced. Even linking the most severe form of dissociation on the spectrum with Dissociative Identity Disorder. This finding agrees with the literature that dissociative symptoms and features are found to be on a spectrum.

The findings show that clinicians are reluctant to diagnosis children with dissociation, stating that they rather focus on the traumatic experience and the impact this had on the self that resulted in dissociation. The findings discussed that the most applicable diagnosis of children who present with dissociation would be a trauma informed diagnosis.

5.2.3. To Determine the Theoretical Underpinning that Inform South African Clinicians' Understanding of Dissociation as it Pertains to Children who have Experienced Trauma.

The theoretical understanding of dissociation by the participants was described as dissociation being a phenomenon that creates a sense of safety and protects the child from the realisation of the trauma. The finding that dissociation is a phenomenon which creates a sense of safety for children during and after a trauma agrees with psychodynamic theory. The function of dissociation in children was discussed to be protective to ensure psychological survival. The findings stated that the protective function of dissociation develops into a defence structure within the self. Theoretical descriptions of dissociation indicate that it is a protective mechanism against processing and experiencing trauma and the findings agrees with this.

The findings defined dissociation to be a disconnecting experience for the child, resulting in feelings of being outside their bodies and watching the trauma happening to them. The sense of disconnecting can be associated with the fragmenting of the self in response to an incomprehensible experience. This ties in with the theory of dissociation being a disconnecting phenomenon from trauma.

The findings describe the phenomena of dissociation to take place within the neurobiological structures within the brain which are responsible for survival and are primitive in nature. These neurobiological structures were identified as being the brain stem and the amygdala. The findings

show that it is an unconscious and automatic response to trauma that children have. This finding directly correlates with the theory relating to the neurobiological areas of the brain which activates the freeze response to trauma and has been connected to the phenomenon of dissociation. Furthermore, these findings emphasize the concept of self defence structures such as dissociation to be connected to bodily and neurological functions and not just a psychological response.

5.2.4. To Determine the Therapeutic Approaches to Treating Dissociation Among Children who have Experienced Trauma that South African Clinicians Find to be Most Effective.

Play therapy was indicated as being the primary therapeutic approach which is used in treating dissociation among children who have experienced trauma. The findings discussed the use of figurines (toys with human characteristics) in play therapy as forms of projection and transference to assist with processing the traumatic experience. This ties in with the literature that play is the language of the child and the way a child makes sense of their experiences.

The findings strongly showed that creating a sense of safety within the therapeutic relationship and therapy room is fundamental for therapy with the child who has experienced trauma. One participant stated that the clinician needs to be a calm and regulated person who has processed their own trauma so that the child can experience the clinician as safe. The findings indicated that the child experiencing a sense of safety within the therapeutic relationship is vital in being able to integrate the trauma which resulted in the development of dissociation. This finding directly concurs with the literature relating to trauma therapy which states that re-establishing a sense of safety for the child needs to come first before the trauma is processed for integration.

Regulation and grounding techniques were discussed as therapeutic techniques that are used to help the nervous system and self of the child to not have to rely on dissociation to cope with the physiological responses to triggers. The findings emphasised co-regulation between the caregivers and the child by teaching the caregiver how to help the child regulate. This concept of co-regulation is connected to the psychodynamic theory of the caregivers being the ones who make sense of the child's world during infancy.

The findings discussed the involvement of the caregiver in the therapeutic process. The findings stated that the most effective therapeutic intervention with children who have experienced a trauma and present with dissociation is when the caregiver is included. The findings emphasised using activities at home and in the therapy sessions to strengthen and rebuild the attachment between the child and the caregiver.

The findings showed psychoeducation to be a prominent therapeutic intervention. The findings indicated that psycho-educating the caregivers, teachers and the child creates understanding of

the symptoms and the features of dissociation in response to trauma. The findings stated that this would help the child to feel less shameful as well as helping the role-players in the child's life to understand the meaning of the symptoms. The therapeutic intervention of psychoeducation is found throughout the literature of therapeutic interventions with children who have experienced trauma.

5.3. Recommendations

The researcher will now present the recommendations as based on the conclusions of the findings.

5.3.1. Recommendations for Future Research

The findings highlighted that dissociation is a response to trauma in children. Comparing the findings to the literature on the topic there is very limited in-depth understanding of trauma in children, particularly in South Africa. The impression and indication within the findings are that there is a need for a deeper understanding of dissociation and trauma. The data further indicates that there is a need for a more thorough theoretical understanding of how dissociation presents in children.

Therefore, it is recommended for more research to be completed on how children living within South Africa are effected and impacted by both generational and experiential trauma and what interventions are used that are successful in preventing the development of dissociation.

5.3.2. Recommendations for Clinicians

During the process of gathering literature and data there was a strong emphasis on the involvement of the caregiver in the therapeutic interventions and the benefit of a secure attachment between the child and the caregiver. The only protective factor identified which prevented the development of dissociation was a secure attachment between the child and the caregiver. Therefore, it is recommended that clinicians who render therapy to children start with working with the caregivers and strengthening the attachment as a primary goal of the therapeutic intervention.

The findings show that rather than diagnosing the child with a pathology, the focus of assessment should be discovering the trauma the child experienced and the impact this had on the self which resulted in the development of dissociative symptoms and features. Therefore, it is recommended to clinicians rendering therapy to children who present with dissociative symptoms and features to focus on integrating and processing the trauma rather than diagnosing a pathology of dissociation.

Based on the findings it is recommended that clinicians working in South Africa need to be aware that most of their child clientele would have experienced a trauma. Indicating to clinicians that a trauma informed approach needs to be taken when rendering therapeutic services to children living in South Africa.

5.3.3. Recommendations for Trauma Informed Policy Development

Due to the high rate of children who have experienced trauma it is recommended that stakeholders adopt trauma informed interventions and policies. The findings indicate that children experiencing trauma are widely impacted by these experiences. Implementing trauma informed policies and interventions will assist with deeper and longer lasting change. It is recommended that trauma informed care policies are developed for teachers, social workers, therapists, and any service providers who work with children in South Africa.

5.3.4. Recommendations for Universities

Throughout the research process the connection between the experience of trauma on children and the development of pathology was highlighted. The findings indicate that understanding trauma is vitally important for clinicians working with children. Therefore, it is recommended that universities training clinicians offer theoretical and practical courses which aim to develop skills and understanding related to trauma. Particularly for clinicians who render therapy to children as this will assist with preventing the development of pathology in adulthood.

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APPENDIX ONE:

Consent form and Information Sheet

Project Title: Clinician Perspectives on Dissociation while working with traumatized children in the South African Context.

Researcher: Ruth Prinsloo

This form is divided into two sections. Section 1 is the information sheet which gives the participant information on the research project. Section two is the consent form where the participant will give signed consent should they agree to participate in the research project.

Section 1: Information Sheet

Introduction

My name is Ruth Prinsloo and I would like to invite you to participate in this research project which forms part of my training in the clinical social work master's program at the University of Cape Town. I am doing research on the clinician's perspectives on dissociation while working with traumatized children in the South African context. I am going to give you information about the study here and invite you to be part of this research.

Purpose of the research

The Purpose of this research study is to gain a deeper understanding of dissociation in children who are traumatized in South Africa through the perspectives and experience of the clinicians who work with them therapeutically. I would like to learn more about how dissociation presents and develops in response to trauma for children in South Africa and the approaches to treatment of the clinicians who treat them.

Research Participation

Your participation in the research study will involve your participation in an interview discussion that will take about an hour.

Participant Selection

You are being invited to take part in this research study because of your experience as a clinician therapeutically working with children who have experienced trauma and live in South Africa. This experiential knowledge will contribute much to our understanding and knowledge of trauma related dissociation in children.

Voluntary Participation

Your participation in this research is entirely voluntary. It is your choice whether to participate or not. You may change your mind and withdraw your participation in the study at any point with no consequence to you at all.

Procedures

I am asking you to help me learn more about trauma related dissociation in children in South Africa. I am inviting you to take part in this research project. If you accept, you will be asked to be interviewed on a chosen date that suits yourself and I.

In the interview there will only be myself and you. I will be the researcher who will be inquiring about your experience working therapeutically with traumatized children who present with dissociation. I will ask you questions about how dissociation presents and develops among your child clients, the features and symptoms of dissociation you observe, how common dissociation is in your practice and what therapeutic interventions you have used in sessions with children who present with dissociation.

I will not ask you to share personal beliefs or stories about your clientele and you do not have to share any information that you are not comfortable sharing.

The interview will need to take place over Zoom and no-one besides myself will be present in the room during the interview. Should you rather request that we conduct the interview face to face that is also an option but strict CO-VID 19 regulations will need to be followed. The Zoom program as well as my cellphone will be recording the interview, this file will be kept safely on my laptop and be password protected. The information recorded is confidential, and no-one else except myself will have access to the recording and my supervisor may have access to the transcripts for verification. Should this be the case, strict confidentiality policies will be followed to ensure confidentiality. Should you not wish to answer any of the questions during the interview, you may say so and the interviewer will move on to the next question.

Right to Refuse or Withdraw

It is your right to refuse or to withdraw from this research project at any point. It is your right to withdraw or refuse to answer any questions during the interview.

Contact details:

Should you have any questions that you would like to ask, before or after the interview you are welcome to contact Ruth Prinsloo.

Ruth Prinsloo

Social Work Reg No: 1044158

Cell phone Number: 0715620354

Email Address: hoperuth89@gmail.com

Section 2: Consent Form

I, _____ volunteer to participate in a research project conducted by Ruth Prinsloo, a Clinical Social Work Masters student at the University of Cape Town for the completion of the Clinical Social Work Master's program. I understand that this research project is designed to study clinician's perspective on dissociation while working with traumatized children in the South African context. My interview will form part of the data of the aforementioned research project to gather insight into trauma related dissociation in children in South Africa.

As a _____ at _____, I understand that I am being invited to take part in an interview. I understand that in agreeing to participate:

- My participation is voluntary. I understand that I will not be paid for my participation.
- The interview will last approximately 60 minutes. Notes might be written during the interview and it will be recorded.
- I understand that if I feel uncomfortable in any way during the interview, I have the right to decline to answer any question or to terminate the interview session immediately.
- I understand that the researcher will not identify me in any way, including by name in the research report. My confidentiality as a participant will remain secure. Subsequent uses of recordings and data by the researcher will be subject to standard data use policies which protect anonymity of individuals and institutions.
- No other person will be present during the interview nor have access to field notes or transcripts of the interview. All data will be stored in a password protected space.
- If I choose to be interviewed, I have the right to view and comment on the transcribed interview data before the findings are analysed.
- I have read and understand the participant information sheet provided to me. I have had all my questions answered to my satisfaction, and I voluntarily agree to participate in this research project.

- I have been given a copy of this consent form.

hereby agree / disagree (circle the applicable option) to participate in the interview for this research project.

I hereby agree / disagree (circle the applicable option) to the recording of my interview for this research project.

Name _____

Signed _____

Date _____

APPENDIX TWO:

Data Collection Instrument

Section 1: Demographics

Demographics of Participant:

Name: _____

Date of Birth: _____

Gender: _____

Race and Ethnicity: _____

Profession: _____

Qualification(s): _____

University of Qualification: _____

Time in Practise: _____

Area of Practise: _____

Primary Therapeutic Framework: _____

Demographics of Child Clientele

Age group range of Child Clientele: _____

Average Socio-Economic Class of Child Clientele: _____

Race and Ethnicity range of Child Clientele: _____

Section 2:

2.1. On average how many children have you therapeutically treated that have experienced a trauma?

2.2. In your experience what are the different types of traumas that your child clientele experience?

2.3. On average how many children have you therapeutically treated that have presented with dissociation?

2.4. In your opinion what is the relationship between trauma and the development of dissociation in your child clientele?

2.5 In your experience what are the types of trauma you mostly see in your clients that result in dissociation?

2.6. From your perspective what is the function that dissociation plays in response to the trauma your child clientele have experienced?

2.7. In your opinion does the age of the child play a role in the severity of dissociation that develops in response to the trauma experienced, and if so what is your reasoning?

2.8. In your opinion what role does attachment style play in the development of dissociation?

2.9. From your experience what type of attachment styles do your child clientele who display dissociation have with their caregivers?

Section 3:

3.1. From your experience what symptoms and features of dissociation have you observed in your child clientele, please list them?

3.2. From your experience are there age specific symptoms and features of dissociation that you have observed in your child clientele, if so can you please list them?

3.3. In your opinion what are the symptoms and features of dissociation that needs to be observed in children for a diagnosis of a dissociative disorder?

3.4. In your opinion what are the diagnosis of dissociation that can be given to a child and which have you given to your child clientele?

3.5. In your opinion can dissociation present on a spectrum and if so, how would you describe this spectrum?

3.6. From your perspective are there symptoms and features you have observed in your child clientele that you have linked to dissociation that is generally not considered to be dissociation?

3.7. From your experience please describe what you have noticed about the self-structure-this being the psyche and inner world, of a child who displays dissociation? From your experience what have you noticed across your child clientele on the impact of the shaping of trauma and dissociation on how they present to you as their own person?

3.8. From your experience do children who present with dissociation have an awareness of the development and presence of their symptoms and features of dissociation?

Section 4:

4.1. Please give your professional understanding of dissociation.

4.2. Please indicate what your theoretical explanation of dissociation is - if you use one.

4.3. Are you aware of other theoretical explanations and understanding of dissociation, if so can you please name them.

4.4. In your opinion and understanding what happens from a biopsychosocial perspective to a child when a trauma is experienced and then dissociation is developed.

Section 5:

5.1. What therapeutic modality and methods do you use to treat a child client who presents with dissociation?

5.2. In your experience what are the intervention techniques you have used that have successfully integrated the trauma the child has experienced that is related to dissociation?

5.3. In your experience do you include the caregiver in your therapeutic work with children who display dissociation and if so how?

5.4. From your experience what activities and modalities do you use to facilitate the development and strengthening of attachment between the child clientele who presents with dissociation and their caregivers?

5.5. Do you apply psychoeducation and inform your clients and their caregivers about what happens inside the brain and the body from trauma resulting in the development of dissociation and if so how?

5.6. Do you give home activities or interventions to the family to assist with coping and healing related to dissociation? And if so what are these?

5.7. On average how long is a child who has experienced trauma and displays dissociation in therapy with you for?

5.8. From your experience what are the determining factors that indicate to you that therapy is completed with a child clientele who present with dissociation?