

**Exploring the outcomes of experiential art activities on the behaviour and
psychological functioning of children**

by

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degree**

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Paulo Coelho wrote: *“When you want something, all the universe conspires in helping you to achieve it”.*

Abstract

This study is based at a university-run clinic called Itsoseng Clinic located in Mamelodi at the University of Pretoria. Itsoseng Clinic has a large volume of referred cases and as a result many children seeking help have to be placed on a waiting list where they remain for several months, up to a year or even longer. Most children are referred to Itsoseng Clinic for behavioural and other related problems that require psychological intervention. Over time, the staff members at Itsoseng clinic have established various group work modes, involving non-verbal activities that have been informally reported to be effective. The study aims to explore the outcomes of experiential art activities on the behaviour and psychological functioning of these children.

Using the waiting list, children were randomly allocated to a group and each participant had the same probability of being assigned to either the experimental group or the control group. Children in the control group were offered an opportunity to be part of the experiential art group programme after the study.

This study comprised a quantitatively-driven core component plus a qualitative supplementary component using a brief interview schedule. The use of the Child Behaviour Checklist (questionnaires) seemed applicable to comparing the differences in scores, and supplementing this with follow up qualitative interviews enabled the researcher to gain a more in-depth understanding and knowledge of the children's and caregivers' experiences and behaviours.

Results showed both a decrease and an increase in some of the variables from the Child Behaviour Checklist. Potential influences were further explored and

discussed alongside the impact of the experiential art activities. Themes derived from a brief interview schedule involved discussions regarding participation and engagement in several activities, academic progress, and various behaviours and attitudes with or towards peers and family members.

Key words: *Behaviour, children, child behaviour checklist, experiential art activities, Itsoseng Clinic, Mamelodi, waiting list*



List of Abbreviations

ASEBA	Achenbach System of Empirically Based Assessment
BASC	Behaviour Assessment System for Children
CBCL	Child Behaviour Checklist
Comp	Competence (scores)
ICC	Intra-class Correlation
ICF	International Classification of Functioning
NGOs	Non-Governmental Organisations
Quan+qual	Quantitatively (QUAN) driven core component plus a qualitative supplementary
RSG	Random Small Group (experimental design)
SPSS	Statistical Package for the Social Sciences
WHO	World Health Organisation

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Chapter One – Introduction

1.1 Introduction

Health care services are believed to be negatively affected by long waiting times in South Africa and internationally (Mokgoko, 2014). Mokgoko (2014) cites a study conducted by Barlow in 2002 showing that this is a worldwide phenomenon and not unique to South Africa. The study further indicates that health care users have expressed dissatisfaction with waiting times for health care services at public hospitals and clinics in South Africa. It is therefore supposed that waiting time, or being placed on a waiting list, may have negative implications for patients while waiting for health care and related services (Mokgoko, 2014).

Saidi (2007) found that patients from various hospitals in South Africa are frequently sent back to Community Health Centres, which often results in extended waiting time and frustration. Mokgoko (2013) discusses how, despite the several advances in medical and health care systems, patients still experience extended periods of waiting in hospitals and clinics.

In addition to waiting time as a concern; it is also important to consider the environment in which the waiting occurs. This may eventually have various effects on the patient's condition (Saidi, 2007). Ajayi (2002) stated that few studies have attempted to identify the activities patients engage in while waiting to be helped in clinics. Such activities may result in a number of different effects on the patient's condition. Ajayi (2002) further highlighted the possibility of patients adopting a



positive attitude towards the long waiting period if a programme perceived to be useful to them occupied their waiting time (Ajayi, 2002).

Waiting time, according to *Oxford Dictionary* (2011), is “delaying action until a particular time or event”. Therefore, in the context of this research study, waiting time will refer to the period from the moment the patients or clients register for psychological services at Itsoseng Clinic in order to get their files, to being seen by the psychological clinic staff and receiving psychological intervention.

Saxena, Thornicroft, Knapp, and Whiteford (2007) have stated that resources for mental health are scarce and are also inequitably distributed among countries, regions, and within communities.

In the South African context, various studies (Blokland, 2014; Lifschitz & Oosthuizen, 2001; Ruane, 2010; Timm, 2007) have described how health care and social services are generally limited resources; one of these studies (Blokland, 2014) referred to limited resources in Mamelodi specifically. Communities such as Mamelodi often have populations with high rates of socio-economic deprivation and are likely to have the highest need for mental health care but the lowest access to it (Saxena et al., 2007).

A study by Ruane (2006) indicated that South Africa’s historical context has contributed to the development of psychological problems and stressors, especially within disadvantaged communities. Most populations in disadvantaged communities are not able to afford psychological interventions; hence the need for community interventions (Ruane, 2006). The Itsoseng Clinic was developed in an attempt to actively explore the needs of the Mamelodi community and to design appropriate community interventions (Ruane, 2006).



1.2 Research Problem

Itsoseng is a university-run psychological facility, based at the University of Pretoria; Mamelodi, with a large referral for mental health services for children and youth. A study by Ruane (2010) indicates that Itsoseng Clinic is one of a small number of formal psychological service providers in Mamelodi, which has a population of approximately one million people. Blokland (2014) writes that Itsoseng Clinic has a large volume of referred cases and, as a result, many children seeking help have to be placed on a waiting list for several months or even a year. Within this interim period, crises often present that need to be dealt with urgently, further interrupting and delaying services to those on the waiting list (Blokland, 2014).

This study forms part of an ongoing staff research study run by Dr C Asanbe and Dr L Blokland entitled “Comparison of clinical outcomes for children in treatment groups and on a waiting list: A community-based sample”. The study is based at Itsoseng Community Clinic located at the University of Pretoria in Mamelodi. The current research aims to assist in the broader study by providing information on the outcomes that are specific to children who are on the waiting list and who take part in the informal experiential art activities run at the clinic. Information is continually reviewed at various points to compare the behaviour and psychological functioning of children receiving child-oriented psychotherapy with those of children on the waiting list.

The study aims to investigate whether engaging in informal group experiential art activities influences the behaviour and psychological functioning of these children. The results of this study may assist in the bigger project, which aims to assist in alleviating the waiting period through the use of informal group modes or experiential



activities. This may further assist in assessment of the services provided by the clinic, as well as potential future improvements.

1.3 Justification, Aim and Objectives

In addition to the issues surrounding the waiting list at the Itsoseng Clinic discussed above, it is also essential to note the need for more research into experiential activities in general. Conducting this study could potentially provide the researcher with an opportunity to explore whether these experiential activities complement child psychotherapy while they wait (Asanbe & Blokland, 2014). At Itsoseng Clinic, children are often referred for psychological services by schools. The school is one of the few formal systems where behavioural problems can be identified (Blokland, 2014; Viding, McCrory, Blakemore, & Frederickson, 2011).

The research sets out to gather empirical data that may inform the development and delivery of effective mental health services for children in a university-run clinic. The larger study comprises three groups; group 1 are children who receive child-oriented psychotherapy, group 2 are children who are on the waiting list and take part in the experiential activities, and group 3 are children who are on the waiting list only (not in the activity group).

(Details about the larger study are included here in response to a specific request from reviewers to do so.)

As part of Asanbe and Blokland's (2014) research, this study proposes to:

- Assess children on the waiting list + activities (art group activities): Group 2 in the main study by Dr Asanbe and Dr Blokland.

- Determine whether the art activities influence the children's behaviour and psychological functioning, using the Child Behavioural Checklist (CBCL) (Achenbach & Rescorla, 2001; Asanbe & Blokland, 2014) before and after the experiential art activity programme.

- Administer the same assessment instrument (CBCL) with children on the waiting list only (Group 3 in main study) as a control.

- Administer a brief interview schedule with the parents or caregivers of children from both groups. (Topics in the interview were based on the parents' or caregivers' views of their children's general behaviour at home and at school). The interview schedules can provide useful information about their children's experiences, especially if the children have difficulty in expressing their experience/s.

The findings from the study could have implications for enhancing the clinic's programmes in formulating policies and developing new levels of service. The use of expressive arts, especially with children, can move towards a task-shifting process in which clients and patients are able to access service alternatives (Asanbe & Blokland, 2014). In some clinical settings, one-on-one services may be expensive and time-consuming; other settings are in a geographic location where they are not readily available or accessible (Asanbe & Blokland, 2014).

1.4 Overview of Study

Chapter two presents a review of the literature related to this study and describes the study context, namely Mamelodi and the Itsoseng Clinic. It contains a section that focuses on children; as they are the study population, and considers the factors that may influence their behaviour, the various ways in which behavioural problems

can present, and the inability of some children to express their emotions. The chapter highlights the impact of language and cultural barriers while working with children and it looks at alternative means or media to overcome these barriers. This then leads to a discussion about expressive art methods and activities, as well as the use of experiential art activities at Itsoseng Community Clinic.

Chapter three focuses on the theoretical point of departure of this study. It first discusses expressive arts and the person-centred approach and then discusses the behavioural approach to children and the expressive arts.

Chapter four discusses the research methodology adopted in this research. This includes the research approach, the research design and the methods used in the research process. The chapter includes a section on the population, the inclusion criteria, and the random allocation process of participants into their allocated groups (experimental or control group) and concludes with a discussion of ethical considerations.

Chapter five presents the findings and results of the overall data of the study. The first part of the chapter focuses on results in relation to the Child Behaviour Checklist (CBCL). The results are presented separately for the experimental group and the control group. The second part of the chapter focuses on the themes that emerged from the semi-structural interviews before and after the presentation of the experiential (expressive) art group programme.

Chapter six provides a discussion of the findings. The outcome of the children's behaviour is further explored in this chapter by looking at results from the Child Behaviour Checklist and themes derived from the semi-structured interviews.

Chapter seven presents the conclusions, limitations and recommendations based on the findings and process of the study.

Chapter Two – Literature Review

2.1 Introduction

This chapter explores the context of the study by providing background information about Mamelodi and the Itsoseng Clinic. It also focuses on the study population, namely children, and considers the factors that may influence their behaviour, the various ways in which behavioural problems may present in children, and the difficulties that may occur while working with children. It includes a discussion of expressive art methods and activities and the use of experiential art activities at Itsoseng Community Clinic.

2.2 Contextualising the Study

2.2.1 Mamelodi.

Mamelodi community is a township that forms part of the City of Tshwane metropolitan municipality in South Africa (Mailula, 2009). The name “Mamelodi” is said to have been taken from the Tswana phrase “Tshwane ya Mamelodi” which means “musical whistle from the Tshwane river” (Chiloane, 1990). The township is situated in the east of Tshwane and was established during the 1950s (Mailula, 2009).

Chiloane (1990) states that the reasons for the establishment of Mamelodi were essentially political and socio-economic. The government developed a segregated township during the apartheid era (Chiloane, 1990).

According to Peeters and Osman (2005), Mamelodi was similar to other townships on the borders of South African cities planned by the apartheid authorities as a temporary residential area for black labour. Eskell-Blokland (2005) and Timm (2007) also point out that township areas were designated residential areas for the black population by the government of the time. Residents were forced to relocate to various parts of Mamelodi that did not reflect their own traditional lifestyles; this led the residents to blend their traditional customs and rituals with modern or urban ways of life (Blokland, 2014). Several residents were moved from their traditional residential areas in order for them to become workers that serviced the cities (Blokland, 2014).

Mamelodi has had problems similar to those of other under-served townships. These problems include isolation from the central business district (CBD), a shortage of job opportunities, poor quality housing and several informal settlements (Peeters & Osman, 2005).

Statistics South Africa's (2011) census stated that the total population of Mamelodi was estimated to be 334,577. Major resources are being provided in and around the city of Tshwane however, apparently there are still limited resources within the townships (Blokland, 2014). Mamelodi residents are still required to travel long distances and use their own inadequate funds to access appropriate health services such as clinical psychological services, psychiatric care, occupational therapy, speech or audiology services, remedial educational assessments and treatments (Blokland, 2014).



2.2.2 The Itsoseng Clinic.

The Itsoseng Psychology Clinic was established in response to the manifest need for psychology-based mental health care services in Mamelodi (Blokland, 2014). Phala (2008) conducted a study which provided a holistic view of the foundation of Itsoseng Clinic, its functioning, and the role it plays within the community.

The Itsoseng Clinic is situated on the Mamelodi Campus, which currently forms part of the University of Pretoria. Itsoseng Clinic was established in 1997 as part of the Department of Psychology of what was then Vista University (Phala, 2008). Over the years, there had been a growing need for psychological services in the Mamelodi community (Phala, 2008). The Department of Psychology later included an academic programme (Master of Arts in Psychology) within the Itsoseng Clinic to address the community's need for psychological services, mainly for people who were underprivileged and had limited access to these services (Phala, 2008).

Itsoseng Community Clinic is one of a number municipal sites that offer psychological services and assessments in Mamelodi township (Blokland, 2014).

Blokland (2014) highlights the fact that the presenting problems seen in the Itsoseng Clinic frequently differ from those found in more western-acculturated societies. There is little awareness of what therapeutic psychology is in Mamelodi township; the local population rarely considers life challenges from a psychological perspective (Blokland, 2014). Blokland (2014) further indicates that clients' problems are often likely to "present in the form of psychosomatic symptoms; proclaimed spirit afflictions; or vague feelings of dis-ease, with many of these symptoms being accompanied by stigma" (p.181).

Phala (2008) suggested that several people benefit from the services of the clinic. It has been pointed out that schools in Mamelodi have steadily become one of

Itsoseng's main referral sources. The Itsoseng Clinic was upgraded in the year 2004 with the inclusion of a nursing sister, a medical doctor and final-year occupational therapy students (Phala, 2008).

2.2.3 Children (the study population).

The specific study population in this research is children. The Constitution of South Africa provides the legal definition of a child as a person under the age of 18 years (Children's Act 38 of 2005 – Department of Justice, 2016). Therefore, the terms 'child' and 'children' in this study are used to indicate a person under the age of 18 years.

As mentioned above, Blokland (2014) states that “children are often referred to Itsoseng Clinic (Mamelodi) for psychological services by the school. The school is one of the few formal systems where behavioural problems can be picked up” (p.181). The Itsoseng Clinic often receives referrals by teachers of children who have been described as having challenges at school, difficulty or failure to learn, or conduct problems (misbehaviour), and these children are often given the label “learning problems” (Blokland, 2014). It is important to explore the label “learning problems” further, because children's problem behaviour and difficulty to perform at school may represent a variety of other underlying problems (Blokland, 2014). Behavioural problems in children often present in various forms (Achenbach & Edelbrock, 1981). Some behavioural problems are generally relatively well-known and receive more attention than others, whereas some social and emotional problems traditionally receive little attention and are often associated with a referral or label related to behavioural problems (Achenbach & Edelbrock, 1981).



There are several factors that contribute to behavioural problems in children. Dodge, Lansford, Burks, Bates, Pettit, Fontaine, and Price (2003) conducted a study that considered the relation between social or peer rejection and aggression or antisocial behaviour. Findings in the study indicated that rejection exacerbated antisocial development among children who were predisposed to aggressive behaviour.

Parents' interactional patterns and conflict resolution styles may contribute differently to the presence of internalising and externalising behaviour in children (Katz & Gottam, 1993). Parenting styles may be considered in various ways, depending on the level of parental warmth or affection, behavioural control and psychological control (Aunola & Nurmi, 2005). The level of behavioural control that a parent has may be based on the extent to which they manage their children's behaviour, either by being very controlling or by setting some rules and regulations (Baumrind, 2005). Parental warmth, on the other hand, can be referred to as the extent to which parents are accepting of and responsive to their children's behaviour, rather than being rejecting and unresponsive (Baumrind, 2005). Various combinations of these aspects create distinct parenting styles, such as authoritative, authoritarian, permissive, and uninvolved (Baumrind, 2005). These aspects are regarded as the most influential when predicting children's internal and external behaviours (Aunola & Nurmi, 2005).

Research has shown, for example, that authoritative parents usually encourage their children to be independent while maintaining limits and controls of their actions and behaviour (Uji, Sakamoto, Adachi, & Kitamura, 2014). Their children, in turn, learn how to appropriately negotiate and engage with others, with the result that they are more likely to be socially competent, responsible and autonomous (Baumrind,

2005). Authoritative parenting style has also supposedly resulted in children having higher levels of self-concept, psychological health and a better quality of life than authoritarian and permissive parenting styles (Rezai-Niaraki & Rahimi, 2013).

Children of authoritarian parents are often led by strict disciplinarians, who use restrictive and punitive styles to get them to follow parental directions (Uji et al., 2014). This may result either in children who become rebellious and show aggressive behaviours, or in children who are relatively submissive and tend to be dependent on their parents (Baumrind, 2005).

Permissive parents are considered to be passive in their parenting and seem to believe that the way to show their love towards their child or children is to grant their wishes (Rezai-Niaraki & Rahimi, 2013). As a result, the children of such parents are allowed to make several decisions without parental input (Baumrind, 2005).

Barnes and Farrel (1992) suggested that positive parenting techniques such as high levels of parental support and monitoring often resulted in children who were less likely to display deviant behaviour and misconduct. Conversely, negative techniques such as poor parental supervision, inconsistent discipline, and corporal punishment contributed to children displaying negative behaviour (Sangwi, Adams, & Reissland, 2015).

Children are also affected by social stressors such as problems in their family household and marital problems between parents (Katz & Gottman, 1993). Loeber and Stouthamer-Loeber's study, conducted in 1986, demonstrated that family systemic changes in parenting behaviours may also influence the degree of involvement in delinquent activities and conduct problems.

There are children with socio-economic stressors that resort to working part-time to earn money to support their family. Bachman and Schulenberg (1993) researched

the way in which part-time work intensity relates to problem behaviour, time use and satisfaction among high school children. Findings showed that work intensity appeared to reduce the likelihood of sufficient sleep (Bachman & Schulenberg, 1993). Part time work was considered to be a facilitator and a problem in this regard. Insufficient sleep influenced school performance significantly (Bachman & Schulenberg, 1993).

A factor at school that may also influence problem behaviours is the interaction between teachers and their learners (Stormont, 2002). Negative interactions with other children and limited support for various internalising and externalising behaviours may exacerbate the problem (Stormont, 2002). Social, emotional, and behavioural problems require early identification, screening and assessment, and effective early interventions (Briggs-Gowan, Carter, Bosson-Heenan, Guyer, & Horwitz, 2006).

The clear challenge with children is that they often have difficulty regulating and expressing their emotions appropriately (Southam-Gerow & Kendall, 2002). This often results in 'problem behaviours' that are often misrepresented or misunderstood because children struggle to verbally express their challenges, such as emotional problems (Southam-Gerow & Kendall, 2002).

Cohen and Mendez's 2009 study (as cited in Cross, 2011) showed that children who had behavioural issues were also likely to have difficulties understanding language and regulating their emotions. These children were from low socio-economic groups and their ability to interact with others was poor or diminished over the years during the course of the study.



2.3 Language Barriers and Difficulties in Communicating with Children

Mailula (2009) wrote that the population of Mamelodi comprises mostly black people from various cultural and ethnic backgrounds. Mamelodi residents form a diverse community whose members speak a number of different languages, such as Sotho, Pedi, Tswana, Tsonga, Zulu, Afrikaans and English (Ruane, 2010).

Blokland (2014) points out that language barriers may present challenges even to speakers of local African languages, as clients may come from anywhere in South Africa or even from neighbouring countries as refugees. This may present further cultural barriers in addition to those already being experienced (Blokland, 2014). Staff members and students who provide services at the Itsoseng Clinic are often not familiar with all languages and cultural aspects; they often encounter difficulties when they are confronted with these barriers and may feel hindered from engaging with the clients (Blokland, 2014).

A study by Chand (2005) highlighted some of the limitations and difficulties encountered by health professionals in their attempts to interpret particular words and phrases during the process of communicating with children. The study emphasised the importance of considering how language barriers can exacerbate discrimination against minority ethnic groups or families (Chand, 2005). Misunderstandings often occur due to cultural variations in verbal and non-verbal communication, and this may lead to feelings of estrangement and/or an inability to develop trust and rapport between the client (the child) and the health professional (Sue & Sue, 1977).

Language barriers often disadvantage minority ethnic communities when they access primary health care services (Gerrish, Chau, Sobowale, & Birks, 2004).

Interpreting services have generally been considered to be inadequate, and in some instances reliance has been placed on family members to interpret. This has been considered an inappropriate way to overcome language barriers (Gerrish et al., 2004).

Several misunderstandings may occur where there are language barriers and when interpretation is used. A survey was conducted by Abbe, Simon, Angiolillo, Ruccione, and Kodish (2006) in which groups of health professionals expressed considerable concern about the process of communicating across a language barrier. These concerns included the accuracy and completeness of interpretations, the complexity of information, and loss of confidence in and control over the communication process (Abbe et al., 2006). Information may become too complex for interpreters; they might become overwhelmed by an overload of information and they may possibly miss important information (Abbe et al., 2006). Interpreters may also have limited clinician sensitivity towards the cultural and socio-economic backgrounds of families with limited proficiency in English (Abbe et al., 2006). Conclusions in the survey indicated that some of the concerns could be minimised through efforts to enhance interpreter accuracy and completeness, including the use of simple, easy-to-understand language (Abbe et al., 2006).

Faulkner and Coates (2011) wrote about alternative means of communication to overcome language and cultural barriers, particularly among young children who have only recently learned to speak their home language. Expressive art activities have been considered as an alternative means of communicating, without individuals having to verbally express their thoughts and feelings (Malchiodi, 2012). Making use of expressive art activities could be potentially useful in overcoming language and cultural barriers (Malchiodi, 2012).

2.4 Experiential/Expressive Art Activities

This study will research non-therapeutic experiential art activities. Little research in psychology has been conducted in this area (Dragon & Madsen, 2015), as it is not formally within the field of psychotherapy theory. This study will, however, provide an overview of the literature on a varied range of art-related psychotherapeutic methods, including art therapy. Art methods in psychotherapy will be explored in an attempt to understand underlying factors which may contribute to the psychological and emotional well-being of children engaged in such activities (Dragon & Madsen, 2015). However, the main focus of the study remains behaviour change measured by the Child Behaviour Checklist, and not the formulation of the intervention, as it is primarily a waiting list study.

2.5 Expressive Arts Methods/Activities and Children's Behaviour

Activities such as drawing, drumming, creative movement, and play permit individuals of all ages to express their thoughts and feelings in a manner that is different from strictly verbal means, and have unique properties as interventions (Malchiodi, 2005; Malchiodi, 2012). With the initiation of brief forms of treatment, many therapists find that the expressive methods help individuals to communicate relevant issues quickly in ways that talk therapy cannot (Malchiodi, 2012). The process of carrying out art tasks is said to be much more significant than the created products. The range of materials used in expressive methods, such as wet clay and finger paint, are psychologically stimulating and able to provoke primitive kinds of

experiences (Dragon & Madsen, 2015; Weiner, 1999). Malchiodi (2012) supposes that expressive methods add a unique dimension to psychotherapy and counselling because they have several specific characteristics not always found in strictly verbal therapies, such as self-expression, active participation, imagination and mind-body connections. Expressive or creative activities include programmes that are playful, non-pressured and socialising in nature (Caplow-Lindner, Harpaz, & Samberg, 1979; Chaiklin & Wengrower, 2009).

Shennum (1987) reported a study on the effect of an art and dance/movement (expressive) therapy programme on children's behaviour in residential treatment. The results indicated that greater amounts of expressive activity reduced children's levels of emotional unresponsiveness and 'acting out' problem behaviour (Ritok & Bodoczky, 2012; Shennum, 1987).

Smeijsters and Cleven (2006) explore the treatment of aggression using art therapy and describe various types of such therapy (i.e. drama, music, art, and dance/movement therapy) in a forensic psychiatry context using practice, theory and research. Findings show that art therapies can help to decrease levels of aggression and recidivism (Smeijsters & Cleven, 2006).

Banks, Davis, Howard and McLaughlin (1993) examined the effect of directed art activities on the behaviour of two pre-school children. The behaviours measured in the study were aggression, eye contact and social initiation. The results indicated that the directed art activity had a pronounced effect on the two children's social behaviour (Banks et al., 1993).

Play has been said to be the primary source of development in children of pre-school age, and its importance in child development and child therapy has long been recognised by theorists such as Jean Piaget and Virginia Axline (Bockarova, 2015).



Peer play groups combined with art activity groups have been shown to improve depression and hyperactivity scores according to the Child Behaviour Checklist. This has been found with children who have at least one parent suffering from alcohol or drug dependency (Surhone, Tennoe, & Hessonow, 2010). Aggression and delinquent behaviours significantly decreased in boys involved in play combined with art therapy (Surhone et al., 2010).

A study by Puig, Lee, Goodwin, and Sherrard (2006) showed that participation in creative arts therapy interventions enhanced psychological well-being by reducing negative emotional states and enhancing positive states of group participants within the study. The study recommended future research in this area (Puig, Lee, Goodwin, & Sherrard, 2006).

Stuckey and Nobel (2010) conducted a review in an attempt to explore the relationship between engagement with the creative arts and health outcomes, specifically the health effects of music engagement, visual arts therapy, movement-based creative expression, and expressive writing. Evidence showed that art-based interventions are effective in reducing adverse physiological and psychological outcomes; however, the extent to which these interventions enhance health status was mostly unknown (Stuckey & Nobel, 2010). Stuckey and Nobel (2010) encouraged further investigation into this subject and further research into the complexities of engagement with the arts and health.

Dragon and Madsen (2015) suggest that little research has been conducted on expressive activity methods and indicate that further development in this area is required; this formed part of the rationale for this study.

‘Expressive activity-based methods’ are considered to be supplementary in nature, rather than serving as children’s primary source of therapy (Isbell & Raines,

2003). Children's need for emotional expression and learning can perhaps be best met by programmes such as expressive activity methods, which are conducted in their own setting and which minimise disruption in various contexts (Ceausu, 2016). If this is so, then one would expect emotional problem behaviours to decline in children who engage in such activities or receive such therapy (Malchiodi, 2012; Shennum, 1987).

It has been predicted that children who received greater amounts of art and/or dance/movement therapy would display less emotional unresponsiveness and less 'acting-out' problem behaviour than children who received little or no therapy (Burkitt & Lowry, 2015; Shennum, 1987). Coholic (2010) reported that art-based methods facilitate psychological wellbeing because they help children to express themselves and understand their feelings, thoughts and behaviours more clearly. Art-based methods also teach children more useful social and coping skills (Coholic, 2010; Dragon & Madsen, 2015).

Dunphy, Mullane, and Jacobsson (2013) reviewed several studies that focused on the effectiveness of expressive art methods. They highlighted Karatas and Gokcakan's (2009) study which indicated that drama has the potential to reduce behavioural issues for school students. However, this population was not representative of the broader range of clients and conditions, hence pointing to significant opportunities for further research (Dunphy, Mullane, & Jacobsson, 2013).

Experiential art activities and methods could also be considered within the cluster of extracurricular activities. Massoni (2011) wrote a paper describing the role of extracurricular activities on school children, including sports, clubs, drama, and other social events. Results indicated that these activities could have positive effects on

students of all kinds, ranging from the above average student to the student who is on the brink of dropping out of school (Massoni, 2011).

It has been suggested that expressive and experiential art activities are particularly useful in cross-cultural settings of practice where practitioners typically face several challenges in their effective client engagement (Malchiodi, 2012). Art-based methods may become effective with the use of culturally-appropriate symbols and mythologies (Blokland, 2014). Success through these processes has been reported on when working across cultures and with various age groups and disorders (Blokland, 2014). This further highlights the significance of using art-based methods in cross-cultural settings such as Mamelodi.

2.6 The Use of (Non-Therapeutic) Experiential Art Activities at Itsoseng Community Clinic

Blokland (2014) indicates that, over time, the staff members at Itsoseng Clinic have established various group work modes, involving non-verbal activities that have been found to be effective. Visser and Du Plessis (2015) also conducted a study at Itsoseng Clinic that involved the use of expressive art group interventions for sexually-abused adolescent females. The expressive art activities were believed to create opportunities for participants to explore and express difficult emotions in a non-threatening and indirect way (Visser & Du Plessis, 2015). Sturgeon and Keet (2010) had highlighted the value and usefulness of group interventions in various mental health settings; Visser and Du Plessis (2015) accordingly aimed to explore the feasibility of expressive art group interventions as alternative means of treatment for sexual abuse and other clients at Itsoseng Clinic.

Non-therapeutic group activities have also been developed and initiated at the Itsoseng Clinic in an attempt to ease the waiting experience of children who have been placed on the waiting list (Blokland, 2014). The impact of these informal activities is explored in this study out of concern for the many children who are on the waiting list for an extended period. The children are invited to attend the groups every week. The activities in the groups include various forms of expressive art such as music, art, dance, drama, and sport (Blokland, 2014).

Blokland (2014) writes that instances of remarkable changes were observed in the groups. She provides a specific example of a child, coming from extreme circumstances of neglect and abuse and who had not spoken for years, starting to communicate spontaneously after the expressive art activities. Participants from Visser and Du Plessis' (2015) study reported that the expressive art group intervention was an enriching experience that improved their self-esteem, their relationships, and their ability to cope with negative emotions. Children's caregivers, who generally accompanied the children to the clinic, reported stories of changed behaviours (Blokland, 2014). The changes in behaviour occurred through no specific therapeutic intervention, as the groups were non-therapeutic groups designed merely for children to have fun, be creative, and have a contained space (Blokland, 2014).

Blokland (2014) goes on to explain that the use of expressive art activities in group mode has enabled the clinic staff to reach more children and adults in a shorter space of time and to address issues of language and culture. Visser and Du Plessis (2015) added that using expressive art group interventions could allow more clients to have alternate treatment that is readily accessible in poorly-resourced areas and takes less time than waiting for individual psychotherapy.

The current study took place within the context of research at the Itsoseng Community Clinic. It explored the question whether placing children in experiential activities can provide therapeutic benefits or whether such activities are just a “fill in the gap” solution to delayed therapy (Blokland, 2014). It has also been reported that there is a need for more research into experiential activities to determine what they can offer to complement child psychotherapy for children who have to be on a waiting list until formal therapy interventions can be provided (Blokland, 2014).

2.7 Chapter Conclusion

This chapter reviewed the role and functions that the Itsoseng Clinic plays within the Mamelodi community, especially in relation to children who are referred to the clinic. It also touched on several factors that contribute to behavioural problems in children, and how they may be affected by social stressors within their environments. The chapter explored the limitations and difficulties encountered by health professionals in attempts to interpret and communicate during the processes of working with children. It then considered experiential and expressive art methods as potential alternative means for children to express themselves. The chapter concluded by looking at the use of experiential art activities at Itsoseng Community Clinic. The following chapter will focus on the theoretical point of departure of this study.

Chapter Three – Theoretical Point of Departure

3.1 Introduction

This chapter focuses on the theoretical point of departure of this study. It first discusses the person-centred approach and expressive arts to provide a theoretical understanding of various expressive art methods. This chapter also discusses spontaneous creative expressions and how engaging in expressive art activities may contribute to the psychological and emotional well-being of children (Dragon & Madsen, 2015). As mentioned before, the main focus of this study remains behaviour change, as it primarily explores the effects of expressive art activities on children's behaviour and psychological functioning. The behavioural approach was therefore used to assist in the conceptualisation of these children's behaviour as measured by the Child Behaviour Checklist and semi-structured interviews. The chapter discusses the behavioural approach as the main focus, while including the basic assumptions of the social learning theory. The chapter will then discuss behaviour theory, children, and expressive arts together.



3.2 Expressive Arts and The Person-Centred Approach

3.2.1 The person-centred approach.

The expressive art activities that were used in this study may be understood by employing the notion of the person-centred approach as a base in relation to children's inner experiences while engaging with the expressive art activities.

The person-centred approach is based on the premise that every one carries various inner resources, and each individual has the capacity to become more fully themselves (Rogers, 2011). The focus of the person-centred approach is creating a facilitative environment with the appropriate conditions for the client's full self to bloom (Rogers, 2011). This suggests that the all the children in this study have the capacity and resources to be fully themselves when provided with an appropriate space to facilitate this process (Rogers, 2011).

The term 'person-centred approach' contains the word 'person', which already within itself possesses an implied meaning (Schmid, 1998). Schmid (1998) states that Rogers deliberately chose this name because of its essential meaning: "the person-centered approach takes a radical look at the human being as a person" (Schmid, 1998, p.38).

The term 'person' is commonly associated with the term 'human' or 'human being', accompanied by certain characteristics (Entwistle & Watt, 2013). Characteristics that are often associated with the concept of 'person' include the ability to reason and to communicate, emotionality, the ability to act with intention, self-awareness, self-regulation, and the interest to preserve and develop the self and its identity (Entwistle & Watt, 2013).



Carl Rogers (1959) called his therapeutic approach client-centred or person-centred therapy because of the focus on the person's subjective view of the world. The premise of the person-centred approach is that every human being has the capacity to shape his or her own life, and that the central point of assistance should focus on and support this capacity by providing freedom and autonomy (Schmid, 1998).

The person-centred approach entails a focus on therapeutic relationships, intrinsic motivation, and human potential (Joseph & Murphy, 2013). The general premise is that the client enters person-centred therapy in a state of incongruence. It is thus the role of the therapist to reverse this situation (McLeod, 2015). Rogers developed the person-centred theory on the basis of his work with emotionally troubled people and claimed that people have a significant capacity to self-heal and enjoy personal growth that leads to self-actualisation (McLeod, 2015). The focus is on the person's current perception and their ability to be in the 'here and now' (McLeod, 2015). Roger's (1959) theory also encompasses the notion of 'self' or 'self-concept', which is described as the organised, consistent set of perceptions and beliefs about the self (i.e. ideas and values that characterise 'I' and 'me', 'what I am' and 'what I can do') (McLeod, 2015). The intention of the person-centred approach is to increase a person's feelings of self-worth, reduce the level of incongruence between the ideal and the actual self, and help a person become more functional (McLeod, 2015).

The core principles of the person-centred approach that should ideally reflect the attitude of the therapist to the client include *congruence* with the client, having an *unconditional positive regard* towards the client, and showing *empathetic understanding* to the client (Corey, 2013). These core principles were considered

and emphasised by the facilitators when engaging with the children in this study during the expressive art activity programme.

According to Rogers (1959), congruence is the most important attribute in a therapist-client relationship; congruence is also referred to as genuineness. The person-centred approach allows the client and the therapist to experience each other as they really are (authentically) (Corey, 2013).

Another core principle that is essential in the person-centred approach is unconditional positive regard. Rogers (1959) believed that it is important for people to be valued unconditionally for who and what they are in order for them to grow and fulfil their potential. Unconditional positive regard refers to the therapist's deep and genuine caring for the client. The therapist may not approve of all of the client's actions, but the therapist approves of the client (McLeod, 2015). Ideally, the therapist should have an attitude of "I'll accept you as you are" (McLeod, 2015). The person-centred therapist is thus careful to maintain a mostly positive attitude towards the client, even when they disapprove the client's actions (Corey, 2013).

Empathy is the ability to understand what the client is experiencing and feeling (Corey, 2013). This refers to the therapist's ability to understand, sensitively and appropriately (but not sympathetically), the client's experience and feelings in the here-and-now (Corey, 2013). It is important for the person-centred therapist to attempt to follow accurately what the client is experiencing and feeling, and to communicate to them their understanding of what they are feeling (Corey, 2013).

3.2.2 Person-centred expressive arts therapy.

'Person-centred expressive arts therapy' is Natalie Roger's integration of the arts into therapeutic practice (Rogers, 2001). The various expressive art media generally

include dance, art, music, journal writing, poetry, imagery, meditation, and improvisational drama (Rogers, 2001).

The expressive arts are used to promote emotional healing, resolve inner conflict, and stimulate individual creativity (Rogers, 2001). The children who formed part of this study expressed their inner feelings by creating outer (external) forms through their art (Rogers, 2001). When these feelings were expressed through visible forms or media, they reflected the use of art as a language to communicate their inner truths (Rogers, 2001). The inner truths which are evoked are often revealed with new depth and meaning (Rogers, 2001). Art, in this context, was essentially used to let go, to express, and to release (Rogers, 2001).

Corey (2013) further discusses how Rogers expanded on the person-centred approach by including the expressive arts approach. This consists of spontaneous creative expression which symbolises deep and sometimes inaccessible feelings and emotional states (Corey, 2013).

3.2.3 Spontaneous creative expressions.

Spontaneous creative expressions, including play, can be used to understand affective processes in children (Russ & Kaugars, 2001). Various modes of art have the ability to connect the child with a range of feelings that cannot otherwise be confronted (Davis, 2010). The arts engage with one's senses and evoke strong and affective responses in both the creator and the witness of the art (Lawrence, 2008). Arts provide means to communicate emotions that go beyond language and cultural barriers (Lawrence, 2008).

Spontaneous art expression is considered to be an alternative yet natural way in which human beings can self-express (Di Leo, 2013). The meaning of spontaneous

expression is about the here and now (the present moment) which is experienced by the child in this context (Di Leo, 2013). Young children's spontaneous artistic expressions can shed light on their experiences during the processes of their creations (Di Leo, 2013).

Rogers (2001) coined the term "creative connection" to describe a process "in which one art form stimulates and fosters creativity in another art form, linking all of the arts to our essential nature" (p.232). She describes this notion by providing the following illustration (Rogers, 2001):

Movement unlocks our creative energy, which gets expressed in visual art. Expressing the self through visual art fosters poetry or spontaneous writing. As we take risks and experiment, we are capitalising on the brain's right hemisphere and its capacity for nonverbal, nonlinear experience. Inner healing takes place because of this 'creative connection'. (p232)

3.2.4 Expressive arts and children.

Expressive art is described as a way of using the emotional, intuitive aspect of ourselves in various media. It is a process of discovering ourselves through any art form that comes from an emotional fullness (Rogers, Tudor, Tudor, & Keemar, 2012). The art-based practices that formed part of this study facilitated the process of assisting the children to remain centred, aligned, present in the moment, and alert (Kossak, 2009). The expressive arts activities may have assisted in increasing the children's personal awareness, group understanding and cohesion (within group contexts) (Newsome, Henderson, & Veach, 2005).



An expressive and creative art medium such as music is understood to be a powerful therapeutic intervention with children and adolescents following various traumatic experiences (e.g. exposure to a tornado or other natural disasters) (Davis, 2010). Music has been described as having helpful implications in relation to traumatic experiences (Davis, 2010).

Expressive arts thus allow trauma survivors to reframe their stories in a way that has meaning for them. The art activities that the children in this study engaged in may have provided them with ways in which to construct, deconstruct, or reconstruct their narratives and retell their stories (Parr, 2015). Children often 'say' what they would like to express through their art works. Their art work often mirrors their thoughts and feelings about their situations (Wikström, 2005). Themes of fear, powerlessness and longing may emerge through their art works (Wikström, 2005).

Expressive arts are frequently used as a tool to help children express themselves. The child is able to do what they would most likely want to do because the activity they choose, or consider as first preference, often influences the starting point (Wikström, 2005).

In conceptualising the child, one considers the premise that imagination and reality have to be combined in the expressive art activity (Wikström, 2005). Artwork allows for alternative ways of communicating and engaging in an experience through the use of creativity which can broaden perspectives (Sidney-Ando, 2014).

According to Malchiodi (2005), expressive arts fall into the category of expressive therapies that mental health practitioners use to address the differences people have in their communication styles (Parr, 2015). Expressive arts such as theatre, dance, art, and creative writing have been considered to increase well-being in children (Barnes-Smith, Frotz, Kohorst, & Vascimini, 2015). Engaging in expressive arts

activities helps strengthen the child's sense of agency and their ability to form and follow their own path to recovery, especially in times when verbal modalities are not readily accessible to them (Parr, 2015).

According to Rogers (2011); expressive arts have the capacity to cut across different developmental stages from childhood to late adulthood. As aforementioned, the expressive arts have been considered an effective intervention tool for adult and child survivors who have been adversely affected by various traumatic situations (Parr, 2015).

Undeveloped verbal skills or language barriers due to age and/or educational experience can at times restrict verbal means of communicating, particularly with children (Parr, 2015). If the child is unable to verbally express themselves it may cause feelings of constriction, threat, confusion and isolation. The child may feel a lack of control in this regard (Parr, 2015). Expressive art techniques assist children in finding alternative ways of expressing themselves, thereby facilitating their coping and problem-solving skills (Parr, 2015). This can further enable children to develop the ability to process emotional challenges that they may be going through (Parr, 2015).

Carandang (2009) discusses expressive arts as one of the methods within the child-directed play therapy (CDPT) mode of intervention, where children are able to express themselves in a natural and age-appropriate way using drawing materials, clay, paint, and so on. The therapeutic properties of expressive arts have been proven effective with adolescents and adults (Carandang, 2009).

As mentioned above, expressive art approaches use a variety of artistic forms such as writing, drawing, painting, sculpting, movement and music to assist growth, healing and self-discovery (Corey, 2013).

These expressive art media were incorporated into the informal (non-therapeutic) art groups held at the Itsoseng Clinic. When children engaged in expressive art activities, they were offered ways in which to express their emotions in an environment that may have reconditioned their behaviour (Hartas, 2011).

3.3 Behavioural Approach

In this study, the behavioural approach was adopted to conceptualise the behaviour of the children taking part. As mentioned above, the focus of this study is on exploring the outcomes of behaviour, and potential behavioural changes in relation to expressive art activities.

Behaviourists focus on observable behaviour, current determinants of behaviour, and learning experiences that promote change (Corey, 2013). Behaviour theory is based on the principles of learning that are meant to help people to change their maladaptive behaviours (Corey, 2013). Behaviour theory recognises the importance of the individual, the individual's environment, and the interaction between the person and their environment in facilitating change (Corey, 2013).

Behaviourists view the environment as the single most important variable in shaping behaviour. From this perspective, children react to the forces in their environment (Isenberg & Jalongo, 2010). There are various factors that may contribute towards the manifestations of behavioural problems in children. Behavioural problems in childhood are mainly due to maladaptive learning experiences, failures of adequate parenting, family stress, poor education and adverse peer influence (environmental influences) (Campbell, Shaw, & Gilliom,

2000). These experiences and influences can elicit negative responses in the form of aggression, hyperactivity, and conduct problems (Campbell et al., 2000).

There is, however, a generally positive effect from early intervention before problems solidify, but this depends on suitable adaptations to the different social and psychological stresses (Sheldon, 2011).

3.3.1 Social learning theory.

Bandura and Walters (1963) are among the founders of the social learning theory. The basic assumption of the social learning theory is that people are capable of self-directed behaviour change, and that the person is the agent of change (Bandura & Walters, 1963; Corey, 2013). Social learning theory views individuals as active participants in their own behaviour, where the individual has the ability to interpret events and independently select courses of action based on their past experiences (Corey, 2013).

Social learning theory proposes that behaviour change is effected by environmental influences, personal factors, and attributes of the behaviour itself (Ozmete & Hira, 2011). These factors may affect or be affected by each other (Ozmete & Hira, 2011). The theory focuses on how patterns of behaviour are acquired and how their expression is continually regulated by the interchange between self-generated influences and other sources of influence (Bandura & Walters, 1977).

Bandura (1982) considered 'self efficacy' to have a major impact on models of behaviour change. Self efficacy is described as a person's belief in their ability to successfully carry out the necessary actions to deal with specific situational demands (Bandura, 1982; Corey, 2013). Social learning theory supposes that new

behaviour patterns can be acquired through direct experience or by observing other people's behaviours (Bandura & Walters, 1977). Thus, when children such as those in this study are provided, through the expressive art activity group, with opportunities for skills development, training and modelling, this experience may influence their behaviour (Ozmete & Hira, 2011).

3.3.2 Behaviour theory, children, and expressive arts.

Both behavioural approaches and expressive art methods share a common goal: for their clients to achieve behavioural change (Meyer, 2011). The children in this study may have been helped to examine the way in which they understand themselves and their environment and to experiment with new ways of behaving (Corey, 2013; Deines, Torres-Harding, Reinecke, Freeman, & Sauer, 2011).

Children learn to express themselves through art by interacting with their environment. Learning takes place in the context of what is known (Isenberg & Jalongo, 2010; Lowenfeld & Brittain, 1982). Engaging in expressive art methods stimulates the child to think and to awaken their senses and helps them to identify and understand their emotions (Rosal, 2001). The process of creation uncovers the child's images, messages, and memories, which can be translated through various art forms such as sculpting (engaging with clay), drawing, or painting (Rosal, 2001). Art works provide a record of inner processes that can be explored (past events can be recalled), discussed, and potentially altered (Rosal, 2001).

This can be explained in terms of social learning views, in that children learn socially appropriate behaviour by observing and imitating models in their world (Isenberg & Jalongo, 2010; Isenberg & Jalongo, 2014).

According to behaviourist views; children become more interested in participating in expressive art activities when they are in a creative environment that encourages and rewards engagement in various art forms (Isbell & Raines, 2003).

They also gain more interest in art when they witness and observe their models (e.g. their parents) engaging in art activities, whom they then follow by imitating them (Isbell & Raines, 2003).

Ozmete and Hira (2011) cited a study conducted by Bandura in 1989 that shows the influences of behaviour associated with basic human capacities. Bandura highlighted the influence of emotional arousal and coping. This refers to an individual's ability to respond to emotional stimuli in various ways (Ozmete & Hira, 2011).

As mentioned above, creative artistic forms facilitate the process of stimulating various feelings and emotions. Therefore, the expressive art activities that were undertaken in this study may also have enabled the children to externalise their internal states through various art media (Pearson & Wilson, 2009). Creative art activities offer several ways for children to express what is inexpressible, while reducing their 'acting out' behaviour (Pearson & Wilson, 2009). Change in children's behaviour represents change in their emotions (Hartas, 2011). This supports the view that creative art activities influence emotions and may further activate behaviour change (Pearson & Wilson, 2009). This study is primarily concerned with measuring behaviour change following participation in experiential art activities in a group while on a waiting list for formal treatment.



3.4 Chapter Conclusion

This chapter provided information on the core principles of the person-centred approach that are incorporated when using various expressive arts methods and working with children. It also discussed behaviourist views on various determinants of behaviours and learning experiences that could promote change. The chapter ended by looking at the common goals shared by behavioural approaches and expressive art methods and highlighting the way in which creative artistic forms stimulate the expression of various feelings and emotions, which in turn influences behaviour.

Chapter Four – Research Methodology

4.1 Introduction

This chapter focuses on the research methodology used in the study by describing how the practical research was carried out. It also discusses the research approach, the research design, the research methods used, the study population (the participants), sampling, the data collection methods and data analysis. The chapter also explores the concepts of reliability and validity in relation to the assessment measure used, as well as some significant aspects of the ethical considerations involved.

4.2 Research Approach

A mixed method simultaneous approach was selected because it could provide both quantified comparisons and qualitative descriptions to assist in understanding the outcomes and experiences that relate to experiential art activities and children's behaviour.

4.2.1 Mixed method simultaneous quantitative and qualitative approach.

Willig (2013) suggests that the most appropriate way to answer a research question sometimes requires the use of two or more research methods (mixed methods). A combination of qualitative and quantitative methods may be used within the same study to answer related questions. Teddlie and Tashakkori (2009) defined



mixed methods as a type of research in which qualitative and quantitative approaches are used in questions, research methods, data collection, analysis procedures and/or inferences. An example would be using questionnaires to establish whether there are significant differences between two groups with regard to their behaviour and using semi-structured interviews to find out why such differences may exist by obtaining more qualitative information regarding the groups' behaviour (Willig, 2013).

Mixed method designs offer the possibility of expansion, where qualitative data could be used to elaborate on findings from quantitative data (Palinkas, Aarons, Horwitz, Chamberlain, Hurlburt, & Landsverk, 2011). Quantitative methods are considered to offer a breadth of understanding, while qualitative methods are used to complement quantitative methods by providing a depth of understanding (Palinkas et al., 2011).

Qualitative methods are used mostly in studies designed to assess the process of implementation and to offer contextual understanding that will assist in understanding qualitative findings, whereas quantitative methods are used to measure and evaluate intervention outcomes and certain aspects regarding the content of the intervention (Palinkas et al., 2011).

Quantitative and qualitative approaches are diverse at various levels; each approach has its strengths and weaknesses, and commonly the strengths of the one approach may be regarded as the weaknesses of the other approach, and vice versa (Gelo, Braakmann, & Benetka, 2008). Mixing quantitative and qualitative research may demonstrate how using both methodologies represents an interactive continuum, where the researcher can plan a study while alternating dynamically between generalisation and contextualisation, explanation and understanding,

deduction and induction, and hypotheses-testing and hypotheses-generating (Gelo et al., 2008).

The mixed methods research model that incorporates a qualitative component into a primarily quantitative study appears to be the preferred one. This model is usually thought to provide the illustrative power of narrative (Hesse-Biber, 2010). Mixed method approaches adopt strategies of inquiry that involve collecting data simultaneously or sequentially to better understand the research problem (Creswell, 2014).

This study comprised a quantitatively (QUAN) driven core component, using the Child Behavioural Checklist (CBCL), and a qualitative (qual) supplementary component using a brief interview schedule (Morse & Niehaus, 2009). The qualitative aspect of this study was used to supplement the data provided by the quantitative instrument (CBCL) (Morse & Niehaus, 2009).

The use of the Child Behaviour Checklist (questionnaires) seemed appropriate for comparing the differences in scores/results, and supplementing this with follow-up qualitative interviews enabled the researcher to gain a more in-depth understanding and knowledge of the children's and the caregivers' experiences and behaviours.

4.3 Research Design

4.3.1 Randomised, pre-test-post-test, control group design.

The study used a randomised pre-test-post-test control group design. Purswell and Ray (2014) discuss random small-group (RSG) experimental design, which they define as a randomised clinical trial that involves 30 or fewer participants. Their focus was on randomised pre-test-post-test control group design. Kirk (2009) suggests that

including one or more control group/s in an experiment vastly increases the internal validity of a design.

‘Random selection’ describes the process of drawing a sample from a population where the participants in the sample are not known in advance (Purswell & Ray, 2014). A simple random sample of a certain number of participants is often determined by chance, where each individual in the population has the same and equal probability of being selected (Purswell & Ray, 2014). Random allocation then takes place when the sample participants that have been identified are randomly assigned to a group or treatment and each participant has the same probability of being assigned to any particular group or treatment (Purswell & Ray, 2014).

Participants are randomised into two or more groups, and all participants are given a pre-test assessment (Purswell & Ray, 2014). The experimental group undergoes an intervention or programme, while the control group continues as normal without treatment or intervention (Dimitrov & Rumrill, 2003). After the intervention or programme, all participants are given a post-test assessment that is the same as the one used in the pre-test (Purswell & Ray, 2014).

In this study using the waiting list, children were randomly allocated, by the roll of two fair six-sided dice, alternately to either the experiential art group or the control group. In random allocation, participants are randomly assigned to a group and each participant has the same probability of being assigned to any particular group (e.g. treatment or control group) (Kanik, Tasdelen, & Erdogan, 2011). For instance, if the dice fell on the number nine, the ninth child on the waiting list was allocated to the experiential art group, and the next roll of the dice would be allocated to the control group until both groups had eight participants. This procedure was followed alternately, so that each child had a fair chance of being allocated to either the

experiential art group or the control group. The process was further determined by which child was available to participate at that particular time. Participants from the control group would also be given a chance to later participate in the art group activities.

4.4 Participants and Sampling Methods

Participants were recruited from the Itsoseng Clinic in Mamelodi. The participants had been referred for psychotherapy or psychological assessments from the school system, private practitioners, social work organisations, NGOs (crisis centres), UP Mamelodi staff and students, individual community members, and a few cases from a law enforcement agency (police). The assignment of children to either the activity or the non-activity group was random. It has been noted that children who were not initially assigned to participate in the art activities would be provided with an opportunity to do so at a later stage. The sample consisted of black South African children whose primary language was Tswana, Northern Sotho, Zulu, Sepedi, Tsonga, Siswati or Ndebele. Eligible children were identified and their families were contacted. The experimental group consisted of eight children and the control group consisted of seven children; this was due to one of the participants from the control group not showing up for the scheduled interviews. A review of the project was discussed thoroughly, with the intention of obtaining informed consent from the parents for the children to participate in a voluntary capacity (Asanbe & Blokland, 2014) (see Appendix 5-10).



4.4.1 Inclusion criteria.

The children were identified/ selected based on the following criteria:

- The child had been referred to the clinic and was on the waiting list for psychotherapy;
- The child was able to participate in an experiential activity (i.e. art group);
- The child was between the ages of 7 and 12 years.

As discussed above, the children were assigned randomly to either the experiential art group or the control group. Participants from the control group would also be given a chance to participate in the art group activities later.

Once the participants had been identified, parents were contacted by the clinic's operational manager and invited to the clinic for a briefing about the study. The researcher and trained volunteers who shared the language knowledge of the parents and children assisted them in translating and understanding the consent forms. Parents or caregivers who volunteered to participate in the study were required to sign written informed consent forms that gave permission for their children to be participants in the study (see Appendix 5, 6, & 7). The children were required to indicate their willingness to participate in the study on age-appropriate informed assent forms (see Appendix 8, 9 & 10). All participants were informed about the content and the purpose of the study and the six-week duration of the study, and it was also clarified that they had full rights to withdraw from the study at any time (Asanbe & Blokland, 2014). An effort was made to reassure the participants that their withdrawal from the study would not have any negative repercussions.



4.4.2 Art activities.

The art programme was an informal activity that focused on the fun aspect of making art but with no formal focus on psychological processes or interpretation. The activities included drawing, painting, working with clay, collages and other art activities. All materials were provided by the Itsoseng Clinic. An experienced and trained volunteer who is not a professional psychologist facilitated the art programme.

4.5 Data Collection Process

4.5.1 Quantitative data: assessment measure Child Behaviour Checklist (CBCL).

The quantitative data was collected using the Child Behaviour Checklist (CBCL) (see Appendix 3). The CBCL is a widely-used method of identifying problem behaviour in children. It is a component in the Achenbach System of the Empirically Based Assessment (de Wolff, Vogels, & Reijneveld, 2014). The Achenbach System of Empirically Based Assessment (ASEBA) screens child populations and identifies those at high risk of mental disorders. ASEBA identifies children at risk of eight syndromes: anxiety, depression, somatic complaints, social problems, cognitive problems, attention difficulties, rule breaking behaviour and aggressive behaviour (de Wolff, Vogels, & Reijneveld, 2014). Problems are identified by a respondent who knows the child well, usually a parent, caregiver or a teacher (Surhone, Tennoe, & Henssonow, 2010).

This study used the school-age version (CBCL/6-18) for children aged 6 to 18 years. The checklist consists of a number of statements about the child's behaviour,

e.g. *Acts too young for his/her age*. Responses are recorded on a Likert scale: 0= Not True, 1= Somewhat or Sometimes True, 2=Very True or Often True. The school-age checklist contains a total of 120 questions (Surhone et al., 2010). The CBCL has strong reliability, with internal consistency figures between .78 and .97. These figures also hold for translated versions of the CBCL (Albores-Gallo, Lara-Munoz, Esperon-Vargas, Cardenas, Perez, & Villanueva, 2007). The scales correlate fairly well (.70) with corresponding scales on other well-known measures such as the Behavioural Assessment System for Children (BASC) (Eklund, Tanner, Stoll, & Anway, 2015; Reynold & Kamphaus, 1992). The CBCL has been translated into four major South African languages (Afrikaans, Sesotho, Xhosa, and Zulu). Translated versions were available based on the choice of language of the participants (Asanbe & Blokland, 2014).

The Child Behaviour Checklist is usually administered with parents or caregivers who know the child well (de Wolff, Vogels, & Reijneveld, 2014). The children's parents or caregivers in this study were contacted before and after the experiential art programme, and the researcher facilitated the process of filling in the CBCL. The answers were noted down and parents or caregivers selected the appropriate tick boxes or ranges within the scale that represented the statement about their child's behaviour. The total score on the CBCL was used as a quantitative measure of general psychological health of the children (before and after the expressive art programme) (Asanbe & Blokland, 2014).

4.5.1.1 Reliability and validity statistics of the CBCL.

a) *Reliability.* Reliability refers to the agreement between repeated assessments of phenomena when the phenomena themselves are expected to remain constant (Achenbach & Rescorla, 2001).

There are two forms of reliability in relation to ASEBA items; one of them is ‘inter-interviewer reliability’ and the second is ‘test-retest reliability’ (Achenbach & Rescorla, 2001). Inter-interviewer reliability distinguishes whether different interviewers obtain similar item scores (Achenbach & Rescorla, 2001). Test-retest reliability is regarded as the degree of agreement between item scores obtained from the same respondents over brief intervals when the children’s behaviour was assumed to remain constant (Achenbach & Rescorla, 2001).

To assess the reliability of Child Behaviour Checklist (CBCL) item scores, the intraclass correlation coefficient (ICC) was computed from one-way analyses of variance (Bartko, 1976; Achenbach & Rescorla, 2001). The ICC reflects the proportion of total variance in item scores that is associated with differences between the items themselves, after the variance due to a specific source of unreliability has been subtracted (Achenbach & Rescorla, 2001).

The inter-interviewer and test-retest reliabilities of the CBCL item scores were supported by intraclass correlations of .93 to 1.00 for the mean item scores obtained by different interviewers and for reports by parents on two occasions (seven days apart), reflected in Achenbach and Rescorla’s (2001) excerpt.

b) *Validity.* Validity refers to the accuracy with which instruments assess what they are supposed to assess (Achenbach & Rescorla, 2001). As mentioned above, the main purpose of the ASEBA school-age instruments is to identify children who may need professional assistance for behavioural, emotional or social problems, and

for those who may need help in strengthening what they are competent in as well as their adaptive functioning (Achenbach & Rescorla, 2001).

Achenbach and Rescorla's (2001) excerpt presented evidence for the content validity, criterion-related validity, and construct validity of the CBCL.

Content validity is essentially the degree to which the instrument's content includes what the instrument intends to assess (Achenbach & Rescorla, 2001). According to Achenbach and Rescorla (2001), the content validity of the competence, adaptive, and problem item scores has been supported by four decades of research, consultation, feedback and revision, as well as by findings that all items discriminated significantly ($p < .01$) between demographically matched referred and non-referred children.

Criterion-related validity refers to the degree of association between a particular measure (i.e., a scale scored from an ASEBA form) and an external criterion for the characteristics that the scale is intended to assess (Achenbach & Rescorla, 2001). According to Achenbach and Rescorla (2001), the criterion-related validity of the CBCL scale was supported by multiple regressions, odd ratios, and discriminant analyses which all showed significant ($p < .01$) discrimination between referred and non-referred children.

Construct validity of a measure involves determining the extent to which a measure of a construct is empirically related to other measures with which it is theoretically associated (Terre Blanche, Durrheim, & Painter, 2006). ASEBA scores can be perceived as representing constructs that have been obtained by systematically ordering scores on the items of the ASEBA forms which tap informants' experience relating to the children they assess (Achenbach & Rescorla, 2001). According to Achenbach and Rescorla (2001), the construct validity of the

CBCL scales has been supported by evidence of significant associations with analogous scales of other instruments and with DSM (Diagnostic Statistical Manual of mental disorders) criteria, by cross-cultural replications of ASEBA syndromes, by genetic and biochemical findings, and by predictions of long-term outcomes.

4.5.2 Qualitative data: semi structured interviews.

The qualitative data collection was done with a brief interview schedule with the children's parents or caregivers after the completion of the experiential art programme. This was done with both the experiential art group and the control group. The interview was used to explore some CBCL items in more depth (interview schedule attached, see Appendix 4). Discussions in the interview focused on the prominent behaviours that had been highlighted by the parents or caregivers and from the CBCL before commencement of the experiential activity programme. Any new behaviours that could potentially constitute change or improvement were noted (Sheldon, 2011).

4.6 Data Analysis Procedure

The process of analysis took place conjunctively during the course of the interviews because some aspects were noticed and observed during that time. Questions were read out to the participants. Most interviews were conducted in Northern Sotho and/or Setswana. It was noticeable that some participants answered questions with certainty and confidence; which largely indicated the extent to which they had considered their child's behaviour. Other participants seemed uncertain; they took a while to recall details and answer questions about their children's

behaviour. Some participants were noticeably annoyed when sharing their views of their children's misconduct; they made gestures that indicated a strong need for assistance.

One noteworthy challenge and consideration that the researcher had to bear in mind was that of alternating between different sets of data. Not only was the data collected and analysed using mixed methods (quantitative and qualitative methods), but there were two groups to be considered (the group in the art programme and on the waiting list, and the group on the waiting list only).

The trustworthiness of the findings were ensured through the use of an independent coder; the supervisor checked the analysis.

4.6.1 Quantitative analysis.

The quantitative data was scored on the Child Behaviour Checklist (CBCL). Participants' responses from the CBCL were computer scored and data was analysed using the "Statistical Package for the Social Sciences" (SPSS version 24.0) ("IBM SPSS Statistics - United States", 2016); this is a widely used package in the social and behavioural sciences for manipulating, analysing, and presenting data (Bakeman & Quera, 2011; Landau & Everitt, 2004). In order to conduct scoring and analysis, a non-parametric analysis suitable for small samples was used, viz. the Wilcoxon signed rank test (Bakeman & Quera, 2011). A statistical consultant, Miss Liz-Marie Basson, assisted with the quantitative/ statistical analysis procedure.

4.6.1.1 The sample.

Descriptive statistics was used to describe the basic characteristics of the data in this study. Descriptive statistics often provides summaries in relation to the sample



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and the measures by simplifying large amounts of data in a sensible way (Lane, 2011).



a) *Gender*

Table 1: The sample: Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	10	10.2	66.7	66.7
	Female	5	5.1	33.3	100.0
	Total	15	100.0	100.0	

67% (N = 10) of the sample were male and 33.3% (N = 5) were female.



b) *Language*

Table 2: The sample: Language

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Swati	1	1.0	6.7	6.7
	Tsonga	1	1.0	6.7	13.3
	Zulu	4	4.1	26.7	40.0
	Sotho	3	3.1	20.0	60.0
	Sepedi	3	3.1	20.0	80.0
	Nbebele	1	1.0	6.7	86.7
	Tswana	2	2.0	13.3	100.0
	Total	15	15.3	100.0	

6.7% (N = 1) of participants were Swati, Ndebele and Tsonga respectively. The majority of participants were Zulu (26.7%; N = 4). 20% (N = 3) of participants spoke Sotho and Sepedi respectively. 13.3% (N = 2) of participants spoke Tswana.



c) *Experimental and control group*

Table 3: The sample: Experimental and control group

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Experimental	8	8.2	53.3	53.3
	Control	7	7.1	46.7	100.0
	Total	15	15.3	100.0	

53.3% (N = 8) of participants were in the experimental group and 46.7% (N = 7) were in the control group.

d) *Age*

Table 4: The sample: descriptive statistics

	N	Minimum	Maximum	Mean	Std. Deviation
Age	15	8	12	10.00	1.363
Valid N	15				

The minimum age of participants was 8 with a maximum age of 12. The mean age was 10 with a standard deviation of 1.363.

4.6.1.2 Test for normality (per variable).

Tests for normality are intended to calculate the probability of a sample as being drawn from a normal population (Ghasemi & Zahediasl, 2012). The hypotheses that are used are often either those that indicate that the sample data is not significantly different from a normal population, or that the sample data is significantly different from a normal population (Ghasemi & Zahediasl, 2012). The preferred effect is for the data to be no different from normal, fundamentally accepting the null hypothesis (Ghasemi & Zahediasl, 2012). Thus, when testing for normality probabilities greater than 0.05 mean the data is normal, while probabilities less than 0.05 mean the data is not normal (Ghasemi & Zahediasl, 2012).

The main tests considered for the assessment of normality are the Kolmogorov-Smirnov (K-S) test, Lilliefors corrected K-S test, Shapiro-Wilk test, Anderson-Darling test, Cramer-von Mises test, D'Agostino skewness test, Anscombe-Glynn kurtosis test, D'Agostino-Pearson omnibus test, and the Jarque-Bera test (Öztuna, Elhan, & Tüccar, 2006; Ghasemi & Zahediasl, 2012). Among these, the tests which are most often used are the K-S and Shapiro-Wilk tests (Ghasemi & Zahediasl, 2012). The Shapiro-Wilk test can be conducted in the SPSS Explore procedure (Analyze → Descriptive Statistics → Explore → Plots → Normality plots with tests) (Elliott & Woodward, 2007; Ghasemi & Zahediasl, 2012).

As mentioned above, The Shapiro-Wilk test is one of the main tests for the assessment of normality (Razali & Wah, 2011). The Shapiro-Wilk test is based on the correlation between the data and the corresponding normal scores (Peat & Barton, 2008) and it is said to provide better power than the K-S test even after the

Lilliefors correction (Steinskog, Tjøstheim, & Kvamstø, 2007; Ghasemi & Zahediasl, 2012). Some researchers recommend the Shapiro-Wilk test as the best selection for testing the normality of data (Thode, 2002).

The Shapiro-Wilk (1965) test was originally restricted for a sample size of less than 50. This test was the first test that was able to detect deviations from normality due to either skewness or kurtosis, or to both (Shapiro & Wilk, 1965). The Shapiro-Wilk test is still considered most suitable for small sample sizes (less than 50 samples), but it can also be administered for sample sizes as large as 2000 (Razali & Wah, 2011). For this reason, the Shapiro-Wilk test was used as the numerical means of assessing normality for this study (Razali & Wah, 2011).

If the significant value (p-value) of the Shapiro-Wilk test is greater than 0.05, the data is considered normal, whereas, if it is below 0.05, the data significantly deviates from a normal distribution (Razali & Wah, 2011).

In this study; the *paired sample t-test* was used for the data that was normally distributed (Ross & Willson, 2017). If the data was not normally distributed; the *Wilcoxon signed rank test* was used (Rosner, Glynn, & Lee, 2006). Thus, for the paired sample t-test to work, the data for both the pre-test and the posttest (for control and experimental group) per variable should be normally distributed (Ross & Willson, 2017). If both or either the pre-test or the posttest is not normally distributed, taking into account the control or experimental groups, a non-paradigmatic test is used (Wilcoxon signed rank test) (Rosner, Glynn, & Lee, 2006).

4.6.1.3 Paired sample t-test analysis.

The paired sample t-test is a statistical procedure that is used to establish whether the mean difference between two sets of observations is zero (Ross &

Willson, 2017). In a paired sample t-test, when referring to two sets of observations it means that each entity or subject is measured twice (Ross & Willson, 2017). Paired sample t-tests are commonly utilised in case control studies or repeated measures designs (Ross & Willson, 2017). Examples of these processes could be before-and-after observations on the same subjects, where a class of students' test results before and after a particular module are compared (Ross & Willson, 2017), or a comparison of two different methods of measurement or treatments, where the measurements or treatments are applied to the same subjects (e.g. blood pressure measurements using a stethoscope and a dynamap) (Bland & Altman, 2010).

The paired sample t-test was administered for all the variables in the data that was normally distributed. The effect size was then calculated to assess the importance of our findings by providing an indication of whether or not the differences between the groups were statistically significant (Tabachnick & Fidell, 2007). Calculating the effect size was also used to determine to what extent the variables associated with one another (Tabachnick & Fidell, 2007).

Effect size is also referred to as 'strength association'; it is described as "the set of statistics that indicate the relative magnitude of the differences between means, or the amount of the total variance in the dependent variable that is predictable from knowledge of the levels of the independent variable" (Tabachnick & Fidell, 2007, p.54). The effect size was calculated for both the experimental and the control group. Comparisons were made between pretest and posttest scores; results will be discussed further in the findings.

4.6.1.4 Wilcoxon signed rank test.

The Wilcoxon signed rank test is a commonly used nonparametric test for paired data (e.g., consisting of pre- and posttreatment measurements) based on independent units of analysis (Rosner et al., 2006). The Wilcoxon signed rank test does not assume normality in the data; it can be used when the use of the dependent t-test (i.e. paired sample t-test) is inappropriate (Rey & Neuhäuser, 2011). It can be used to compare two sets of scores that come from the same participants. This can occur when we wish to explore any change in scores from one point in time to another, or when individuals are subjected to more than one condition (Rey & Neuhäuser, 2011).

For example, in this study the Wilcoxon signed rank test could be used to understand whether there was a difference in children's behaviour before and after a six week expressive art programme (i.e., our dependent variable would be the "children's behaviour", and our two related groups would be the child behaviour checklist scores "before" and "after" the experiential art group programme). We were also able to use a Wilcoxon signed rank test to understand whether there was a difference under two different conditions (i.e., our dependent variable would be "children's behaviour" and our two related groups would be before and after outcomes for "children who were on the waiting list and participated in experiential art group" versus "children who were on the waiting list only" (no participation in art groups; control group).

The Wilcoxon signed rank test was administered on the data that was not normally distributed. The effect size was also calculated for the Wilcoxon signed rank test variables. The following variables were not normally distributed, and they were analysed using the Wilcoxon signed rank test.

Competence social (pretest control group, Sig. value = 0.044 ; posttest control group, Sig. value = 0.008), *withdrawn/depressed* (posttest experimental group, Sig. value = 0.049), *somatic complaints* (pretest experimental group, Sig. value = 0.037; posttest experimental group, Sig. value = 0.004), *aggressive behaviour* (posttest control group, Sig. value = 0.031), *thought problems* (posttest experimental group, Sig. value = 0.041), *other problems* (posttest control group, Sig. value = 0.031).

The statistician went through every variable in determining whether or not the data is normally distributed.

4.6.2 Qualitative analysis: Thematic analysis.

Thematic analysis was used for the qualitative data derived from the semi-structured interview schedules. Thematic analysis is a widely used method for identifying, analysing, and reporting patterns or themes within data. It enables the researcher to organise and describe data sets in rich detail (Braun & Clarke, 2006). One of the benefits of thematic analysis is that it provides a flexible and useful research tool through its theoretical freedom (Braun & Clark, 2006). Thematic analysis is not bound to any pre-existing theoretical framework and can thus be used within various theoretical frameworks for several aspects (Braun, & Clark, 2006).

Thematic analysis includes a process of several phases which will inform the meaning of patterns or themes that will contribute to the interpretation of results (Braun & Clarke, 2006). The study used Braun and Clarke's (2006) phases of thematic analysis which are described as follows:

The initial phase involved becoming familiar with the data; for the researcher the process involved reading and re-reading transcripts from the interview while noting down ideas and relating the responses given from the CBCL questionnaires (Braun

& Clarke, 2012). The researcher noted items of potential interest in a notepad; this enabled her to read the data merely as data (Braun & Clarke, 2012). Braun and Clarke (2012) explain that reading data as *data* does not imply merely absorbing the surface meaning of the words on the page, as one might read a novel or magazine, but rather reading the words actively, analytically, and critically, while beginning to think about what the data could mean. This involves asking questions like, *“How does this participant make sense of their experiences?”* *“What assumptions do they make in interpreting their experience?”* *“What kind of world is revealed through their accounts?”* (Braun & Clarke, 2012, p.61).

The questions related somewhat to the responses that were from the CBCL questionnaire; the CBCL was used as a guideline for the questions asked in the interview schedule. This entailed the caregivers providing a description of the child’s behaviour in relation to his/her hobbies, activities or games; responsibilities, chores, or jobs; social situations or play, school or academics, and with their family.

In analysing the data during this phase, the researcher noted that the caregivers were easily able to provide answers because the questions were related to behaviours which they had personally observed and experienced directly from the children.

The second phase included generating initial codes. Coding the data is a process that involves attentively working through the text in order to identify meaning units, and labelling these with a code that captures the meaning identified (Willig, 2013). The researcher assigned codes which emerged from the preliminary data set, after which she reviewed all the codes while searching for connections between them and paying attention to any potential patterns in the data set (Willig, 2013).

During this phase, the researcher noted that the codes captured were interrelated in the sense that most responses provided by the caregivers reflected similar experiences (e.g. “...*child gets along well with family now compared to before...*”). Another code that was prominent was “*improvements at school*”.

As mentioned above, the trustworthiness of the findings were ensured through the use of an independent coder; the supervisor checked the analysis.

Braun and Clarke (2006) regarded the third phase of analysis as the phase in which “searching for themes” takes place. In this phase, the analysis starts to take shape as the researcher shifts from codes to themes (Braun & Clarke, 2006). A theme “captures something important about the data in relation to the research question and represents some level of *patterned* response or meaning within the data set” (Braun & Clarke, 2006, p. 82).

Braun and Clarke (2012) point out that searching for themes is an *active* process, which entails generating or constructing themes rather than discovering them. This phase involves reviewing the coded data to identify areas of similarity and overlap between codes; this includes collapsing or clustering codes that seem to share some common features together, so that they emerge and describe a coherent and meaningful pattern in the data (Braun & Clarke, 2012).

In this process, once the coding had been completed and revisited, the excerpts that related to a particular code were clustered and documented onto a separate document (Braun & Clarke, 2012).

One of the challenges that the researcher experienced was refraining from presuming in advance what the possible themes would be. It was thus important for the researcher to code and note all various patterns that emerged, in an attempt to broaden the perspective at this stage. Another consideration and realisation that the

researcher encountered was the process of working with two different groups that had been asked a similar set of questions but had given diverse responses. While working through the two data sets, it happened that although the responses regarding a particular subject were different, the themes still related, as they were somewhat connected and accommodated both data sets appropriately.

This phase also highlighted for the researcher the likelihood that some themes would be prevalent in most responses because they were guided by particular subjects that related to the Child Behaviour Checklist.

The fourth phase involves a repeated process where the developing themes are reviewed in relation to the coded data and the entire data set (Braun & Clarke, 2012). Braun and Clarke (2012) describe this phase as essentially being about quality checking.

The initial step is to check the themes against the assembled extracts of data and to explore whether the theme works in relation to the data (Braun & Clarke, 2012). According to Braun and Clarke (2012), it may happen that some codes need to be discarded or relocated to other themes, or one may alternatively reposition the margins of some themes in order for them to meaningfully capture the relevant data. The abovementioned occurred particularly for the researcher where it was necessary to refine themes while at the same time ensuring that they accommodated both groups (data sets) and captured relevant and meaningful data.

While attempting to provide a rich description of the data through the themes, some considerations had to be made regarding themes that did not provide enough data to support their presence; these themes were discarded from the analysis. Braun and Clarke (2006) suggested that the whole data set should be re-read to consider the validity of the themes in relation to the data set as a whole. Once the

abovementioned process was completed, the data was re-read while considering the validity of the themes in relation to the whole data set. Seven themes were generated from our data set; these will be further discussed in the results.

The fifth phase involves generating names and definitions for each theme while still refining the specifics of each one, as well as going through the overall story that the analysis relays (Braun & Clarke, 2006). This phase involves the process of creating an understanding of what the data entails; it also attempts to make sense of what participants have said and why they might have said it (Braun & Clarke, 2006; Willig, 2013).

During this phase the researcher considered Braun and Clarke's (2006) recommended questions that one could ask oneself. *"What does this theme mean?"*; *"What are the assumptions underpinning it?"*, *"What are the possible implications of this theme?"* and *"What is the overall story that the different themes might reveal about the topic?"* (Braun & Clarke, 2006; Willig, 2013, p. 63).

In the process of selecting and analysing the extracts, it eventually became apparent that the researcher had paraphrased some content from the data. It was noted that most themes seemingly reported quite closely what the participants had said (Braun & Clarke, 2012). Braun and Clarke (2012) explain that this process is not just about reporting words; it also involves organising and interpreting these words to fit within a larger conceptual framework. According to Braun and Clarke (2012), the analysis needs to be driven by the question; one can use the data to make a point. In using the above premise as a guide; the researcher then considered the relevance and usefulness of the extracts and themes in relation to the research question. Each theme needed to be developed in relation to the research question and to other themes (Braun & Clarke, 2012). After this was considered, the process of

establishing names for the themes took place; the naming process attempted to capture significant information that related to the data set, while also trying to keep it concise and engaging (Braun & Clarke, 2012).

Phase six involves the final analysis and write-up of the report. According to Braun and Clarke (2006); the task of the write-up of a thematic analysis is to tell the story of the data in a concise, coherent, and logical way while providing adequate evidence relating to the themes within the data.

Writing and analysing are interlinked processes that often vary from informal note-writing and memos to formal analysis and report writing (Braun & Clarke, 2012).

In this final stage the researcher was required to consider how to package and present the data in a concise and logical form. It was also important for the information in the report to be relayed in words or in a language that was recognised by the participants, readers and the researcher. The themes will be discussed in the findings.

4.7 Ethical Considerations

The project incorporated the Itsoseng Psychology Clinic staff and researchers. Ethical clearance was granted by the Faculty Research Committee for the primary (main) study to be conducted (see Appendix 1 & 2).

4.7.1 Voluntary participation.

Marczyk, DeMatteo, and Festinger (2017) postulate that voluntary participation and consent is a requirement in social research studies. Consent is considered voluntary if or when the participants are able to consent, they are free from coercion,

and they can comprehend the potential risks and benefits involved in the research study (Marczyk et al., 2017). Participation in the current study was considered voluntary; all participants were informed about the content and the purpose of the study, and it was also be clarified that they had full rights to withdraw from the study at any time (see Appendix 5 & 8).

4.7.2 Confidentiality.

The right to confidentiality generally involves an individual's right to have power over the use of or access to their personal information, as well as the right to have the information that they share in the research study kept private (Marczyk et al., 2017). The researcher is responsible for maintaining the confidentiality of all information protected by law, as well as information that might affect the privacy and dignity of the research participants (Marczyk et al., 2017).

It was explained to the research participants that their personal information would be kept confidential, and necessary steps were taken to ensure safety and protect privacy against public disclosure. No identifying factors such as the children's or parent's/guardian's/caregiver's names were included in the data coding or analyses. With regard to the results of the study being presented or published, data will be presented in group form to protect the identity of the child (Asanbe & Blokland, 2014) (see Appendix 5 & 8).

4.7.3 Informed consent.

The process of consent involved the researcher comprehensively explaining all significant information related to confidentiality, limitations to confidentiality, as well as safeguards that had been designed to protect their confidentiality (Marczyk et al.,

2017). It was also important for the researcher to note the serious effects that would ensue in cases where confidentiality was breached (Marczyk et al., 2017). The basis for thoroughly explaining the research study to the participants was to offer them an opportunity to make autonomous and informed decisions regarding whether to participate i.e. informed consent (Marczyk et al., 2017).

Parents or caregivers who volunteered to participate in the study were required to sign written informed consent forms that gave permission for their children to be participants in the study. The children were required to sign or indicate on age-appropriate informed assent forms their willingness to participate in the study (see Appendix 5 & 8).

4.7.4 Autonomy.

Respect for the dignity and autonomy of persons are included in the important aspects of ethical considerations highlighted by Terre Blanche, Durheim and Painter (2006). Individuals should be treated as autonomous agents; it is a requirement to acknowledge their autonomy, and persons with diminished autonomy are entitled to protection (Marczyk et al., 2017). This aspect was considered throughout the study.

4.7.5 Beneficence.

Marczyk et al. (2017) highlighted two general principles that express the concept of beneficence; the first one is not to harm the participants, and the second is to maximise possible benefits while minimising possible harms. Efforts were made by the researcher to secure the person's well-being while attempting to maximise potential benefits (Terre Blanche et al., 2006). All children on the waiting list (control group) were given a chance to participate later in the expressive art activities.

4.7.6 Justice.

The core principles of justice were highlighted by Terre Blanche et al. (2006) where they expressed the view that justice in general requires that people receive what is due to them, and that the researchers should treat their research participants with fairness and equality during all stages of the research. Justice can for instance be applied to the fair selection of research participants; selection of participants should not be based on convenience (Terre Blanche et al., 2006). This aspect was considered in the random selection process of the participants.

According to Terre Blanche et al. (2006), justice also necessitates that researchers have some responsibility to provide care and support for participants who may become distressed or harmed by the study. If there were any form of distress or harm in relation to the participants, they would be offered necessary assistance by trained counselling or clinical psychology students, or other staff members at the Itsoseng Clinic.

4.8 Chapter Conclusion

This chapter provided a detailed description of the processes and methods that were used in this research. The use of mixed methods was discussed, as well as the randomised, pretest posttest, control group design. The chapter focused on the participants and the sampling methods, the data collection processes, and the data analysis procedure. This chapter lastly discussed the ethical considerations of the study. The following chapter focuses on the results and findings of the study.

Chapter Five – Research Findings (Results)

5.1 Introduction

This chapter presents the findings of the overall data of the study. The first part of the chapter focuses on results of the different variables derived from the Child Behaviour Checklist (CBCL). As mentioned in the research methodology chapter a statistical consultant assisted with the statistical analysis procedure and the presentation of quantitative results in this regard. The results are presented separately for the experimental group and the control group. Comparison tables are also provided to enable comparison of findings between the experimental group and the control group. The second part of the chapter focuses on the themes that emerged from the semi-structured interviews before and after the completion of the experiential (expressive) art group programme.

As aforementioned, when describing the characteristics of the sample, 67% (N = 10) of the sample were male and 33.3% (N = 5) were female (refer to Table 1, p. 53). With regards to the language composition, 6.7% (N = 1) of participants were Swati, Ndebele and Tsonga respectively. The majority of participants were Zulu (26.7%; N = 4). 20% (N = 3) of participants spoke Sotho and Sepedi respectively. 13.3% (N = 2) of participants spoke Tswana (refer to Table 2, p.54).

53.3% (N = 8) of participants were in the experimental group and 46.7% (N = 7) were in the control group (refer to Table 3, p.55). While the minimum age of

participants was 8 with a maximum age of 12. The mean age was 10 with a standard deviation of 1.363 (refer to Table 4, p.55).

5.2 Findings for Child Behaviour Checklist

The CBCL used in this study has the following competence scales: Activities, School, and Social (Achenbach, 2001). Competence Activities scale evaluates the participation and skill in sports, games, hobbies, chores, jobs and other activities (Achenbach, 2001). The Competence School scale considers the participant's overall performance at school, potential school problems, any repeated grades, or attendance of special classes (Achenbach, 2001). The Competence Social scale assesses aspects such as the participant's participation in organisations, the number of friends and frequency of contact with those friends, behaviour with others and behaviour alone (Achenbach, 2001). The Total T score comp comprises of the total problems scores for the competence scales (i.e. activities, social, and school) (Achenbach, 2001).

The CBCL also has the following syndrome scales: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule breaking behaviour, aggressive behaviour other problems (de Wolff et al., 2014). These scales were formed based on experts' ratings on how well the scale items fit the DSM (Diagnostic Statistical Manual of mental disorders) criteria for example; relevant major and dysthymia for affective problems, anxiety problems, oppositional defiant problems, and conduct problems (Coulacoglou & Saklofske, 2017). The syndrome scales also have a Total T score which are composites for internalizing and externalizing problems (Coulacoglou et al., 2017).



5.2.1 Results for paired sample t-test: Experimental group.

For findings to be considered statistically significant, the p score (Sig. 2-tailed) should be less than or equal to 0.05.

Findings:

5.2.1.1 Activities.

There was a statistically significant **increase** in Competence (Comp) Activities scores from pre-test (M = 6.374, SD = 1.680) to post-test (M = 8.376, SD = 2.282), $t(7) = -2.639$, $p = 0.033$ (two-tailed). The mean increase in activities scores was -2.003 with a 95% confidence interval ranging from -3.79657 to -0.20843. The eta squared statistic (0.499) indicated a large effect size.

5.2.1.2 School.

There was a statistically significant **increase** in Comp school scores from pre-test (M = 2.803, SD = 0.841) to post-test (M = 3.846, SD = 0.677), $t(7) = -3.662$, $p = 0.008$ (two-tailed). The mean increase in school scores was -1.044 with a 95% confidence interval ranging from -1.718 to -0.3670. The eta squared statistic (0.489) indicated a large effect size.

5.2.1.3 Total T score comp.

There was a statistically significant **increase** in Total T comp scores from pre-test (M = 31.00, SD = 6.370) to post-test (M = 40.25, SD = 9.130), $t(7) = -3.250$, $p = 0.014$ (two-tailed). The mean increase in Total T Syndrome scores was -9.250 with



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a 95% confidence interval ranging from -15.979 to -2.521. The eta squared statistic (0.657) indicated a large effect size.



Table 5: Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Comp_Activities_Pre	6.3738	8	1.68043	.59412
	Comp_Activities_Post	8.3763	8	2.28158	.80666
Pair 2	Comp_School_Pre	2.8025	8	.84086	.29729
	Comp_School_Post	3.8463	8	.67663	.23922
Pair 3	Total_TScore_Comp_Pre	31.00	8	6.370	2.252
	Total_Tscore_Comp_Post	40.25	8	9.130	3.228
Pair 4	Anxious/Depressed_Pre	8.38	8	4.779	1.690
	Anxious/Depressed_Post	6.13	8	3.907	1.381

Table 6: Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Comp_Activities_Pre & Comp_Activities_Post	8	.447	.267
Pair 2	Comp_School_Pre & Comp_School_Post	8	.452	.260
Pair 3	Total_TScore_Comp_Pre & Total_Tscore_Comp_Post	8	.508	.198
Pair 4	Anxious/Depressed_Pre & Anxious/Depressed_Post	8	.946	.000



Table 7: Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Comp_Activities_Pre - Comp_Activities_Post	-2.00250	2.14596	.75871	-3.79657	-.20843	-2.639	7	.033
Pair 2	Comp_School_Pre - Comp_School_Post	-1.04375	.80622	.28504	-1.71777	-.36973	-3.662	7	.008
Pair 3	Total_Tscore_Comp_Pre - Total_Tscore_Comp_Post	-9.250	8.049	2.846	-15.979	-2.521	-3.250	7	.014
Pair 4	Anxious/Depressed_Pre - Anxious/Depressed_Post	2.250	1.669	.590	.855	3.645	3.813	7	.007

5.2.1.4 Anxious/depressed.

There was a statistically significant **decrease** in anxious/depressed scores from pre-test (M = 8.38, SD = 4.779) to post-test (M = 6.13, SD = 3.907), $t(7) = 3.813$, $p = 0.007$ (two-tailed). The mean decrease in anxious/depressed scores was 2.250 with a 95% confidence interval ranging from 0.855 to -3.645. The eta squared statistic (0.675) indicated a large effect size.



5.2.1.5 Rule breaking behaviour.

There was a statistically significant **decrease** in rule breaking behaviour scores from pre-test (M = 4.50, SD = 2.976) to post-test (M = 1.13, SD = 1.126), $t(7) = 2.826$, $p = 0.026$ (two-tailed). The mean decrease in rule breaking behaviour scores was 3.375 with a 95% confidence interval ranging from 0.551 to 6.199. The eta squared statistic (0.533) indicated a large effect size.

5.2.1.6 Internal A T score.

There was a statistically significant **decrease** in internal A T score scores from pre-test (M = 66.50, SD = 10.100) to post-test (M = 60.13, SD = 11.319), $t(7) = 3.480$, $p = 0.010$ (two-tailed). The mean decrease in internal A T scores was 6.375 with a 95% confidence interval ranging from 2.044 to 10.706. The eta squared statistic (0.634) indicated a large effect size.

5.2.1.7 External B T score.

There was a statistically significant **decrease** in External B Score Syndrome scores from pre-test (M = 61.50, SD = 7.709) to post-test (M = 49.38, SD = 8.651), $t(7) = 3.003$, $p = 0.020$ (two-tailed). The mean increase in external B T scores was 12.125 with a 95% confidence interval ranging from 2.578 to 21.672. The eta squared statistic (0.563) indicated a large effect size.

5.2.1.8 Total T Score Syndrome.

There was a statistically significant **decrease** in Total T Score Syndrome scores from pre-test (M = 64.63, SD = 8.383) to post-test (M = 53.88, SD = 10.776), t



(7) = 3.578, $p = 0.009$ (two-tailed). The mean increase in Total T Syndrome scores was 10.750 with a 95% confidence interval ranging from 3.646 to 17.854. The eta squared statistic (0.646) indicated a large effect size.

Table 8: Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Attention Problems Pre	8.00	8	4.000	1.414
	Attention Problems Post	5.00	8	3.251	1.150
Pair 2	Rule-Breaking Behaviour Pre	4.50	8	2.976	1.052
	Rule-Breaking Behaviour Post	1.13	8	1.126	.398
Pair 3	Internal A Tscore Pre	66.50	8	10.100	3.571
	Internal A Tscore Post	60.13	8	11.319	4.002
Pair 4	External B T Score Pre	61.50	8	7.709	2.726
	External B T Score Post	49.38	8	8.651	3.059
Pair 5	Total T Score Syndrome Pre	64.63	8	8.383	2.964
	Total T Score Syndrome Post	53.88	8	10.776	3.810



Table 9: Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Attention Problems Pre & Attention Problems Post	8	.494	.213
Pair 2	Rule-Breaking Behaviour Pre & Rule-Breaking Behaviour Post	8	-.192	.649
Pair 3	Internal A Tscore Pre & Internal A Tscore Post	8	.889	.003
Pair 4	External B T Score Pre & External B T Score Post	8	.029	.946
Pair 5	Total T Score Syndrome Pre & Total T Score Syndrome Post	8	.632	.093



Table 10: Paired Samples Test

	Paired Differences						t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference					
				Lower	Upper				
Pair 1 Attention Problems Pre - Attention Problems Post	3.000	3.703	1.309	-.096	6.096	2.291	7	.056	
Pair 2 Rule-Breaking Behaviour Pre - Rule-Breaking Behaviour Post	3.375	3.378	1.194	.551	6.199	2.826	7	.026	
Pair 3 Internal A Tscore Pre - Internal A Tscore Post	6.375	5.181	1.832	2.044	10.706	3.480	7	.010	
Pair 4 External B T Score Pre - External B T Score Post	12.125	11.420	4.037	2.578	21.672	3.003	7	.020	
Pair 5 Total T Score Syndrome Pre - Total T Score Syndrome Post	10.750	8.498	3.004	3.646	17.854	3.578	7	.009	

5.2.2 Results for Paired Sample T-Test: Control group

As mentioned above, for findings to be considered statistically significant, the p score (Sig. 2-tailed) should be less than or equal to 0.05.

Findings:

5.2.2.1 Attention problems.

There was a statistically significant **decrease** in attention problem scores from pre-test (M = 8.86, SD = 1.864) to post-test (M = 7.57, SD = 1.988), $t(6) = 6.971$, $p = 0.000$ (two-tailed). The mean decrease in attention problem scores was 1.286 with a 95% confidence interval ranging from 0.834 to 1.737. The eta squared statistic (0.884) indicated a large effect size.

5.2.2.2 Total T Score Syndrome.

There was a statistically significant **decrease** in total T score syndrome scores from pre-test (M = 61.14, SD = 8.030) to post-test (M = 59.57, SD = 7.115), $t(6) = 2.976$, $p = 0.025$ (two-tailed). The mean decrease in Total T Syndrome scores was 1.571 with a 95% confidence interval ranging from 0.279 to 2.864. The eta squared statistic (0.596) indicated a large effect size.

Findings for all other results regarding the control group were insignificant; namely the following: activities, school, total T score competence, anxious/depressed, rule breaking, internal A T score, and external B T score.



Table 11: Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Comp_Activities_Pre	9.4329	7	2.70933	1.02403
	Comp_Activities_Post	9.3757	7	2.53208	.95704
Pair 2	Comp_School_Pre	2.5014	7	.80419	.30395
	Comp_School_Post	2.7029	7	1.10236	.41665
Pair 3	Total_TScore_Comp_Pre	36.86	7	9.957	3.763
	Total_Tscore_Comp_Post	37.57	7	10.261	3.878
Pair 4	Anxious/Depressed_Pre	5.14	7	3.436	1.299
	Anxious/Depressed_Post	5.00	7	2.646	1.000

Table 12: Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Comp_Activities_Pre & Comp_Activities_Post	7	.971	.000
Pair 2	Comp_School_Pre & Comp_School_Post	7	.936	.002
Pair 3	Total_TScore_Comp_Pre & Total_Tscore_Comp_Post	7	.968	.000
Pair 4	Anxious/Depressed_Pre & Anxious/Depressed_Post	7	.935	.002



Table 13: Paired Samples Test

		Paired Differences					t	df	Sig. (2-tailed)
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower	Upper			
Pair 1	Comp_Activities_Pre - Comp_Activities_Post	.05714	.65764	.24856	-.55107	.66536	.230	6	.826
Pair 2	Comp_School_Pre - Comp_School_Post	-.20143	.44916	.16977	-.61684	.21398	-1.186	6	.280
Pair 3	Total_TScore_Comp_Pre - Total_Tscore_Comp_Post	-.714	2.563	.969	-3.085	1.657	-.737	6	.489
Pair 4	Anxious/Depressed_Pre - Anxious/Depressed_Post	.143	1.345	.508	-1.101	1.387	.281	6	.788



Table 14: Paired Samples Statistics

		Mean	N	Std. Deviation	Std. Error Mean
Pair 1	Attention Problems Pre	8.86	7	1.864	.705
	Attention Problems Post	7.57	7	1.988	.751
Pair 2	Rule-Breaking Behaviour Pre	3.86	7	3.078	1.164
	Rule-Breaking Behaviour Post	4.00	7	3.162	1.195
Pair 3	Internal A Tscore Pre	62.57	7	9.572	3.618
	Internal A Tscore Post	62.14	7	8.552	3.232
Pair 4	External B T Score Pre	54.57	7	10.814	4.087
	External B T Score Post	54.86	7	8.552	3.232
Pair 5	Total T Score Syndrome Pre	61.14	7	8.030	3.035
	Total T Score Syndrome Post	59.57	7	7.115	2.689



Table 15: Paired Samples Correlations

		N	Correlation	Sig.
Pair 1	Attention Problems Pre & Attention Problems Post	7	.970	.000
Pair 2	Rule-Breaking Behaviour Pre & Rule-Breaking Behaviour Post	7	.873	.010
Pair 3	Internal A Tscore Pre & Internal A Tscore Post	7	.996	.000
Pair 4	External B T Score Pre & External B T Score Post	7	.945	.001
Pair 5	Total T Score Syndrome Pre & Total T Score Syndrome Post	7	.990	.000



Table 16: Paired Samples Test

	Paired Differences						t	df	Sig. (2-tailed)
	Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference					
				Lower	Upper				
Pair 1 Attention Problems Pre - Attention Problems Post	1.286	.488	.184	.834	1.737	6.971	6	.000	
Pair 2 Rule-Breaking Behaviour Pre - Rule-Breaking Behaviour Post	-.143	1.574	.595	-1.598	1.312	-.240	6	.818	
Pair 3 Internal A Tscore Pre - Internal A Tscore Post	.429	1.272	.481	-.748	1.605	.891	6	.407	
Pair 4 External B T Score Pre - External B T Score Post	-.286	3.904	1.475	-3.896	3.325	-.194	6	.853	
Pair 5 Total T Score Syndrome Pre - Total T Score Syndrome Post	1.571	1.397	.528	.279	2.864	2.976	6	.025	

5.2.3 Paired sample t-test: Experimental and control group results

comparison table.

This table provides an overall representation of results from the paired sample t-test for the experimental group and control group.

Table 17: Paired sample t-test: Experimental and control group results comparison

Score	Experimental	Control
Comp activities Activities	There was a statistically significant increase in Comp Activities scores from pre-test (M = 6.374, SD = 1.680) to post-test (M = 8.376, SD = 2.282), $t(7) = -2.639$, $p = 0.033$ (two-tailed). The mean increase in activities scores was -2.003 with a 95% confidence interval ranging from -3.79657 to -0.20843. The eta squared statistic (0.499) indicated a large effect size.	*Results not significant
Comp School	There was a statistically significant increase in comp school scores from pre-test (M = 2.803, SD = 0.841) to post-test (M = 3.846, SD = 0.677), $t(7) = -3.662$, $p = 0.008$ (two-tailed). The mean increase in school scores was -1.044 with a 95% confidence	*Results not significant



	interval ranging from -1.718 to -0.3670. The eta squared statistic (0.489) indicated a large effect size.	
Total TScore Comp	There was a statistically significant increase in Total T comp scores from pre-test (M = 31.00, SD = 6.370) to post-test (M = 40.25, SD = 9.130), $t(7) = -3.250$, $p = 0.014$ (two-tailed). The mean increase in Total T Syndrome scores was -9.250 with a 95% confidence interval ranging from -15.979 to -2.521. The eta squared statistic (0.657) indicated a large effect size.	*Results not significant
Anxious/depressed	*There was a statistically significant decrease in anxious/depressed scores from pre-test (M = 8.38, SD = 4.779) to post-test (M = 6.13, SD = 3.907), $t(7) = 3.813$, $p = 0.007$ (two-tailed). The mean decrease in anxious/depressed scores was 2.250 with a 95% confidence interval ranging from 0.855 to -3.645. The eta squared statistic (0.675) indicated a large effect size.	*Results not significant
Attention problems	Results not significant	There was a statistically significant decrease in attention problem scores from pre-test (M



		= 8.86, SD = 1.864) to post-test (M = 7.57, SD = 1.988), $t(6) = 6.971$, $p = 0.000$ (two-tailed). The mean decrease in attention problem scores was 1.286 with a 95% confidence interval ranging from 0.834 to 1.737. The eta squared statistic (0.884) indicated a large effect size.
Rule-breaking behaviour	*There was a statistically significant decrease in rule breaking behaviour scores from pre-test (M = 4.50, SD = 2.976) to post-test (M = 1.13, SD = 1.126), $t(7) = 2.826$, $p = 0.026$ (two-tailed). The mean decrease in rule breaking behaviour scores was 3.375 with a 95% confidence interval ranging from 0.551 to 6.199. The eta squared statistic (0.533) indicated a large effect size.	*Results not significant
Internal A TScore	*There was a statistically significant decrease in internal A Tscore scores from pre-test (M = 66.50, SD = 10.100) to post-test (M = 60.13, SD = 11.319), $t(7) = 3.480$, $p = 0.010$ (two-tailed). The mean decrease in internal A T scores was 6.375 with a 95% confidence interval ranging from 2.044 to 10.706. The eta squared	*Results not significant



	<p>statistic (0.634) indicated a large effect size.</p>	
<p>External B TScore</p>	<p>*There was a statistically significant decrease in External B Score Syndrome scores from pre-test (M = 61.50, SD = 7.709) to post-test (M = 49.38, SD = 8.651), $t(7) = 3.003$, $p = 0.020$ (two-tailed). The mean increase in external B T scores was 12.125 with a 95% confidence interval ranging from 2.578 to 21.672. The eta squared statistic (0.563) indicated a large effect size.</p>	<p>*Results not significant</p>
<p>Total TScore Syndrome</p>	<p>*There was a statistically significant decrease in Total T Score Syndrome scores from pre-test (M = 64.63, SD = 8.383) to post-test (M = 53.88, SD = 10.776), $t(7) = 3.578$, $p = 0.009$ (two-tailed). The mean increase in Total T Syndrome scores was 10.750 with a 95% confidence interval ranging from 3.646 to 17.854. The eta squared statistic (0.646) indicated a large effect size.</p>	<p>There was a statistically significant decrease in total T score syndrome scores from pre-test (M = 61.14, SD = 8.030) to post-test (M = 59.57, SD = 7.115), $t(6) = 2.976$, $p = 0.025$ (two-tailed). The mean decrease in Total T Syndrome scores was 1.571 with a 95% confidence interval ranging from 0.279 to 2.864. The eta squared statistic (0.596) indicated a large effect size.</p>

*Important to note – statistically significant results with a decrease in scores are ideal for the experimental group, and for the control group, the expectation would be non-significant results.

For findings to be considered statistically significant, the p score (Sig. 2-tailed) should be less than or equal to 0.05.



5.2.4 Results for Wilcoxon signed rank test: Experimental group.

The Wilcoxon signed rank test was administered on the data that was **not normally distributed**. The following variables consisted of data that was not normally distributed: Competence Social scale pre and post, Withdrawn/Depressed, Somatic complaints, Social problems, Thought problems, Aggressive behaviour, and Other problems.

For findings to be considered statistically significant, the p score (Asymp Sig. 2-tailed) should be less than or equal to 0.05.

Findings:

5.2.4.1 Somatic complaints.

A Wilcoxon signed rank test revealed a statistically significant reduction in somatic complaint scores following participation in the art group, $z = -2.207$, $p < 0.027$, with a large effect size ($r = 0.552$). The median somatic complaint score decreased from the pre-test ($Md = 3$) to post-test ($Md = 1$).

5.2.4.2 Social problems.

A Wilcoxon signed rank test revealed a statistically significant reduction in social problem scores following participation in the art group, $z = -2.132$, $p < 0.033$, with a large effect size ($r = 0.533$). The median social problem score decreased from the pre-test ($Md = 6$) to post-test ($Md = 2$).



5.2.4.3 Thought problems.

A Wilcoxon signed rank test revealed a statistically significant reduction in thought problem scores following participation in the art group, $z = -2.375$, $p < 0.018$, with a large effect size ($r = 0.594$). The median thought problem score decreased from the pre-test (Md = 4.5) to post-test (Md = 1).

5.2.4.4. Aggressive behaviour.

A Wilcoxon signed rank test revealed a statistically significant reduction in aggressive behaviour scores following participation in the art group, $z = -2.201$, $p < 0.028$, with a large effect size ($r = 0.550$). The median aggressive behaviour score decreased from the pre-test (Md = 8) to post-test (Md = 4.50).

5.2.4.5 Other problems.

A Wilcoxon signed rank test revealed a statistically significant reduction in other problem scores following participation in the art group, $z = -2.214$, $p < 0.027$, with a small effect size ($r = 0.172$). The median other problem score decreased from the pre-test (Md = 4.50) to post-test (Md = 3).

Table 18: Descriptive Statistics

	N	Percentiles		
		25th	50th (Median)	75th
Comp_Social_Pre	8	4.1700	7.0000	9.5825
Withdrawn/Depressed Pre	8	2.25	3.00	6.00
Somatic Complaints Pre	8	2.00	3.00	5.75
Social Problems Pre	8	3.50	6.00	8.50



Thought Problems Pre	8	1.25	4.50	5.75
Aggressive Behaviour Pre	8	6.25	8.00	14.25
Other Problems Pre	8	3.00	4.50	8.00
Comp_Social_Post	8	5.4975	9.5000	9.9175
Withdrawn/Depressed Post	8	.25	2.00	5.25
Somatic Complaints Post	8	.00	1.00	3.50
Social Problems Post	8	.50	2.00	4.75
Thought Problems Post	8	.00	1.00	3.50
Aggressive Behaviour Post	8	.75	4.50	7.25
Other Problems Post	8	.50	3.00	3.00



Table 19: Ranks

		N	Mean Rank	Sum of Ranks
Comp_Social_Post -	Negative Ranks	3 ^a	2.33	7.00
Comp_Social_Pre	Positive Ranks	4 ^b	5.25	21.00
	Ties	1 ^c		
	Total	8		
Withdrawn/Depressed Post -	Negative Ranks	5 ^d	3.50	17.50
Withdrawn/Depressed Pre	Positive Ranks	2 ^e	5.25	10.50
	Ties	1 ^f		
	Total	8		
Somatic Complaints Post -	Negative Ranks	6 ^g	3.50	21.00
Somatic Complaints Pre	Positive Ranks	0 ^h	.00	.00
	Ties	2 ⁱ		
	Total	8		
Social Problems Post - Social	Negative Ranks	6 ^j	4.42	26.50
Problems Pre	Positive Ranks	1 ^k	1.50	1.50
	Ties	1 ^l		
	Total	8		
Thought Problems Post -	Negative Ranks	7 ^m	4.00	28.00
Thought Problems Pre	Positive Ranks	0 ⁿ	.00	.00
	Ties	1 ^o		
	Total	8		
Aggressive Behaviour Post -	Negative Ranks	6 ^p	4.50	27.00
Aggressive Behaviour Pre	Positive Ranks	1 ^q	1.00	1.00
	Ties	1 ^r		
	Total	8		
Other Problems Post - Other	Negative Ranks	6 ^s	3.50	21.00



Problems Pre	Positive Ranks	0 ^t	.00	.00
	Ties	2 ^u		
	Total	8		

Table 20: Test Statistics

	Withdrawn/Depressed	Somatic Complaints	Social Problems	Thought Problems	Aggressive Behaviour	Other Problems	
Comp_Social_Post	Post -	Post -	Post -	Post -	Post -	Post -	
Comp_Social_Pre	Pre	Pre	Pre	Pre	Pre	Pre	
Z	-1.192 ^b	-.597 ^c	-2.207 ^c	-2.132 ^c	-2.375 ^c	-2.201 ^c	-2.214 ^c
Asymp. Sig. (2-tailed)	.233	.551	.027	.033	.018	.028	.027

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

c. Based on positive ranks.

5.2.5 Results for Wilcoxon signed rank test: Control group.

The Wilcoxon signed rank test was done on the data that was **not normally distributed**, namely; Competence Social scale pre and post, Withdrawn/Depressed, Somatic complaints, Social problems, Thought problems, Aggressive behaviour, and Other problems.

For findings to be considered statistically significant, the p score (Asymp Sig. 2-tailed) should be less than or equal to 0.05.

Findings:

5.2.5.1 Withdrawn/depressed.

A Wilcoxon signed rank test revealed a statistically significant reduction in withdrawn/depressed scores following the course of the experiential art group, $z = -2.236$, $p < 0.025$, with a large effect size ($r = 0.598$). The median score on the withdrawn/depressed decreased from the pre-test ($Md = 4$) to post-test ($Md = 3$).

5.2.5.2 Other problems.

A Wilcoxon signed rank test revealed a statistically significant reduction in other problem scores following the course of the experiential art group, $z = -2.060$, $p < 0.039$, with a large effect size ($r = 0.551$). The median score on other problems decreased from the pre-test ($Md = 5$) to post-test ($Md = 4$).

These were the only two statistically significant findings, the rest of the findings were not significant.



Table 21: Descriptive Statistics

	N	Percentiles		
		25th	50th (Median)	75th
Comp_Social_Pre	7	5.6700	6.0000	8.0000
Withdrawn/Depressed Pre	7	2.00	4.00	5.00
Somatic Complaints Pre	7	1.00	4.00	7.00
Social Problems Pre	7	2.00	3.00	3.00
Thought Problems Pre	7	1.00	3.00	4.00
Aggressive Behaviour Pre	7	1.00	7.00	9.00
Other Problems Pre	7	4.00	5.00	11.00
Comp_Social_Post	7	5.6700	6.0000	8.0000
Withdrawn/Depressed Post	7	1.00	3.00	5.00
Somatic Complaints Post	7	2.00	3.00	6.00
Social Problems Post	7	1.00	3.00	3.00
Thought Problems Post	7	.00	3.00	4.00
Aggressive Behaviour Post	7	1.00	6.00	9.00
Other Problems Post	7	3.00	4.00	8.00



Table 22: Ranks

		N	Mean Rank	Sum of Ranks
Comp_Social_Post -	Negative Ranks	0 ^a	.00	.00
Comp_Social_Pre	Positive Ranks	0 ^b	.00	.00
	Ties	7 ^c		
	Total	7		
Withdrawn/Depressed Post -	Negative Ranks	5 ^d	3.00	15.00
Withdrawn/Depressed Pre	Positive Ranks	0 ^e	.00	.00
	Ties	2 ^f		
	Total	7		
Somatic Complaints Post -	Negative Ranks	3 ^g	2.50	7.50
Somatic Complaints Pre	Positive Ranks	1 ^h	2.50	2.50
	Ties	3 ⁱ		
	Total	7		
Social Problems Post - Social	Negative Ranks	2 ^j	1.50	3.00
Problems Pre	Positive Ranks	0 ^k	.00	.00
	Ties	5 ^l		
	Total	7		
Thought Problems Post -	Negative Ranks	3 ^m	2.67	8.00
Thought Problems Pre	Positive Ranks	1 ⁿ	2.00	2.00
	Ties	3 ^o		
	Total	7		
Aggressive Behaviour Post -	Negative Ranks	2 ^p	2.25	4.50
Aggressive Behaviour Pre	Positive Ranks	1 ^q	1.50	1.50
	Ties	4 ^r		



Total		7		
Other Problems Post - Other	Negative Ranks	5 ^s	3.00	15.00
Problems Pre	Positive Ranks	0 ^t	.00	.00
	Ties	2 ^u		
Total		7		

Table 23: Test Statistics

		Withdrawn/Depressed	Somatic Complaints	Social Problems	Thought Problems	Aggressive Behaviour	Other Problems
	Comp_Social_Post - Comp_Social_Pre	Post - Pre	Post - Pre	Post - Pre	Post - Pre	Post - Pre	Post - Pre
Z	.000 ^b	-2.236 ^c	-1.000 ^c	-1.414 ^c	-1.134 ^c	-.816 ^c	-2.060 ^c
Asymp. Sig. (2-tailed)	1.000	.025	.317	.157	.257	.414	.039

a. Wilcoxon Signed Ranks Test

b. The sum of negative ranks equals the sum of positive ranks.

c. Based on positive ranks.

5.2.6 Wilcoxon signed rank: Comparison table for experimental and control group results.

This table is provided to present an overall description of the results for the experimental and control group.

Table 24: Wilcoxon signed rank: Comparison table for experimental and control group results

Score	Experimental	Control
Comp social pre and post	Not significant	Not significant
Withdrawn/Depressed.	Not significant	A Wilcoxon signed rank test revealed a statistically significant reduction in withdrawn/depressed scores following participation in the art group, $z = -2.236$, $p < 0.025$, with a large effect size ($r = 0.598$). The median score on the withdrawn/depressed decreased from the pre-test ($Md = 4$) to post-test ($Md = 3$).
Somatic complaints	A Wilcoxon signed rank test revealed a statistically significant <i>reduction</i> in somatic complaint scores following participation in the art group, $z = -2.207$, $p < 0.027$, with a large effect size	Not significant



	($r = 0.552$). The median somatic complaint score decreased from the pre-test ($Md = 3$) to post-test ($Md = 1$).	
Social problems	A Wilcoxon signed rank test revealed a statistically significant <i>reduction</i> in social problem scores following participation in the art group, $z = -2.132$, $p < 0.033$, with a large effect size ($r = 0.533$). The median social problem score decreased from the pre-test ($Md = 6$) to post-test ($Md = 2$).	Not significant
Thought problems	A Wilcoxon signed rank test revealed a statistically significant <i>reduction</i> in thought problem scores following participation in the art group, $z = -2.375$, $p < 0.018$, with a large effect size ($r = 0.594$). The median thought problem score decreased from the pre-test ($Md = 4.5$) to post-test ($Md = 1$).	Not significant
Aggressive behaviour	A Wilcoxon signed rank test revealed a statistically significant <i>reduction</i> in aggressive behaviour scores	Not significant

	following participation in the art group, $z = -2.201$, $p < 0.028$, with a large effect size ($r = 0.550$). The median aggressive behaviour score decreased from the pre-test ($Md = 8$) to post-test ($Md = 4.50$).	
Other problems	A Wilcoxon signed rank test revealed a statistically significant <i>reduction</i> in other problem scores following participation in the art group, $z = -2.214$, $p < 0.027$, with a small effect size ($r = 0.172$). The median other problem score decreased from the pre-test ($Md = 4.50$) to post-test ($Md = 3$).	A Wilcoxon signed rank test revealed a statistically significant reduction in other problem scores following participation in the art group, $z = -2.060$, $p < 0.039$, with a large effect size ($r = 0.551$). The median score on other problems decreased from the pre-test ($Md = 5$) to post-test ($Md = 4$).

Important to note – For the experimental group; the ideal situation would be obtaining statistically significant results with a decrease in scores from pre-test to post test. For the control group the expectations are non-significant results.

For findings to be considered statistically significant, the p score (Asymp Sig. 2-tailed) should be less than or equal to 0.05.

5.3 Thematic Analysis Findings: Semi structured Interviews

This section will discuss the themes and sub-themes that emerged from the analysis process of the data. The findings were divided into the following themes:

- Participation and engagement in activities
- Willingness to do chores
- Social engagement and play
- Academic performance



- Behaviour towards family

Table 25: Themes

Themes	Sub-themes
Theme 1 Participation and engagement in activities	Child's engagement in activities
	Group activity participation
	Child's behaviour during/towards hobbies
Theme 2 Willingness to do chores	Child's responsibilities at home
	Child's behaviour/attitude towards chores or jobs
Theme 3 Social engagement and play	Child's social engagement and play with peers/friends
	Child's social engagement and play with siblings/ family members
	Violence and/or aggressive behaviour
Theme 4 Academic performance	Child's progress at school
	Child's attitude towards school and learning
Theme 5 Behaviour towards family	Child's attitude towards parents/ caregivers
	Child's behaviour towards other family members
	Obedience and disobedience towards family



5.3.1 Theme 1: Participation and engagement in activities

This theme encompasses experiences shared by parents and caregivers regarding their children's behaviour and involvement in hobbies, activities and/or games. The concepts of participation and engagement have been defined in various ways based on different contexts. According to the World Health Organization's (2001) International Classification of Functioning, Disability and Health (ICF), participation is broadly defined as involvement in a life situation. This definition entails an interaction with the social and physical environment, as well as an individual's intention and desire to participate in activities (Almqvist, Uys, & Sandberg, 2007). The concept of participation is closely linked to engagement in activities such as play and taking part in daily activities or hobbies (Almqvist et al., 2007). McWilliam and Bailey (1992) defined engagement as the amount of time children spend interacting appropriately with their environment at various levels. It reveals the sustained behaviour of the child over time and the extent to which the child is involved (Almqvist et al., 2007).

5.3.1.1 Subtheme 1.1 – Child's engagement in activities.

The parent/s or caregiver/s of the participants (children) were asked to describe their child's general behaviour and engagement in activities.

One of the parents whose child was in the experimental group explained: *"...used to spend a lot of time playing games on his phone but that made him less social, he did not engage much in active tasks with other children. Now he plays more with other children and he socialises more"*.



Another parent whose child was a member of this group expressed the following: *“...likes playing soccer and video games with his friends, they have their moments of disagreements, but they eventually play well and fair together”*.

A parent whose child was in the control group replied by saying: *“...fights often when playing with other children; she hardly participates in activities”*.

Another caregiver whose child was a member of the control group said: *“...is alright when he’s busy with activities, he is very active”*.

These were some of the views shared by some parents and caregivers when asked about their children’s behaviour in relation to their engagement in activities.

5.3.1.2 Subtheme 1.2 – Group activity participation.

The above subtheme took shape as an expansion of the question asked of the children’s parent/s or caregiver/s about their general behaviour and engagement in any other activities. The topic of group activities emerged when parent/s or caregiver/s commented on their children’s behaviour in relation to group activity participation at Itsoseng Clinic and/or other settings (e.g. school). The caregiver of one of the children in the experimental group expressed the following: *“... enjoys being part of groups now. She used to shy away from group activities; however, since the art activities started, she has been excited to attend the groups each week.”*

Another caregiver whose child was part of this group said: *“... has enjoyed the group, she also recently joined the choir group at school; she is committed and does not miss a session of choir practice”*.

The parent of a child from the control group responded by saying: *“...disengages from socialising with other children; his participation in group activities is very little”*.



Another caregiver whose child was in the control group expressed the following: *"...is ok in group settings as far as I have seen, like when he does homework with other children he is alright"*.

Parents and caregivers from both the experimental group and the control group shared their views regarding their children's behaviour and participation in group settings.

5.3.1.3 Subtheme 1.3 – Child's behaviour during/towards hobbies.

Parent/s and caregiver/s were also asked to describe their child's behaviour in relation to their hobbies. The caregiver of a child in the experimental group shared their view as follows: *"I feel that since my child recently started reading more; his studies have improved"*.

Another parent from this group shared this: *"He really enjoys playing soccer. Soccer has been a good distraction from negative influences and fights that often happen in the neighbourhood"*.

The parent of a child from the control group indicated that *"...takes part in sports and likes playing video games, at times he displays violent behaviour while playing his games"*.

Another parent whose child was in the control group said the following: *"She plays netball quite well; the only problem is when they start fighting with opposing teams then she wants to hit the other girls"*.

Different views were shared by parents and caregivers regarding certain hobbies that their children took part in, and their subsequent behaviour in that context.



5.3.2 Theme 2: Willingness to do chores.

This theme is centred around parents' and caregivers' views of their children's behaviour or attitude towards responsibilities, chores, and jobs. Weisner (2001) emphasises the importance of children contributing to the family through participation in household responsibilities, as this facilitates their development. Klein, Graesch and Izquierdo (2009) indicated that children's household chores play a fundamental part in the socialisation process of defining family roles, responsibilities and obligations. It is also important to understand and explore whether children participate in household chores willingly or if they resist these responsibilities, and what the reasons for this may be (Weisner, 2001). The concept of these children's willingness to do chores or responsibilities emerged while the parents and caregivers of this particular study described their children's behaviour. The Oxford English Dictionary (2008) defines 'willingness' as "the quality or state of being prepared to do something, or readiness". This concept was then linked to the attitude and behaviour that these children had towards their chores and responsibilities at home.

5.3.2.1 Subtheme 2.1 – Child's responsibilities at home.

Parents and caregivers were asked to describe their child's behaviour in relation to his or her responsibilities at home.

Responses relating to participants from the experimental group stated the following: Parent 1: "*...he initially tended to ignore or delay doing tasks; his mother had to repeatedly remind him before he eventually did what he needed to. Now he's a bit better with washing dishes without being asked first*".

Parent 2: "*...there has been an improvement in doing tasks such as cleaning and cooking; she does them more willingly now*".



Parent 3: *"...we're happy with the way she carries out tasks in the house, she does them well and willingly, without us having to ask her"*.

Parents and caregivers whose children were in the control group responded as follows:

Parent 1: *"...he delays when he has to do house chores like washing dishes or cleaning his room"*.

Parent 2: *"...he doesn't complete household tasks when given; he requires motivation or an incentive before he does it"*.

5.3.2.2 Subtheme 2.2 – Child's behaviour in relation to chores or jobs.

This subtheme related closely to the previous one; participants were asked to describe their children's behaviour in relation to any chores or jobs in general if they had any. These were some of the responses provided by parents or caregivers of children from the experimental group:

Parent 1: *"...he has no formal job; however, he sometimes offers to wash my car for pocket money"*.

Parent 2: *"...when I used to ask him to babysit, he would reluctantly agree to look after his baby sister, now he seems more willing to babysit"*.

A response from one of the participants from the control group stated that the child *"...often does not see the need to work because his mother does most of the house chores...but, after several requests and pleas, he eventually does the chores"*.

Parents and caregivers had differing views about their children's attitude and behaviours towards doing their chores, responsibilities and jobs. They shed some light on their children's willingness to do chores.

5.3.3 Theme 3: Social engagement and play.

Children's behaviour and social engagement are influenced and encouraged mostly by interactions that take place in various social contexts such as at home or the school environment (Almqvist et al., 2007). According to Almqvist et al. (2007), it is essential for parents and caregivers to reinforce and encourage social interactions amongst children to enhance the practice of social skills through problem solving and persistence.

Children learn social engagement through play, as this is often their daily activity and enables them to explore and discover their environment (Hughes, 2009). Play is viewed as the means by which a child can develop different roles that are required of them to interact with different people in diverse situations (Johnson, Christie, Yawkey, & Wardle, 1987). Pellegrini, Dupuis, and Smith (2007) stated that play is an essential activity of early childhood, as it contributes to the cognitive, social, and emotional development of children. Children who are able to engage in pretend play are considered to have high social competence (Uren, 2009). Social competence is related to a child's ability to engage in pretend play which often involves imitation, either immediate or deferred, as children engage in routine action sequences with familiar toy objects (Uren, 2009). Participating in play offers an opportunity for parents and caregivers to fully engage with their children while strengthening their relationship with the child (Goldstein, 2012).

5.3.3.1 Subtheme 3.1 – *Child’s social engagement and play with peers or friends.*

Parents and caregivers were asked to describe their child’s social engagement and play behaviour with their peers or friends. Goldstein (2012) highlighted the significance of peer engagement and acceptance, which was described as being determined by the identification of a child’s social status within their peer group, as well as the number of mutual friendships that exist amongst the children.

One of the parents of a participant from the experimental group provided the following response: *“He’s ok when he is with his friends; they get along quite well, he no longer engages in a lot of fights like he used to”.*

Another caregiver responded by saying: *“He likes being ahead of his peers, he wants to do better, he doesn’t like being left behind”.*

The parent of a child from the control group indicated that *“... gets into a lot of fights with his peers, he only behaves after being reprimanded by his elders”.*

Another parent from this group said the following: *“...she gets along well with her friends, the only person she struggles to get along with is her younger brother”.*

This subtheme provided some views of parents and caregivers’ perceptions of their children’s behaviour in relation to engagement with their peers. They later shared views regarding their children’s engagements with their siblings.

5.3.3.2 Subtheme 3.2 – *Child’s social engagement and play with siblings and family members.*

This subtheme expanded on the social engagement and play behaviour of these children towards their siblings and other family members. Parents and caregivers’ interaction with their children during play provides an idea of the level of

reciprocity and social engagement between them (Campbell, Leezenbaum, Mahoney, Moore, & Brownell, 2016). This is the view of the parent of a participant from the experimental group: “...*the play with her siblings has changed; she used to be rude and impatient towards her siblings, however, now she’s more understanding and patient. I think being with other children while engaging in the activities seems to have shown her how to interact or play appropriately with others*”.

Another caregiver from the experimental group said this: “*He shares his toys and involves us in his play. He is also sensitive to the way he impacts his younger sister; he looks out for her*”.

The parent of a child from the control group said: “*Other family members think he is too active and loud during play. He is quite possessive over his belongings and toys*”.

Another parent whose child formed part of this group expressed: “*She plays well with her siblings and cousins, they get along*”.

These were some of the views that parents and caregivers provided when describing their children’s social engagement and play behaviour with their peers and other family members.

5.3.3.3 Subtheme 3.3 – Violence and/or aggressive behaviour.

The subtheme of violence and/or aggressive behaviour emerged from parents’ and caregivers’ responses regarding their children’s behaviour in relation to social engagement and play. Violence in children comprises a variety of behaviours such as bullying, aggressive behaviour towards others, threats, and explosive temper tantrums (Mitrofan, Paul, Weich & Spencer, 2014). Aggressive behaviour may be an



indication of a range of different problems, and it is commonly present in different psychiatric conditions, medical problems, and life situations (Mitrofan et al., 2014).

A parent from this particular study whose child was in the experimental group expressed the following experience: *"...used to be friends with children in the community who were rough and played violently; this negatively influenced his behaviour because he also became very aggressive. Now the way he interacts and plays with his peers has changed; he is more focused on befriending other peers that have a positive influence. The peers he plays with currently are more obedient, and this has shifted his behaviour because he has also become well-behaved and obedient"*.

The parent of a child who was in the control group said: *"...is unruly; he has several fights with his peers and siblings. He watches wrestling and plays violent video games that encourage him to play violently with his sister. He ends up hurting her and this then turns into a fight"*.

Overall, this theme revealed different views about children's behaviour during social engagement and play with others. Some parents and caregivers shared positive responses regarding their children's behaviour towards others, while others spoke about their children displaying violent and aggressive behaviour in this regard.

5.3.4 Theme 4: Academic performance.

Academic performance in the context of this study is represented by the extent to which a child is able to achieve their academic (scholarly) goals. York, Gibson and Rankin (2015) see academic performance as encompassing academic achievement, attainment of learning objectives, satisfaction, persistence, and acquisition of desired skills and competencies. An example could be that of a child who successfully

completed a particular grade at school; this represents academic performance and achievement. Academic performance also extends beyond the classroom setting; some children succeed at other extra-mural activities such as athletics, soccer, or music etc (York et al., 2015). The ability to master a diverse set of skills demonstrates initiative, curiosity, persistence and competence (York et al., 2015).

5.3.4.1 Subtheme 4.1 – Child’s progress at school.

Parents and caregivers were asked to describe how their child was doing generally at school. The following responses were provided by some of the parents and caregivers from the experimental group:

“He has currently improved at school; he used to struggle with completing his school work and homework, his books used to be empty. Since he started attending the art group and receiving assistance with homework here at Itsoseng, he has really improved. Even his mother has commended his improvement; she often used to be called in at his school due to him not completing his school work, however, she has since not been called in at school for any school related problems”.

“She’s doing ok; there are still some drawbacks to a certain extent, however, there are slight improvements here and there...there are more subjects that have improved as compared to last term. Last term she failed all her subjects; however, this term she passed most of them and only failed two subjects. I have seen an improvement, and I am hopeful that there might be more improvement in her school work”.

Parents and caregivers whose children were in the control group shared the following views:



“He’s struggling at school; his teachers often report on his misbehaviour. They say he likes to play in class, and he struggles to focus”.

“She has been failing her subjects since the beginning of the year, I am very concerned because nothing has changed...I am even considering taking her to a different school”.

5.3.4.2 Subtheme 4.2 – Child’s attitude towards school and learning.

This subtheme emerged as parents and caregivers were describing how their children were doing at school. Some parents and caregivers also described their children’s attitude towards school and learning.

The parent of a child who was part of the experimental group explained: *“His attitude towards school has changed, he is more willing to go to school, and he initiates his homework without being asked by us”.* Another parent of a child in the experimental group said: *“She shows more effort and commitment now; she never used to show us her test timetable, but now she shows us on which days she’s writing and we help her do mock tests in preparation for her tests now. She has been a lot more productive”.*

The caregiver of a child who was part of the control group mentioned the following: *“She doesn’t want to go to school; she often says that she is sick and wants to be excused from going to school or attending classes”.*

Parents and caregivers shared various views with regard to their children’s progress at school, their children’s behaviour and attitude towards school and learning.

5.3.5 Theme 5: Behaviour towards family.

Family plays a fundamental role in the child's development and behaviour (De Figueirido & Dias, 2012). Children's behaviour towards their family could be influenced by various aspects such as family dynamics, relationships, and family structure (Ryan, Claessens, & Markowitz, 2013). The quality of communication between the child and their family member/s is a significant factor in determining the child's behaviour towards their family (Smith & Hubbard, 1988). Changes in the family dynamic and structure, such as divorce, for example, may also have an impact on children's behaviour because divorce can be a stressful experience for the child/ren (De Figueirido & Dias, 2012). Children may, for example; have feelings of resentment towards either or both of their parents during or after a divorce, causing them to retaliate or misbehave as a result (De Figueirido & Dias, 2012). De Figueirido and Dias's (2012) study indicated that the children of single parents have more behavioural problems in different dimensions than children with married parents.

The manner in which parents uphold their values and socialise their children could also result in favourable behaviour and attitude from their children (Xiao, 1999). Socialisation is said to be the process by which children are taught a range of values, attitudes and behaviours of society which are practised in different cultures worldwide (Xiao, 1999). The child-rearing practices used by parents determine the child's value systems, attitude and behaviour (Xiao, 1999).

5.3.5.1 Subtheme 5.1 – Child's attitude towards parents or caregivers.

Parents and caregivers in this study were asked to describe their child's attitude towards them personally. The following responses were provided by parents and caregivers whose children were part of the experimental group:



Parent 1: *“His behaviour towards me is alright, he listens to me when I talk to him”.*

Parent 2: *“Her attitude towards me has changed, she never used to talk openly with me, and she seemed to have kept many things to herself...now she engages me a lot more in discussions”.*

Parent 3: *“He has no problems; we get along, he’s much better because he listens to me a lot more than he did before”.*

Parents and caregivers whose children were part of the control group said the following: Parent 1: *“She is very moody, and she is often disrespectful towards me”.*

Parent 2: *“We have our ups and downs, we get along, but then we argue a lot when he misbehaves”.*

5.3.5.2 Subtheme 5.2 – Child’s behaviour towards other family members.

Parents and caregivers also commented on their children’s behaviour and attitude towards other members of their family. Some participants with children from the experimental group shared the following responses:

Parent 1: *“He’s ok towards other family members. I have to remind [him] and explain to him that when visiting other family members; they need to share...for example food and behave in a manner that is appropriate to all. He is now showing interest in spending more time with extended family members”.*

Parent 2: *“She is normal towards other family members; she’s respectful and gets along with them. There have been no problems encountered with her and other family members”.*

Some parents and caregivers with children who form part of the control group shared the following views:



Parent 1: *“He is ok towards other family members. I think he might act different with them because he is shy and not so used to them”.*

Parent 2: *“She doesn’t engage much with other family members especially when they come visit us at our home... She often stays in her room”.*

Parents and caregivers shared some of their views regarding their children’s behaviour towards them and other family members. They often referred to the level of respect their children demonstrated, and the manner in which their children engaged with them as family members.

5.3.5.3 Subtheme 5.3 – Obedience and disobedience towards family.

This subtheme occurred when parents and caregivers shared their views regarding their children’s attitude and behaviours towards the family. The concepts of obedience and disobedience were prominent in their descriptions of their children’s behaviour. Obedience can be described as compliance with an instruction or request which has been issued by an authority figure (Bocchiaro & Zamperini, 2012). Obedience is vital to various aspects of social life and it contributes to the maintenance of social order and stability (Passini & Morselli, 2009). Disobedience may be perceived as a protest which undermines the authority figure’s demands or requests (Passini & Morselli, 2009). In this instance, we refer to the authority figures as the parents and caregivers of children in this study. These views were shared by some parents and caregivers of the children who were in the experimental group:

Parent 1: *“He behaves well towards other members within the family; he is obedient and respectful”.*

Parent 2: *“He also listens and shows respect towards other family members. For example; his aunties...yoh they love him so much”.*

Parent 3: *“Her behaviour towards me is good; she has always been respectful and obedient towards me”.*

These are some views shared by parents and caregivers of children who were in the control group:

Parent 1: *“He has his moments when he does not want to listen to me, he sometimes disobeys the rules of the house, and he goes against my wishes”.*

Parent 2: *“He requires discipline, I reprimand him when he is disobedient, and he only listens after being reprimanded”.*

This theme presented various opinions from parents and caregivers regarding their children’s behaviour and attitude towards them as family members. Describing the level of respect, obedience and disobedience became a prominent reference point in describing the children’s behaviour.

5.4 Chapter Conclusion

Chapter five presented the results and findings of the overall data of the study. The first part of the chapter focused on results in relation to the Child Behaviour Checklist (CBCL). The results were presented separately for the experimental group and the control group. The second part of the chapter focused on the themes that emerged from the semi-structured interviews before and after the course of the experiential (expressive) art group programme.

Results showed both a decrease and an increase in some of the variables from the Child Behaviour Checklist. The themes derived from the semi-structured interview involved discussions regarding participation and engagement in several activities, academic progress, and various behaviours and attitudes with/towards



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peers and family members. The following chapter will focus on the discussion of the findings.

Chapter Six – Discussion of Findings

6.1 Introduction

This chapter presents a discussion of the findings obtained in this study. The outcome of the children's behaviour is explored in this chapter by looking at results from the Child Behaviour Checklist for the experimental group and for the control group. It is important to note that findings from this study should be regarded with caution and with consideration of potential limitations such as the sample size and ability to generalise the findings. Themes derived from the semi-structured interviews are also further discussed in this chapter.

6.2 Discussion of Quantitative Findings: Child Behaviour Checklist (CBCL)

6.2.1 Discussion for Paired sample t-test and Wilcoxon signed rank test:

Experimental groups.

In relation to the experimental groups; *statistically significant* results were anticipated with a *decrease* in scores from pre-test to post-test. There were however various factors that might influence the outcome of either an increase or decrease in the scores between the pre-test and the post-test.

In the paired sample t-test experimental group findings, the following variables indicated decreases in their scores: the anxious/depressed scale, rule breaking behaviour, internal A T score, external B T score, and total T score syndrome score.

In the Wilcoxon signed rank test experimental group findings, the following variables indicated reductions in scores: somatic complaints, social problems, thought problems, aggressive behaviour and other problems.

A reduction in scores between the pre-test and post-test would imply that there is likely a decrease in various behavioural problems in the presence of experiential art groups. As mentioned in the literature review; participation in expressive art activities indicated reduced levels of emotional unresponsiveness and ‘acting out’ problem behaviour in children (Ritok & Bodoczky, 2012; Shennum, 1987). It was also predicted that children who received greater amounts of art and/or dance/movement type of interventions would display fewer emotional and behavioural problems than children who received little or no type of intervention (Burkitt & Lowry, 2015; Shennum, 1987).

There are, however, reported increases in some problem areas relating to activities, school, and the total T competence scale which were found in the paired sample t test experimental group findings between the experiential art program start and end. This is contrary to the results of other variables that indicated decreases in problem behaviour. These contradictory findings may reflect shifts that may have occurred in various contexts within the period of the evaluation process of the experiential art group program.

Our literature review also spoke about several other factors that may contribute to behavioural problems in children. González-García, Bravo, Arruabarrena, Martín, Santos, and Del Valle (2017) mentioned that adverse family conditions, abuse and neglect can induce emotional and behavioural problems. Dysfunctional parenting in discipline situations and exposure to unfavourable or hostile environmental influences may also potentially exacerbate some behavioural problems (Arnold,

O’Leary, Wolff, & Acker, 1993). These factors are only a few of numerous other factors that could lead to an increase in children’s problem behaviours.

It was also mentioned in the literature chapter that Itsoseng Clinic often receives referrals from schools, that teachers often described the children being referred as having challenges at school, difficulty or failure to learn, and misbehaviour, and that they are often given the label of “learning problems” (Blokland, 2014).

Achenbach and Edelbrock (1981) suggested that behavioural problems in children present in various forms. Children who exhibit problem behaviours at school or within the classroom setting have very different experiences from those of their peers (Gunter, Denny, Jack, Shores, & Nelson, 1993). Most of these children are reprimanded much more frequently, seldom praised for their efforts, and less likely to be called on academically, all of which can contribute to increasing defiant behaviour (Gunter et al., 1993). Children with problem behaviours have less positive interaction with their teachers, and this may often aggravate their behaviour at school (Gunter et al., 1993). Some children meet the criteria for attention deficit/hyperactivity disorder (ADHD), a disorder characterised by a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development (American Psychiatric Association, 2013). ADHD can result in difficulty completing assigned work, following instructions, and following general classroom rules, further compromising the child’s emotional and behavioural state (DuPaul, Ervin, Hook, & McGoey, 1998).

Relative to the findings that indicate significant reductions in children’s behaviour problems; factors besides the experiential art group that may have contributed to these behavioural shifts are improved parenting practices, more favourable environmental influences (i.e. increased consistency, decreased power assertive

techniques), an increased sense of efficacy, and reduced parenting stress (Feinfield & Baker, 2004).

Feinfield and Baker's (2004) study provided evidence to indicate that improved parenting practices mediated reductions in child behaviour problems and that child improvements mediated changes in parent attitudes and stress. Reports were also given by the children's teachers regarding improvements in these children's behaviours at school (Feinfield & Baker, 2004).

6.2.2 Discussion for Paired sample t-test and Wilcoxon signed rank test:

Control group.

In considering the control groups, the expectation would be results that were not statistically significant, indicating that the control group remained unchanged. There were, however, findings from the control group that indicated decreases within their scores (i.e. total T score syndrome and attention problems, withdrawn/ depressed, and other problems). These variables may have been affected by various factors that could have resulted in the decreased scores. Attention, withdrawal and depression, as well as other problems, could possibly have been influenced by shifts in various environments to which the children were exposed (Arnold et al., 1993). Children who have attention problems (e.g. attention deficit/hyperactivity disorder) may benefit from obtaining appropriate treatment for their condition, and this may reduce the attention problems (Du Paul et al., 1998). More positive interactions between children and their parents or teachers, or improvements in learning processes at school or in the classroom, may also decrease their problem behaviour (Gunter et al., 1993). Children who have depression, withdrawal, and/ or other problems could also benefit from receiving appropriate treatment (Ryan, 2005).

Changes in children's environment such as better discipline situations, having more favourable family dynamics or peer relations may also reduce behaviour problems (Arnold et al., 1993). Alterations in these aspects may influence total t syndrome scores and other behavioural problems, thus resulting in a significant decrease in scores. Other results show no significance, which indicates that there was no significant difference within the rest of the variables of the control group. This is in line with the expected results regarding the control groups which signify little or no change between the pre- and post-test scores.

6.3 Discussion of qualitative findings: Semi structured interviews (Thematic analysis).

6.3.1 Participation and engagement in activities.

The first theme explored the children's participation and engagement in activities and daily hobbies before and after the process of the experiential art activity program at Itsoseng Clinic. Parents and caregivers had different views of their children's behaviour, and this included, to some extent, reported shifts in this behaviour (Pearson & Wilson, 2009). Some participants were described as engaging more in group activities, and this was attributed to being in the experiential art group at the clinic. Most participants who were in the control group were reported by their parents and caregivers as 'not engaging much' or 'not socialising with other children'. Some parents and caregivers reported little participation in activities, while others described improvements in engagement in activities and hobbies. Most parents associated their children's increase in activity and hobby participation with change in their behaviour and emotional states.



When considering the potential reasons for the noted shifts in behaviour in this study, we could refer back to Puig, Lee, Goodwin and Sherrard's (2006) study that illustrated that participation in creative arts therapy interventions enhanced psychological well-being by reducing negative emotional states and enhancing positive states of group participants within the study. It is also implied that expressive art activities in this study may have altered the children's behaviour (Rosal, 2001).

Some of the parents and caregivers shared their views about their children taking part in other extramural activities, such as joining the choir and playing soccer. Participating in extramural activities was described by these parents as apparently having a positive influence on their children's behaviour. Extramural activities were described as keeping their children from various negative influences in the Mamelodi community. This refers us back to Massoni's (2011) paper describing the role of extracurricular activities on school children, which indicated that these activities could have positive effects on students of all kinds, ranging from the above average student to the student that is on the brink of dropping out of school (Massoni, 2011).

6.3.2 Willingness to do chores.

The second theme considered the children's willingness to do chores; either at home or in another working environment. Parents and caregivers shared their views regarding their children's attitude and behaviour towards responsibilities, chores and jobs. The most common response expressed about participants from the experimental group was that, whereas they might initially have tended to ignore or delay doing their chores, they had apparently become better at doing their chores over time. Some parents shared the view that there had been a general improvement and greater willingness to do chores. Most parents and caregivers

whose children were in the control group indicated that their children delayed doing their chores, often did not complete their given tasks, and required motivation or incentives in order to carry out their chores and responsibilities.

When considering factors that may have influenced the children's willingness and motivation to do chores, we could refer back to Massoni's (2011) paper that indicated positive effects on children who engaged in extracurricular activities such as expressive art activities. When the children in this study engaged in expressive art activities, it may have provided them with a space in which they could express their emotions (Ceausu, 2016), resulting in a decline in emotional and behavioural problems, which would affect their readiness to follow orders from authority figures and enable them to do their responsibilities and chores as requested (Bocchiaro & Zamperini, 2012). Burkitt and Lowry (2015) stated that children who received greater amounts of expressive art activities would display less emotional unresponsiveness and less 'acting-out' problem behaviour than children who did not receive any form of expressive art activity.

It is important to also consider the various aspects that may negatively influence these children's motivation and willingness to work or do chores, such as living in a low-income family (Son & Bauer, 2010). Having socio-economic stressors may result in the child resorting to work as a means to support their family (Son & Bauer, 2010). Bachman, Safron, Sy, and Schulenberg (2003) spoke about the negative impacts of part-time work on children, given the intensity of the work and likelihood of limited rest and sleep. If these children do not have enough time to rest, it may affect their motivation and willingness to do other responsibilities, and they may struggle in other areas of their daily functioning (Bachman et al., 2003).



6.3.3 Social engagement and play.

The third theme focused on the social engagement and play behaviour of these children with their peers, friends, siblings, and other family members. Parents and caregivers of participants from the experimental group shared views of their children that mostly suggested that the children might initially not have got along very well with their peers and family members, but did now. One of the parents specifically referred to their child's play behaviour being influenced by the experiential art group activities, in that they used to be rude and impatient towards their siblings but that this had now changed. The parent expressed the view that engaging with other children in the activity group might have helped their child to interact and play more appropriately with other children.

It was mentioned in the literature review that peer play groups combined with art activity groups have been shown to improve depression and hyperactivity scores according to the Child Behaviour Checklist (Surhone et al., 2010). This was found with children who have at least one parent suffering from alcohol or drug dependency (Surhone et al., 2010). This raised an interesting point when considering the impact of play and art activities on children's overall behaviour.

Parents and caregivers whose children were in the control group mostly spoke of their children being involved in many fights with their peers and siblings, and having to be reprimanded before they behaved appropriately. The subtheme of violence and aggression became prominent in parents' responses regarding their children's behaviour while engaging and playing with others. A response given by one of the caregivers whose child was in the experimental group was that their child used to have friends who negatively influenced their behaviour because they used to be rough and aggressive in their play. This, however, changed when the child started

befriending 'more positive friends' from the art group; the child was reportedly more obedient and respectful. On the other hand, a parent whose child was part of the control group shared the view that their child was unruly and had several fights with his peers and siblings. The parent also reported the child liked watching wrestling and playing violently with his sibling, which resulted in him hurting her and them fighting.

It is thus important to consider the various driving forces of violence and aggressive behaviour (Mitrofan et al., 2011). Research conducted by Anderson and Bushman (2001) suggests that exposure to television and movie violence, as well as playing violent video games, increases aggressive behaviour. Children who are exposed to violence experience longstanding physical, mental and emotional harm, which predisposes them to engage in violent and aggressive behaviour themselves (Huesmann, Moise-Titus, Podolski, & Eron, 2003).

Exposure to violence in the community; in settings such as the home or school environment, may also have an influence on aggressive behaviour through imitation of violence, or associated cognitions related to violence which are developed over time (Guerra, Huemann, & Spindler, 2003). A study by Guerra et al. (2003) indicated that prior exposure to violence had a significant effect in increasing aggression, normative beliefs related to aggression, and aggressive fantasy. Unfavourable situations within the family (home environment) additionally influence violent behaviour in children (Geurra et al., 2003). Duman and Margolin (2007) highlighted the various aspects of parenting that may contribute to violent behaviour in children. They considered parenting shortcomings which inadvertently encourage aggressiveness in their children, such as poor supervision, harsh discipline, parental



disharmony, rejection of the child, and limited involvement in the child's activities (Duman & Margolin, 2007).

The study by Smeijsters and Cleven (2006) mentioned in the literature review, exploring the treatment of aggression using art therapies, showed that art therapies can help to reduce levels of aggression and recidivism. This is an important consideration when exploring the outcomes of experiential art activities on the behaviour and psychological functioning of children.

6.3.4 Academic performance.

The fourth theme focused on parents' and caregivers' views of their children's progress at school and their attitudes towards school and learning. Most participants from the experimental group were described as having initially struggled at school; they used to not complete their homework and failed some subjects. However, since they had started receiving assistance with their homework at Itsoseng Clinic and attending the art group, some improvements had been apparent. Parents and caregivers reported that they had noticed some improvements in their children's general academic performance and their willingness to go to school.

By contrast, parents and caregivers of participants from the control group mostly shared views of their children still struggling at school. Misconduct and misbehaviour were commonly brought up by most parents, who had also received reports from their children's teachers. Another common response was the participants' failure to complete homework and pass their subjects. Parents and caregivers also indicated that their children were mostly not keen to go to school.

Factors possibly affecting these children's academic progress could be the type of relationship or interaction the child has with their teacher/s, the classroom

environment, and the measures that the teachers use to reprimand and discipline the children (Gunter et al., 1993). A child who has learning difficulties would also be affected in their academic progress and learning environment (Bethoney, 2016). These are some of the many factors to consider as having possible influences on children's behaviour and attitude towards school and learning.

6.3.5 Behaviour towards family.

This last theme consisted of the parents' and caregivers' accounts of their children's behaviour and attitude towards them and other family members. Participants from the experimental group were commonly described as getting along with their family. One of the parents reported that their child's attitude towards them had changed, in that their child had previously kept a lot to themselves and had not been very open with them but now engaged more openly with their parent. Most participants from the experimental group were also described as being respectful and more obedient towards other family members. It was indicated that some participants were spending more time with their extended family members.

Parents and caregivers whose children were part of the control group mostly described their children as being moody and disrespectful towards them and extended family members. Some participants were described as disobedient and disengaged from other family members. Most parents and caregivers of children from the control group said that they often had arguments with their children about misbehaviour, and they often had to reprimand or discipline their children.

As mentioned before, family dynamics and the family structure likely influence children's behaviour. The literature review also referred to Loeber and Stouthamer-Loeber's (1986) study, which demonstrated that family systemic changes in



parenting behaviours may influence the rate of involvement in delinquent activities and conduct problems. Children may be affected by social stressors such as problems in their family household and marital problems between parents (Kattz & Gottman, 1993). The parents' interactional patterns and conflict resolution styles may contribute differently to the presence of internalising and externalising behaviour in children (Kattz & Gottam, 1993). It is thus important to consider these factors alongside the study, when exploring the outcomes of participation or non-participation in the experiential art group.

6.4 Chapter Conclusion

This chapter provided a discussion of the findings, which were examined by comparing Child Behaviour Checklist scores before participation in the expressive art activity programme and afterwards. The discussion of findings from the experimental group found that there were reductions in scores between the pre-tests and the post-tests of this evaluation. This may imply that participation in experiential art activities are likely to have reduced behavioural problems alongside other potential influences that impacted the decrease in scores. We also considered the variables that contrarily increased in the experimental group; this indicated other potential factors that may have shifted in a range of contexts that these children were exposed to within the period of the evaluation process. Most results from the control group indicated non-significance as anticipated; however, there were some decreases in a few behavioural problems. This may also suggest that exposure to different circumstances and environmental influences influenced their behaviour. It is important to note that findings from this study should be regarded with caution and

consideration of potential limitations, such as the sample size and ability to generalise the findings.

The behaviours and attitudes of these children were further discussed in the semi-structured interview schedules. The themes that emerged were participation and engagement in activities, willingness to do chores, social engagement and play, academic performance, and behaviour towards family. Views from parents and caregivers whose children formed part of the experimental group and control group were discussed. Responses pertaining to change and improvement in behaviour were commonly provided by parents and caregivers of children from the experimental group. Responses that mostly described their children's behaviour as problematic, violent and aggressive, still having difficulty at school, and with peers or family, were mostly provided by parents and caregivers of children from the control group.

The next and final chapter concludes the study by summing up the main aspects of the study, describing the challenges and limitations encountered throughout the study, and providing recommendations for future research.

Chapter Seven – Conclusion

7.1 Summary

The aim of this study was to explore the outcomes of experiential activities on the behaviour and psychological functioning of children. This stemmed from the long-standing problem of the waiting list at Itsoseng Clinic. The study highlighted the reality that Itsoseng Clinic has a large volume of referred cases and that as a result many children seeking help have had to be placed on a waiting list for several months to more than a year. The study intended to assess children who were on the waiting list and took part in the experiential activities, to determine whether the art activities influenced their behaviour and psychological functioning. This was done by administering the Child Behavioural Checklist (CBCL) before and after the experiential art activity programme. The same assessment instrument (CBCL) was administered for children on the waiting list only as a control (control group). A brief interview schedule was administered with the children's parents or caregivers from both the experimental and the control group.

The literature chapter considered the various ways in which behavioural problems can present, and it was noted that some children have difficulty expressing their emotions. The chapter also considered language and cultural barriers that may present while working with children, exploring the use of alternative means or media to overcome these barriers. A discussion of expressive art methods and activities was included, as well as the use of experiential art activities at Itsoseng community clinic.



The next chapter provided a theoretical understanding of expressive arts from the perspective of the person-centred approach. The expressive art media incorporated in the art group activities at the Itsoseng Clinic offered these children ways in which to express their emotions in an environment that might recondition their behaviour. It is important to note that the focus of this study was simply to explore whether engaging in expressive art activities had an impact on these children's behaviour.

The behavioural approach was thus implemented, because children's behaviour was the centre of interest in this study. Behaviourists focus on observable behaviour, current determinants of behaviour, and learning experiences that promote change (Corey, 2013). The behavioural approach recognises the importance of the individual, the individual's environment, and the interaction between the person and their environment in facilitating change (Corey, 2013). While linking the behavioural approach, expressive arts, and conceptualising children, it was then recognised that behavioural approaches and expressive art methods share a common goal for their clients, which is to achieve behavioural change (Meyer, 2011). Various modes of art have been said to have the ability to connect the child with a range of unapproachable feelings (Davis, 2010). In such an instance the child may be helped to examine the way in which they understand themselves and their environment, and to experiment with new ways of behaving (Corey, 2013; Deines, Torres-Harding, Reinecke, Freeman, & Sauer, 2011).

This study comprised a quantitatively (QUAN) driven core component using the Child Behavioural Checklist (CBCL) and a qualitative (qual) supplementary component using a brief interview schedule (Morse & Niehaus, 2009). A mixed method simultaneous approach was selected because it could provide both quantified comparisons and qualitative descriptions to assist in understanding the

outcomes and experiences that relate to experiential art activities and children's behaviour.

The use of the Child Behaviour Checklist allowed the researcher and the statistical consultant to compare the differences in scores/results, while the interview schedules provided useful information about the children's experiences, behaviours and attitudes towards various social settings and different people.

Findings from this study showed that in the paired sample t-test experimental group, the following variables indicated decreases in their scores: the anxious/depressed scale, rule breaking behaviour, internal A T score, external B T score, and total T score syndrome score. In the Wilcoxon signed rank test experimental group findings, the following variables indicated reductions in scores: somatic complaints, social problems, thought problems, aggressive behaviour and other problems. It was noted that reduction in scores between the pre-test and post-test would imply that there is likely to be a decrease in various behavioural problems in the presence of experiential art groups. The literature reviewed in this study also stated that participation in expressive art activities indicated reduced levels of emotional unresponsiveness and 'acting out' problem behaviour in children (Ritok & Bodoczky, 2012; Shennum, 1987). This implies that participation in experiential art activities is likely to have decreased behavioural problems alongside other potential influences.

There were, however, reported increases in some problem areas relating to activities, school, and the total T competence scale which were found in the paired sample t test experimental group findings. These results were contrary to the results of other variables that indicated decreases in problem behaviour. These

contradictory findings may reflect shifts that might have occurred in various contexts within the period of the evaluation process of the experiential art group program.

The literature review highlighted several other factors that may contribute to behavioural and emotional problems in children, such as adverse family conditions, abuse and neglect (González-García et al., 2017). Dysfunctional parenting and exposure to unfavourable or hostile environmental influences may also exacerbate some behavioural problems (Arnold, et al., 1993). These factors are some of several other factors that could lead to an increase in children's problem behaviours.

Most results from the control group indicated non-significance as anticipated; however, there were some decreases in a few behavioural problems. As mentioned before, this may also suggest that exposure to different circumstances and environmental influences influenced their behaviour.

Parents and caregivers also expressed their views regarding the behaviours and attitudes of their children through the semi-structured interview schedules. The themes that emerged were participation and engagement in activities, willingness to do chores, social engagement and play, academic performance, and behaviour towards family. Some of the parents and caregivers from the experimental group reported that their children had started taking part in other extramural activities such as joining the choir and playing soccer. Participating in extramural activities was described by these parents as seeming to have had a positive influence in the way that it had affected their children's behaviour. Extramural activities were described as factors deterring their children from associating or engaging with various negative influences in the Mamelodi community.



One of the parents expressed the view that engaging with other children in the experiential activity group might have helped their child to interact and play more appropriately with other children.

The subtheme of violence and aggression also became prominent throughout parents' responses regarding their children's behaviour while engaging and playing with others. Parents and caregivers whose children formed part of the control group indicated that their children still displayed violent and aggressive behaviours, while a prominent subtheme among parents and caregivers of children in the experimental group was 'obedience towards peers and family members'.

Parents and caregivers also reported that they had noticed some improvements in their children's general academic performance and their willingness to go to school.

By contrast, parents and caregivers of participants from the control group mostly shared views of their children still struggling at school. However, it was noted that children who exhibit problem behaviours at school or within the in the classroom setting have vastly different experiences from those of their peers (Gunter, Denny, Jack, Shores, & Nelson, 1993).

It is thus important to consider the potential reasons that could affect these children's academic progress. The study looked at aspects such as the type of relationship or interaction the child has with their teacher/s, as well as the classroom environment and the measures that the teachers use to reprimand and discipline the children (Gunter et al., 1993). A child who has learning difficulties would also be impacted in their academic progress and learning environment (Bethoney, 2016). These aspects are a few of many to consider as having possible influences on the children's behaviour and attitude towards school and learning.

Overall, the results of this study have shown that art based interventions are somewhat effective in reducing various problem behaviours within the context of this study. However, information related to this study needs to be regarded with caution and consideration of the limitations (e.g. sample size and generalisability of the findings). Information from this study also needs to be continually reviewed at various points to compare the behaviour and psychological functioning of children. It is important to note that little research has been conducted on expressive activity methods, and further development in this area is required (Dragon & Madsen, 2015).

Art-based methods have been supposed to teach children more useful social and coping skills (Coholic, 2010; Dragon & Madsen, 2015). It has also been suggested that expressive and experiential art activities are particularly useful in cross-cultural settings of practice. Thus, in exploring whether placing the children at Itsoseng Clinic in experiential activities would be useful, evidence has indicated that there are therapeutic benefits that could assist while they wait to receive child-oriented psychotherapy. Conducting this study has provided the researcher with information showing the compatibility between experiential art activities and later receiving child-oriented psychotherapy.

The results of this study may assist in the bigger project, which aims to assist in alleviating the waiting period through the use of informal group modes and experiential activities.

7.2 Limitations and Challenges

This study entailed various limitations and challenges that were encountered in the process. An initial challenge that unfolded was that of the evaluation process,

completion of the consent forms, CBCL questionnaires, and the semi-structured interviews. The number of questions to complete on the questionnaires, and reading some of the questions out to the parents and caregivers, required a great deal of time to complete. The intake process, filling in the CBCL, and later answering questions from the interview schedule seemed to be overwhelming for the parents, caregivers, their children, and the researcher.

The process of data collection and analysis was undertaken mainly by the researcher. Some interviews were conducted in the home language of the participants (i.e. Northern Sotho, Setswana, Zulu and so on). This in turn required the researcher to convert the participants' responses into English. Apart from the efforts of the researcher to keep as close as possible to the original information, the researcher is not a trained interpreter and also holds their own notions and perspectives related to the information. Thus, the recording of the story may not have been represented precisely as it was in its original form.

The researcher also experienced a challenge with neutrality. The researcher actively attempted to refrain from presuming what the possible themes would be ahead of time. It was thus important for the researcher to code and note all the various patterns that emerged, in an attempt to broaden their perspective at that stage.

There were limitations and difficulties encountered by the volunteers and staff members who facilitated the experiential art activities in attempts to interpret and communicate with the children during the processes of working them. Language and cultural barriers are very prominent when communicating with the children. It is thus important to review challenges related to interpreters and language barriers.

Other notable challenges and considerations that the researcher had to keep in mind were alternating between different sets of data. Not only was the data collected and analysed using mixed methods, but there were two groups to be considered (experimental group and control group).

The sample size was a limitation because of the type of research problem being explored and the study mainly being quantitatively driven (CBCL) while having a qualitative supplementary component (interview schedule). The sample size was too small for the quantitative component of the study, because the statistical tests often require a larger sample size to ensure a representative distribution of the population (Collins, Onwuegbuzie, & Jiao, 2007). The results from both the experimental group and control group should therefore not be considered generalisable to groups of people beyond the context of this particular study. The small number of participants resulted in a limited ability to generalise the outcomes. The study might have been enhanced if there had been a larger number of participants.

As mentioned before, it has been noted that little research has been conducted on expressive art activity methods and further development in this area is required (Dragon & Madsen, 2015). In an attempt to conduct a study of limited scope and research, there were some limitations in this research process that need to be addressed. There was a shortage of prior research on this topic, and a scarcity of recent resources to cite or make reference to, mainly in the literature review. This leads to a discussion of recommendations for future research.

7.3 Recommendations for Future Research

Dragon and Madsen (2015) point out that little research has been conducted on expressive activity methods and further development in this area is required. It is thus essential to highlight the need for more research into experiential/expressive activities in general. Future research could expand on the exploration of the influence that these expressive/experiential activities may have on individuals' behaviour and psychological functioning. Researchers also have an opportunity to further explore whether experiential activities complement child psychotherapy (Asanbe & Blokland, 2014).

Conducting studies of this nature could potentially assist in considerations of how to improve mental health services provided by clinics and hospitals. It is important to implement early intervention for disruptive behaviour problems (Mc Neil, Capage, Bahl, & Blanc, 1999). More research could be conducted on projects that aim to assist in alleviating the waiting period before receiving formal psychological services. Blokland (2014) has for example explained that the use of expressive arts activities has enabled the clinic staff at Itsoseng to reach more children and adults in a shorter space of time through group modes, and they also address issues of language and cultural barriers. Visser and Du Plessis (2015) added that using expressive art group interventions allows more clients to have alternate treatment that is readily accessible and more prompt than waiting for individual psychotherapy.

Similar studies need to be continually reviewed at Itsoseng Clinic at various points to compare the behaviour and psychological functioning of children over a longer period. As this is continuous work in progress, this kind of research should filter into



other communities and mental health services rendered that consider future improvements.

In considering some of the limitations and challenges that were mentioned in the previous section; it would be recommended that there should be more assistance for the data collection process. In future, researchers could make use of trained language interpreters; not only for the intake interview process, but also for the process of writing and translating the information.

In research that has quantitative components; a larger sample size should be used to ensure a representative distribution of the population. A larger sample could also represent a more diverse population, therefore enhancing the findings of the study.

Relative to the type of research and research approach; the researcher should consider their immersion in and understanding of the context of their study. Having a better understanding of the context may enable the researcher to have a better understanding of their participant/s.



References

- Abbe, M., Simon, C., Angiolillo, A., Ruccione, K., & Kodish, E. D. (2006). A survey of language barriers from the perspective of pediatric oncologists, interpreters, and parents. *Pediatric blood & cancer*, 47(6), 819-824.
- Achenbach, T. M., & Edelbrock, C. S. (1981). Behavioral problems and competencies reported by parents of normal and disturbed children aged four through sixteen. *Monographs of the society for research in child development*, 1-82.
- Achenbach, T. M. (2001). *Child behavior checklist for ages 6-18*. Burlington, VT: University of Vermont.
- Achenbach, T. M., & Rescorla, L. A. (2001). *Manual for ASEBA school-age forms & profiles*. Burlington, V.T: University of Vermont.
- Ajayi, I. (2002). Patients' waiting time at an outpatient clinic in Nigeria—can it be put to better use?. *Patient Education And Counseling*, 47(2), 121-126.
[http://dx.doi.org/10.1016/s0738-3991\(01\)00183-5](http://dx.doi.org/10.1016/s0738-3991(01)00183-5)
- Albores-Gallo, L., Lara-Muñoz, C., Esperón-Vargas, C., Cárdenas, J. Z., Pérez, A. S., & Villanueva, G. C. (2007). Validity and reability of the CBCL/6-18. Includes DSM scales. *Actas espanolas de psiquiatria*, 35(6), 393-399.
- Almqvist, L., Uys, C. J. E., & Sandberg, A. (2007). The concepts of participation, engagement and flow: A matter of creating optimal play experiences. *South African Journal of Occupational Therapy*, 37(3), 8-13.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

- Anderson, C. A., & Bushman, B. J. (2001). Effects of violent video games on aggressive behavior, aggressive cognition, aggressive affect, physiological arousal, and prosocial behavior: A meta-analytic review of the scientific literature. *Psychological science, 12*(5), 353-359.
- Arnold, D. S., O'leary, S. G., Wolff, L. S., & Acker, M. M. (1993). The Parenting Scale: a measure of dysfunctional parenting in discipline situations. *Psychological assessment, 5*(2), 137.
- Asanbe, C., & Blokland, L. (2014). *Comparison of clinical outcomes for children in treatment groups and on a waiting- list: a community- based sample*. Department of Psychology, University of Pretoria: South Africa. Unpublished manuscript.
- Aunola, K., & Nurmi, J. E. (2005). The role of parenting styles in children's problem behavior. *Child development, 76*(6), 1144-1159.
- Bachman, J. G., & Schulenberg, J. (1993). How part-time work intensity relates to drug use, problem behavior, time use, and satisfaction among high school seniors: Are these consequences or merely correlates? *Developmental Psychology, 29*(2), 220.
- Bachman, J., Safron, D., Sy, S., & Schulenberg, J. (2003). Wishing to work: New perspectives on how adolescents' part-time work intensity is linked to educational disengagement, substance use, and other problem behaviours. *International Journal of Behavioral Development, 27*(4), 301-315.
- Bakeman, R., & Quera, V. (2011). *Sequential analysis and observational methods for the behavioral sciences*. Cambridge: Cambridge University Press.
- Bandura, A., & Walters, R.H. (1963). *Social learning and personality development*. New York: Holt, Rinehart & Winston.
- Bandura, A., & Walters, R. H. (1977). *Social learning theory* (Vol. 1). Englewood Cliffs, NJ: Prentice-hall.

- Bandura, A. (1982). Self –efficacy mechanisms in human agency. *American Psychologist*, 37, 122-147.
- Banks, S., Davis, P., Howard, V. F., & McLaughlin, T. F. (1993). The effects of directed art activities on the behavior of young children with disabilities: A multi-element baseline analysis. *Art Therapy*, 10(4), 235-240.
- Barnes, G. M., & Farrell, M. P. (1992). Parental support and control as predictors of adolescent drinking, delinquency, and related problem behaviors. *Journal of Marriage and the Family*, 763-776.
- Barnes-Smith, D. L., Frotz, J., Ito, H., Kohorst, J., & Vascimini, E. (2015). Expressive Arts As A Means Of Increasing Well-Being In Children. *Undergraduate Theses and Professional Papers*. 37. Retrieved from <https://scholarworks.umt.edu/uttp/37>
- Bartko, J. J. (1976). On various intraclass correlation reliability coefficients. *Psychological bulletin*, 83(5), 762.
- Baumrind, D. (2005). Patterns of parental authority and adolescent autonomy. *New directions for child and adolescent development*, 2005(108), 61-69.
- Bethoney, A. (2016). Learning disabilities and academic success. *Perspectives*, 8(1), 1.
- Bland, J. M., & Altman, D. G. (2010). Statistical methods for assessing agreement between two methods of clinical measurement. *International Journal of Nursing Studies*, 47(8), 931-936.
- Blokland, L.M.E. (2014). *Mental health care in Mamelodi: disadvantaged geographical positioning in a South African township*. University of Pretoria: South Africa. *De Jure*, 47(2), 175-188. Retrieved from <http://www.dejure.up.ac.za/index.php/volumes/47-volume-2-2014/38-volumes/47-volume-2-2014/247-mental-health-care-in-mamelodi-disadvantaged-geographical-positioning-in-a-south-african-township>

- Bocchiaro, P., & Zamperini, A. (2012). Conformity, obedience, disobedience: The power of the situation. In G. Rossi (Ed.), *Psychology-Selected Papers* (pp. 275-294). InTech, Retrieved from <http://www.intechopen.com/books/psychology-selected-papers/conformity-obedience-disobedience-thepower-of-the-situation>
- Bockarova, M. (2015). *The importance of play for preschool children's Learning*. C. Portier (Ed.). Unpublished manuscript, Ontario Institute for Studies in Education, University of Toronto, Toronto, Canada.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research In Psychology*, 3(2), 77-101. <http://dx.doi.org/10.1191/1478088706qp063oa>
- Braun, V., Clarke, V., & Terry, G. (2012). Thematic analysis. *APA handbook of research methods in psychology*, 2, 57-71.
- Briggs-Gowan, M. J., Carter, A. S., Bosson-Heenan, J., Guyer, A. E., & Horwitz, S. M. (2006). Are infant-toddler social-emotional and behavioral problems transient? *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(7), 849-858.
- Burkitt, E., & Lowry, R. (2015). Attitudes and practices that shape children's drawing behaviour in mainstream and performing arts schools. *International Journal of Art & Design Education*, 34(1), 25-43. <http://dx.doi.org/10.1111/jade.12033>
- Campbell, S. B., Shaw, D. S., & Gilliom, M. (2000). Early externalizing behavior problems: Toddlers and preschoolers at risk for later maladjustment. *Development and psychopathology*, 12(3), 467-488.
- Campbell, S. B., Leezenbaum, N. B., Mahoney, A. S., Moore, E. L., & Brownell, C. A. (2016). Pretend play and social engagement in toddlers at high and low genetic risk for autism spectrum disorder. *Journal of autism and developmental disorders*, 46(7), 2305-2316.

- Caplow-Lindner, E., Harpaz, L., & Samberg, S. (1979). *Therapeutic dance/ movement: expressive activities for older adults*. New York, NY: Human Sciences Press.
- Carandang, M. L. A. (2009). *The magic of play*. Philippines: Anvil Publishing.
- Ceausu, F. (2016). Developing by drawing creativity of children activities. *Review of Artistic Education*, 1(12). <http://dx.doi.org/10.1515/rae-2016-0022>
- Chaiklin, S., & Wengrower, H. (Eds.). (2009). *The art and science of dance/ movement therapy: life is dance*. New York, NY & London: Routledge; Taylor & Francis Group.
- Chand, A. (2005). Do you speak English? Language barriers in child protection social work with minority ethnic families. *British Journal of Social Work*, 35(6), 807-821.
- Children's Act 38 of 2005 - Department of Justice (2016).
- Chiloane, T. (1990). *The establishment of black settlement areas in and around Pretoria with special reference to Mamelodi, 1900-1970*.(MA History). University of Johannesburg. Retrieved from: https://ujdigispace.uj.ac.za/bitstream/handle/10210/10400/chiloane_tsheko_j_1990_master%20of%20arts%20in%20history.pdf?sequence=3
- Coholic, D. (2010). *Art activities for children and young people in need: helping children to develop mindfulness, spiritual awareness and self-esteem*. London & Philadelphia: Jessica Kingsley Publishers.
- Collins, K. M., Onwuegbuzie, A. J., & Jiao, Q. G. (2007). A mixed methods investigation of mixed methods sampling designs in social and health science research. *Journal of mixed methods research*, 1(3), 267-294.
- Corey, G. (2013). *Theory and practice of counseling and psychotherapy* (9th ed.). Brooks/Cole: Cengage Learning.
- Coulacoglou, C., & Saklofske, D. H. (2017). *Psychometrics and psychological assessment: principles and applications*. London: Academic Press.



- Creswell, J. (2014). *Research design: qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.
- Cross, M. (2011). *Children with social, emotional and behavioural difficulties and communication problems: There is always a reason*. London: Jessica Kingsley Publishers.
- Davis, K. M. (2010). Music and the expressive arts with children experiencing trauma. *Journal of Creativity in Mental Health*, 5(2), 125-133.
- De Figueiredo, C. R. S., & Dias, F. V. (2012). Families: Influences in Children's Development and Behaviour, from Parents and Teachers' Point of View. *Online Submission*, 2(12), 693-705.
- de Wolff, M., Vogels, A., & Reijneveld, S. (2014). The empirical versus DSM-oriented approach of the Child Behavior Checklist. *European Journal of Psychological Assessment*, 30(1), 22-30. <http://dx.doi.org/10.1027/1015-5759/a000164>
- Dictionary, O. E. (2008). Oxford english dictionary. Retrieved from <https://www.oxforddictionaries.com/>
- Dictionary, O. E. (2011). Oxford dictionaries online. Retrieved from <https://www.oxforddictionaries.com/>
- Dienes, K. A., Torres-Harding, S., Reinecke, M. A., Freeman, A., & Sauer, A. (2011). Cognitive therapy. In S.B. Messer & A.S. Gurman (Eds.), *Essential psychotherapies: theory and practice* (3rd ed., pp. 143-183). New York, NY & London: Guilford.
- Di Leo, J. (2013). *Young children and their drawings*. New York: Routledge.
- Dimitrov, D. M., & Rumrill, P. D. (2003) Pre-test-post-test designs and measurement of change. *Work* 20, 159-165. IOS Press.
- Dodge, K. A., Lansford, J. E., Burks, V. S., Bates, J. E., Pettit, G. S., Fontaine, R., & Price, J. M. (2003). Peer rejection and social information-processing factors in the



development of aggressive behavior problems in children. *Child development*, 74(2), 374-393.

Dragon, S., & Madsen, W. (2015). Engaging in creative activity. *Journal of Applied Arts & Health*, 6(3), 323-338. http://dx.doi.org/10.1386/jaah.6.3.323_1

Duman, S., & Margolin, G. (2007). Parents' aggressive influences and children's aggressive problem solutions with peers. *Journal of Clinical Child and Adolescent Psychology*, 36(1), 42-55.

Dunphy, K., Mullane, S., & Jacobsson, M. (2013). *The effectiveness of expressive arts therapies: a review of the literature*. Melbourne: PACFA.

DuPaul, G. J., Ervin, R. A., Hook, C. L., & McGoey, K. E. (1998). Peer tutoring for children with attention deficit hyperactivity disorder: Effects on classroom behavior and academic performance. *Journal of applied behavior analysis*, 31(4), 579-592.

Eklund, K., Tanner, N., Stoll, K., & Anway, L. (2015). Identifying emotional and behavioral risk among gifted and nongifted children: A multi-gate, multi-informant approach. *School Psychology Quarterly*, 30(2), 197-211. <http://dx.doi.org/10.1037/spq0000080>

Elliott, A. C., & Woodward, W. A. (2007). *Statistical analysis quick reference guidebook: With SPSS examples*. Thousand Oaks, Calif: Sage publications.

Entwistle, V. A., & Watt, I. S. (2013). Treating patients as persons: a capabilities approach to support delivery of person-centered care. *The American Journal of Bioethics*, 13(8), 29-39.

Eskell-Blokland, L.M. (2005). *Voice to the silent: An ecology of local knowledge in psychology*. Unpublished Doctoral study. University of Pretoria.

Faulkner, D., & Coates, E. (Eds.). (2011). *Exploring children's creative narratives*. Taylor & Francis.

- Feinfield, K. A., & Baker, B. L. (2004). Empirical support for a treatment program for families of young children with externalizing problems. *Journal of Clinical Child and Adolescent Psychology, 33*(1), 182-195.
- Gelo, O., Braakmann, D., & Benetka, G. (2008). Quantitative and qualitative research: Beyond the debate. *Integrative psychological and behavioral science, 42*(3), 266-290.
- Gerrish, K., Chau, R., Sobowale, A., & Birks, E. (2004). Bridging the language barrier: the use of interpreters in primary care nursing. *Health & social care in the community, 12*(5), 407-413.
- Ghasemi, A., & Zahediasl, S. (2012). Normality tests for statistical analysis: a guide for non-statisticians. *International journal of endocrinology and metabolism, 10*(2), 486.
- Goldstein, J. (2012). *Play in children's development, health and well-being*. Brussels: Toy Industries of Europe.
- González-García, C., Bravo, A., Arruabarrena, I., Martín, E., Santos, I., & Del Valle, J. F. (2017). Emotional and behavioral problems of children in residential care: Screening detection and referrals to mental health services. *Children and Youth Services Review, 73*, 100-106.
- Guerra, N. G., Huesmann, L. R., & Spindler, A. (2003). Community violence exposure, social cognition, and aggression among urban elementary school children. *Child development, 74*(5), 1561-1576.
- Gunter, P. L., Denny, R. K., Jack, S. L., Shores, R. E., & Nelson, C. M. (1993). Aversive stimuli in academic interactions between students with serious emotional disturbance and their teachers. *Behavioral Disorders, 18*(4), 265-274.
- Hartas, D. (2011). Children's language and behavioural, social and emotional difficulties and prosocial behaviour during the toddler years and at school entry. *British Journal*



of *Special Education*, 38(2), 83-91. <http://dx.doi.org/10.1111/j.1467-8578.2011.00507.x>

Hesse-Biber, S. N. (2010). *Mixed methods research*. New York: Guilford Press.

Hsieh, H. F., & Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research*, 15(9), 1277-1288.

Huesmann, L. R., Moise-Titus, J., Podolski, C. L., & Eron, L. D. (2003). Longitudinal relations between children's exposure to TV violence and their aggressive and violent behavior in young adulthood: 1977-1992. *Developmental psychology*, 39(2), 201.

Hughes, F. P. (Ed.). (2009). *Children, play, and development*. Los Angeles: Sage.

Johnson, J. E., Christie, J. F., Yawkey, T. D., & Wardle, F. P. (1987). *Play and early childhood development*. Scott, Foresman & Co.

IBM SPSS Statistics - United States. (2016). *Ibm.com*. Retrieved 18 July 2016, from <https://www.ibm.com/marketplace/cloud/statistical-analysis-and-reporting/faq/us/en-us#product-header-top>

Isbell, R., & Raines, S. (2003). *Creativity and the arts with young children*. Clifton Park, NY: Thomson/Delmar Learning.

Isenberg, J. P., & Jalongo, M. R. (2010). *Creative thinking and arts-based learning: preschool through fourth grade* (5th ed.). Upper Saddle River, New Jersey, Columbus, Ohio: Merrill.

Isenberg, J. P., & Jalongo, M. R. (2014). *Creative thinking and arts-based learning: preschool through fourth grade* (6th ed.). Upper Saddle River, New Jersey, Columbus, Ohio: Merrill.

Jick, T. D. (1979). *Mixing qualitative and quantitative methods: triangulation in action*. *Administrative Science Quarterly*; *Sage Publications*, 24 (4), 602-611. Cornell



<http://www.jstor.org/discover/10.2307/2392366?uid=3739368&uid=2&uid=4&sid=21106431021253>

Joseph, S., & Murphy, D. (2013). Person-centered approach, positive psychology, and relational helping: Building bridges. *Journal of Humanistic Psychology*, 53(1), 26-51.

Kanik, E., Tasdelen, B., & Erdogan, S. (2011). Randomization in clinical trials. *MMJ*.
<http://dx.doi.org/10.5472/mmj.2011.01981.1>

Karataş, Z., & Gökçakan, Z. (2009). The effect of group-based psychodrama therapy on decreasing the level of aggression in adolescents. *Türk Psikiyatri Dergisi*, 20 (4), 1-9.
Retrieved from: <http://www.turkpsikiyatri.com>

Katz, L. F., & Gottman, J. M. (1993). Patterns of marital conflict predict children's internalizing and externalizing behaviors. *Developmental Psychology*, 29(6), 940.

Kendall, P. C., & Hollon, S. D. (1979). *Cognitive behavioural interventions: theory, research, and practice*. New York, NY: Academic Press.

Kirk, R. E. (2009). Chapter 2: Experimental design. In R.E. Millsap & A. Maydeu-Olivares (Eds.), *The SAGE handbook of quantitative methods in psychology* (pp.24-45). doi:
<http://dx.doi.org/10.4135/9780857020994.n2>.

Klein, W., Graesch, A. P., & Izquierdo, C. (2009). Children and chores: A mixed-methods study of children's household work in Los Angeles families. *Anthropology of Work Review*, 30(3), 98-109.

Kossak, M. S. (2009). Therapeutic attunement: A transpersonal view of expressive arts therapy. *The arts in psychotherapy*, 36(1), 13-18.

Landau, S., & Everitt, B.S. (2004). *A Handbook of statistical analyses using SPSS*. Boca Raton, London, New York, NY & Washington, DC: Chapman & Hall/CRC. Retrieved



from:http://www.academia.dk/BiologiskAntropologi/Epidemiologi/PDF/SPSS_Statistical_Analysis_using_SPSS.pdf

- Lane, D. (2011). Online Statistics Education. In *International Encyclopedia of Statistical Science* (pp. 1018-1020). Springer Berlin Heidelberg.
- Lawrence, R. L. (2008). Powerful feelings: Exploring the affective domain of informal and arts-based learning. *New directions for adult and continuing education*, 2008(120), 65-77.
- LeCroy, C. W. (1988). Residential treatment for children & youth: anger management or anger expression; which is most effective?. *Taylor and Francis Online*, 5(3), 29-39. doi: 10.1300/J007v05n03_04
- Lifschitz, S. & Oosthuizen, C. (2001). Discovering Agape: forming and re-forming a healing community. In M. Seedat, M. (Ed.), N. Duncan, & S. Lazarus. (Cons. eds.), *Community psychology: Theory method and practice*. 107-132. Cape Town: Oxford University Press Southern Africa.
- Loeber, R., & Stouthamer-Loeber, M. (1986). Family factors as correlates and predictors of juvenile conduct problems and delinquency. *Crime and justice*, 7, 29-149.
- Lowenfeld, V., & Brittain, W.L. (1982). *Creative and mental growth* (7th ed.). New York, NY: Macmillan.
- Mailula, G. S. (2009). *Listening to the unheard stories of children affected by HIV and AIDS in a bereavement process in the Mamelodi township of Tshwane : a narrative research study*. Doctoral thesis, University of Pretoria. Retrieved from: <http://hdl.handle.net/2263/28178>
- Malchiodi, C.A. (2005). *Expressive therapies: history, theory, and practice*. New York, NY: Guilford Publications. Retrieved from: <https://www.psychologytoday.com/files/attachments/231/malchiodi3.pdf>

- Malchiodi, C. A. (2012). Expressive arts therapy and multimodal approaches. In C. Malchiodi (Ed.), *Handbook of art therapy* (2nd ed., pp.130-140). New York, NY: Guilford Press.
- Marczyk, G., DeMatteo, D., & Festinger, D. (2017). *Essentials of research design and methodology*. John Wiley.
- Massoni, E. (2011). Positive effects of extra curricular activities on students. *Essai*, 9(1), 27.
- McLeod, S. A. (2015). Person centered therapy. Retrieved from www.simplypsychology.org/client-centred-therapy.html
- McNeil, C. B., Capage, L. C., Bahl, A., & Blanc, H. (1999). Importance of early intervention for disruptive behavior problems: comparison of treatment and waitlist-control groups. *Early Education and Development*, 10(4), 445-454.
- McWilliam, R. A., & Bailey, D. B. (1992). Promoting engagement and mastery. *Teaching infants and preschoolers with disabilities*, 2, 230-255.
- Meyer, D. (2011). Cognitive-behavioral theory. In S. Degges-White & N. L. Davis (Eds.), *Integrating the expressive arts into counseling practice: theory-based interventions* (pp. 45-64). New York, NY: Springer Publishing Company, LLC. Retrieved from: <https://books.google.co.za/books?hl=en&lr=&id=ievH9Slq7r4C&oi=fnd&pg=PR7&dq=integrating+the+expressive+arts+into+counseling+practice&ots=9r8QOaLj7l&sig=563fhcPyK2ledxTImZaSKvmVZww#v=onepage&q=integrating%20the%20expressive%20arts%20into%20counseling%20practice&f=false>
- Mitrofan, O., Paul, M., Weich, S., & Spencer, N. (2014). Aggression in children with behavioural/emotional difficulties: seeing aggression on television and video games. *BMC psychiatry*, 14(1), 287.

- Mokgoko, M. M. (2013). *Health care users' experiences and perceptions of waiting time at a diabetes clinic in an academic hospital* (Master of Science in Nursing). University of the Witwatersrand.
- Mokgoko, M. M. (2014). *Health care users' experiences and perceptions of waiting time at a diabetes clinic in an academic hospital* (Doctoral dissertation, University of the Witwatersrand).
- Montero, I., & León, O.G. (2007). A guide for naming research studies in psychology. *International Journal of Clinical and Health Psychology*, 7, 847-862.
- Morse, J. M., & Niehaus, L. (2009). *Mixed method design*. Walnut Creek, California: Left Coast Press.
- Newsome, D. W., Henderson, D. A., & Veach, L. J. (2005). Using expressive arts in group supervision to enhance awareness and foster cohesion. *The Journal of Humanistic Counseling*, 44(2), 145-157.
- Ozmete, E., & Hira, T. (2011). Conceptual analysis of behavioral theories/models: application to financial behavior. *European Journal Of Social Sciences*, 18(3), 386-404.
- Öztuna, D., Elhan, A. H., & Tüccar, E. (2006). Investigation of four different normality tests in terms of type 1 error rate and power under different distributions. *Turkish Journal of Medical Sciences*, 36(3), 171-176.
- Palinkas, L. A., Aarons, G. A., Horwitz, S., Chamberlain, P., Hurlburt, M., & Landsverk, J. (2011). Mixed method designs in implementation research. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(1), 44-53.
- Parr, R. (2015). The use of expressive arts in making sense of traumatic experiences. *Philippine Journal of Psychology*, 48(2), 133-159.

- Passini, S., & Morselli, D. (2009). Authority relationships between obedience and disobedience. *New Ideas in Psychology*, 27(1), 96-106.
- Pearson, M., & Wilson, H. (2009). Using expressive arts to work with mind, body and emotion. *Psychotherapy in Australia*, 16(1), 55 - 64.
- Peat, J., & Barton, B. (2008). *Medical statistics: A guide to data analysis and critical appraisal*. John Wiley & Sons.
- Peeters, N., & Osman, A. (2005). Generating an improved quality of informal housing in Mamelodi, South Africa. *Pretoria: University of Pretoria*.
- Pellegrini, A. D., Dupuis, D., & Smith, P. K. (2007). Play in evolution and development. *Developmental review*, 27(2), 261-276.
- Phala, A. V. M. (2008). *Service delivery at Itsoseng psychology clinic: a programme evaluation* (mini dissertation, University of Pretoria).
- Puig, A., Lee, S. M., Goodwin, L., & Sherrard, P. A. (2006). The efficacy of creative arts therapies to enhance emotional expression, spirituality, and psychological well-being of newly diagnosed Stage I and Stage II breast cancer patients: A preliminary study. *The Arts in Psychotherapy*, 33(3), 218-228.
- Purswell, K., & Ray, D. (2014). Research with small samples: considerations for single case and randomized small group experimental designs. *Counseling Outcome Research and Evaluation*, 5(2), 116-126. <http://dx.doi.org/10.1177/2150137814552474>
- Ralinala, R. M. (2002). *Urban apartheid and African responses: aspects of life in Mamelodi township, 1953-1990*(Doctoral dissertation, University of Cape Town).
- Razali, N. M., & Wah, Y. B. (2011). Power comparisons of shapiro-wilk, kolmogorov-smirnov, lilliefors and anderson-darling tests. *Journal of statistical modeling and analytics*, 2(1), 21-33.

- Rey, D., & Neuhäuser, M. (2011). Wilcoxon-signed-rank test. In *International encyclopedia of statistical science* (pp. 1658-1659). Springer Berlin Heidelberg.
- Reynolds, C. R., & Kamphaus, R. W. (1992). *BASC: Behavior assessment system for children: manual*. American guidance service, Incorporated.
- Rezai Niaraki, F., & Rahimi, H. (2013). The impact of authoritative, permissive and authoritarian behavior of parents on self-concept, psychological health and life quality. *European Online Journal of Natural and Social Sciences*, 2(1), pp-78.
- Ritok, N., & Bodoczky, I. (2012). The positive influence of art activities on poor communities. *International Journal of Education Through Art*, 8(3), 329-336. http://dx.doi.org/10.1386/eta.8.3.329_7
- Rogers, C. R. (1959). *A theory of therapy, personality, and interpersonal relationships: As developed in the client-centered framework* (Vol. 3, pp. 184-256). New York: McGraw-Hill.
- Rogers, N. (2001). Person-centered expressive arts therapy. *Approaches to art therapy: Theory and technique*, 163-177.
- Rogers, N. (2011). *The creative connection for groups: Person-centered expressive arts for healing and social change*. Palo Alto, CA: Science and Behavior Books.
- Rogers, N., Tudor, K., Tudor, L., & Keemar, K. (2012). Person-centered expressive arts therapy: A theoretical encounter. *Person-Centered & Experiential Psychotherapies*, 11(1), 31-47. <http://dx.doi.org/10.1080/14779757.2012.656407>
- Rosal, M. (2001). Cognitive-behavioral art therapy. *Approaches to art therapy: Theory and technique*, 210-225.
- Rosner, B., Glynn, R. J., & Lee, M. L. T. (2006). The Wilcoxon signed rank test for paired comparisons of clustered data. *Biometrics*, 62(1), 185-192.

- Ross, A., & Willson, V. L. (2017). Paired Samples T-Test. In *Basic and Advanced Statistical Tests* (pp. 17-19). SensePublishers, Rotterdam.
- Ruane, I. (2006). Challenging the frontiers of community psychology: A South African experience. *Journal of Psychology in Africa*, 16(2), 283-291.
- Ruane, I. (2010). Obstacles to the utilisation of psychological resources in a South African township community. *South African Journal of Psychology*, 40(2), 214-225.
- Russ, S. W., & Kaugars, A. S. (2001). Emotion in children's play and creative problem solving. *Creativity Research Journal*, 13(2), 211-219.
- Ryan, N. D. (2005). Treatment of depression in children and adolescents. *The Lancet*, 366(9489), 933-940.
- Ryan, R., Claessens, A., & Markowitz, A. J. (2013). Family structure and children's behavior. *Focus*, 30(2), 11-14.
- Saidi, M. (2007). Developing a user-perception assessment tool for health facilities in South Africa. *Architectural Science Intern report* (pp.8-11).
- Sangawi, H. S., Adams, J., & Reissland, N. (2015). The effects of parenting styles on behavioral problems in primary school children: A cross-cultural review. *Asian social science*, 11(22), 171.
- Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *The lancet*, 370(9590), 878-889.
- Schmid, P. F. (1998). On becoming a person-centered approach': A person-centred understanding of the person. *Person-centred therapy: A European perspective*, 38-52.
- Shapiro, S. S., & Wilk, M. B. (1965). An analysis of variance test for normality (complete samples). *Biometrika*, 52(3/4), 591-611.

- Sheldon, B. (2011). *Cognitive- behavioural therapy: research and practice in health and social care* (2nd ed.). London & New York, NY: Routledge; Taylor & Francis Group.
- Shennum, W. A. (1987). Expressive activity therapy in residential treatment: effects on children behavior in the treatment milieu. *Child and Youth Care Quarterly*, 16(2), 81-90. Retrieved from <http://link.springer.com/article/10.1007%2FBF01083973>
- Sidney-Ando, A. (2014). *Art and creative expression for positive social change: Values, identity, and efficacy* (Doctoral dissertation, Saybrook University).
- Smeijsters, H., & Cleven, G. (2006). The treatment of aggression using arts therapies in forensic psychiatry: Results of a qualitative inquiry. *The arts in psychotherapy*, 33(1), 37-58.
- Smith, A. A., & Hubbard, P. M. (1988). The relationship between parent/staff communication and children's behaviour in early childhood settings. *Early Child Development and Care*, 35(1), 13-28.
- Son, S., & Bauer, J. W. (2010). Employed rural, low-income, single mothers' family and work over time. *Journal of Family and Economic Issues*, 31(1), 107-120.
- Southam-Gerow, M. A., & Kendall, P. C. (2002). Emotion regulation and understanding: Implications for child psychopathology and therapy. *Clinical psychology review*, 22(2), 189-222.
- Statistics South Africa. (2011). Retrieved from http://www.statssa.gov.za/?page_id=4286&id=11377
- Steinskog, D. J., Tjøstheim, D. B., & Kvamstø, N. G. (2007). A cautionary note on the use of the Kolmogorov–Smirnov test for normality. *Monthly Weather Review*, 135(3), 1151-1157.
- Stormont, M. (2002). Externalizing behavior problems in young children: Contributing factors and early intervention. *Psychology in the Schools*, 39(2), 127-138.



- Stuckey, H. L., & Nobel, J. (2010). The connection between art, healing, and public health: A review of current literature. *American journal of public health, 100*(2), 254-263.
- Sturgeon, S., & Keet, N. (2010). Groupwork and mental health. *Working with groups, 153-165*.
- Sue, D. W., & Sue, D. (1977). Barriers to effective cross-cultural counseling. *Journal of Counseling Psychology, 24*(5), 420.
- Surhone, L. M., Tennoe, M. T., & Henssonow, S.F. (Ed.). (2010). *Play therapy: psychodynamic, cognitive development, child behavior checklist, attention- deficit hyperactivity disorder, sand tray therapy*. Betascript Publishing.
- Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics*. Allyn & Bacon/Pearson Education.
- Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: integrating quantitative and qualitative approaches in the social and behavioral sciences*. Thousand Oaks, CA: Sage Publications.
- Terre Blanche, M., & Durheim, K., & Painter, D. (Eds.). (2006). *Research in practice: applied methods for the social sciences* (2nd ed.). Cape Town: UCT Press.
- Thode, H. C. (2002). *Statistics: textbooks and monographs, Vol. 164. Testing for normality*. New York, NY, US: Marcel Dekker.
- <http://dx.doi.org/10.1201/9780203910894>
- Timm, V. (2007). *Behaviour problems in primary schools in Mamelodi: an ecological construction*. (MA Counselling Psychology). University of Pretoria.
- Uji, M., Sakamoto, A., Adachi, K., & Kitamura, T. (2014). The impact of authoritative, authoritarian, and permissive parenting styles on children's later mental health in



- Japan: Focusing on parent and child gender. *Journal of child and family studies*, 23(2), 293-302.
- Uren, N., & Stagnitti, K. (2009). Pretend play, social competence and involvement in children aged 5–7 years: The concurrent validity of the Child-Initiated Pretend Play Assessment. *Australian Occupational Therapy Journal*, 56(1), 33-40.
- Viding, E., McCrory, E., Blakemore, S., & Frederickson, N. (2011). Behavioural problems and bullying at school: can cognitive neuroscience shed new light on an old problem? *Trends in Cognitive Sciences*. <http://dx.doi.org/10.1016/j.tics.2011.05.001>
- Visser, M., & Du Plessis, J. (2015). An expressive art group intervention for sexually abused adolescent females. *Journal of Child & Adolescent Mental Health*, 27(3), 199-213.
- Weiner, D. J. (Ed). (1999). *Beyond talk therapy: using movement and expressive techniques in clinical practice*. Washington, DC: American Psychological Association.
- Weisner, T. S. (2001). Children investing in their families: The importance of child obligation in successful development. *New Directions for Child and Adolescent Development*, 2001(94), 77-84.
- Wikström, B. M. (2005). Communicating via expressive arts: The natural medium of self-expression for hospitalized children. *Pediatric nursing*, 31(6), 480.
- Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). New York, NY: Open University Press; McGraw-Hill Education.
- World Health Organization. (2001). *International classification of functioning, disability and health: ICF*. Geneva: World Health Organization.
- Xiao, H. (1999). Independence and obedience: An analysis of child socialization values in the United States and China. *Journal of Comparative Family Studies*, 641-657.



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York, T. T., Gibson, C., & Rankin, S. (2015). Defining and Measuring Academic Success. *Practical Assessment, Research & Evaluation*, 20.



Appendix 1 – Ethics Approval Letter



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

8 November 2016

Dear Prof Maree

Project: Exploring the outcomes of experiential art activities on the behaviour and psychological functioning of children
Researcher: PL Motsa
Supervisor: Dr L Bokland
Department: Psychology
Reference number: 29390576 (GW20161007HS)

Thank you for the response to the Committee's correspondence of 8 November 2016.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 8 November 2016. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

Kindly note that your original signed approval certificate will be sent to your supervisor via the Head of Department. Please liaise with your supervisor.

Research Ethics Committee Members: Prof MME Schoeman (Deputy Dean); Prof KL Harris; Dr L Bokland; Dr R Fassell; Ms KT Govinder; Dr E Johnson; Dr C Parebianco; Dr C Puttergill; Dr D Reayburn; Prof GM Spies; Prof E Taljard; Ms B Tsebe; Dr E van der Kleinhorst; Mr V Sithole



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YUNIBESITHI YA PRETORIA

Appendix 2 – Research Permission Letter



University of Pretoria

Department Of Psychology
c/o Solomon Mahlangu (Hans Strijdom) & Hinterland Street
Mamelodi East
Administration Building
Ground Floor



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA



Tel: 012 842 3515
Fax: 086 551 6828
E-mail: itsoseng.clinic@up.ac.za

Clinic Hours
Mon – Thu: 09h00 – 16h00

CONFIDENTIAL

To whom it may concern,

This is to authorise Palesa Motsa, a student at the University of Pretoria, student number 29390576, to conduct her research at the Itsoseng Clinic.

For any further enquiries please contact us on 012 842 3515.

Dr Linda Blokland
Clinic Director

Itsoseng Clinic
University of Pretoria
Mamelodi Campus
Cnr. Hinterland & Solomon Mahlangu Drive
Mamelodi East, Pretoria
Tel: 012 842 3515

29/02/2016

Date



Appendix 3 – Child Behaviour Checklist for Ages 6 – 18

Please print CHILD BEHAVIOR CHECKLIST FOR AGES 6-18 For office use only ID #

CHILD'S FULL NAME First Middle Last			PARENTS' USUAL TYPE OF WORK, even if not working now. <i>(Please be specific — for example, auto mechanic, high school teacher, homemaker, laborer, lathe operator, shoe salesman, army sergeant.)</i>			
CHILD'S GENDER <input type="checkbox"/> Boy <input type="checkbox"/> Girl		CHILD'S AGE	CHILD'S ETHNIC GROUP OR RACE		PARENT 1 (or FATHER) TYPE OF WORK	
TODAY'S DATE Mo. Day Year		CHILD'S BIRTHDATE Mo. Day Year		PARENT 2 (or MOTHER) TYPE OF WORK		
GRADE IN SCHOOL	Please fill out this form to reflect your view of the child's behavior even if other people might not agree. Feel free to print additional comments beside each item and in the space provided on page 2. Be sure to answer all items.			THIS FORM FILLED OUT BY: (print your full name)		
NOT ATTENDING SCHOOL <input type="checkbox"/>				Your gender: <input type="checkbox"/> Man <input type="checkbox"/> Woman <input type="checkbox"/> Other (specify)		
			Your relation to the child: <input type="checkbox"/> Biological Parent <input type="checkbox"/> Step Parent <input type="checkbox"/> Grandparent <input type="checkbox"/> Adoptive Parent <input type="checkbox"/> Foster Parent <input type="checkbox"/> Other (specify):			

I. Please list the sports your child most likes to take part in. For example: swimming, baseball, skating, skate boarding, bike riding, fishing, etc.

<input type="checkbox"/> None	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
a. _____	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
b. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. Please list your child's favorite hobbies, activities, and games, other than sports. For example: video games, dolls, reading, piano, crafts, cars, computers, singing, etc. (Do not include listening to radio, TV, or other media.)

<input type="checkbox"/> None	Compared to others of the same age, about how much time does he/she spend in each?				Compared to others of the same age, how well does he/she do each one?			
a. _____	Less Than Average	Average	More Than Average	Don't Know	Below Average	Average	Above Average	Don't Know
b. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. Please list any organizations, clubs, teams, or groups your child belongs to.

<input type="checkbox"/> None	Compared to others of the same age, how active is he/she in each?			
a. _____	Less Active	Average	More Active	Don't Know
b. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. Please list any jobs or chores your child has. For example: doing dishes, babysitting, making bed, working in store, etc. (Include both paid and unpaid jobs and chores.)

<input type="checkbox"/> None	Compared to others of the same age, how well does he/she carry them out?			
a. _____	Below Average	Average	Above Average	Don't Know
b. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Be sure you answered all items. Then see other side.

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www.ASEBA.org

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07-02-18 Edition - 201

PAGE 1



Please print. Be sure to answer all items.

- V. 1. About how many close friends does your child have? (Do not include brothers & sisters)
 None 1 2 or 3 4 or more
2. About how many times a week does your child do things with any friends outside of regular school hours? (Do not include brothers & sisters)
 Less than 1 1 or 2 3 or more

- VI. Compared to others of his/her age, how well does your child:
- | | Worse | Average | Better | |
|---|--------------------------|--------------------------|--------------------------|---|
| a. Get along with his/her brothers & sisters? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> Has no brothers or sisters |
| b. Get along with other kids? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| c. Behave with his/her parents? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| d. Play and work alone? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |

- VII. 1. Performance in academic subjects. Does not attend school because _____

Check a box for each subject that child takes	Falling	Below Average	Average	Above Average
a. Reading, English, or Language Arts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. History or Social Studies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Arithmetic or Math	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Science	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other academic subjects—for example, computer courses, foreign language, business. Do not include gym, shop, driver's ed., or other nonacademic subjects.

2. Does your child receive special education or remedial services or attend a special class or special school?
 No Yes—kind of services, class, or school:

3. Has your child repeated any grades? No Yes—grades and reasons:

4. Has your child had any academic or other problems in school? No Yes—please describe:

When did these problems start?

Have these problems ended? No Yes—when?

Does your child have any illness or disability (either physical or mental)? No Yes—please describe:

What concerns you most about your child?

Please describe the best things about your child.



Please print. Be sure to answer all items.

Below is a list of items that describe children and youths. For each item that describes your child now or within the past 6 months, please circle the 2 if the item is very true or often true of your child. Circle the 1 if the item is somewhat or sometimes true of your child. If the item is not true of your child, circle the 0. Please answer all items as well as you can, even if some do not seem to apply to your child.

0 = Not True (as far as you know) 1 = Somewhat or Sometimes True 2 = Very True or Often True

0	1	2	1. Acts too young for his/her age	0	1	2	32. Feels he/she has to be perfect
0	1	2	2. Drinks alcohol without parents' approval (describe):	0	1	2	33. Feels or complains that no one loves him/her
0	1	2	3. Argues a lot	0	1	2	34. Feels others are out to get him/her
0	1	2	4. Falls to finish things he/she starts	0	1	2	35. Feels worthless or inferior
0	1	2	5. There is very little he/she enjoys	0	1	2	36. Gets hurt a lot; accident-prone
0	1	2	6. Bowel movements outside toilet	0	1	2	37. Gets in many fights
0	1	2	7. Bragging, boasting	0	1	2	38. Gets teased a lot
0	1	2	8. Can't concentrate, can't pay attention for long	0	1	2	39. Hangs around with others who get in trouble
0	1	2	9. Can't get his/her mind off certain thoughts; obsessions (describe):	0	1	2	40. Hears sound or voices that aren't there (describe):
0	1	2	10. Can't sit still, restless, or hyperactive	0	1	2	41. Impulsive or acts without thinking
0	1	2	11. Clings to adults or too dependent	0	1	2	42. Would rather be alone than with others
0	1	2	12. Complains of loneliness	0	1	2	43. Lying or cheating
0	1	2	13. Confused or seems to be in a fog	0	1	2	44. Bites fingernails
0	1	2	14. Cries a lot	0	1	2	45. Nervous, highstrung, or tense
0	1	2	15. Cruel to animals	0	1	2	46. Nervous movements or twitching (describe):
0	1	2	16. Cruelty, bullying, or meanness to others	0	1	2	47. Nightmares
0	1	2	17. Daydreams or gets lost in his/her thoughts	0	1	2	48. Not liked by other kids
0	1	2	18. Deliberately harms self or attempts suicide	0	1	2	49. Constipated, doesn't move bowels
0	1	2	19. Demands a lot of attention	0	1	2	50. Too fearful or anxious
0	1	2	20. Destroys his/her own things	0	1	2	51. Feels dizzy or lightheaded
0	1	2	21. Destroys things belonging to his/her family or others	0	1	2	52. Feels too guilty
0	1	2	22. Disobedient at home	0	1	2	53. Overeating
0	1	2	23. Disobedient at school	0	1	2	54. Overtired without good reason
0	1	2	24. Doesn't eat well	0	1	2	55. Overweight
0	1	2	25. Doesn't get along with other kids	0	1	2	56. Physical problems without know medical cause:
0	1	2	26. Doesn't seem to feel guilty after misbehaving	0	1	2	a. Aches or pains (not stomach or headaches)
0	1	2	27. Easily jealous	0	1	2	b. Headaches
0	1	2	28. Breaks rules at home, school, or elsewhere	0	1	2	c. Nausea, feels sick
0	1	2	29. Fears certain animals, situations, or places, other than school (describe):	0	1	2	d. Problems with eyes (not if corrected by glasses) (describe):
0	1	2	30. Fears going to school	0	1	2	e. Rashes or other skin problems
0	1	2	31. Fears he/she might think or do something bad	0	1	2	f. Stomachaches
				0	1	2	g. Vomiting, throwing up
				0	1	2	h. Other (describe):

PAGE 3 Be sure you answered all items Then see other side.



Please print. Be sure to answer all items.

0 = Not True (as far as you know)

1 = Somewhat or Sometimes True

2 = Very True or Often True

0 1 2	57. Physically attacks people	0 1 2	84. Strange behavior (describe):
0 1 2	58. Picks nose, skin, or other parts of body (describe):	0 1 2	85. Strange ideas (describe):
0 1 2	59. Plays with own sex parts in public	0 1 2	86. Stubborn, sulen, or irritable
0 1 2	60. Plays with own sex parts too much	0 1 2	87. Sudden changes in mood or feelings
0 1 2	61. Poor school work	0 1 2	88. Sulks a lot
0 1 2	62. Poorly coordinated or clumsy	0 1 2	89. Suspicious
0 1 2	63. Prefers being with older kids	0 1 2	90. Swearing or obscene language
0 1 2	64. Prefers being with younger kids	0 1 2	91. Talks about killing self
0 1 2	65. Refuses to talk	0 1 2	92. Talks or walks in sleep (describe):
0 1 2	66. Repeats certain acts over and over; compulsions (describe):	0 1 2	93. Talks too much
0 1 2	67. Runs away from home	0 1 2	94. Teases a lot
0 1 2	68. Screams a lot	0 1 2	95. Temper tantrums or hot temper
0 1 2	69. Secretive, keeps things to self	0 1 2	96. Thinks about sex too much
0 1 2	70. Sees things that aren't there (describe):	0 1 2	97. Threatens people
0 1 2	71. Self-conscious or easily embarrassed	0 1 2	98. Thumb-sucking
0 1 2	72. Sets fires	0 1 2	99. Smokes, chews, or sniffs tobacco
0 1 2	73. Sexual problems (describe):	0 1 2	100. Trouble sleeping (describe):
0 1 2	74. Showing off or clowning	0 1 2	101. Truancy, skips school
0 1 2	75. Too shy or timid	0 1 2	102. Underactive, slow moving, or lacks energy
0 1 2	76. Sleeps less than most kids	0 1 2	103. Unhappy, sad, or depressed
0 1 2	77. Sleeps more than most kids during day and/or night (describe):	0 1 2	104. Unusually loud
0 1 2	78. Inattentive or easily distracted	0 1 2	105. Uses drugs for nonmedical purposes (don't include alcohol or tobacco) (describe):
0 1 2	79. Speech problem (describe):	0 1 2	106. Vandalism
0 1 2	80. Stares blankly	0 1 2	107. Wets self during the day
0 1 2	81. Steals at home	0 1 2	108. Wets the bed
0 1 2	82. Steals outside the home	0 1 2	109. Whining
0 1 2	83. Stores up too many things he/she doesn't need (describe):	0 1 2	110. Wishes to be of opposite sex
		0 1 2	111. Withdrawn, doesn't get involved with others
		0 1 2	112. Worries
		0 1 2	113. Please write in any problems your child has that were not listed above:
		0 1 2	_____
		0 1 2	_____
		0 1 2	_____

Appendix 4 – Interview Schedule Themes

(For parent/s or caregiver/s)

Thank you again for participating in this study. Your time and effort will help us at the clinic to know better how to help children who come to see us.

We are interested in talking to you about the responses you have given us on the Child Behaviour Checklist you completed for us. We will also ask you if you have seen any changes in your child. This will take about 30 minutes of your time. You do not have to answer any questions you do not want to.

1. Hobbies/ Activities/Games

- Please describe your child's behaviour in his/ her hobbies.
- Please describe your child's behaviour in any other activities.
- Please describe your child's behaviour if/when they engage in games.

2. Responsibilities/Chores/Jobs

- Please describe your child's behaviour in relation to his/her responsibilities at home.
- Please describe your child's behaviour towards any chores or jobs if any.

3. Social/Play

- Please describe your child's social/ play behaviour with his/ her peers/ friends.
- Please describe your child's social/play behaviour with siblings or other family members.

4. School/ Academics

- Please describe how your child is doing at school.



- How would you describe your child's attitude towards school?

5. Family

- Please describe your child's behaviour/attitude towards you.
- Please describe your child's behaviour/attitude towards other family members.

Appendix 5 – Information Letter for Participation in a Research Study

Information Letter for Participation in a Research Study University of Pretoria

Re: Exploring the outcomes of experiential art activities on the behaviour and psychological functioning of children.

This information can be explained to you by an interpreter.

This research intends to explore the outcomes of experiential art activities for children on the waiting list at Itsoseng Clinic. The experiential activities will take six weeks on a weekly basis. Activities include drawing, painting, working with clay, collage and other fun art activities. All materials are provided by the Itsoseng Clinic, there are no costs for participation in the study. Pre and post assessment procedures will be used to compare outcomes on a before and after basis.

- Parents or caregivers will be asked to complete a questionnaire (Child Behaviour Checklist) which consists of a total of 120 questions. The questions are designed to assess your child's behaviours and feelings during the past 6 months. It takes about 20-30 minutes to complete the questionnaire.
- Parents or caregivers will also be asked to have a brief interview after the experiential art activities.
- The questions are not hard, but it could happen that you feel uncomfortable while answering some of the questions. If there is any discomfort for you or your child during this study, or after it, you may stop answering the questions and talk with Palesa or Rico in the clinic. They will help you sort out what is bothering you or take you to someone else who can.
- There are no known risks associated with this research.
- If you or your child needs counselling as a direct result of participation in this study, you will be fast tracked to an available counsellor in the clinic.
- The information collected from this study will be stored as hard copies and in an electronic format. The hard copies will be safely stored in a locked cabinet



in the Humanities Building, University of Pretoria. The electronic information will be secured using a password, and only Dr Blokland (supervisor) and Palesa (researcher) will have access to this information. All the information will be kept for at least 15 years as required by the University of Pretoria.

- The information collected from this study may be used again in further research, but it will remain anonymous.
- Information collected from this study will be published as a Master's mini-dissertation, scientific article and/ or conference papers.
- We will do everything we can to protect your privacy. Your identity will not be revealed in any publication resulting from this study.
- Your participation in this research study is voluntary. You may choose not to participate, and you may withdraw your consent to participate at any time. You will not be penalised in any way should you decide not to participate or to withdraw from this study. If you decide to leave the study, please tell Palesa, Rico or one of the other counsellors you see in the clinic.

This research project is conducted by Ms Palesa Motsa under the supervision of Dr. Linda Blokland.

If you have questions or concerns about this study, you may contact:

- **Itsoseng clinic, Mamelodi** (Rico Visser)
Tel: 012 842 3515
Fax: 086 518 3871
Email: itsoseng.clinic@up.ac.za
- **Dr Linda Blokland** (linda.blokland@up.ac.za),
- **Or Palesa Motsa** (plmotsa@gmail.com)



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Appendix 6 – Itsoseng Consent Form 2



University of Pretoria
Department Of Psychology
Mamelodi Campus
Hinterland Street
Mamelodi East
Administration Building
Ground Floor



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Tel: 012 842 3515

Fax: 086 518 3871

itsoseng.clinic@up.ac.za

Clinic Hours

Mon – Thu: 09h00 – 16h00

CONSENT FORM 2:

PARENTAL AGREEMENT TO INTERVENTION FOR A CHILD:

Name of Child: _____ Surname: _____

Date of Birth: _____ Age: _____ Male/ Female: _____

Address: _____

Telephone Number (Parent/ Guardian): _____

Parent/ Guardian Name: _____

Identity number: _____

Supervising Psychologist: _____ Intern/ Student: _____

Nature of Intervention:

THERAPY	
---------	--

ASSESSMENT	
------------	--

Benefits of Therapy and Client Rights:

Therapy can contribute towards the improved ability to cope with stress and difficult life situations, while possibly increasing understanding of oneself and others. Therapy can assist a person in developing new skills and can support one in changing negative behavioural patterns. Furthermore, therapy can facilitate a process where existing resilience and resources of strengths are identified and built upon.

I understand that it is important to mention any concerns or questions that I may have at any time during the process of therapy.

Benefits of Psychometric/ Psychological Assessment and Client Rights:

By means of psychometric and/ or psychological assessment clients can gain better understanding of their current problem and/ or functioning. The assessment results can assist individuals in making better-informed decisions for the future and provide the assessor with information to make appropriate recommendations or plan future interventions.



Appendix 7 – Consent Form for Participation in Research Study

Consent Form for Participation in a Research Study University of Pretoria

Re: Exploring the outcomes of experiential art activities on the behaviour and psychological functioning of children.

This information can be explained to you by an interpreter.

Parental agreement to intervention for a child

Acknowledgement and Consent:

We, _____ and _____, acknowledge that we have read and understood the information regarding the study, and that any questions or concerns that we had have been answered. We hereby give our consent to participate in the study.

I have read this consent form and have been given the opportunity to ask questions. I give my consent to participate in this study.

Name and Surname: _____

Signed: _____ **Date:** _____

We hereby give permission for our child's files to be used for research purposes and understand that no identifying information will be disclosed. Yes No

Signed: _____ **Date:** _____



This research project is conducted by Ms Palesa Motsa under the supervision of Dr. Linda Blokland.

If you have questions or concerns about this study, you may contact:

- **Itsoseng clinic, Mamelodi** (Rico Visser)
Tel: 012 842 3515
Fax: 086 518 3871
Email: itsoseng.clinic@up.ac.za
- **Dr Linda Blokland** (linda.blokland@up.ac.za),
- Or **Palesa Motsa** (plmotsa@gmail.com)

Appendix 8 – Child Picture Information Letter

Child Picture Information Letter for Participation in Research Study

University of Pretoria

This information can be explained to you by an interpreter.

Project Title: Exploring the outcomes of experiential art activities on the behaviour and psychological functioning of children.

Who will do the study? Ms Palesa Motsa under the supervision of Dr Linda Blokland.

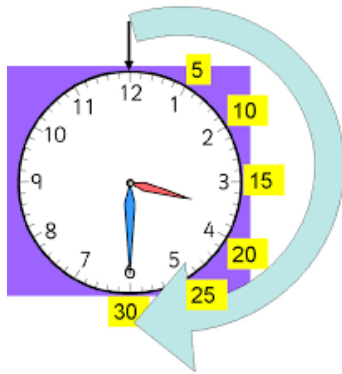
Where will this happen? Itsoseng Clinic, Mamelodi

What you must do: Take part in art activities. Someone will help you understand.





Time it will take:



20-30mins

Possible Discomforts and Risks:



?

worried



!

scared



?

sad



Someone to talk to.



You can choose to be in the study or not to be in the study.



You can leave at any time you want to.



Nothing bad will happen if you choose not to be a part of the study, or if you want to leave the study.



No one will know your name or what you said.



_____ If you have any questions speak to Ms Palesa Motsa or Rico Visser at (012) 842 3515 or ask either of them to contact Dr. Linda Blokland for you.

This research project is conducted by Ms Palesa Motsa under the supervision of Dr. Linda Blokland.

If you have questions or concerns about this study, you may contact:

- **Itsoseng clinic, Mamelodi (Rico Visser)**
Tel: 012 842 3515
Fax: 086 518 3871
Email: itsoseng.clinic@up.ac.za
- **Dr Linda Blokland** (linda.blokland@up.ac.za),
- **Or Palesa Motsa** (plmotsa@gmail.com)



Appendix 9 – Child Assent Form

Child Assent Form for Participation in a Research Study

University of Pretoria

Re: Exploring the outcomes of experiential art activities on the behaviour and psychological functioning of children.

This information can be explained to you by an interpreter.

Statement of Consent: (Circle your choice)

I have read the description of this research	Yes	No
Someone has explained the study to me	Yes	No
and I understand it.	Yes	No

All my questions have been answered to my satisfaction. I voluntarily agree to participate in this study.

Name and Surname: _____

Signed: _____ **Date:** _____

I hereby give permission for my files to be used for research purposes and understand that no identifying information will be disclosed. Yes No

Signed: _____ **Date:** _____

This research project is conducted by Ms Palesa Motsa under the supervision of Dr. Linda Blokland.



If you have questions or concerns about this study, you may contact:

- **Itsoseng clinic, Mamelodi** (Rico Visser)
Tel: 012 842 3515
Fax: 086 518 3871
Email: itsoseng.clinic@up.ac.za
- **Dr Linda Blokland** (linda.blokland@up.ac.za),
- Or **Palesa Motsa** (plmotsa@gmail.com)

Appendix 10 – Child Picture Assent Form

Child Picture Assent Form for Participation in a Research Study

University of Pretoria

This information can be explained to you by an interpreter.

Project Title: Exploring the outcomes of experiential art activities on the behaviour and psychological functioning of children.

Statement of Consent: (Circle your choice)

I have read the description of this research	Yes	No
Someone has explained the study to me	Yes	No
and I understand it.	Yes	No



I am happy to be in the study.



I agree to the activities.

Name and Surname: _____

Signed: _____ **Date:** _____

I hereby give permission for my files to be used for research purposes and understand that no identifying information will be disclosed. Yes No

Signed: _____ **Date:** _____

This research project is conducted by Ms Palesa Motsa under the supervision of Dr. Linda Blokland.



If you have questions or concerns about this study, you may contact:

- **Itsoseng clinic, Mamelodi** (Rico Visser)
Tel: 012 842 3515
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Email: itsoseng.clinic@up.ac.za
- **Dr Linda Blokland** (linda.blokland@up.ac.za),
- Or **Palesa Motsa** (plmotsa@gmail.com)

Appendix 11 – Declaration by Language Editor

I, Glenda Holcroft, ID Number 5103060026082, a professional language practitioner, declare that I conducted the language editing (excluding the references and appendices) of this dissertation, *Exploring the outcomes of experiential art activities on the behaviour and psychological functioning of children*, submitted by Palesa Lomfundvo Motsa, student number 29390576.

Signature

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