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USING HEALING PLAY TO REDUCE TRAUMA-RELATED SYMPTOMS OF SCHOOL-AGE CHILDREN: A SINGLE-CASE RESEARCH DESIGN

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Master of Philosophy
(Counselling Psychology)
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DECLARATION

STUDENT'S DECLARATION

I, ANGELINA AMOAKOWA MENSAH declare that this thesis, with the exception of quotations and references contained in published works, which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted, either in part or whole, for another degree elsewhere.

SIGNATURE: ………………………………………….…………

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SUPERVISORS' DECLARATION

We hereby declare that the preparation and presentation of this work was supervised in accordance with the guidelines for supervision of thesis as laid down by the University of Education, Winneba.

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DEDICATION

This thesis is dedicated to my mother Akosua Konamah, son Dodzi, Dr. Timothy Friesen and Dr. Hannah Emma Acquaye.

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ABSTRACT

Adversity is ubiquitous and occurs across the lifespan. When adults encounter trauma-related experiences, they often use words to express themselves. Children, on the other hand, use play and toys to express all these emotions that adults go through. Children in Ghana are expected to attend school, and the school is expected to provide psycho-social support to enhance their growth. However, despite GES's good intentions, public schools in Ghana do not have enough counselling-related support for students. It is in this vein that this study set out to explore if a five-session Child Directed Healing play therapy (CDHPT) could help children overcome their adversity-related experiences. CDHPT is a training given to both professional and nonprofessional adults to help children process their grief and frustration in a safe environment. In CDHPT, unique set of local toys are used to help children work through their trauma experiences. Using a single-subject research design within the quantitative approach, four basic school students were purposively selected from screened students. The ACEs questionnaire and Youth Outcome Questionnaire were used as instruments for screening and for pre-and-post assessment respectively. Results indicated that each of the participants had reduced indices between pre-test and post-test. These results, though exploratory, provide evidence that if willing and able adults are trained to support school counsellors, children will be able to get the psycho-social support needed in the school environment to help them effectively process their trauma-related experiences.

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CHAPTER ONE

INTRODUCTION

1.0 Introduction to the Chapter

This chapter exposes the reader(s) to the concept of play therapy, trauma and its related symptoms, and clinical-research work involving children. These variables are addressed through background to the study, statement of the problem, purpose of the study, objectives, and research questions. Additionally, the theory that drives the study vis-a-vis the conceptual framework is discussed. The significance of the study and delimitations or assumptions that underpinned the study are also addressed in this chapter.

1.1 Background to the Study

The cost of mental and behavioural disorders to the global economy is estimated at US$2.5 trillion (Bloom et al., 2012; WHO, 2012). In Ghana, 7% of the nation's Gross Domestic Product (GDP) is lost to mental health Issues. The prevalence of mental and behavioral disorders is about 10% of adult population with non-communicable diseases like asthma, dermatitis, urinary tract infections, hypertension, pulmonary diseases, and cancer in the lead. Adverse Childhood Experiences (ACEs; Felitti et al., 1998) increases adults' chances of having cancer, chronic pulmonary diseases, and stroke (Felitti et al., 1998; Monnat & Chandler, 2015; Centers for Disease Control [CDC], 2020). ACEs are those traumatic experiences that happen to a child before they reach 18 years (Felitti et al., 1998; Bartlett & Sacks, 2019). These experiences include, but are not limited to neglect, verbal abuse, physical abuse, psychological abuse, and sexual abuse, and having a parent with mental illness.

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A child is naturally wired to communicate through play, a medium that allows for optimum growth and development (Axline; 2012, 1974; Landreth, 2012; O'Connor, 2000). In play therapy, there is a vibrant interactive relationship between the child and a trained person. This trained person uses procedures and selected play materials to facilitate a therapeutically empowering environment for the child to explore and express themselves through play (Friesen, 2020; Landreth, 2012). Human adults have fully developed brains that allow them to put their feelings, anxieties, and personal problems into diverse verbal expressions (Landreth, 2012). Children, unfortunately, are not able to express themselves completely and coherently through verbalization. When children are provided the appropriate opportunity, they are able to express their frustrations, anxieties, and feelings through play. Thus, whereas adults use words to express themselves, children use toys to express themselves (Landreth, 2012; O'Connor et at., 2015). Thus, whether in joy or in adversities, while adults use words, children use toys and play.

Adversity is not restricted to adults or a certain race. When challenging experiences force people beyond their natural ability to cope, it is referred to as 'trauma' (Ball & Stein, 2012; Crowder et al., 2022). Traumatic experiences for children could include bullying in school, exposure to victimisation, neglect, abuse of varying forms, and exposure to violence at home (D'Andrea et al., 2012). Trauma leaves an imprint on anyone visited - child or adult - and it could be psychological but also physically. Trauma and trauma-related stressors can be revealed through somatic symptoms, hyperactivity/distractibility, aggression and conduct problems (van der Kolk, 1994, 2003, 2014).

When the effects of trauma persist, they become debilitating and prevent full functioning - whether in adults or in children. Some of the symptoms representative of

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the effects of trauma include re-experiencing, avoidance, hypervigilance, emotional numbness, and affect dysregulation (American Psychiatric Association [APA], 2013). Both adults and children exhibit this by demonstrating irritability, panic attacks, hopelessness, nightmares, and flashbacks. Loss of interest in activities for adults may look different for children. Also, self-destructive behaviors in adults which could include excessive alcohol or drugs could look different in children, maybe because of lack of access or lack of power.

When trauma is present, children between 0-5 years may become sensitive to noise and struggle with separation anxiety (APA, 2013). For children 6-12 years, they may exhibit dysregulation which is seen as emotional ups and downs. There have been other reports of 6-12-year-olds demonstrating unexpected mood changes, and learning problems (D'Andrea et al., 2012; Landreth, 2012). Reactions from trauma are attempts that the child makes to gain safety and achieve a sense of control - survival - the basic instinct for all mammals. When children are denied the chance to express their frustrations and anxieties through play, they have the tendency to act out.

1.2 Statement of the Problem

Globally, five out of every top ten deaths are caused by ACEs (CDC, 2012). More than two thirds of children report at least one traumatic event by age 16 (Substance Abuse and Mental Health Services Administration [SAMHSA], Trauma and Justice Strategic Initiative, 2012). These traumatic events occur within the community (at home and in school). In Ghana, most children are expected to be in school by their sixth-year post-birth, with a few aberrations that could be due to socio-economic and/or psychological factors on the part of the child and/or their caretakers. In the school environment, children are supposed to be given the conducive environment to thrive and succeed. Conducive environment includes available resources for teaching

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and learning, but more importantly, psychosocial support in the form of school counselling. According to the World Bank collection of development indicators, the percentage net of school enrollment for primary level was 86.16% (Ghana - School Enrollment, Primary (% Net) - 2022 Data 2023 Forecast 1999-2019 Historical (tradingeconomics.com).

Currently, Ghana Education Service requires that guidance and counselling is delivered at the school level and led by the Guidance and Counselling Coordinator (https://ges.gove.gh/girl-child/accessedonDecember 1, 2022).

According to the Guidance and Counselling Unit of the Ghana Education Service (GES, 2022), the Guidance and Counselling coordinator "shall lead the planning, coordination, and implementation of all activities in the school in collaboration with the school Head and other members of staff whose services may be required." These activities are done with a focus on vocational-related issues, academic or educational concerns, and personal-social themes. A priority programme for the Guidance and Counselling Unit is to eradicate all forms of violence against children in the schools. This is done by providing a safe, secure, and enabling environment for teaching and learning. This enabling environment involves all stakeholders, but more importantly, for the counsellor, whose training affords them the opportunity to pick up on psychological-related challenges of students.

Anecdotal reports indicate that for many basic schools in Ghana, there is no designated trained person to act as a school counsellor in the school. What pertains is that teachers end up doubling as counsellors. The conundrum is that teachers are overwhelmed with their daily class-related responsibilities, and may not have the needed capacity to address students' trauma-related challenges. If children are spending the greater part of the day in schools, it is reasonable to assume that their parents may

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not be able to pick up on their trauma-related symptoms. Moreover, parents may not have the necessary academic training to recognize when children's emotional dysregulation stems from psychological and not physiological challenges.

As of January 2023, there were 78 public basic schools in Winneba. Of this number, 26 were Kindergarten (K.G.); 27 were primary; and 24 were Junior High Schools (JHS). The total number of pupils in these basic schools was 14,516 (Education Management Information System [EMIS], of the Effutu Municipality, 2023; verbal communication). All the 14,516 students are served by three professionally trained counsellors. These professional counsellors are sometimes assisted by volunteer school based counsellors, most of whom are untrained.

This lack of awareness about psychological distress and challenges, coupled with inadequate psychological support in the schools, makes it challenging for children to effectively thrive in the school environment. Should there be a system of training for either professionals or trusted adults to provide this psychological support for children in the school, it will greatly enhance children's ability to express themselves and resolve their own emotional challenges in a healthy and conducive atmosphere. The ability to resolve their own emotional challenges primes children up for healthy attachment and citizenship, a core focus on the new educational reforms (Home - Ministry of Education Ghana (moe.gov.gh), accessed on December 1, 2022).

Although play therapy has been found to be an avenue where children can adequately express their emotions in terms of joy, sadness, excitement, frustrations, irritation, and grief, resolving their own trauma-related issues in the process, there seems to be very little empirical support of its efficacy. Majority of the studies done so far have been done outside of Ghana. In what seems to be the only study conducted and published so far in Ghana (Osae-Larbi et al., 2014), play was used to distract children

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during painful cancer treatment procedures. Results revealed researchers achieved their aim. Notwithstanding the fact that the results of the study indicated that the play intervention was effective, the population was made up of only clinical samples.

The researcher in the present study used non-clinical samples. This filled the population gap (Miles, 2017). In the same study, no clear methodology was identified as one that grounds the study. However, this present study uses the quantitative methodology, specifically the homogenous purposive sampling technique to select the sample for this study. By so doing, a methodological gap has been filled (Miles, 2017). Again, there seems to be no mention of the theory that guides their study. On the other, the Adlerian theory, the Child-Centered theory and the Incarnational theory were employed to underpin this study. Consequently, a theoretical gap has been filled (Miles, 2017). Furthermore, the addition of the results from the current study to existing ones and the publication thereof will contribute to knowledge and also fill an empirical gap (Miles, 2017).

1.3 Theoretical Framework

The researcher in an attempt to address the phenomenon employed the use of three theories: The Adlerian Individual Psychology (Corey, 2016), the Child Centered Theory (Jones-Smith, 2016), and the Incarnational Theory (Friesen, 2020).

1.3.1 Adler's Individual Psychology

According to Adler, human beings are social in nature and thrive on social interconnectedness. The need to be accepted and belong is inherent in every human being right from infancy till one exits the surface of this earth. Whatever happens in the life of a child, to a large extent, informs who the child becomes as an adult. For a healthy adulthood, one needs the love of family and significant others in the early stages of life. The lack of it makes one develop an inferiority complex (Corey, 2016 & Jones-smith,

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2016), where individuals see less of themselves and are unable to function fully within the society. In order for such a person to move from inferiority to superiority, the atmosphere of belongingness and social connectedness ought to be created so that the child will feel safe and be able to grow into a healthy adult.

1.3.2 Child- Centered Theory

Child centered therapy emanated from the Person-Centered Therapy by Carl Rogers where the individual with the presenting problem becomes the center of the therapeutic relationship (Corey, 2016). Thus, the therapy sessions are tailored to suit the pace of the client. In the same way, the child centered theory upon which the Child Directed Healing Play Therapy was built has the child at the center of the therapy sessions. The therapist is not allowed to lead but to follow the child's lead. With that the child takes control and is able to believe in their abilities and own initiatives. This tends to build the confidence level of the child and help the child in telling their story through play or the stories they share.

1.3.3 Incarnational Theory

The Incarnational Theory (Friesen, 2020) is grounded in the Christian tradition and built on the example of Jesus Christ. According to this theory and the Christian faith, God came to earth in the form of man - Jesus Christ - to offer mankind an escape from sin (destruction). Specifically, trained Child Directed Healing therapists minister healing to hurting adults and kids through the empowering of the Holy Spirit. This theory of change is termed “incarnational" because God’s love is invoked into the distress situation and the healing process. Children need love and care in order to have healthy psychological health and grow into healthy adults. Research shows that children who suffer neglect grow to have relationship and emotional regulation issues among others. However, when they are able to find that kind of love, care and devotion in a

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trusted adult in the community, this trusted adult serves as a surrogate to the child. The therapist who now serves as the surrogate is able to help the child work out some of the trauma related problems.

1.4 Conceptual Framework

A conceptual framework is a map that connects the variables in a study into a coherent whole. Specifically, it describes the association between and among study variables from a statistical frame of reference (Berman, 2013; Grant & Osanloo, 2014).

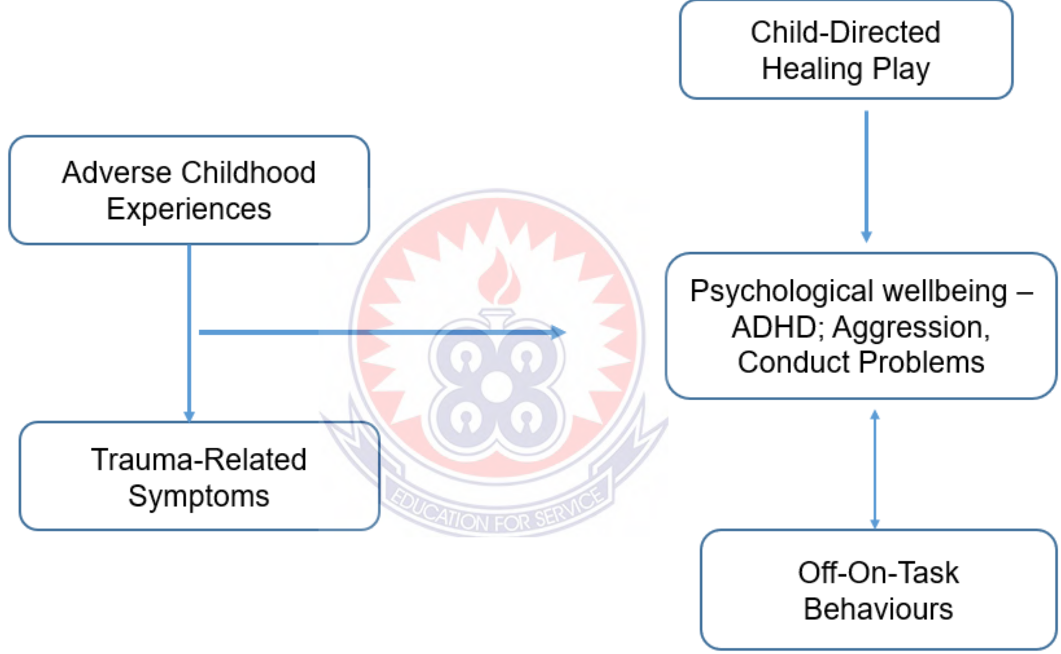

Figure 1: Conceptual Framework of Trauma and Play Therapy

Adverse childhood experiences which include diverse forms of abuse and neglect meted out to children (e.g., hitting, yelling at, lack of food, etc.) lead to trauma-related symptoms which affect psychological wellbeing. Psychological wellbeing is measured in multiple ways; however, this study focuses on aggression, conduct problems, and hyperactivity and distractibility, which are easily seen in school going children, either in the classroom or on the playground. The psychological wellbeing indices are further demonstrated in the off-on-task behaviors of children. These are

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behaviors normally seen as stage-appropriate or developmentally appropriate behaviors in children (e.g., Berger, 2020). For example, the attention span of a four-year old boy will be shorter than a 12-year-old boy. Therefore, if a teacher gives a developmentally appropriate assignment to a 4-year-old boy, the length of time required to sit still will be shorter than that required of a 12-year-old boy. The provision of Child-Directed Healing Play as a therapeutic intervention will affect psychological wellbeing and invariably off-on-task behaviors.

1.5 Purpose of the Study

The purpose of the study was to explore if a five-session Child-Directed Healing Play as a therapeutic intervention could help reduce trauma-related symptoms in school-aged children in a fishing community in Ghana. For the sake of this study, "pupils" and "children" will be used interchangeably.

1.6 Objectives of the Study

The following objectives guided the study:

1. Assess children's trauma-related experiences.
2. Assess children's psychological well-being.
3. Observe children in class to establish their off-and-on-task behaviours in the classroom of selected children at baseline.
4. Apply child directed healing play as a therapeutic modality and assess if there are changes in off-and-on-task behaviours in the classroom of selected children.

1.7 Research Questions

The study set out to address the following research questions:

1. What are the trauma-related experiences of a group of school-age children in as measured by the ACES inventory?

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2. What are the psychological well-being scores of a group of school-age children as measured by the Youth Outcome Questionnaire?
3. At baseline, what are the off-and-on-task behaviours in the classroom of selected school-age children?
4. Upon the intervention phase, what are the off-and-on-task behaviors in the classroom of selected school-age children?

1.8 Significance of the Study

Addressing issues of trauma in children is of great importance to the nation as it helps to cut down on the trillions of dollars of the national GDP lost to expenditures made on mental health issues. First, the findings of the study will help stakeholders (Ministry of Health, GES, parents) identify cost effective intervention that will help in equipping volunteer community based (trusted adults) counsellors with the requisite and age-appropriate skills for dealing with children's mental health challenges. These skills are necessary in helping the children within the community deal with their trauma-related symptoms which will eventually improve their overall wellbeing in the here and now and in their adult years.

As evidenced in literature, ACEs increases adults' chances of having cancer, chronic pulmonary diseases, stroke among other non-communicable diseases which forms a greater chunk of the nation's annual expenditure. Empirical evidence about adverse childhood experiences could significantly reduce ACEs-related physical health challenges. Invariably, a reduction in these symptoms would mean the country does not spend on medical insurance nor do they have to carry the burden of health due to absences from these adults.

Again, it will help the majority of the youth who find themselves in prison owning to their inability to self-regulate when triggered emotionally. Also, the Child

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Directed Healing Play when taught to trusted adults does not just benefit the children, but also the trusted adults themselves. Trained adults are first taught to process their own trauma issues before going out to help others to resolve their trauma related issues (Friesen, 2020). This will encourage trusted adults to serve as lay counsellors within their various communities as they stand to directly benefit from the training they acquire.

Furthermore, the training institutions engaged in teaching professionals and counsellors for the basic schools can adopt or adapt the intervention to boost the skills of trainees to be able to identify and help children they handle in their classrooms as it does not require any extensive training. Training takes approximately two weeks. Additionally, the school-based counsellors and the coordinators who are already in the system helping the children with their counselling needs can receive the training to boost their skills. In that way, GES will be sure of the appropriateness of the psychological help received by the children entrusted into their care. It will also help the children improve academically as mental health issues have a direct bearing on academic success of both the sufferers and all persons within the school environment.

Finally, the results from the study will serve as a groundbreaking research in the field of play therapy; this will be an aspect of training given to both with background knowledge about counselling and those without the formal training. This will likely arouse the interest of a body of researchers in the area to help bridge both the empirical and population gap that has existed over the years. Currently, there is a paucity of literature in the field of ACEs and Play therapy in Ghana, Africa and the world as a whole compared to other interventions in mental health research.

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1.9 Delimitation of the Study

Although there are varied forms of trauma symptoms that children encounter when they experience adversity, the researcher in this study captured only those arising out of ACEs. Moreover, there are six indices assessed by the Youth Outcome Questionnaire (YOQ): Social Isolation, Somatic Symptoms, Aggression, Conduct Problem, Hyperactivity/distractibility, and Anxiety/Depression. All of these are possible outcomes of ACEs. However, only three of these outcomes were the variables of interest to the researcher; Aggression, Conduct Problems, Hyperactivity/Distractibility. Also, only school-age children between the ages of 6-12 at a basic school in the fishing community were involved in the study.

1.10 Operational Definition of Terms

- ***Play therapy:*** Play therapy is defined as a developmentally sensitive therapeutic modality in which a trained play therapist uses the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development.
- ***Trauma:*** For the purpose of this study, trauma is defined as any child exhibiting signs of emotional dysregulation, specifically Aggression(A), Hyperactivity/ Distractibility (HD), and Conduct Problems (CP) as a result of Adverse Childhood Experiences (ACEs).
- ***Adverse Childhood Experiences:*** Adverse Childhood Experiences (ACEs) are traumatic experiences that children experience before they reach their 18th birthday.
- ***Emotional Regulation:*** Emotion regulation is the ability to exert control over one's own emotional state. It is a practice of cultivating a sacred buffer of time between feeling the emotion and your reaction to that emotion.

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- ***Emotional Dysregulation:*** Emotional dysregulation refers to experiencing difficulty when trying to diffuse or manage strong emotions, particularly those considered negative like anger, frustration, and jealousy.
- ***School-age Children:*** Children between the ages of six to twelve years. It is the Erikson's 4th stage of industry vs inferiority.
- ***Safe-adult:*** A Safe Adult is any person within the community; school, church, mosque, or home, who a child can go to if they ever feel unsafe, have ever been hurt, or if they're not sure if a situation is unsafe.
- ***Efficacy:*** This means how potent a five-session Healing Play Intervention is, in helping school-age children cope with aggression, hyperactivity/distractibility, and conduct problems.

1.11 Organisation of the Study

The current study is organized into five chapters. Chapter one is the introduction of the entire study where the background that grounds the study, the problem statement where gaps in past literature are identified, the framework (theoretical and conceptual), the purpose, objectives and research questions are discussed. Additionally, the significance, delimitation, operational definition of terms used and general organization of the study are equally discussed and outlined in this chapter.

Literature of past studies are reviewed in chapter two. In this chapter, literature on trauma, trauma-related reactions in children, effects of trauma in the school and at home, play therapy, effects of play therapy on emotional regulation and dysregulation, and finally, the diverse aspects and nuances of play therapy are synthesized.

Chapter three is the methodology that drives the present study. The chapter provides information about the protocol used to collect the data. It addresses the research paradigm adopted for the study, the research approach and research design. Thereafter,

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it explains the population, describes the type of sampling technique, and provides a sample size that is consistent with similar studies and standards for this design. The instruments used in data collection are explained. An overview of the data analytic plan is provided, and finally, ethical considerations for both research and counselling psychology are explored.

The next is chapter is chapter four and labelled results/findings. The chapter describes the limitations of the study, the participants, explains and discusses the results from the data collected, and connects the results to the literature reviewed.

The final chapter is chapter five. The chapter summarizes the major research findings and enumerates the contribution of this research work to knowledge. It also includes conclusions, implications and recommendations of the study. Suggestions for future research are also made.

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CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction to the Chapter

Chapter two synthesizes the literature on trauma, trauma-related reactions in children, effects of trauma in the school and at home, play therapy, effects of play therapy on emotional regulation and dysregulation, and finally, the diverse aspects and nuances of play therapy. The literature review is grouped under the following sub-topics: (a) understanding trauma; (b) trauma in children; (c) play therapy; (d) the Jacaranda Healing Play concept. The literature reviewed will form the base of the whole research.

2.1 Understanding Trauma

Trauma is described as an emotional response to a terrible external event, series of events, or set of circumstances (Myers, Bratton, Hagen, & Findling, 2011; APA, 2013). These events, series of events, or circumstances are experienced intimately and forcefully by a child or adult. The experience may be physically, cognitively and/or emotionally harmful or life threatening. The experience may also have lasting negative effects on a child or adult's functioning, including their mental, physical, social, emotional, or spiritual well-being. (Substance Abuse and Mental Health Services Administration [SAMHSA], Trauma and Justice Strategic Initiative, 2012; Gregorowski & Seedat, 2013). For an event to be considered traumatic there should be 3 key parts: First, something happened; secondly, perceived level of threat or danger experienced by a child or adult, and finally, the lasting negative effects after an event.

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2.1.1 Something Happened (Activating Event)

When a terrible occurrence like an accident, rape, or natural disaster happens, this unfortunate event serves as the activating event. An activating event is an event—current, past, or anticipated that triggers irrational beliefs and disruptive emotions (Beck & Emery, 1985; Ellis, 1956; 1958). It is any action that prompts an undesirable reaction. The event or circumstance may involve either actual harm or threats of physical or psychological harm.

Similarly, the activating event can either be an individual event or series of events that happen repeatedly over time. For example, if a child suddenly becomes aggressive towards others after the loss of her mother, the activating event here is the death of the mother. It is that single event (the loss of the mother) that has prompted the undesirable aggressive outburst in the child. In another instance, a 10-year-old child steals money from others at the least opportunity. After taking a preliminary assessment it was revealed that the behaviour of the child is as a result of being regularly starved by care-givers. In this instance, the activating event that is eliciting the undesirable externalising behaviour of the child is the starvation.

However, unlike the single activating event in the form of death as previously mentioned, the activating event (starvation) in this instance is a recurring phenomenon in the life of the child. As a result, the child steals in the anticipation that he or she is going to be starved and if that happens the stolen money could be used to buy some food. This is the first piece of the definition of trauma from a cognitive behavioural perspective.

2.1.2 Perceived Level of Threat or Danger

Individuals differ in their capacity to handle tragic events. An event that is traumatic to one person may not be traumatic to another. For example, a school-age

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child whose parents are divorced but is adequately catered for may not feel traumatised by the death of the parents no matter how the death occurred. On the other hand, depending on the personality, another child in the same developmental age may exhibit symptoms of trauma-and-related stressors because of the breakdown in the family unit and subsequent hardships being experienced (Friesen, 2020).

The trauma-related symptoms are also shaped by multiple factors. These factors include personality, cultural beliefs, availability of a positive support system, and emotions experienced by the child. Another factor that could shape the symptoms include chronological age and developmental stage of the child. For example, there is a difference between the concrete understanding of a 6-year-old and the abstract understanding of a 10-year-old. All these factors impinge on how traumatic events are experienced by different people at different chronological and developmental states of life (Corey, 2016; Jones -Smith, 2016).

2.1.3 Lasting Negative Effects after an Event

Response to trauma could either be concurrent or delayed. There could be an Immediate response that occurs as the activating event is ongoing, or delayed reaction either immediately after the event or in the unforeseeable future. The duration of reactions can be short term or last a lifetime. Again, the effects of trauma can affect our emotions, behaviours, spiritual life, and physical state. It is important to understand the effects of trauma as we listen to stories from victims of trauma because the effects may play out differently in different people and at different times.

2.2 Trauma and the Child's Brain

In the psychology literature, several experts are credited with different child development theories (Nelson et al., 2006; Capuzzi & Stauffer, 2016). Two of the popular theories are Jean Piaget's theory of Cognitive Development and Lev

Vygotsky's Social Development Theory. These theorists agree that children's brains start developing in-utero and from birth, continue to develop through connections with their daily experiences (Corey, 2016; Jones-Smith, 2016). Attachment theorists like Bowen and Ainsworth connect brain development of infants to their early attachments with caregivers. These attachment theorists agree with developmental theorists that interactions with significant caregivers as well as the environment stimulate children's brains. The stimulation and connections last for a lifetime. Therefore, what a child experiences in childhood lasts throughout their development till death.

Between the ages of two years to six years, children's perception, coordination, language, attention, and imagination improves greatly. It is believed that the size of the brain increases to almost the total (from 70% to 90%) of its adult weight (Nelson et al., 2006). While the brain is developing, secure attachment and bonding with primary caregivers are considered to be very important. This is because between 12-18 months, children's attachment patterns are relatively stable, and these patterns are reported to predict how well a person relates to others in adulthood (Capuzzi & Stauffer, 2016).

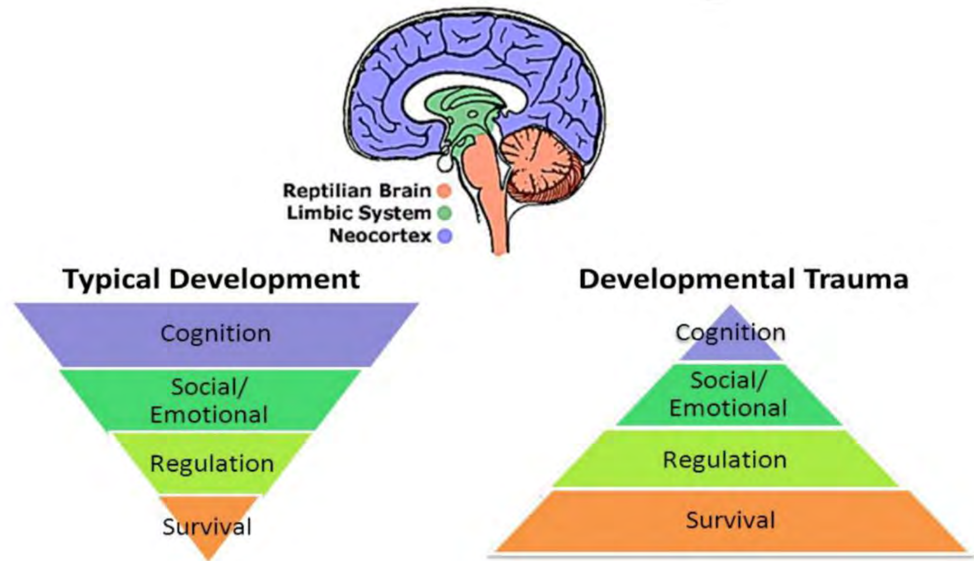

Figure 2: Trauma and Brain Development
Source: Adapted from Holt and Jordan, Ohio Dept. of Education (2020)

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2.2.1 Trauma in Children – Adverse Childhood Experiences (ACEs)

Trauma is not reserved for only adults. It can happen to any individual regardless of the developmental stage of life. It happens to all persons across the lifespan (Crowder et al., 2020). According to the Substance Abuse and Mental Health Services Administration [SAMHSA], Trauma and Justice Strategic Initiative, (2012), more than two thirds of children report at least one traumatic event by age 16**.** Total annual costs attributable to ACEs were estimated to be US$581 billion in Europe and $748 billion in north America. More than 75% of these costs arose in individuals with two or more ACEs (Bellis et al., 2019).

Adverse Childhood Experiences (ACEs) are traumatic experiences that children experience before they reach their 18th year. These experiences can have lasting impact on their mental health, physical health, and general well-being. The World Health Organization (WHO) defines ACEs as stressful occurrences in a child's life. The Center for Disease and Control, CDC (2020) describes Adverse Childhood Experiences (ACEs) as highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust, or bodily integrity. They are specific events that happen to children, within their immediate environment, and mostly involve their caregivers. These adversities include but not limited to abuse and neglect. Abuse includes physical, sexual, verbal, and emotional. Neglect encompasses physical, emotional, mental illness of household members, mental illness of parents, a family member who is in prison, witnessing a household member being abused, losing a parent through divorce or separation and losing a breadwinner through death.

Although ACEs take place at the early stage of life development, its impact can be either acute, chronic, or both. Thus, the effect of an adversity can manifest shortly

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after the incidence, or delayed till a future date. Also, ACEs can be either life altering and last a lifetime, or even end one's life. Adversity can affect development in myriad ways, and at different developmental stages. However, early exposure is likely to leave lasting impact (Bellis et al., 2019). It is also worth knowing that there are contextual variations to the discussion: type of adversity, duration of adversity, developmental status and critical period timing. Included also is the number of adversities and the interaction among them, exacerbating factors, supportive family environments, and individual variation of pre-existing characteristics.

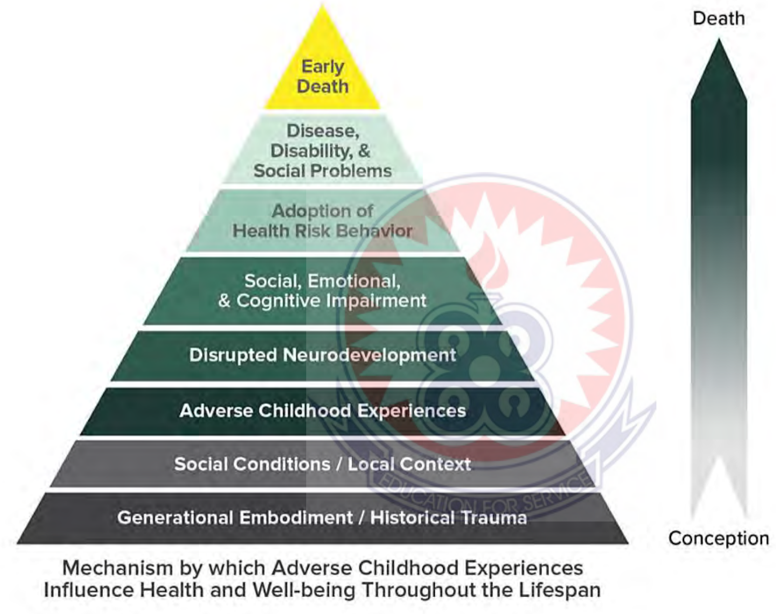

Figure 3: The ACEs Pyramid

Sources: Centers for Disease Control and Prevention (2020a; Felitti et al., 1998).

ACEs have both physical and behavioral outcomes that influence health and wellbeing throughout the lifespan by disrupting neurodevelopment, impairing social, emotional and cognitive development, adoption of health-risk behaviours, disease, disability and social problems, and early death (CDC, 2020; Felitti et al., 1998). Severe childhood trauma raises the risk of other mental health issues, such as post-traumatic

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stress syndrome (PTSD), self-harm or suicidal tendencies, and conduct problems. When there is Generational history of Trauma, unfavourable local social conditions become a trigger. In such instances, sufferers become perpetrators.

A groundbreaking study was conducted by the Centers for Disease Control and Prevention (CDC), in conjunction with Kaiser Permanente between 1995 to 1997. The goal of this first study of ACEs was to come up with a framework for this concept. Over 17,000 Health Maintenance Organisation members from Southern California receiving physical exams and also completed confidential surveys regarding their childhood experiences (including abuse, violence, neglect, and abandonment) and current health status and behaviours. An estimated 66% of responders revealed that they had experienced at least one ACE; 20% had experienced three ACEs. The researchers noted connections between experiencing ACEs and detriments to one's physical health years later, including heart disease and cancer (CDC, 2020). In a 2014 UK study on ACEs, 47% of people experienced at least one ACE with 9% of the population having 4+ ACEs (Bellis et al., 2014).

Children also have their fair share of traumatic experiences which may present in a wide range of symptomatology (Szymanski et al., 2011) ranging from Somatic (S), Social Isolation (SI), Conduct Problems (CP), Aggression (A), Hyperactivity/Distractibility (HD), to Depression/Anxiety (DA) (Burlingame et al., 2002; Szymanski et al., 2011).

2.2.2 Childhood Trauma and Somatic Symptoms (S)

Somatic symptoms are a disorder that is characterized by extreme attention on physical symptoms like pain or fatigue (Diagnostic and Statistical Manual of Mental Disorders, [DSM], APA, 2013). The focus on the pain causes major emotional distress and can cause dysfunction in everyday activities (APA, 2013). Past and present studies

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(Bonvanie et al., 2015; Flaherty et al., 2009; Hart et al., 2013; 2017; Lee, 2020) have pointed to a strong association between childhood trauma and somatic symptoms in children, indicating a high adverse effect both concurrently and in the unforeseeable future. Somatic symptoms are commonly understood as subjective reports of physical discomfort without an identified cause. Some Common somatic symptoms in children include headaches, dizziness, stomachaches, fatigue, and muscle tension or pain and troubles related to sleep (APA, 2013; Burlingame et al., 2014; Campo, 2012; Lee, 2020; Williams & Zahka, 2017).

The presentations of somatic symptoms are dynamic in the interactions among biological (e.g., sex and onset of puberty), psychological (e.g., insecure attachment, anxiety sensitivity, and depression), and socio-environmental factors (e.g., childhood trauma, social capital, and peer victimization (Engel, 1981; Hart et al., 2013; Ibeziako & Bujoreanu, 2011; Kugler et al., 2012; Nelson et al., 2017; Susman et al., 2003; Waldinger et al., 2006). Thus, symptoms are best viewed from a biopsychosocial perspective and not teleological view. Campo (2012) reports that there is a widespread of somatic symptoms in community based as well as clinical samples of children and adolescents.

2.2.3 Childhood Trauma and Social Isolation (SI)

Social isolation has been described as having few people to interact with regularly and/or the lack of social contacts (www.nia.nih.gov). Some of the symptoms of social isolation could include insomnia, poor self-care, anxiety, lethargy, and aggressive behavior. Research has shown that children with ACEs find it difficult to develop age-appropriate peer and adult relationships, thereby isolating themselves from others in their social circles (Brunzell et al., 2016). They find it difficult to form healthy relationships that are relevant to the growth of every growing child. When we consider

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Erikson's psychosocial stages (Corey, 2017), school-going age children fall within the third to the fifth stages. Specifically, people grapple with the initiative versus guilt continuum where they develop the basic virtue of purpose. During the next stage, they navigate the industry versus inferiority continuum where they develop the basic virtue of competency. They finally fall in the group of identity versus role confusion continuum and work towards the basic virtue of fidelity. Thus, if people within these stages struggle with social isolation, then the crux of their development is called into question, and they may struggle to transition to higher stages effectively.

2.2.4 Childhood Trauma and Conduct Problems (CP)

Conduct Disorder is a DSM-5 diagnosis that is typically assigned to children (18 and below) who habitually violate the rights of others (APA, 2013). These children will not conform to their behavior to the law or social norms appropriate for their age. Conduct Disorder may also be described as juvenile delinquency behavior patterns which will bring a young person into contact with the juvenile justice system, or other disciplinary action from parents or administrative discipline from schools. Conduct Problems are described by Burlingame and fellow researchers (2004) as socially related problematic behaviours. They are delinquent behaviours for which a care-giver will seek the help of a therapist for a child. These delinquent behaviours include destruction of property, telling of lies, stealing, breaking of social rules, and disrespecting others.

According to DSM-5, the symptoms of conduct disorder include four or more of the following: Aggressive behavior toward others and animals; frequent physical altercations with others; use of a weapon to harm others; deliberately physically cruel to other people; deliberately physically cruel to animals; involvement in confrontational economic order crime - e.g., mugging, has perpetrated a forcible sex act on another, property destruction by arson, property destruction by other means; engaging in non-

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confrontational economic order crime (e.g., breaking and entering); engaging in non-confrontational retail theft (e.g., shoplifting); disregarding parental curfew prior to age 13; running away from home at least two times; and being truant before age 13.

It has been found that the rate of Conduct Disorder resulting in adult criminality is as high as 50% (Bonin et al., 2011). Middle childhood to middle adolescence is the time frame where Conduct Disorder symptoms are most apparent, come to parental/educational/clinical attention, and seen to be more frequently diagnosed in boys than in girls (APA, 2013). Neurological malfunction in the amygdala and the orbito-frontal cortex are implicated in the clinical manifestations of Conduct Disorder. The inability to self-regulate combined with a more activated fear/anger center is an alignment for the production of dysregulated behavior (Finger et al., 2011). Children who suffer ACEs have difficulty self-regulating and may become defiant to authority and cause destruction to others and property. Consequently, these children produce poorer academic outcomes, and are subject to greater disciplinary actions (Wolpowet al., 2009). Moreover, lack of economic opportunity is frequently cited in literature as a cause of delinquency, as well as parental criminality, and youths having unoccupied/unsupervised time (Felitti et al., 1998; CDC, 2020).

2.2.5 Childhood Trauma and Aggression (A)

Aggression in children can be understood as exhibiting or engaging in physical violence towards or with others (Momeni & Kahrizi, 2015). It is any harmful externalising behaviour towards adults or peers. Issuing threats against others, biting, kicking, scratching, hitting, and engaging in physical fights are some of the descriptors of aggression in children (Burlingame et al., 2004).

Abend et al. (2018) have posited that intense or prolonged pediatric mental distress caused through attention bias to threat are likely to trigger aggression in

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adolescents. Children who have experienced adversity develop their violent attitudes and behaviors through inhibition of emotional regulation in the limbic system, which makes them more vulnerable to threats by enhancing attention bias to fear-related information and associating it with past painful episodes. As a result of failing to control their attention in the brain, abused youths are more likely to suffer from psychological distress while developing violent behaviours in response to potential threats in society (Momeni & Kahrizi, 2015). ACEs, major negative life events during childhood are associated with pervasive health-risk behaviors and social problems including aggressive behaviors, especially throughout childhood and early adolescence (Harris, 2018; Hildyard & Wolfe, 2002). Existing literature indicate a comorbidity between aggression and other behavioural disorders (APA, 2013; Hildyard & Wolfe, 2002). This means that aggression and other behavioural disorders generally go hand-in-hand.

2.2.6 Childhood Trauma and Depression/Anxiety (DA)

The Center for Diseases Control and Prevention describes anxiety as the presence of so many fears and worries that interfere with school, home, and play activities, and depression as a prolonged or persistent feeling of sadness disinterest in activities that used to be fun and hopelessness in situations that are within the child's control. Children are more likely to develop anxiety or depression when they experience trauma or stress resulting out of maltreatment, bullying, or rejection. Biological history of anxiety or depression have been found to be a cause as well.

A cross-sectional study subject of 180 homeless individuals in the south-central U.S. found a link between people who more frequently suffer from traumatised youth experiences and their risks of anxiety (Munoz et al., 2018). When the researchers measured the participants' levels of PTSD, anxiety, and adverse experience with PTSD-8, GAD-7, and ACEs scales, the results showed that PTSD brought by ACEs positively

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associated with their anxiety levels while exerting their attention to the remembrance of past adverse episodes (Munoz et al., 2018). In other words, the brain under the influence of ACEs cannot control attention to threats and thus prompts abused children to readily access adverse memories as fear stimuli when they face even minor stressful events. In such circumstance, the child is psychologically distressed, prompting aggressive outburst due to increased anxiety levels (Cheng & Ray, 2016; Gregorowski & Seedat, 2013; Szymanski et al., 2011).

Similarly, a study about an association between threat bias and anxiety in youth, the researchers gathered 1291 participants aged 6–18 and measured their attention bias and severity of anxiety symptoms by using the visual dot-probe task and questionnaire of the Screen for Child Anxiety Related Emotional Disorder, respectively (Abend et al., 2018). The statistical data revealed threat bias significantly correlated with social anxiety and school phobia, regardless of age and gender (Abend et al., 2018). Thus, the higher sensitivity to threat that children have, the more severe the social and school anxiety they will experience.

In another study conducted by Jiang, Ji, Chi & Sun, (2022) in China showed a higher prevalence rate of depression and anxiety symptoms that are ACEs related in girls than in boys. School-aged children, according to Weinstein et al. (2000) have heightened levels of psychopathology, including severe fears and anxiety when faced with a wide range of situations (Gregorowski & Seedat, 2013; Weinstein et al., 2000).

2.2.7 Childhood Trauma and Hyperactivity/Distractibility (HD)

Following an initial symptom of distress, some children over time develop sustained psychological difficulties including behavioural symptoms (CDC, 2020; Naderi et al., 2010; Schilpzand et al., 2017). Schilpzand et al. (2017) in their study of a group of Australian children between the ages of 6-8 revealed that Among those with

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ADHD, trauma-exposed children had higher parent-reported ADHD severity and more externalizing problems than non-exposed children. They argued that children with ADHD were more likely to have experienced a traumatic event than controls. The researchers suggested that the high prevalence of trauma exposure suggests that clinicians should evaluate for trauma histories in children presenting with ADHD. In another research, Brunzell and colleagues it was shown that children with ACEs display hypervigilance, and have problems with attention, decision making, and impulsivity (Brunzellet al., 2016). These children have poorer academic outcomes, and are subject to greater disciplinary actions and have issues with the juvenile system (Wolpowet al., 2009). In the long run, it affects their chances of employment, job sustainability, and economic freedom.

2.3 Play Therapy

Play therapy is defined as a developmentally sensitive therapeutic modality in which a trained play therapist uses the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development (Axline, 1974; Landreth, 2012). Many children struggle to verbalise their feelings (Friesen, 2020; Landreth, 2012), play is therefore the medium through which they communicate by acting out stressful issues, and eventually, resolving these issues in an accepting and safe environment (Axline, 1974; Landreth, 2012).

2.3.1 Approaches to Play Therapy

There are several approaches to play therapy. Whereas some of these approaches are based on traditional counselling and psychotherapy theories (e.g., Adlerian, Gestalt, and Cognitive behavioral; Corey, 2016), others (e.g., Child-Centered, Child Directed Play, Filial, Jacaranda Child Directed Healing Play Therapy) are uniquely created for play therapy. Virginia Axline is credited as the mother of play

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therapy. Her model, originally named *nondirective play therapy*, has also been referred to as client-centered play therapy (Dorfman, 1951) and child-centered play therapy (Ginott, 1959). Child-Centered play therapy has been found to be an effective intervention in reducing trauma related symptoms in elementary school students who were ethnically and socio-economically diverse (Meany-Walen et al., 2017; Swank et al., 2015).

Child Directed Play is a special form of one-to-one play between a therapist and the child in which the child directs and leads the play. Child Directed Play therapy can be used with children who are between about 2 and 10 with slight adjustments for age or developmental level (Friesen, 2020). Research shows that playing with a child in this way can build a sense of self-direction and self-confidence in the child, foster child language and social development, allow the child to receive focused attention without having to misbehave to get it, strengthen caregiver-child bond, and help practice parenting skills (Axline, 1974; Friesen, 2020; Landreth, 2012; Meany-Walen et al., 2017).

People may argue about the seriousness of play therapy. It takes a unique skill set to provide unconditional positive regard for a child and trust the general process to allow the child to work out his or her issues. Porter and colleagues agree that "many parents have difficulty understanding that a therapist is 'playing' with their child and find it hard to understand how this will help their child resolve problems" (Porter et al., 2009, p. 1032). In the play therapy relationship, a child is not inhibited by social and cultural cues that occur at home during parenting. Thus, the child discovers self as a unique individual, while exploring new ways to adjust to human relations – family and social ones included (Axline, 1974). Generally, when children come for play therapy, it is because some significant adult in their lives sees a problem and recognizes the

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wisdom in asking for help. When a person is physically sick, they go to a doctor for help. Similarly, when a person is psychologically unwell, they seek help from a psychotherapist. In all the various approaches to play therapy, therapists strive to display respect for the child, autonomy in action, and responsibility for choice (Axline, 1974; Friesen, 2020; Landreth, 2012).

2.4 The Jacaranda Healing Play Concept

The Jacaranda Communities of Hope, led by Dr. Friesen, came up with Jacaranda Healing Play concept with the sole purpose of demonstrating love to children going through trauma and suffering. This approach to working with children was named "Self-Directed Healing Play Therapy." Self-Directed Healing Play therapy is a biblically based play therapy that seeks to inspire humanity to see an alternative to a hitherto hopeless situation in perilous times (Friesen, 2020). In this work, "Self-Directed Healing Play", "Child-Directed Healing Play", and Healing Play therapy" will be used interchangeably.

Healing play therapy provides a structure and nurturing in equal measures and creates the space for what has been termed the 3Ts. These 3Ts are-Time (time structured intervention); Telling (allow the child to tell their stories); and Tears (creates the space for the child to express their emotions).

2.4.1 Components of Healing Play

There are some components that make up the Healing play therapy. These components form the backbone of the Healing play intervention. It is the basis upon which practitioners of healing play provides healing to hurting children (Friesen, 2020). These are 1) Structuring, 2) Empathic Listening, 3) Interactive Play, and 4) Limit Setting.

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1) **Structuring**: It is the setting up of an environment that provides safety and consistency, and gives the message that the adult is there for the child. Structure for each healing play is set using the following guidelines: On the first day it is important to introduce yourself and ask for the child's name. The mat is used to create a specific space where healing play will occur. Every day the therapist must say, "You are welcome to join me on the mat. We have this special time together for you to use my toys in this bag. Many children like to play with the toys. (Holding the bag open and presenting it to the child). You can do whatever you like. If there is something I do not want you to do, I will tell you." After the introduction, the therapist then hands the bag to the child like giving the child something special. It is fine to encourage the child to look into and play with the toys, but the child cannot be forced. Five minutes prior to ending a play session (first bell) the therapist must say, "There are five minutes left." Some children do not understand five minutes, but they learn that five minutes means they are almost done. Until the sound of the second bell which signals that your healing play session is finished, no cleanup is done. However, if the child starts to put the toys away after the first bell, the therapist can say, "we still have time today, I will tell you when we are finished" or "You can continue to play however you like." Finish and clean up comes after the second bell. This structure is consistent across healing play sessions and in all countries and settings.

2) **Empathic Listening:** Listening with the ears, seeing with the eyes, and feeling with the heart. This is the aspect of healing play when full

attention is given to the child (gift of PRESENCE) and what the child is doing, focusing on the way the child plays and draws, and how the child expresses emotions through his or her play. The adult does not lead the play or even offer suggestions. Ways to get involved in the play session includes: -Expressing what you see the child doing like a commentator. You observe and then put into words what you see, for example, "the big man is walking away from the child". The therapist tries to make a comment every 1-2 minutes, so that within 20 minutes about 10-20 comments have been made, making sure neither to talk too much nor too little, but working on finding the balance of how much to say. Emotions that are observed being demonstrated by the child are identified.

3) **Interactive Play:** Interactive play involves getting involved in the play at the invitation of the child. The child is in charge and might want the therapist to play a certain role. Generally, a child will give feedback if the role is not played correctly. Sometimes the child will give correction and information on how to play, and other times the therapist might need to ask how to play your part.

4) **Limit Setting:** Limit setting is part of the structure of all play therapy interventions (Landreth, 2012). Limit setting is a three-step process in Healing Play therapy: firstly, when the therapist believes that the child is going to act in a harmful or destructive way, the first step is to create a limit. Secondly, if the child breaks the limit a second time with the same action, the same information is repeated and the consequence is to stop healing play early if they disobey again. Finally, if the child disobeys a third time, the therapist follows through with the

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consequence and ends the play. This structure in play therapy provides consistency for the child, while teaching them responsibility and accountability (Landreth, 2012).

2.4.2 Tenets of Healing Play

The Jacaranda Healing Play premises on 5 Ps: Presence, Prayer, Partnership, Posturing, and Patience.

1) **Presence:** *Presence* is demonstrated in the unconditional relationship that the therapist gives to the child. *Presence* in Healing Play Therapy is seen as a gift of the complete personhood and presence that the therapist gifts to the child. It is also the gift that the therapist receives from the child in the form of any emotion, verbal and non-verbal narrative received from the child in the here-and-now (Chari & Friesen, 2022; verbal communication). Thus, with "presence" the therapist is present to receive the child's pain, joy, hold the child's tender feelings, allow expressions of anger, and receive a child's story. A safe space is created on a mat where there is structure for the child to be able to feel at ease and be able to externalize all those internalized emotions. These are some Biblical scriptures that the concept developer grounded the tenet of Presence on – (Matt.18:20, NIV): "For where two or three are come together in my name, there am I with them." – (Is. 41:10, NIV) "Fear not, for I am with you; be not dismayed, for I am your God; I will strengthen you, I will help you, I will uphold you with my righteous right hand." God is present with us. – (Ps.16:1, NIV): "You make known to me the path of life; in your presence there is fullness of joy; at your right hand are pleasures forevermore." God's presence brings us joy; in the same way, the therapist's presence is meant to bring joy to the child.

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2) **Prayer:** Prayer in itself is seen as one of the tools through which healing is obtained from God. The Healing Play therapists is mandated to offer prayers to God and for their clients during and after sessions. This enables them to gain deeper insight into the child's problem through the empowering of the Holy Spirit. Being attentive to the children and alert for prompting of the Holy Spirit is highly recommended. For therapists who are not Christians, they are recommended to focus on the 'object' of their sacred, center themselves, and use their being to project healing in a sacred space.
3) **Partnering:** Therapists see themselves as invoking God's presence in partnership with the Holy Spirit who provides the ability to use reflections in a way that enables healing. Under "Presence", the mat represents a sacred and safe place for the child where help is obtained, and without the help of the Holy Spirit the Helper "can do nothing". In addition, the therapist sees themselves as a partner with a child. The therapist's role is to assist a child as the child shares his/her story with you. You are not with the child to take charge (prompt the child of what to say or do, correct the child, or give advice) of the situation as a teacher or parent might do. You are there to love the child and through your presence, bring hope.
4) **Posturing:** The therapist's posture and proximity to a child on the mat can help a child feel safe. It is recommended that the therapist maintain eye contact and lean towards the child while in session. However, there are some children who struggle with feeling safe because they live with violence and may need to keep their distance from the therapist. Some children may seek physical contact through wanting to sit on your lap or holding your hand. Physical contact for these children can be healing. If a child is shy, physical

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contact is not forced. In all instances of play therapy, touch is used circumspectly and in a culturally appropriate manner (Landreth, 2012).

5) **Patience:** Although it is important to mirror what the child is saying or demonstrating in session, the therapist ought to be careful in order not to be in charge. You need to know when to or not to reflect. Ultimately, the presence of the therapist is what the child needs. Rely on the Holy Spirit to know when to speak or when to be silent. Also, you may need patience for a child who is very shy and does not talk or play with the toys. Some children will wait for you to tell them what to do because this is what they typically expect from adults. However, patiently waiting communicates that it is fine to take their time to decide what to do. It is very important for each child to feel safe to create trust.

2.5 Play Therapy in Ghana

In Ghana, anecdotal reports indicate that play therapy combined with some form of art and drama are being used in a few places. Some of these places include the children unit of the Koforidua hospital, as well as the oncology unit of the Korle-Bu Teaching Hospital. In as much as there are reports on these interventions being helpful for children, to the best of my knowledge, there has been only one empirical evidence of their efficacy with the client samples they serve. In this study by Osae-Larbi et al. (2014) at the children unit of the Korle-Bu Teaching Hospital, play was used as a destruction for children receiving cancer treatment. In as much as they met their aim, the study made use of only clinical samples. Again, there was no structure to the play, and no information on who qualifies to apply the intervention. No mention was made of the sample size, study design nor the demographic information of the participants and their care-givers.

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It is apparent that there is a dearth of research investigating the use of play therapy in both clinical and non-clinical samples in Ghana. Anecdotal evidence supports the efficacy of Healing Play therapy for both trainees and children in trauma-based environments. Multiple countries have benefited from Healing Play during both natural and man-made disasters. In many cases, adults are supplied with food and shelter and children's psychological needs have been left untreated. The Jacaranda Communities of Hope, through the Healing Play therapy, have served children in Syria, Nigeria, Lebanon, Zimbabwe, Kenya, Mozambique, and more recently, in Mongolia(https://www.facebook.com/search/top?q=twelve12%3Ahope). Consistently, both trainers and trainees are admitting how helping the program is, first for themselves as they go through the training, and secondly for the children and how much healing they see them experiencing.

2.6 Chapter Summary

This chapter explored trauma, specifically trauma as it affects children. The chapter has also examined how adverse childhood experiences affect children and later in their adult years in terms of psychological and physical health. The bulk of the chapter took an in-depth knowledge of Healing Play, the intervention that grounded the study. Literature looked at the concept and tenants of Healing play, vis-à-vis countries and client samples that have benefited from Healing Play. Finally, the lens was brought to Ghana to examine how play therapy has worked, empirically and clinically, with both children and adults in Ghana.

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CHAPTER THREE

RESEARCH METHODOLOGY, MATERIALS AND METHODS

3.0 Introduction to the Chapter

This chapter provides information about the protocol used to collect the data. It addresses the research paradigm adopted for the study, then explores the research approach and research design. Thereafter, it explains the population, describes the type of sampling technique, and provides a sample size that is consistent with similar studies and standards for this design. The instruments used in data collection are explained, providing evidence for their efficacy. An overview of the data analytic plan is provided, and finally, ethical considerations that satisfy both research and counselling psychology are explored.

3.1 Research Paradigm

Experts agree that the research paradigm is a philosophical framework upon which the research is grounded (Bryman, 2015; Gall, Gall, & Borg, 2007; Patten & Newhart, 2018). Research paradigms form the philosophy of research projects and drive the methodology used in the research. Moreover, knowledge of these philosophical foundations has the tendency of increasing the quality of the research and improving the performance of the diverse analyses that are used in understanding the data (Bryman, 2015). A research paradigm consists of the research philosophy and the research methodology. Specifically, a research paradigm consists of ontology, epistemology, and research methodology.

3.1.1 Ontology

Ontology seeks to find an answer to the question, “what is reality?” (Bryman, 2015; Moon & Blackman, 2014). According to Moon and Blackman (2014), ontology

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deals with the truth claims that a researcher can make about reality, specifically, how researchers deal with different and conflicting ideas of reality (Figure 4).

Realism: one reality			Relativism: multiple realities exist	
Naïve realism	**Structural Realism**	**Critical Realism**	**Bounded Relativism**	**Relativism**
Reality can be understood using appropriate methods	Reality can be described by scientific theory, but its underlying nature remains uncertain	Reality captured by broad critical examination	Mental constructions on reality are equal in space and time within boundaries (e.g., cultural, moral, cognitive)	Realities exist as multiple, intangible mental constructions; no reality beyond subjects.

Table 4: Ontological Perspectives

Source: Adopted from Moon and Blackman (2014)

Ontological approaches range from realism to relativism. Realism holds the philosophical assumption that reality can be understood using appropriate methods (Moon & Blackman, 2014; Patten & Newhart, 2018). Relativism, on the other hand, believes in multiple realities that can co-exist. While these two are at the end of a continuum, there are multiple nuanced ontological perspectives that range from naïve realism to bounded relativism (see Figure 4).

This study was grounded on the realism ontological perspective. The position was guided by the researcher's belief that trauma in children can be understood using appropriate methods (e.g., Adverse Childhood Experiences scale to assess children's trauma-related experiences; Youth Outcome Questionnaire to assess well-being related behaviours).

3.1.2 Epistemology

Epistemology answers the question, 'how is it possible to know reality?' Specifically, epistemology deals with the 'how' of knowledge gathering as well as the sources from which this 'knowledge' is gathered (Bryman, 2015). Epistemology

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influences how researchers frame their research in their quest to discover knowledge. According to Moon and Blackman (2014), and Patten and Newhart (2018), epistemology ranges from 'objectivism' through 'constructionism' to 'subjectivism' (see Figure 5).

Objectivism	Constructionism	Subjectivism
Meaning exists within an object: an objective reality exists in an object independent of the subject	Meaning created from interplay between the subject and object: subject *constructs* reality of object	Meaning exists within the subject: subject imposes meaning on an object

Table 5: Epistemological Outlooks

Source: Adopted from Moon and Blackman (2014)

According to Moon and Blackman (2014), 'Objectivism' epistemological perspective subscribes to the belief that meaning exists in an objective independent of the subject. 'Constructionism' on the other hand believes that meaning is created from an intersection of the subject and the object. Specifically, the subject constructs the reality of the object (phenomenon). Finally, 'subjectivism' epistemological perspective believes that meaning exists within the subject and that the subject has the ability to impose meaning on an object (Moon & Blackman, 2014).

This research study was grounded on objectivism epistemology. The researcher believes that the variables of this study; hyperactivity/distractibility, conduct problems, and aggression are observable behaviours that can be objectively investigated without the researcher's interference.

3.2 Research Approach

The study made use of the quantitative approach (Field, 2018; Lomax & Hahs-Vaughn, 2012). Experts agree that there are generally three main types of research approaches (Creswell & Creswell, 2014). These approaches are quantitative,

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qualitative, and mixed methods. None of these approaches is better than the other; each has its own strengths and limitations.

According to Allen (2017), Babbie (2010) and Brains (2011), quantitative approaches focus on objective modes of measuring traits and using statistical or numerical analysis of these data to answer research questions. Quantitative approaches aim at generalising these gathered data across groups of people or use the data to explain phenomena under study. Generally, quantitative approaches are either exploratory or conclusive in nature. When they are exploratory, they set out to develop general insights by exploring the variables in depth. However, when they are conclusive, they aim to reach a definitive conclusion about the variables (Balkin & Kleist, 2017; Patten & Newhart, 2018). Quantitative approaches focus on numerical data collection and analyses. The aim of the quantitative approach is to test theories and hypotheses. These tests are then analyzed through mathematics and statistics, and are mainly expressed in numbers, graphs, and tables.

Contrarily, qualitative approaches are used to understand concepts, thoughts or experiences analyzed by summarizing, categorizing, and interpreting expressed in words (Creswell & Creswell, 2014). In a qualitative research approach, researchers focus on the 'whys' and 'hows' of experience or event under study. Whereas quantitative approach focuses on 'how many' and 'how often', qualitative approach focuses on the 'how' and 'why' of a specific event. Moreover, a qualitative research approach counts on data gained by the researcher from interviews, questionnaires, artefacts, documents, case studies, recordings, first-hand observations, and sometimes participant-observation. Furthermore, whereas the goal of quantitative approach is measurement of traits, the goal of qualitative approach is 'felt' - very subjective and non-measurable.

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The third approach is the mixed methods approach (Creswell & Creswell, 2014). Some authors refer to the mixed methods approach as 'multimethodology' or 'multimethod' research. What this approach does is to include the use of more than one approach. According to Schoonenboom and Johnson (2017), the mixed methods approach is characterized by combining at least one qualitative and one quantitative approach in the methodology. Thus, there is an integration of both quantitative and qualitative methods in a single research study.

Because the researcher's ontological stance is realism and her epistemological underpinning is objectivism, the quantitative approach was the natural approach. Trauma can be objectively measured; there are valid and reliable instruments to assess trauma as well as mental health strengths and challenges related to the effects of traumatic experiences in children.

3.3 Research Design

The design for this study was the Single-Case Research Design (SCRD; Kadzin, 1982) also referred to as Single Subjects Research Design (Ledford & Gast, 2018). In this study, all the terminologies will be used interchangeably. Thereafter, an explanation of the Single-Case Research Design is explored. Finally, the design is connected to the purpose of research to provide coherence for readers.

3.3.1 Single-Case Research Design

Single-Case Research Designs are considered experimental rather than quasi-experimental (Kadzin, 1982; Ledford & Gast, 2017). They involve a repeated assessment of a particular behaviour over time in at least one individual (Herrera & Kratochwill, 2005; Kadzin, 1982). They have been used in multiple areas of research including psychology, education, psychiatry, and rehabilitation. They have also been referred to by different terms.

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Some of these terminologies are *intra-subject replication designs*; *N = 1 research*; *single case designs*; *single subjects research design*; and *intensive designs*. This design is reported to be an evaluative method used rigorously to test the success of an intervention on a particular subject (Kratochwill et al., 2010). This type of quantitative design seeks to critically investigate the behaviour of each of a small number of participants independent of each other. What this means is that we are not comparing participants to each other like we would be doing in a randomised control trial. Instead, we look at each individual by themselves as it applies to a particular behaviour (Coffee, 2011). Each individual is his or her own control.

In single-case research design, both quantitative and qualitative data are collected to understand the subjects. While they may appear to contain information generally found in mixed methods designs, single-case research design ***is not a mixed methods design***, but a quantitative experimental design. Data gathered included direct observation, narrative information from significant others of the subjects, and/or data from surveys/instruments.

3.4 Population

In research, population refers to the entire group of people one may be interested in (Patten & Newhart, 2018). A population of interest could be individuals, events, objects, or organisations that researchers are interested in. Because it is not generally feasible to study the entire population (i.e., conduct a census), researchers have devised multiple ways to select a few (sample) from the population in order to effectively generalise the findings to the population.

The targeted population for this study was all Basic School pupils within the Effutu Municipality. Currently, there are 78 Public Basic Schools in Winneba. There are 26 Kindergartens (KGs); 27 Primary Schools, and 24 Junior High Schools (JHS).

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The schools are divided into three circuits: Circuits A, B, and C – and each of these circuits contains KG, primary, and JHS levels. The total number of pupils in these basic schools by 2023 enrolment year was 14,516 (EMIS, 2023). According to the EMIS (2023), of this enrollment number, KG comprised 2,337; Primary comprised 8,303; and JHS comprised 3,876. For these numbers, there are only three professionally trained counsellors serving all three circuits and all 14,516 students. These counsellors report that they are sometimes assisted by untrained school-based volunteer counsellors.

The accessible population were all Basic school pupils in Ansarudeen Islamic basic School. The population of the school stood at 353 at the time of the study. The number of pupils at the Primary level were 253, and that of the Junior High School level stood at 100.

The class of focus is basic four pupils because students in this class are supposed to take part in the National Standardized tests. While basic two pupils are also required to take the standardized examinations, the researcher served as a clinical intern at this site and the lowest class was those in basic four. Moreover, interacting with both teachers and pupils revealed that psychological challenges the pupils had could prevent them from succeeding in higher classes (e.g., inability to focus in class; anti-social behavioral problems).

3.5 Sample and Sampling Techniques

This study used homogenous purposive sampling, a non-probability sampling method (Gall et al., 2007; Patten & Newhart, 2018). Purposive sampling involves gathering information from people considered to be 'information rich' – those who have the information to contribute to the problem under study. In this case, pupils who scored above clinical cut off on both ACEs and YOQ – the instruments used in screening for children who had trauma-related symptoms.

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A sample refers to the unit selected from the entire population (Patten & Newhart, 2018). A sample is also described as the smaller and often more manageable number than the actual population (Bryman, 2015). In a way, a sample is a subset of the population. Depending on what researchers are trying to assess, sampling can be done using either a probability or non-probability approach (Patten & Newhart, 2018).

When sampling is probabilistic, each member in the unit has an equal chance of being represented. However, when sampling is non-probabilistic, participants are selected based on some unique trait they have (e.g., they are available, or they have certain required characteristics of interest to the researcher). It is recommended that quantitative approaches use probability sampling, while qualitative approaches use non-probability sampling (Creswell & Creswell, 2014). However, because of the unique nature of research carried out by counselling psychologists, it is not always feasible to use probability sampling for quantitative approaches.

3.5.1 Purposive Sampling Technique

Purposive sampling, also known as judgmental, selective or subjective sampling technique according to Patten & Newhart (2018) represents a group of non-probability sampling that occurs when research units (e.g., people, cases/organisations, events, pieces of data) to be studied are chosen based on the judgment of the researcher. Usually, the sample being investigated is quite small, especially when compared with that of probability sampling techniques. Unlike the various sampling techniques that can be used under probability sampling (e.g., simple random sampling, stratified random sampling, etc.), the goal of purposive sampling is not to randomly select units from a population to create a sample with the intention of making generalisations (i.e., statistical inferences) from that sample to the population of interest which is the general intent of research that is guided by a quantitative research design. The main goal of

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purposive sampling is to focus on particular characteristics or traits of a population that are of interest, which will best enable the researcher to answer research questions.

Purposive sampling comes in different types: The 'typical case' sampling is a type of purposive sampling that is useful when a researcher is looking to investigate a phenomenon or trend as it compares to what is considered typical or average for members of a population; the 'extreme or deviant case' sampling is the opposite of typical case sampling. It is used when researchers want to investigate the outliers from the "norm" when it comes to a particular trend. By looking into these outliers, researchers are able to develop a stronger understanding of behaviour patterns in the population.

The 'critical case' sampling is a type of purposive sampling in which one case is chosen for investigation because researchers believe that by investigating it, insights into other similar cases will be revealed; the 'maximum variation' purposive sample is also referred to as a heterogeneous purposive sample. Researchers use this technique when they are looking to examine a diverse range of cases that are all relevant to a particular phenomenon or event. This allows researchers to gain as much insight from as many angles as possible during their survey; and the 'homogenous' purposive sample is the opposite of a maximum variation purposive sample, as it is selected because members of the sample have a shared characteristic or a shared set of characteristics.

In this study, the specific type of purposive sampling used was the homogeneous sampling. This is because the researcher in an attempt to answer the research questions posed needed samples that shared similar characteristics because such characteristics were of particular interested to the researcher.

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3.5.2 Inclusion Criteria

The following were the criteria for inclusion:

(a) participants within the school-age bracket (Corey, 2016; Jones-Smith, 2016);

(b) participants to exhibit signs of aggression, hyperactivity/distractibility, and conduct problems as demonstrated by above-clinical cut-off on the YOQ (Burlingame et al., 2014);

(c) symptoms mentioned in (b) above should be a result of trauma-related experiences as demonstrated by ACEs score of at or above (CDC, 2020; Felitti et al., 1998).

In summary, the purpose of the study was to assess the efficacy of Healing Play which leans towards establishing clinical significance using a small number of research participants, rather than establishing statistical significance or making statistical inferences. Clinical significance is the focus of the single-subjects research design while statistical significance is the focus of inferential statistical studies like pre-post-tests.

3.6 Sample Size

Since Single-case research design studies participants' behaviours in detail, the sample size is typically between 1 and 8 participants (Kadzin, 1982; Ledford & Gast, 2018). This study originally set out to purposively select 8 pupils. However, after the screening, only six became part of the inclusion criteria. While ethical requirements of school counseling allow *in-loco parentis* from the Head (Remley & Herlihy, 2018), the requirements from research, specifically the use of the ASEBA Direct Observation Form (details in subtopic 3.7: Instrumentation) required a connection with caretakers, therefore the caretakers' permission for each of the participants was sought.

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Unfortunately, two caretakers and their wards were consistently unavailable and/or wards were not regular in school. Therefore, the two were taken out of the sample. The sample was therefore left with 4 who fit the inclusion criteria.

3.7 Instrumentation

Research instrument refers to the tool(s) used to collect data on the phenomenon of interest (Patten & Newhart, 2018). There were two self-report measures, a demographic questionnaire and an observation tool used to collect data in this study. The two self-report measures were the Adverse Childhood Experiences questionnaire and the Youth Outcome Questionnaire. The observation tool was ASEBA Direct Observation form. Apart from the demographic questionnaire, all three instruments used in this study were adopted.

3.7.1 Adverse Childhood Experiences (ACEs) Questionnaire (Felitti et al., 1998)

The ACEs score is a 10-item yes/no instrument that is used to assess childhood trauma. The instrument measures 10 types of childhood trauma. Five of these ten are personal. They are physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect. The other five are related to witnessing violence. Specifically, questions 1-3 refer to emotional, physical, and sexual abuse. The next two questions assess emotional and physical neglect, while the last four focus on household dysfunction (Centers for Disease Control and Prevention [CDC], 2014).

Sample questions include "did a parent or other adult in the household often push, grab, slap, or throw something at you?"; "were your parents ever separated or divorced?" Responses to these questions are "yes" and "no". The more ACEs a person has, the greater their risk for chronic disease, mental illness, violence, and being a victim of violence. If a person has an ACEs score of 1, research indicates that there is

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an 87% chance that they have encountered two or more adverse childhood experiences. The ACEs was used to screen pupils who had gone through and were still going through traumatic related experiences or exposure either at school or at home. A score of 3 and above was considered critical (Felitti et al., 1998; Ray et al., 2022).

3.7.2 Youth Outcome Questionnaire [YOQ] (Y-OQ 30.2; Burlingame et al., 2002)

The YOQ is a 30-item instrument that provides a 'snapshot' of an adolescent's current functioning across a wide variety of disorders. It describes a wide range of troublesome situations, behaviours and moods that are common to adolescents (Burlingame et al., 2002). The YOQ assesses mental health functioning across six domains. The domains are Somatic (S), Social Isolation (SI), Conduct Problems (CP), Aggression(A), Hyperactivity/Distractibility (HD), and Depression/Anxiety (D/A).

The scale is rated on a 5-point Likert-type scale ranging from Never/Almost never (0), Rarely (1), Sometimes (2), Frequently (3), to Almost Always/Always (4). Scores on the Y-OQ can help identify areas of immediate clinical concern and help in treatment planning for youth. Scores range from 0 to 120 with scores 31 and above indicative of clinical significance. Sample questions include "I feel like I don't have any friends or that no one likes me"; and "I worry and can't get thoughts out of my mind." The instrument developers caution clinicians to pay attention to clients who may fail to complete items that assess drug and alcohol use. They indicate that when clients skip these questions, that attitude may suggest a meaningful pattern "that may have clinical utility" (Burlingame et al., 2002).

The YOQ is used for children between ages 4 and 17 years old. For children who are unable to read, there is a parent version of the instrument. The YOQ is sensitive

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to short-term change, thus making it useful for evaluating clients' progress at any point during treatment – hence its appropriateness for this study.

3.7.3 Direct Observation Form (DOF; McConaughy & Achenbach, 2009)

The Direct Observation Form (DOF) is part of the Achenbach System of Empirically Based Assessment (ASEBA). The DOF, in combination with the other ASEBA assessments, are designed to provide standardized descriptions of a person's functioning (https://aseba.org/direct-observation-form-dof-ages-6-11). It was designed to observe children in school classrooms, during break times, and in other group settings. Observers could be teachers' assistants, undergraduate or graduate students, as well as other professionals in education, psychology and related helping professions. Observers write narrative description of children's behaviours during 10-minute periods during group settings like classrooms or at break. Observers rate on-task behaivours at ten 1-minute intervals. At the end of the 10-minute observation, observers also rate 88 problem items that include the following: "acts too young for age", "confused or seems to be in a fog"; "disturbs other children"; and "difficulty organizing activities or tasks."

Norm scoring is based on ethnically diverse samples of 661 children for classroom observations and 224 children for break time observation. The on-task and problem ratings are scored in relation to gender-specific norms for children who are supposed to be between class 1 to class 6 (ages 6-11 years old).

In this study, observers were three undergraduate students who were in their second year and had taken courses in child development. They had also received training in the use of the DOF by a professor of counselling psychology from the institution under whose guidance this study took place. After their training, they were assigned to observe multiple children similar to the participants, over a two-week

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period. Each observation score on the DOF of these observers was scored. When they reached an interrater reliability of .90 and above for multiple observation (≥ 3), they were deemed ready to be part of the study. However, because one of the observers had a family emergency, the remaining two were used for the observation process of the study.

3.7.4 Demographic Questionnaire

A demographic questionnaire was used to elicit information like gender, age, home situation. This questionnaire was necessary to confirm or disconfirm some of the information on the ACEs questionnaire. These questions were also a necessary requirement for the ASEBA DOF.

3.8 Ethical Considerations for the Study

Ethics are very critical aspects of research (Patten & Newhart, 2018). Ethical considerations are meant to ensure that participants in any kind of research are protected and free from exploitation at all times. According to multiple helping professional organizations (e.g., Ghana Psychology Council, American Psychological Association, American Counseling Association), all researchers are advised to adhere to some professional ethical codes and regulations while undertaking research. Creswell and Creswell (2017) also argue that research participants need to be protected to promote the integrity of research, develop trust with them, guard against misconduct and impropriety that might reflect on their organizations or institutions and cope with new and challenging problems. It is important to consider the issue of ethics when conducting any research. Some of these ethical considerations may be in relation to the subjects you are going to use, whether human beings or animals (Hossain, 2011). According to Creswell (2009), any researcher should foresee or anticipate any ethical issues and make an effort to address them.

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Therefore, in relation to this study, the ethical consideration was in line with the following codes of ethics: The Ghana Psychology Council, the American Education Research Association, the American Psychological Association, and the American Counseling Association. All these organisations address ethical protocols of confidentiality, respect for autonomy and informed consent.

Confidentiality is where the details of the participants for the study are concealed or protected. Psychologists have a primary obligation to protect confidential information of participants. Psychologists are also encouraged to take reasonable precautions to protect information obtained through and stored in any medium. They are cautioned to recognize the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship (American Psychological Association, 2002). Hence the researcher ensured that the privacy and identity of the participants were respected and protected by giving the participants the right to choose their Pseudonyms. In relation to autonomy, participants were given the information they would need in order to decide to enter a study or not to participate. This implied that each person (both child and parent/guardian) was given the respect, time, and opportunity necessary to make his or her own decisions.

Informed consent involves properly informing the participant about everything to do with the study: procedure, objectives, risks, and benefits as a basis for consenting or not to participate. The researcher used English and Fante to make every information clear to participants and their parents as and when necessary throughout the study. In addition, informed consent was sought from the participants and their parents in relation to recording. The participants were also made to understand that they have the right to refuse to participate or withdraw from the study at any time. No participant was forced

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or coerced to participate in the research, it was on a voluntary basis. There were no monetary incentives for participants as well.

3.9 Data Collection Procedure

Permission was sought from the Department of Counselling Psychology of the University of Education, Winneba. Prior to this letter, the researcher had undertaken training in Human Subjects Research, particularly, because the participants were children and care had to be taken in order not to do or say anything covertly or overtly to harm them physically and psychologically (Patten & Newhart, 2018; Remley & Herlihy, 2018).

After the departmental permission, the researcher took the letter to the Municipal directorate of the Ghana Education Service, where she demonstrated that all research protocols would not harm the students. A letter from the Municipal Directorate was also given to be submitted to the school before data collection began. The children were all screened with both ACEs and YOQ questionnaires. Students who fell at or above the clinical cut-off scores were separated. Their primary caregivers were visited, and the study explained to them. Six participants originally had their caregivers grant permission for them to take part in the study. The children were given permission to provide assent (Remley & Herlihy, 2018) in order to recognize the ethical power of autonomy. Although ethics recognizes the heads of schools as having *in-loco parentis*, because of the clinical relationship already forged with the researcher, the participants were allowed to provide their own assent (Remley & Herlihy, 2018). Two of them were consistently absent at baseline, therefore the four who were consistent became the final participants for the study.

Three research assistants were trained to use the Direct Observation Form. One of them indicated that she could not stay behind during the holidays to undertake the

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research. The two who stayed used non-participating students to establish inter-rater or inter-observer reliability (Patten & Newhart, 2018). When inter-rater reliability reached .90 and above for three consecutive observations, actual data collection began.

The researcher, together with a mentoring professor in healing play therapy, took the four children through a five-session healing play therapy intervention. The following are the details of how the research ensued:

(a) The first week was used to establish baseline off-on-task classroom and break time observations.

(b) The second week, teachers went on an industrial strike action, consequently, students did not have any in-class exercises. The research assistants therefore observed them at play.

(c) By the third week, teachers were back from their strike action, so intervention began, and observation continued.

(d) During the subsequent week, intervention stopped, and observation continued.

(e) The researcher thereafter visited the homes of the participants to double-check on the information provided by caregivers. She also took the chance to express gratitude to the caregivers / caretakers for allowing the children to take part in the research study.

3.10 Data Analyses Procedure

In Single Subjects Experimental Designs, visual analysis is used to understand the data (Ledford & Gast, 2018; krasny-Pacini & Evans, 2018). Graphic displays include line graphs, bar graphs, and cumulative graphs. According to Kadzin (1982) and Ledford and Gast (2018), graphs help in organizing data during data collection, thereby facilitating formative evaluation. Secondly, graphs provide a detailed summary

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and description of individual behaviour over time. This description of individual behaviour allows readers to analyze the relationship between the independent and dependent variables.

Data collected at baseline, during the intervention phase, as well as post-intervention were imported into Microsoft Excel. Thereafter, using the "insert" prompt and line and bar graph options, the visual presentation were created to describe participants' increases and decreases in reported traits. In Single Subjects Experimental Designs, the dependent variable is represented on the y-axis of the graph (Figure 3.4). The independent variable is measured constantly over time (represented by the x-axis) at regular intervals. For example, the participants could be tested at condition A (Baseline), then tested at Condition B (intervention), then again at Condition A (when intervention is removed).

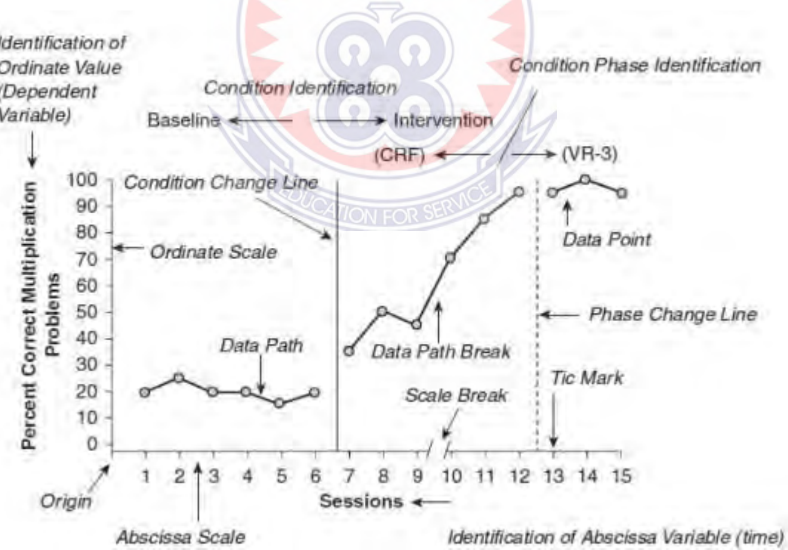

Figure 6: Generic Single-Subjects Line Graph (Ledford & Gast, 2018; p. 256-257).

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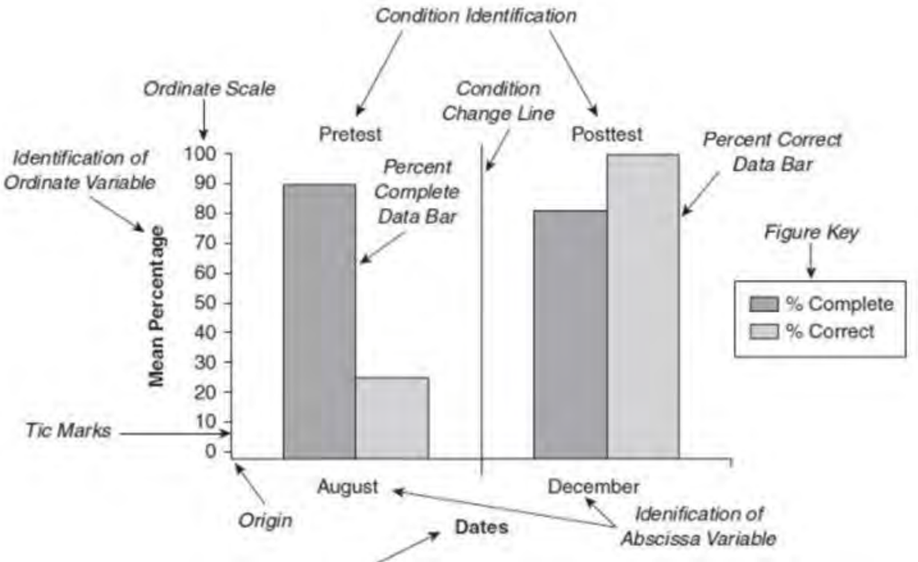

Figure 7: Generic Single-Subjects Bar Graph (Ledford & Gast, 2018; p. 256-257).

Unlike randomized control trials where participants are compared to each other, in Single Case Research Design, participants serve as their own baseline. Therefore, participants' behaviours are compared to themselves before and after the application of an intervention; in this case, play therapy.

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CHAPTER FOUR

RESULTS/FINDINGS

4.0 Introduction to the Chapter

This chapter describes the limitations of the study, the participants, explains and discusses the results from the data collected, and connects the results to the literature reviewed. The framework that grounded this study posited that trauma-related symptoms of the children could be described through their adverse childhood experiences as well as their psychological wellbeing.

4.1 Limitations

Although this study provides a groundbreaking and important contribution to the limited literature on play therapy in children, more specifically in Ghana, there are several limitations that merit comment. First, this study used the SCRD which mostly uses a smaller sample size and relies on visual observation and analysis of data. These forms of data collection and analysis are prone to biases. Moreover, because it is not a common methodology in Ghana, especially in the field of counseling psychology, readers are bound to push for qualitative methodology because of the narrative, or even mixed methods because of the combination of quantitative and qualitative data.

Again, the ABA single subjects research design is seen as a moderately rigorous form in the SCRD compared to other forms of the SCRD. A more rigorous type like the ABAB, the ABCABC or the *multiple Baseline designs* could be used to establish strong causality and generalizability.

Finally, the SCRD is geared towards establishing clinical significance and not statistical significance. For establishing a statistical significance, other forms of experimental designs with larger samples will have to be used.

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Secondly, the measures used in the present study have not been validated for use outside of Western cultures. As discussed above, they may be limited in their validity with respect to language and assessing the cognitions and behaviours of Ghanaian children as well as culturally acceptable displays of emotion. Because overt displays of emotion are more culturally acceptable in Ghana, the wellbeing subscales may not measure culturally defined dysregulated behaviors in Ghanaian children. In terms of the ACEs scale, items may not have accurately captured the forms of adversities that affect children in Ghana. Although corporal punishment has been banned from the educational settings, some teachers still engage in the act, and it is still seen as a culturally acceptable form of nurturing in Ghana. Also, in a low-income economy like Ghana, three square meals for child are a luxury. Children going hungry is the common narrative. Thus, while ACEs recognizes lack of food as trauma-inducing, in some communities in Ghana, going without food may be culturally or religiously acceptable.

Finally, because the researcher had already encountered these children, it is possible that the children's responses were different than if they had been interviewed by a researcher they had never encountered. For example, seeking to win the researcher's approval may have influenced children's answers during the pre and post intervention assessments.

4.2 Analysis of Demographic Information

All participants were in Basic 4 of a local basic school in Winneba. Participants were given the opportunity to provide a nickname for themselves. This was both to protect their anonymity and build their confidence. The decision to allow participants to provide a nickname / pseudonym for themselves is consistent with the ethical

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principles of respect for autonomy, beneficence, and respect for persons (Remley & Herlihy, 2018).

Table 1. Participants' Demographic Information

Pseudonym	Gender	Age	Religious Faith	Living Situation
Rashid	Male	12	Muslim	Biological parent
Tetteh	Male	11	Christian	Biological parent
Anso-Fati	Female	12	Muslim	Grandmother
Lady Ash	Female	12	Muslim	Grandmother

There were two males and two females who participated in the study. Each of the participants were seen as part of a larger family with significant others who could speak to both their home life and their school life (e.g., class teacher in school and a guardian at home.). Three of the participants were 12 years old and one was 11 years old. While two lived with biological parents, two others lived with their grandmothers; all four, however, shared the same classroom teacher. Three of the four participants were Muslim and one self-reported as Christian.

4.3 Analyses of Research Questions

The study set out to answer four research questions. These questions were:

1. What trauma-related experiences are identified in a group of basic school pupils as measured by the ACES inventory in Winneba?
2. What are the psychological wellbeing scores of a group of basic school pupils as measured by the Youth Outcome Questionnaire in Winneba?
3. At baseline, what are the off-and-on-task behaviours in the classroom of selected pupils in Winneba?

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4. Upon the intervention phase, what are the off-and-on-task behaviours in the classroom of selected pupils in Winneba?

A term generally used in research work connected to clinical populations is "clinical cutoff". Specifically, a clinical cutoff in layman's terms represents the level of distress exhibited by clients. The term "clinical cutoff" is a statistical term (portion of an equation) used to differentiate a clinical population from non-clinical populations (https://blog.betteroutcomesnow.com/2017/09/15/the-ominous-clinical-cutoff-anddataaccuracy#:~:text=The%20%E2%80%9Cclinical%20cutoff%E2%80%9D%20is%20a,called%20non%2Dclinical%20population). In psychological and medical-related lingo, clinical population refers to those seeking help from a therapist or a doctor.

4.3.1 Trauma Related Experiences

Trauma related experiences were assessed via the Adverse Childhood Experiences Scale.

Table 2. ACEs Screening Indices of Participants

	Range Score	Clinical Cut Off	Rashid	Tetteh	Anso Fati	Lady Ash
Total ACES	0-10	3	4	4	3	4

Results of this assessment indicated that all four participants had scores at or above the clinical cut-off.

None of the participants had been touched in a sexual way and had not had an experience with street drugs and a relative struggling with so much alcoholism that their

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daily livelihoods were affected. None of them had also experienced a parent being lost to them through divorce, abandonment, or another reason.

Even though participants indicated a ‘no’ for item 6, their caregivers reported otherwise. Rashid’s mother reports of being separated from the father for some years. She stated that she does not know the where about of Rashid’s father aside knowing that he is somewhere learning a trade. He offers no form of support to the child.

Table 3. Detailed ACES Responses of Participants

Statement	**Rashid**	**Tetteh**	**Anso Fati**	**Lady Ash**
1. Swearing, insulting, humiliating by adult	Yes	Yes	Yes	Yes
2. Push, grab, slap, or throw at by adult	Yes	Yes	Yes	No
3. Touch, fondle... in a sexual way	No	No	No	No
4. Feeling unloved or unsupported	No	Yes	No	Yes
5. Neglect – food, clothes; drunken caregivers	No	No	Yes	Yes
6. Biological parent – divorce, abandonment	No	No	No	No
7. Saw step/ mother being pushed, slapped…	Yes	No	No	No
8. Alcoholism, street drugs…	No	No	No	No
9. Household member mentally ill; depressed	No	Yes	No	No
10. Household member imprisoned	Yes	No	No	Yes

Similarly, Lady Ash’s grandmother reported that her father lived in the community but had no connection with the child. According to the grandmother, he sees Lady Ash daily, but hardly ever speaks to her, does not support her socially, emotionally, or financially. It was reported that Anso Fati had lost her father to death.

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That is what accounted for Anso Fati coming to live with her grandmother. Tetteh's mother has also separated from the father, with the mother currently living in her family house with Tetteh and his siblings. She reports of shouldering all the financial burden of the family and gave that as a contributing factor to their separation. Unlike Lady Ash's father and Tetteh's father comes around to visit with him occasionally.

Each of them had had some experience with being insulted, humiliated, put down or made to feel afraid that they may be physically hurt. Only one member had had some experience with a household member being mentally ill or depressed. About 75% of the participants had been pushed, slapped, hit so hard that they had marks on their bodies or injured. The two females who also live with their grandmothers indicated that they often felt they did not have enough to eat, had to wear dirty clothes, and felt they had nobody to protect them, or take them to a doctor if they needed it. About 50% of the participants felt that no one in the family loved them or felt they were important or special. And the same percentage had experienced a household member go to prison.

4.3.2 Psychological Wellbeing Scores

Psychological well-being was measured by the YOQ® 30.

Table 4. YOQ and Domain Indices at Baseline

	Range Score	Clinical Cut Off	Rashid	Tetteh	Anso-Fati	Lady Ash
Total YOQ	0-120	31	58	38	46	86
Conduct Problems	0-24	12	11	9	12	21
Aggression	0-12	4	9	5	8	12
Hyperactivity / Distractibility	0-12	5	7	6	7	8

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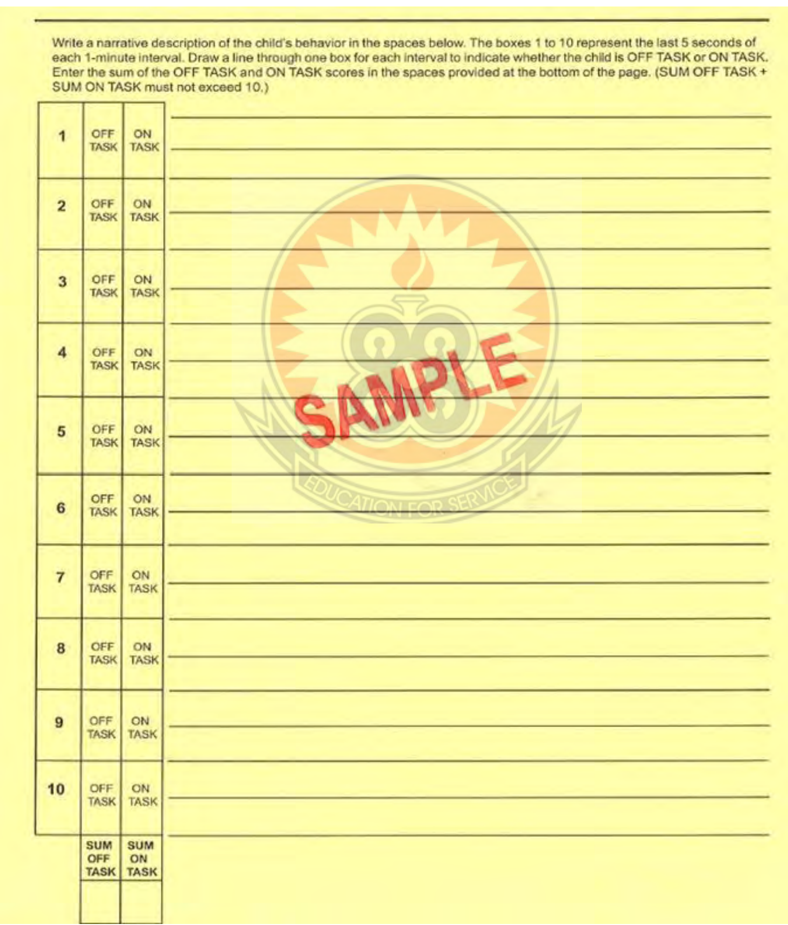
As an instrument that provides a snapshot of current functioning across a variety of disorders, the YOQ® 30 is a screening tool and does not purport to provide a comprehensive diagnosis of any psychological disorder (Burlingame et al., 2002). Each of the participants had an above-clinical cut-off score for Total YOQ, Conduct problems, Aggression, and Hyperactivity/Distractibility. Lady Ash had above clinical cut-off on both the Total YOQ and all the other indices.

4.3.3 Off-on task Behaviors at Baseline

The ASEBA DOF provides a total score of 10 for off-on-task behaviors.



Write a narrative description of the child's behavior in the spaces below. The boxes 1 to 10 represent the last 5 seconds of each 1-minute interval. Draw a line through one box for each interval to indicate whether the child is OFF TASK or ON TASK. Enter the sum of the OFF TASK and ON TASK scores in the spaces provided at the bottom of the page. (SUM OFF TASK + SUM ON TASK must not exceed 10.)

1	OFF TASK	ON TASK	
2	OFF TASK	ON TASK	
3	OFF TASK	ON TASK	
4	OFF TASK	ON TASK	
5	OFF TASK	ON TASK	
6	OFF TASK	ON TASK	
7	OFF TASK	ON TASK	
8	OFF TASK	ON TASK	
9	OFF TASK	ON TASK	
10	OFF TASK	ON TASK	
	SUM OFF TASK	SUM ON TASK	

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Figure 8: Sample ASEBA DOF **(ASEBA, 2009).**

The sum of tasks within the observation period must not exceed 10. Combined off-on-task behaviors provides a total of 10 points. The ruled lines provide a chance for observers to write narratives about the observed behaviours.

Because of the time designation for the intervention to take place, each of the participants had at least 3 baseline observations. Furthermore, because of the time constraints for the public-school examination and vacation, vis-à-vis the researcher's timeline for research, intervention started the same week for all participants. The single subjects research design allows for different starting points for intervention because each participant is unique (Ledford & Gast, 2018).

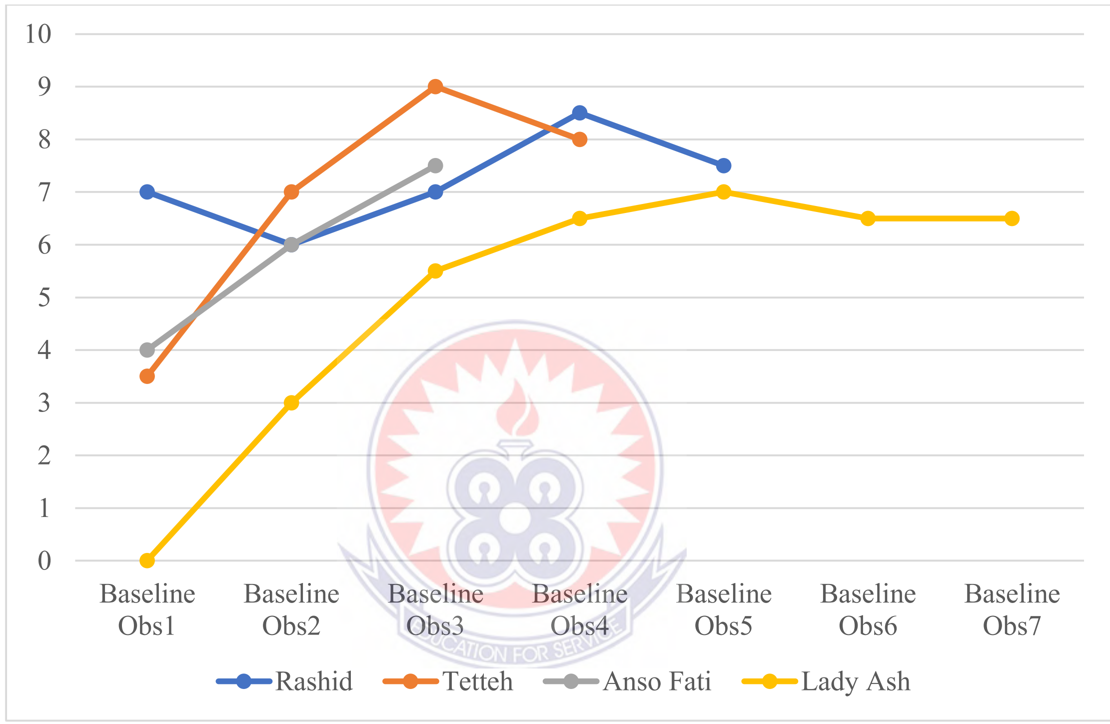

Figure 9: Off-task Behaviors before Intervention

Lady Ash had more observations at baseline because she was regular in school. The one with the least observations was Anso-Fati. If off task scores are above 5, it implies that participants were not doing what was required of them. For example, if the class teacher had instructed the class to read to themselves, an off-task score of above 5 implies that within the observation period, participant was not following the instructions of the classroom teacher. The line graph indicates that before the intervention phase, all the participants were not doing what was expected of them in

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class and/or on the playground, especially compared with others in their age range and given the same instructions.

4.3.4 Off-on task Behaviors at intervention and post-intervention

The analyses within single case research designs are best interpreted when the pre-and-post tests are analyzed together. Each of the participants' scores and graphs will be analyzed separately. As previously explained in the methodology section, in single-case designs, participants serve as their own baseline and therefore are not compared to others like other quantitative designs (e.g., descriptive designs and experimental designs; Field, 2018; Frey, 2022; Ledford & Gast, 2017).

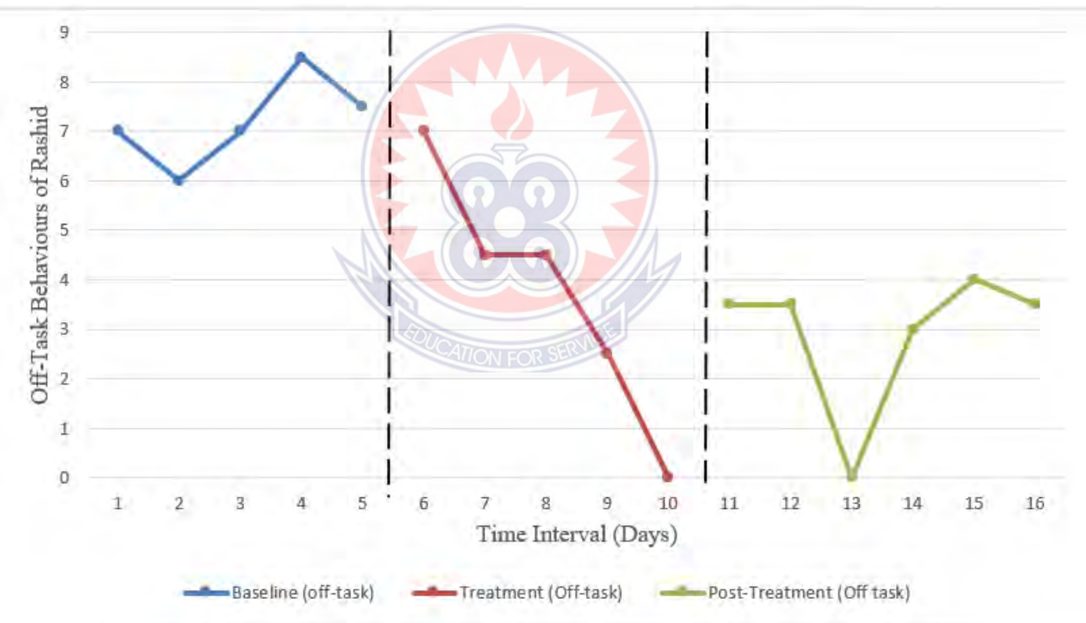

Figure 10: Rashid – During and After Healing Play

Rashid is the second of four siblings. He suffered convulsion at an early stage in childhood, and that persisted for a very long time until he was healed by a traditional healer. By this time, his was far behind academically. His level of brain development did not match his age and that made him struggle to catch up in class. Rashid lives with his mother who is separated from the father. The mother is a trader of a local drink known as "fulla". His father is unemployed and is now learning a trade. The upkeep of

Rashid and his siblings is the sole responsibility of his mother, but occasionally gets some assistance from his maternal aunt. His father is absent in their lives.

Rashid lived with his maternal grandmother from the age of 6 until her demise when Rashid was 10 years old. Rashid does not go to bed early; he prefers watching television to sleeping. He has no assigned duties at home aside being called to assist in chores from time to time. He undertakes a long commute to get to school. Because of the financial challenges, he walks a distance that should be done via car. He barely gets three meals a day, so he is constantly hungry.

Rashid is hot tempered and easily hits others when angry. He gets into fistfights with his siblings a lot. He however does not exhibit such behaviors outside of home. He is very dedicated to whatever he commits to doing and does it with excellence. It is, however, very difficult to get him to commit to something.

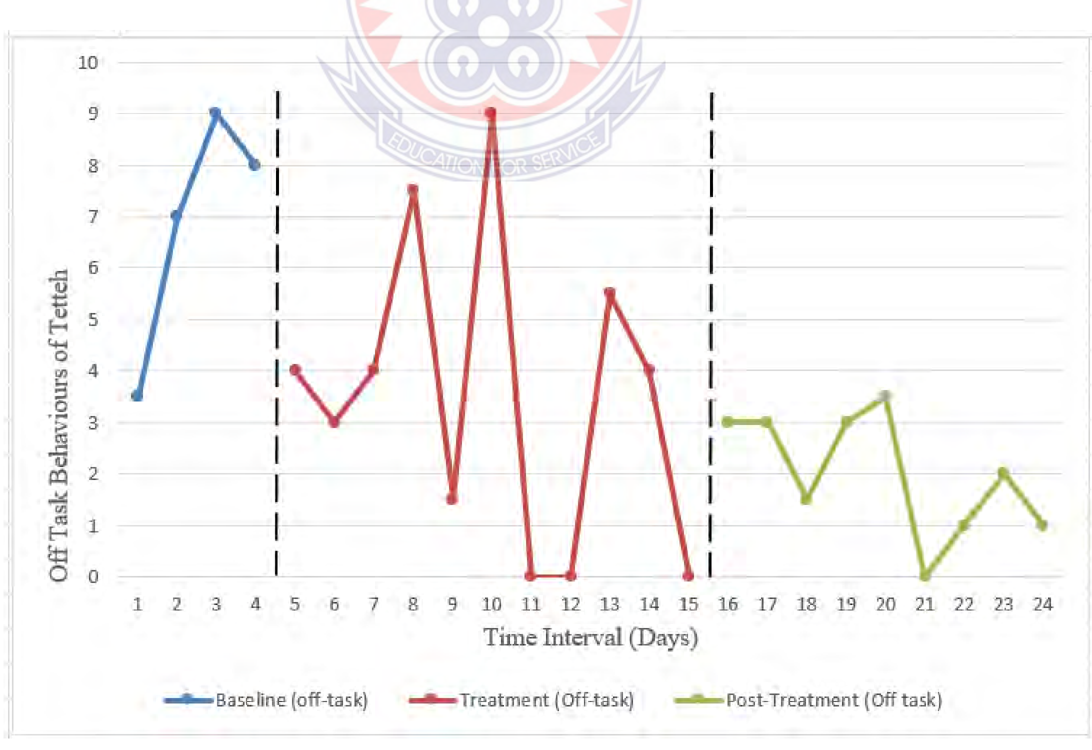

Figure 11: Tetteh –During, and After Healing Play

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Tetteh lives with his mother and siblings in his maternal family house. Some other extended family members also live in the family home. Tetteh's parents are separated; however, his father visits them occasionally. According to Tetteh's mother, this separation was initiated by her because she believed Tetteh's father was not responsible, specifically concerning the upkeep of the family. Tetteh is the third child of his mother, but the first of his father. He has three other siblings after him. The daily upkeep of Tetteh is the responsibility of the mother, a hairdresser. His father, who is a carpenter is not always available to help.

From ages 3-6 years old, Tetteh lived with his maternal grandmother in a fishing community far from where his parents used to live. When he lived with his grandmother, Tetteh never attended school but helped in the fishing activities.

He developed a urinary tract infection which is believed to have been caused by bacteria from a river he used to swim in. That has resulted in him passing out bloody urine from age six to date. The mother says he frequently complains of pain in his penis. Some of the household duties Tetteh is assigned include fetching water for use in the house. According to his mother, he is slow in performing simple household chores and in eating. While he sleeps early in the night – around 7pm – he struggles to wake up in the mornings unless he is awakened. Tetteh's mother finds him exceptional. According to her, Tetteh is intelligent to the point where he helps his holder sister to do her schoolwork when she struggles. His handwriting is beautiful, and he enjoys playing football with friends. His teacher says she finds him hot-tempered; even in the middle of a meal, the slightest provocation causes him to get angry and sometimes cries. Moreover, he is unable to stay still for a long period as his peers can do.

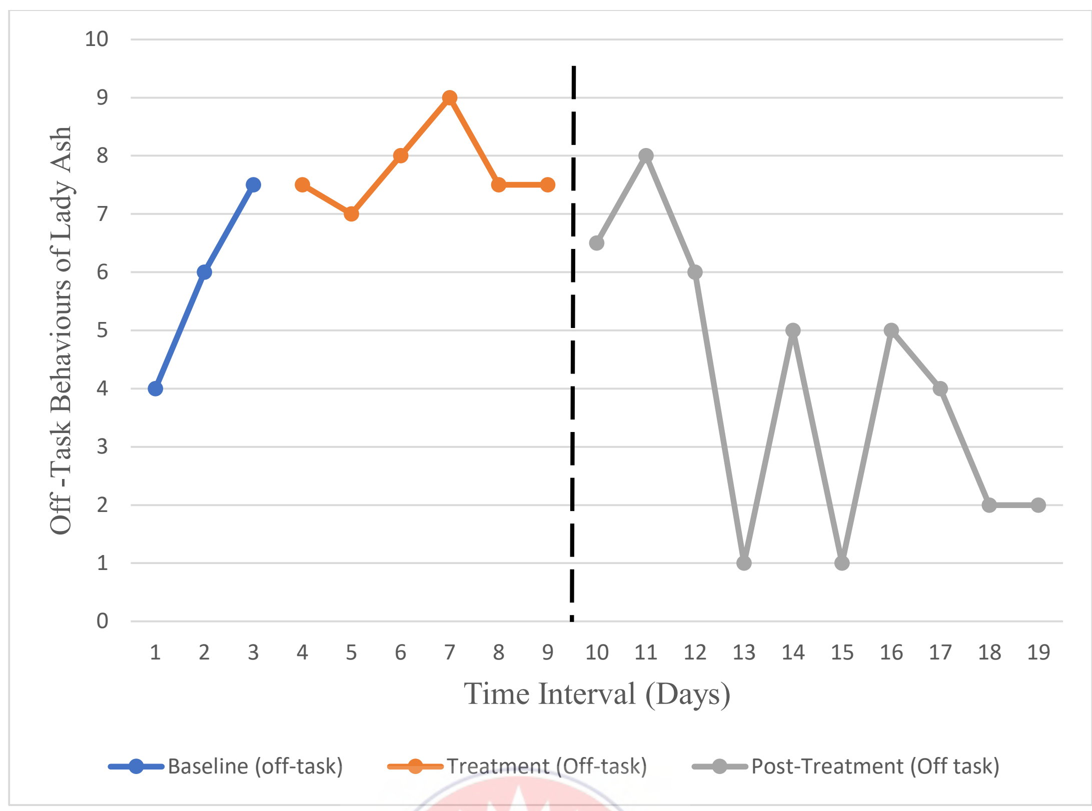

Figure 12: Lady Ash –During, and After Healing Play

Lady Ash lives with her maternal grandmother in a family house. The grandmother operates a convenience shop in their local community. Lady Ash is very instrumental in running her grandmother's business. According to her grandmother, Lady Ash takes care of the shop in her absence just as she, the grandmother, would do. Lady Ash was born to a teenage mother. Her father was also a young man who refused to accept the pregnancy. As a result, the grandmother has been the sole caretaker of Lady Ash since her birth. Her mother has since married and moved to stay with the husband; they have three children of their own. Lady Ash's father is totally absent in her life, but lives within the same community. She sees her father almost every day but has no communication with him. Lady Ash however visits her mother very often.

Lady Ash's teacher describes her as "very hot tempered and gets angry with the least provocation." The grandmother confirms this by saying, "when she is angry, she listens to no one and would not obey any instructions until she calms herself down." It

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appears that after Lady Ash's angry bouts, she finds a way of making up for the wrong and getting back in your good books, an assertion confirmed by both her teacher and her grandmother. Lady Ash is a responsible young girl. She sweeps, cleans utensils and fetches water as expected of her always. She sleeps late because she helps the grandmother around the shop after school. She however wakes up early.

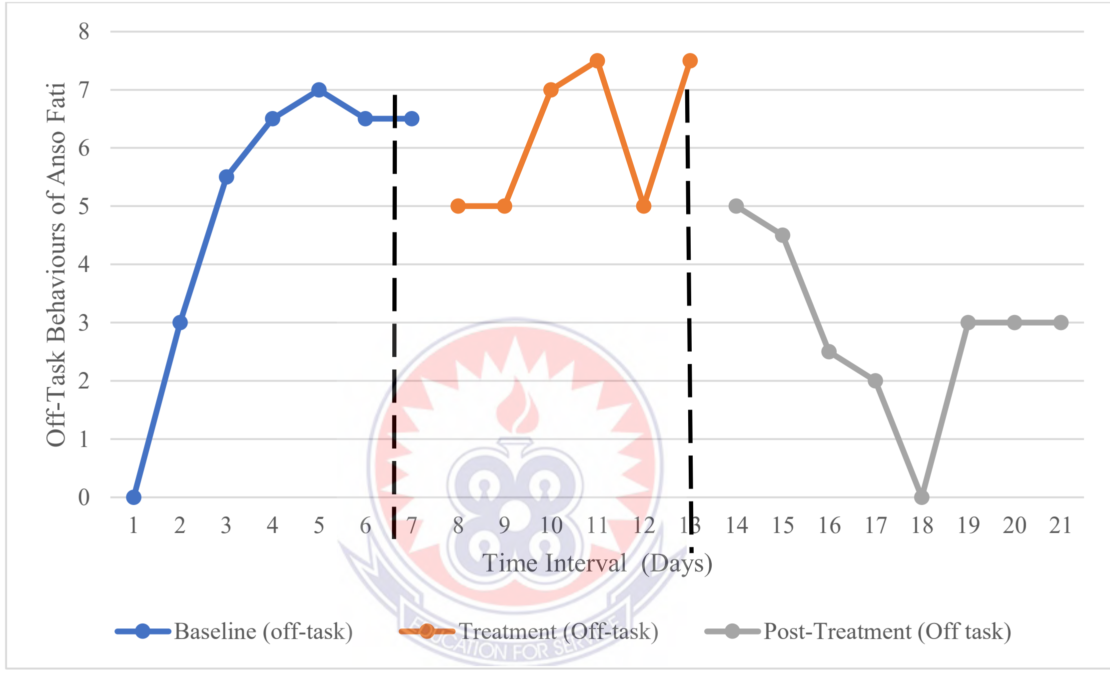

Figure 13: Anso Fati –During, and After Healing Play

Anso Fati lives with the maternal grandmother together with other grandchildren in a big family house. Anso Fati used to live with her parents until the death of her father when the family thought it wise to bring her to stay with the grandmother to lessen the financial burden on the mother. She was brought in at the age of eight. Anso Fati herself admits that she still communicates with her father. She claims her father lives in another West African country and that he communicates regularly with her. According to her grandmother, Anso Fati does not go to bed early because she prefers to stay out late playing with her peers until late at

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night. Unfortunately, she does not study after school and her schoolwork suffers. She is quite helpful at home; she is in charge of cleaning dirty dishes and fetching water for household use. Although she loves to play a lot, she is considered to be well behaved compared to children her age.

Observation after Healing Play indicated that even though the intervention had ceased, the off-task behaviors of participants significantly reduced.

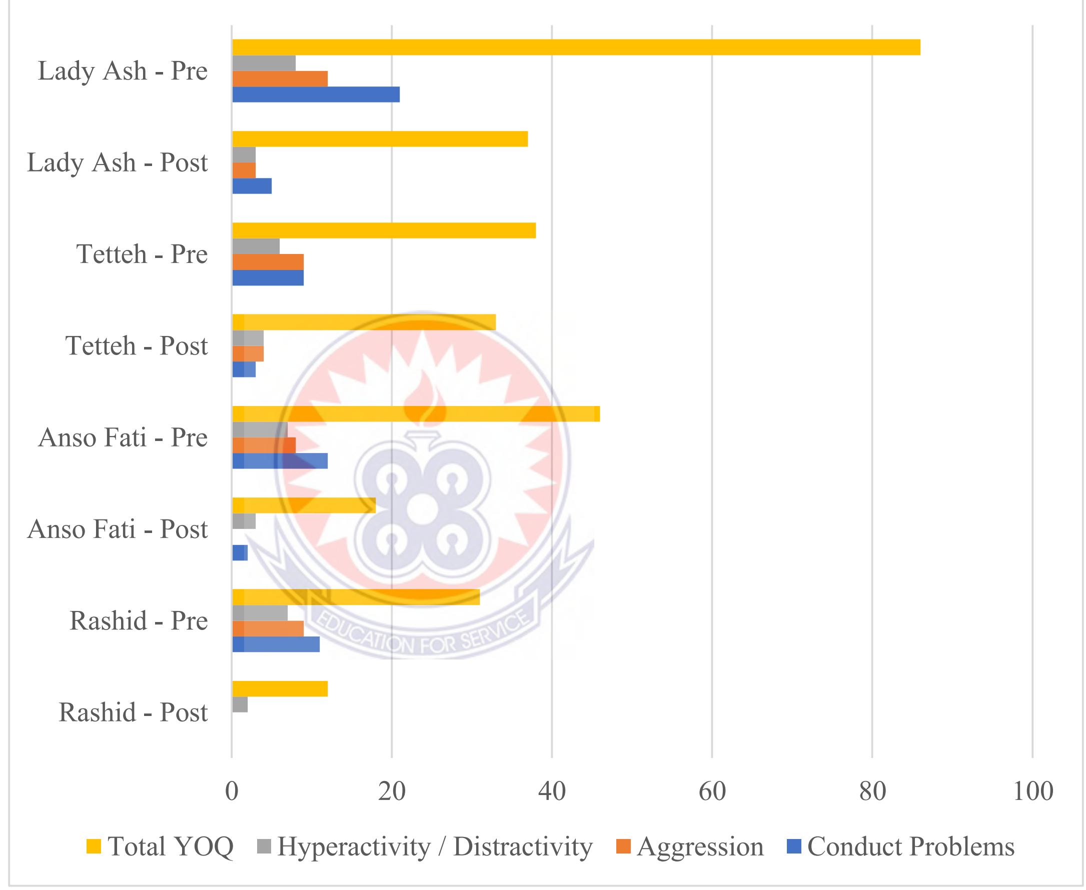

Figure 13: Cluster Bar Graph of Before and After Intervention YOQ Scores

This was confirmed by post-intervention YOQ scores. Because ACEs assesses what participants live with, there was no need to assess that post-intervention as their home and school conditions had not changed. For example, if the child eats once a day, they still go home and eat once again. However, the intervention gave them an avenue to express their emotions and not be emotionally reactive like they were before the intervention.

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4.4 Discussion of Results

4.4.1 ACEs, Children, and Adulthood

The results of this study indicated that each of the children had ACES scores at or above clinical cut off (≥ 3). This however was not supported by the narratives of their caregivers which suggested all the children had scores above clinical cut-off (≥ 4). This score is considered very high and dangerous to the development across the trajectory. Anso Fati who claims to be speaking to her father who is another African country could be one of two things; 1) care givers trying to shield her from feeling the loss of her father, or 2) the child being delusional. In reference to the former, how can care givers know the need to allow a child to grieve if they have no knowledge of the detrimental effect it could possibly cause to the child? And how will they know if no one educates them on that? In the absence of knowledge and information, anything is possible. In case the child is being delusional, then there could be need for further psychopathological assessment and care. The reality of that also exists as she could still be in denial of the reality of the loss. Unfortunately, since this study was exploratory and an initial one, these narratives could further be explored later by using toys and allow the child to express herself using both words and toys.

Some of the experiences of these children included being insulted and humiliated by adults (psychological and verbal abuse) and being pushed, grabbed, slapped, and thrown by adults (physical abuse). D'Andrea et al. (2012) had studied children and their brain development and discovered that these experiences could lead to developmental trauma. Moreover, the big ACES study demonstrates that when people experience 4 or more ACEs, they had a significantly increased risk of getting 7 of the 10 leading adult causes of death (i.e., heart diseases, stroke, cancer, diabetes, Alzheimer's, and suicide). Thus, Rashid, Tetteh, and Lady Ash could possibly have a

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higher chance of getting a heart disease, or stroke or even cancer if no intervention is put in place. Additionally, without a positive buffer (e.g., Healing Play Therapy), these children can get Toxic Stress Response, which in turn can lead to health-related problems like asthma, poor growth, frequent infections, and learning difficulties. According to the Harvard University Center on the Developing Child, toxic stress occurs when children experience strong, frequent, and/or prolonged adversity without adequate adult support. These adversities include physical or emotional abuse, chronic neglect, caregiver substance abuse or mental illness, exposure to violence, and/or the accumulated burdens of family economic hardship (https://developingchild .harvard.edu/science/key-concepts/toxic-stress/, accessed on March 22, 2023). From the ACEs scores of the participants, each of them could be on the road towards toxic stress.

Narratives of caregivers and teachers of these four children confirm that some of the children already have these challenges. For example, Tetteh is reported to have urinary tract infection. Rashid struggles academically and so does Anso Fati. These are physical symptoms reported by caregivers. Psychologically, each of the children struggles with emotional reactivity (i.e., quick temper, anger responses, lack of emotional regulation). For example, both Tetteh and Lady Ash are reported to have 'hot tempers', and these are confirmed by their pre-test scores of YOQ. The clinical cut off point for aggression was 4; Rashid had 9; Tetteh had 5; Anso Fati had 8; and Lady Ash had 12.

Their inability to pay attention in class was also confirmed by their high Hyperactivity / Distractibility score. The clinical cutoff for Hyperactivity / Distractibility was 5; Rashid had 7; Tetteh had 6; Anso Fati had 7; and Lady Ash had 8. Hyperactivity and distractibility are demonstrated by inability to sit still (e.g.,

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Tetteh's teacher's observation). Hyperactivity and distractibility are also demonstrated in acting without thinking, excessive physical movement, and being unable to concentrate on tasks (APA, 2013) – activities that prevent school-aged children from succeeding in school.

4.4.2 Children's Well-Being

Wellbeing results expressed through YOQ indicated that all four of the children had scores that were above the total YOQ score of 30 as well as the domains of interest - aggression, conduct problems, and hyperactivity/distractibility.

Human beings thrive and develop healthily in a socially welcoming environment. As espoused by Adler, social connections have a telling effect on the psychosocial development of the child (Adler & Jelliffe, 1917). A healthy psychosocial development of every child is influenced by the interactions they have with their immediate environment (e.g., home, school, and places of worship). These social interactions have a direct bearing on the development of the child in the here and now and in the unforeseeable future (CDC, 2020; Felitti et al., 1998; Friesen, 2020). Whereas some children are negatively impacted, others develop resilience and are able to successfully navigate through the challenges successfully. This was evident in the case of Lady Ash and Tetteh who have been able to succeed academically whereas Anso Fati and Rashid are still struggling academically. This brings us face to face with specific adversities and its direct resulting effect. Since the purpose of this study was not geared towards that, but to assess the effectiveness of the healing play intervention (Friesen, 2020) and how to give a buffer to the children going through adversity regardless of the how, that could not be explored. In the absence of a positive buffer like healing play, some children get affected and have problems with attention, decision making, and impulsivity (Brunzell, Stokes, & Waters, 2016). This can be seen in the

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case of Anso Fati and Rashid who both exhibit inattentiveness and academic struggles, as well as anger outbursts in social encounters.

4.4.3 Off-on-Task Behaviours of Participants

At baseline, the results of all four participants indicated an increasing trend in their off-task behaviours. However, after the healing play intervention, these off-task behaviours reduced, depicting an improvement in their on-task behaviours. It also goes to support the efficacy of play interventions in special populations (Meany-Walen et al., 2017; Swank et al., 2015). Although play therapy is not geared towards diagnosis, patterns of what the child is experiencing are demonstrated during play. For example, during the second session of healing play with Rashid, he drew a diagram of a male who had turned his back on a mother and her kids (Appendix H). The female child could be seen trying to catch the attention of the father while the mother tries to engage her with a dull. The boy in the drawing was elsewhere playing. He explained that they miss playing with their father.

It is important to note that during the intervention phase, the therapist provided breakfast for the participants. Although that could bias the study, it could also be argued that allowing participants to come early for the intervention and beginning their day on an empty stomach would have worsened their plight and in a way made the therapist an accomplice in unleashing stress unto the children. Provision of their basic physiological needs is also consistent with both the Rogerian theory and the Incarnational Theory. Both theories value human life, which includes sustaining the body through food. Moreover, since the Incarnational Theory is grounded on the principles of Jesus Christ, who is known to have fed multiple people (Matthew 14:13-21; Mark 8:1-9; Luke 9:12-17; John 6:1-14), the intervention phase of this study tapped into recognizing the worth and value of humans and working with the principles of Jesus Christ

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CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

The chapter summarizes the major research findings and enumerates the contribution of this research work to knowledge. It also includes conclusions, implications and recommendations of the study. Suggestions for future research are also made.

5.1 Summary of Findings

This study was conducted for the purpose of determining if a five-session Child-Directed Healing Play therapy could help reduce trauma-related symptoms in school-aged children. The targeted population was all school-age children within the public basic schools in the Effutu Municipality, with the accessible population being children within one of the public basic schools in Winneba. The quantitative approach was employed. Four school-age children were sampled purposively, and three instruments were used - the ACEs, the ASEBA Direct Observation Form, and YOQ. The study was conducted during the 2022 school year. The results of the assessment on participants' trauma related experiences indicated that all four participants had scores at or above clinical cut-off points and needed immediate intervention.

Prior to the application of the intervention, participants had scores that were above the clinical cut-off score for the total YOQ scores, Aggression, and Hyperactivity/Distractibility. However, only one participant had scores above the clinical cut off for Conduct Problems. Post intervention scores indicated a significant drop in each of the participants scores at pre-test. Although two of the participants total YOQ scores still remained above clinical cut-off scores, their current scores were still

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a reduction from their pre-intervention level. All three domains being assessed had scores reduced to clinical cut-off level or below.

The findings revealed a significant improvement in their off-task behaviours. At baseline phase prior to intervention phase, there was an upward trend in the off-task behavior of all four participants. Three of the participants had their levels dropped at the introduction of the intervention. The last participant maintained the same level. At the intervention phase, a downward trend was observed in one participant and upward trend in another. For the other two, no particular trend was observed. At the final phase, there continued to be a change in level observed of behavior of all participants. Two of the participants had a decrease in level while the other had an increase in level. However, three of the participants still recorded a downward trend. For the one whose trend could not be identified, there was still an improvement in behavior compared to baseline and intervention phase.

5.2 Conclusion

There is the need for strengthening play therapy in Ghana, if we seek to make progress in school counselling and mental health delivery in the country. This calls for empirically based research that will inform policy and practice surrounding play therapy in school counselling practice and implementation in the country. Using a five-session child directed healing play intervention, this study has proved the efficacy of play therapy in reducing Aggression, Hyperactivity/Distractibility, and Conduct Problem among school-age children within the Effutu Municipality. The findings have provided insight into how community based (including school) counsellors can use CDHP in the context of their practice.

Similarly, the study has revealed the trauma related experiences of some school-age children as measured by the ACEs inventory, indicating scores that fall within the

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medium to high range at baseline. Participants had among others answered yes to haven been physically abused, emotionally abused, and maltreated.

Also, findings for psychological well-being revealed high scores in targeted behaviours; Aggression, Hyperactivity/Distractibility, and Conduct Problem. These scores were at or above the clinical cut-off point for YOQ assessment at pre-intervention phase. Conversely, the psychological well-being scores for the targeted behaviours post-intervention indicated a reduction in participants' baseline scores. Whereas some of the participants recorded scores below the cut-off points for both the total YOQ scores and the behaviours of interest under the sub-scales, others had reduced to cut-off points. Interestingly, the other indices under the YOQ assessment which were not targeted in the study had also seen a reduction in the scores post-intervention. These behaviours were: Social Isolation, Somatic Symptoms, and Anxiety/Depression.

Finally, the off-on-task behaviours measured at baseline with the DOF revealed an upward trend in all the four participants. At the intervention phase however, although results indicated a downward trend in the off-on-task behaviours in majority of the participants, a clear trend could not be traced in one of the participants. At post-intervention phase, all participants saw a downward trend in their off-on-task behaviours.

5.3 Recommendations

Notwithstanding the limitations discussed in the previous chapter, the current study makes substantial contribution to Play therapy and School counselling practice and research, within the broader task shifting agenda for mental health delivery in Ghana. It is therefore imperative that future studies build on this to provide deeper

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understanding and to improve on counselling practice in Ghana. The following suggestions are therefore made for future studies:

To begin, for methodological development, future studies should focus on series of systematic replication studies in which the characteristics (e.g., investigators, participants, settings) differ from the current study but yield the same outcome. The amount of replication needed to have confidence that the intervention effect will be present in everyday clinical practice is the 5-3-20: A minimum of five SCD research papers examining the intervention that meet quality standards, conducted by at least three different research teams in three different geographical locations with a combined number of 20 single-cases across the papers.

Secondly, it is important for future studies to consider using a larger sample size and employ probability sampling techniques to ensure greater generalisability:

1. use children from different cultures and geographic regions within Ghana in order to allow for generalisability of results,
2. use randomized control trials to establish causality, thereby strengthening the ability to generalise to similar samples.

To fully understand the cultural norms relevant to children's total well-being, future studies should consider measuring CDHP qualitatively to explain and illuminate unanticipated research findings because it allows the researcher to examine specific emotional expression and regulation strategies in depth and in a variety of contexts.

Likewise, future studies should seek to sample children from the middle to high class working families, and other parts of Africa and the world at large in order to compare the universality of the intervention. Finally, other forms of interventions like the Filial play therapy should be used on the same targeted behaviours under the present study, to allow for comparison in determining which intervention works best.

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5.4 Implications from the Study

This section discusses the implications based on the findings from the current study. The implications are discussed in three areas. First, implications of the findings for practice are discussed. Next, the implications of the findings for policy makers, and lastly, implications for research are also discussed accordingly.

5.4.1 Implications for Practice and Training

Based on the findings of the study, several recommendations are made in order to improve school counselling in particular and by extension mental health delivery in Ghana. First of all, the findings revealed that the trauma related experiences were high within participants who happened to be children in the basic school. However, there is not enough counsellors within the basic schools. Whereas the recommended counsellor to students' ratio is 1:250 (America School Counselors, 2021), what pertains currently within Winneba is about 1:1400. This could deny lots of students the psychological help needed to succeed academically. It is recommended that GES will collaborate with the Jacaranda communities of Hope partners to give training to the circuit based counsellors to serve as a refresher course.

Secondly, the school-based counsellors who are augmenting the work of the circuit counsellors should be trained in CDHP so that they will be able to identify children who are struggling with trauma related symptoms. Additionally, it will equip them in offering age-appropriate intervention to the children under their care.

Thirdly, school counsellors will have to embark on psychoeducational programs for their colleagues to educate them on childhood adversity and its effects on the health and educational outcomes of the child and through the various stages of the lifespan. The student population will also need to be educated as well so that they can understand and offer help and support to themselves whenever needed.

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Finally, the training instructions who are vested with the duty of training professionals for the basic schools should include CDHP in their training so that teachers will be better prepared to offer the very least psychological help before the counselling professionals come in. Evidently, CDHP is efficacious in helping children self-regulate, and the training needed compared to other forms of counselling interventions is shorter and less expensive.

5.4.2 Implications for Policy Makers

Findings from the current study has revealed that the five-session CDHP can help children reduce their trauma related symptoms. When the psychological well-being of children is compromised, it does not just affect the child but also the country financially. ACEs have been empirically proven to be a predictor of academic non-achievement, juvenile delinquencies, and several mental health challenges in both childhood and adulthood (Felitti,1998; CDC,2020).

In Ghana, a greater chunk of the country's GDP is lost to fighting non-communicable diseases. Should the government liaise with non-governmental agencies like the Jacaranda Communities of Hope, trusted adults within the community could be trained to offer healing play interventions to children. This will help them to self-regulate and prevent them from having issues with the law. Again, it will help the government reduce the monies spent annually on the correctional facilities in reforming delinquent children and adults. Also, the greater chunk of the country's GDP that goes into fighting non-communicable diseases could be reduced.

5.4.3 Implications for Research

This study examined Ghanaian children from predominately semi-literate lower class, working families in a fishing community within the Effutu municipality of the Central Region. It would be important to see how the results of healing play on Trauma

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related symptoms of children from other rural and disadvantaged municipalities/Regions of Ghana would differ from the current sample.

In addition, in the present study, gathering data from other African samples would have allowed for the influence of shared cultural heritage and also subtle nuances on healing play development to be examined through the comparison of Ghanaian and other African children. Further, because trauma symptoms are likely to vary between cultures, both between countries and within countries, it would be interesting to examine the role of parents and other family members (e.g., siblings) in the healing process. Concerning healing play specifically, it would be interesting to investigate the relationship between healing play strategies and other types of internalizing and externalizing behaviors vis-à-vis other trauma symptomatology in children.

The healing play concept is a five-session therapeutic intervention. It will be interesting to conduct an experiment using more than five sessions to identify the point where healing play is no longer effective (i.e., plateau). The developers used the days of the week to incorporate all aspects of the Jacaranda program (e.g., healing play, mat stories, emotional regulation). It will be interesting to establish at what point healing play alone stops being efficacious or starts demonstrating an ability to reduce trauma-related symptoms.

Furthermore, research that uses other single case research design models (e.g., ABAB and ABCABC), this will help advance the development of the healing play intervention. Notwithstanding, future studies should not advance in measuring healing play quantitatively, but also qualitatively (e.g., Narrative enquiry). These are necessary to fully understand the cultural norms relevant to children's total wellbeing. Narrative enquiry has the potential to explain and illuminate unanticipated research findings because it allows the researcher to examine specific emotional expression and

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regulation strategies in depth and in a variety of contexts (e.g., during interpersonal interactions, in school and home environments). Further, the duration, intensity, and frequency of emotion expression can be evaluated using this methodology.

Finally, research that examines the efficacy of play therapy interventions in Ghana is necessary to further our understanding of trauma related symptoms in children and the variables that promote and facilitate healthy well-being in the Ghanaian context. Play therapy is a construct that is receiving increased attention in the field of counselling as research reveals significant positive effect of Play Intervention on children's healthy psychological functioning and overall wellbeing (Friesen, 2020). These findings are limited in value however, if they cannot be applied to individuals from a variety of backgrounds and circumstances. As more research is conducted examining the efficacy of play interventions within Ghana, it will be possible to uncover patterns that will allow for advances in understanding the role of play therapy in children's mental health across diverse populations.

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APPENDICES

Appendix	Description
A	Informed Consent
B	Demographic Information
C	Adverse Childhood Experiences Questionnaire
E	Youth Outcome Questionnaire
F	Letter of Introduction from Department
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H	Sample pictures of Healing Play therapy intervention

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Appendix A

Informed Consent

University of Education, Winneba
Faculty of Educational Studies
Department of Counselling Psychology

Effect of Healing Play on Emotional Regulation of Traumatized Children

Informed Consent

Principal Investigator: Angelina Amoakowa Mensah
Faculty Supervisors: Dr. (Mrs.) Epiphania E. Bonsi
Mr. John N-yelbi

You are being invited to participate in a research study. The study is *voluntary* so you can choose to take part or not.

Purpose of the study: The purpose of this study is to find out how healing play can help reduce your stressful symptoms both in school and at home.

What you will be asked to do in the study: When you take part in this study, we will ask you to complete a demographic questionnaire. You will also be asked to play with a therapist twice a week for 3 weeks. The therapist will bring some toys and a mat and go through some playing time with you. She will explain to you what you can and cannot do.

In-Loco Parentis: Your headteacher will give permission to have you take part in this study. You must be enrolled in the basic school, have gone through a screening test to make sure the intervention will be beneficial to you.

Study contacts for questions about the study or to report a problem: If you have questions, concerns, or complaints, or think the research has impacted you negatively in any way, talk to: Ms. Angelina or tell your Headteacher about it ok?

______________________	______________________
Head Teacher Name	Student Name
______________________	______________________
(Signed Consent)	(Signed Assent)
Date: ______________	Date: ______________

____

Name of Parent (Guardian)

______________________ Date: ______________

Signature of Parent / Guardian

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Appendix B

Demographic Information

Demographic Information

1. Gender:
a. Male [ ]
b. Female [ ]
2. What is your date of birth? ________________________________
3. How old are you as of today? ________________________________
4. What religious faith/belief do you have?
   a. Buddhist [ ]
   b. Christian [ ]
   c. Muslim [ ]
   d. Traditionalist [ ]

5. Who do you stay with?
   a. Live at home with biological parents [ ]
   b. Live with grandmother [ ]
   c. Live with grandfather [ ]
   d. Live with other relatives [ ]
   e. Live with friends [ ]
   f. Live by myself [ ]

6. Who takes care of your daily needs?
   a. My parents [ ]
   b. The relatives I stay with [ ]
   c. I take care of these needs myself [ ]
   d. My boyfriend/girlfriend [ ]

7. How would you describe your family rank?
   a. First born [ ]
   b. Middle child [ ]
   c. Only gender (only boy or only girl among siblings) [ ]
   d. Only child [ ]
   e. Last born [ ]
   f. It is complicated because it is different on my father's side and different on mother's side [ ]

8. How would you describe the relationship between you and the people you stay with?
   a. It is cordial – there is mutual respect [ ]
   b. It is ok – not bad, and not good [ ]
   c. If I had an option, I would leave [ ]

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Appendix C

Adverse Childhood Experiences Questionnaire

Adverse Childhood Experiences (ACEs) Questionnaire

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?
   ○ Yes ○ No

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?
   ○ Yes ○ No

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral or anal intercourse with you?
   ○ Yes ○ No

4. Did you often or very often feel that … No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?
   ○ Yes ○ No

5. Did you often or very often feel that … You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ○ Yes ○ No

6. Was a biological parent ever lost to you through divorced, abandonment, or other reason?
   ○ Yes ○ No

7. Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   ○ Yes ○ No

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   ○ Yes ○ No

9. Was a household member depressed or mentally ill? or Did a household member attempt suicide?
   ○ Yes ○ No

10. Did a household member go to prison?
    ○ Yes ○ No

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Appendix D

Youth Outcome Questionnaire

Youth Outcome Questionnaire

Read each statement carefully. Decide how true this statement is during the **past 7 days**. Complete each part as it most accurately describes the past week. Fill in only one answer for each statement. You can erase any unwanted marks.

Statement	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
1. I have headaches or feel dizzy					
2. I don't participate in activities that used to be fun					
3. I argue or speak rudely to others					
4. I have a hard time finishing my assignments or I do them carelessly					
5. My emotions are strong and change quickly					
6. I have physical fights (hitting, kicking, biting, or scratching)					
7. I worry and can't get thoughts out of my mind					
8. I steal or lie					
9. I have a hard time sitting still (or I have too much energy)					
10. I use alcohol or drugs					
11. I am tense and easily startled (jumpy)					
12. I am sad or unhappy					
13. I have a hard time trusting friends, family members, or other adults					
14. I think that others are trying to hurt me even when they are not					
15. I have threatened to, or have run away from home					
16. I physically fight with adults					
17. My stomach hurts or I feel sick more than others my same age					

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Statement	Never or Almost Never	Rarely	Sometimes	Frequently	Almost Always or Always
18. I don't have friends or I don't keep friends very long					
19. I think about suicide or feel I would be better off dead					
20. I have nightmares, trouble getting to sleep, oversleeping, or waking up too early					
21. I complain about or question rules, expectations, or responsibilities					
22. I break rules, laws, or don't meet others' expectations on purpose					
23. I feel irritated					
24. I get angry enough to threaten others					
25. I get into trouble when I'm bored					
26. I destroy property on purpose					
27. I have a hard time concentrating, thinking clearly, or sticking to tasks					
28. I withdraw from my family and friends					
29. I act without thinking and don't worry about what will happen					
30. I feel like I don't have any friends or that no one likes me					

Endorsed:

Dr. (Mrs) Epiphania E. Bonsi
Date: 14th October, 2022

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Appendix E

Letter of Introduction from Department

UNIVERSITY OF EDUCATION, WINNEBA
FACULTY OF EDUCATIONAL STUDIES
DEPARTMENT OF COUNSELLING PSYCHOLOGY

18th October, 2022

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

LETTER OF INTRODUCTION

I write to introduce to you, ANGELINA AMOAKOWA MENSAH, the bearer of this letter who is a student in the Department of Counselling Psychology of the University of Education, Winneba. She is reading Master of Philosophy in Counselling Psychology with index number 202121337.

She is conducting a research on the topic: EFFECT OF HEALING PLAY ON EMOTIONAL REGULATION OF TRAUMATIZED CHILDREN. This is in partial fulfillment of the requirements for the award of the above mentioned degree.

She is required to administer questionnaire to help her gather data for the said research and she has chosen to do so in your outfit.

I will be grateful if she is given permission to carry out this exercise.

Thank you.

Yours faithfully,

DR. PAUL KOBINA A. BEDU-ADDO
AG. HEAD OF DEPARTMENT

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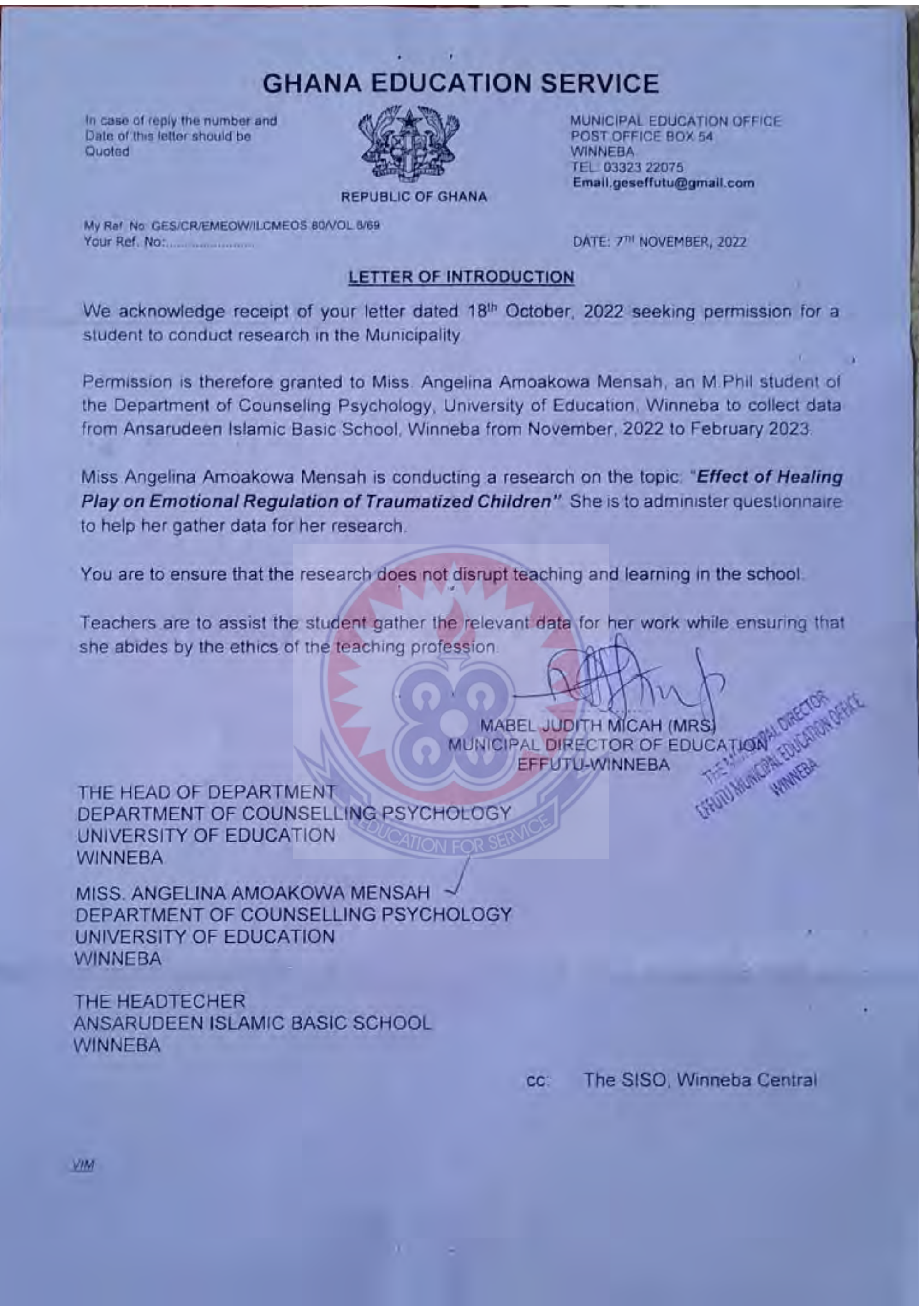
Appendix F

Letter of Introduction from Municipal Directorate



GHANA EDUCATION SERVICE

In case of reply the number and Date of this letter should be Quoted

REPUBLIC OF GHANA

MUNICIPAL EDUCATION OFFICE
POST OFFICE BOX 54
WINNEBA
TEL: 03323 22075
Email.geseffutu@gmail.com

My Ref. No: GES/CR/EMEOW/ILCMEOS 80/VOL 8/69
Your Ref. No:......................

DATE: 7TH NOVEMBER, 2022

LETTER OF INTRODUCTION

We acknowledge receipt of your letter dated 18th October, 2022 seeking permission for a student to conduct research in the Municipality.

Permission is therefore granted to Miss. Angelina Amoakowa Mensah, an M.Phil student of the Department of Counseling Psychology, University of Education, Winneba to collect data from Ansarudeen Islamic Basic School, Winneba from November, 2022 to February 2023.

Miss Angelina Amoakowa Mensah is conducting a research on the topic: ***"Effect of Healing Play on Emotional Regulation of Traumatized Children"***. She is to administer questionnaire to help her gather data for her research.

You are to ensure that the research does not disrupt teaching and learning in the school.

Teachers are to assist the student gather the relevant data for her work while ensuring that she abides by the ethics of the teaching profession.

MABEL JUDITH MICAH (MRS)
MUNICIPAL DIRECTOR OF EDUCATION
EFFUTU-WINNEBA

THE HEAD OF DEPARTMENT
DEPARTMENT OF COUNSELLING PSYCHOLOGY
UNIVERSITY OF EDUCATION
WINNEBA

MISS. ANGELINA AMOAKOWA MENSAH
DEPARTMENT OF COUNSELLING PSYCHOLOGY
UNIVERSITY OF EDUCATION
WINNEBA

THE HEADTECHER
ANSARUDEEN ISLAMIC BASIC SCHOOL
WINNEBA

cc: The SISO, Winneba Central

VIM

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Appendix G

Healing Play Therapy Sessions in a Basic School

The "Mat" providing STRUCTURE in the Healing Play therapy session, while therapists demonstrate PRESENCE, PRAYER, PATIENCE, POSTURING, and PARTNERING in allowing the children to lead.

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Appendix H

Artifacts from Healing Play Therapy in a Basic School

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