

Equine assisted object-relations psychotherapy for adolescents with a diagnosis  
of conduct disorder: An exploratory study

by

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## SUMMARY

Conduct disorder (CD) is the most common diagnosis amongst adolescents that present with behavioural difficulties. These behavioural difficulties may include; defiance, hostility, no respect for authority figures, stealing, lying, manipulation and harming others as well as setting fires, damaging property, and truancy. As the literature reveals there are various comorbid diagnoses that may also be present with these behavioural difficulties, such as attention deficit hyperactivity disorder (ADHD) as well as depression. Adolescents diagnosed with conduct disorder can be a challenging population to work with and treat and they may invoke negative countertransference in the healthcare professionals that treat them.

Various conventional methods such as behavioural management, anger management, parenting programmes, family therapy, hospitalization and pharmacology has shown some useful results when working with this population, but they are not optimal. Statistics obtained mostly from the United States and Europe indicate that behavioural difficulties and especially violence is on the increase with often disastrous consequences for the family and community surrounding these adolescents as well as huge financial implications.

Melanie Klein, a psychoanalyst and the mother of psychodynamic object relations, postulates that these behavioural difficulties are because of a possible hostile and rejecting relationship with the primary object and form the basis for the adolescent's object-relations, resulting in behavioural difficulties.

An alternative method of treatment, equine assisted psychotherapy (EAP), the use of horses in the psychotherapeutic process has been proposed and this research explores the outcomes of using this type of therapy with adolescents diagnosed with conduct disorder from a psychodynamic object relations perspective.

This research sourced 15 adolescents between the ages of 13 years and 17 years 11 months, from the local child welfare for the experimental group, and 15 adolescents within the same age range from the same local child welfare for the control group. The experimental group underwent six, 30 – 40 minute sessions of EAP each at a stable yard situated in the south of Gauteng. A mixed methods approach (both qualitative and quantitative methodology) was used in this research in order to fully and effectively research this phenomenon and the outcomes thereof.

Child and adolescent interviews, background histories, transcripts of the EAP sessions as well as clinical observations were used for the qualitative data and administered to the participants in the experiential group. The quantitative data consisted of scientific assessment

procedures, namely the 6-18 Child Behaviour Checklist (CBCL) Youth Checklist, as well as the Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A). These assessments were administered prior to the start of the EAP sessions to both the experimental and control groups as well as approximately six months afterwards, once again to both groups.

The EAP sessions were transcribed verbatim from the tape recordings and this formed part of the raw data. These transcripts were then analysed using thematic analysis and common themes were reported on as well as integrated with the relevant literature and psychodynamic object relations theory.

The quantitative data was obtained through the use of the 6-18 CBCL Youth Checklist and MMPI-A and was analysed using the Wilcoxon Signed Rank Test.

The results of this research propose to add value through adding to the limited amount of data pertaining to the use of EAP on adolescents diagnosed with conduct disorder from a psychodynamic object-relations perspective as well as exploring the possibility that EAP may be a useful and alternative method in treating these adolescents.

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# CHAPTER 1

## INTRODUCTION: ORIENTATION, MOTIVATION AND OBJECTIVES

The current chapter serves to introduce the reader to the topic of this research namely, the effectiveness of Equine Assisted Psychotherapy (EAP) from psychoanalyst Melanie Klein's psychodynamic object relations perspective, with adolescents diagnosed with conduct disorder (CD).

Furthermore, this chapter offers an orientation and motivation for the present study as well as clarifying this study's aims and objectives. The value of the research is explained, which is followed by a brief overview of this study's chapters.

### 1.1. Orientation

Adolescents diagnosed with conduct disorder (CD) have been defined as a heterogeneous group that display a repetitive and persistent pattern of behaviour in which the basic rights of others and the major societal norms and values are violated (American Psychiatric Association, 2013). These individuals often bully, threaten, or intimidate other individuals, have been physically cruel to others or animals, have stolen and/or lied, deliberately destroyed someone's property, and are truant from school (American Psychiatric Association, 2013).

It is in the researcher's experience that these children can be challenging to work with and are often marginalised by healthcare professionals, partially since these professionals feel helpless and powerless to assist with the demanding and challenging behaviour displayed by this group of adolescents. This research proposes an alternative to traditional psychodynamic psychotherapeutic treatment for working with adolescents diagnosed with CD, namely working with animals, known as animal assisted therapy (AAT). AAT has been defined as goal-orientated and structured interventions that intentionally incorporate animals as part of the therapeutic team working under the direction of a professional for the purpose of therapeutic gains (Pet Partner's, 2018). More specifically, this research will focus on the use of horses (equines) in psychodynamic psychotherapy. This type of psychotherapeutic approach is known as Equine Assisted Psychotherapy (EAP). Chapter two will focus on explicating the different definitions of AAT and EAP.

EAP has been defined as a process utilizing the animal-human bond in a goal directed intervention as an integral part of the therapeutic process (Delta Society, 1997). Furthermore, EAP is not a specific therapeutic paradigm such as cognitive behavioural therapy (CBT) or psychodynamic psychotherapy, but rather it is a process involving a registered therapist working from his/her paradigm of choice and

utilizing a horse that is present for part or all of the therapy sessions. The therapist's chosen paradigm is then used for the interpretation and contextualization of the EAP sessions.

EAP has been shown to be effective with a variety of psychiatric conditions such as anxiety, depression, and attention deficit hyperactivity disorder in a variety of contexts (Martin, & Farnum, 2002; Nimer, & Lundahl, 2007; Schuck, Emmerson, Fine, & Lakes, 2013). This research proposes to research the outcomes and effectiveness of EAP with adolescents diagnosed with conduct disorder.

The motivation for this research is explored in more detail in the next section.

## **1.2. Motivation for the study**

In 2011, adolescent violence was the second leading cause of death for young people between the ages of 10 and 24 years old (Mahajan, Kaur Arora, Gupta, & Kapoor, 2011). A few years later, the American Academy of Child and Adolescent Psychiatry (2015), stated that there was great concern about the growing incidence of violence amongst children and adolescents and that children as young as preschool can become violent. It would appear that violence, a behavioural difficulty, amongst adolescents still remains a great concern and an increasing phenomenon in society. The latest statistics released report that 0.2% of the prison population consists of adolescents and children (World Prison Brief, 2015).

There are various factors that may cause an adolescent to become violent, but this research will focus on those diagnosed with conduct disorder.

It is often the case that it is a demanding process to establish a relationship and sense of rapport with these adolescents in which to work with therapeutically and facilitate a process of change. Therapeutic work with adolescents, who present with conduct disorder, is not always effective and as experienced by the researcher, these adolescents may be seen by many different healthcare professionals and placed in many different facilities to assist them.

Furthermore, it is also in the researchers experience that these children are often marginalised within the psychiatric population and it is felt that nothing can be done for them, thus labelling them with a poor prognosis. They are more often than not merely placed on medication and sent to the outskirts of their community i.e. trade, industrial schools, or non-governmental organisations providing residential care for "challenged youth". They can often also be found as making up a large majority of the juvenile prison population. These children can evoke a very negative countertransference in the mental health care professionals working with them, due to an often experienced aggressive and hostile nature. They may not necessarily benefit from "talk" psychotherapy and medication as much as they could and/or should.

This research proposes an alternative method for working with adolescents diagnosed with CD, which may be more beneficial and may possibly result in behaviour modification, the development of insight into their behaviour and the possibility that these children can be placed in mainstream schools and develop into adults that add value to society, thus also decreasing the children that are marginalised and placed in trade schools or juvenile detention facilities. The study's specific aims and objective are outlined next.

### **1.3. The study's aims and objectives**

The main aim of the study was to explore, under specified conditions, the measured effective change of EAP when combined with object-relations psychotherapy with adolescents with a diagnosis of conduct disorder.

This was measured through the use of both quantitative and qualitative research measures, namely the Minnesota Multiphasic Personality Inventory-Adolescent (MMPI-A), the 6-18 Child Behaviour Checklist (CBCL) Youth questionnaires and a thematic analysis of the transcripts of the EAP sessions. Each child underwent six 30 to 40-minute sessions of EAP by relevantly qualified professionals.

The study used a control group as well as an experimental group. The sample for the study consisted of 11 participants, 5 for the experimental group and 6 for the control group. Both male and female children between the ages of 13 years and 17 years 11 months, diagnosed with conduct disorder were purposely selected from a local welfare agency.

The thematic analysis of the EAP sessions provides the reader with an in-depth and descriptive explanation of the EAP process and the effect that it had on the adolescents. The research attempted to elicit central and common themes characterising the behaviour of adolescents diagnosed with conduct disorder. The quantitative analysis provides the reader with more objective and statistically relevant results regarding the effectiveness of the EAP sessions.

One of the objectives was to explore whether using horses as part of the therapeutic process and as a therapeutic object would assist in changing the adolescent's internalized object. Object relations has been described by Colman (2006), as the emotional bond that individuals form with instinctual objects and encompasses a relationship and an emotion directed towards this object. An example of such an object would be the child's primary caregiver. Adolescents diagnosed with a conduct disorder typically struggle to form relationships with objects due to difficult attachments (Greenberg, & Mitchell, 1983). This will be further discussed in Chapter 3, the paradigmatic point of departure section. Such children and adolescents can often have feelings of anger, aggression and hostility directed towards these objects, which can become internalised. In researching the effectiveness of the

psychotherapeutic method, the prognosis for adolescents with a diagnosis of CD may be improved. This may possibly be achieved through facilitating a process of change by addressing the emotional connection of the adolescent as well as behavioural modification. Such possible change was measured through the use of the MMPI-A and CBCL. Chardonens (2011), found through a case study that therapy involving animals as co-therapists can lead to a clear reduction of symptoms and development of core competencies that enhance relational competencies.

#### **1.4. Possible value of the study**

This study hopes to add value in presenting to the reader an alternative psychotherapeutic way of treating adolescents diagnosed with conduct disorder that may produce some results with regards to behaviour modification as well as their internalised sense of objects thus possibly allowing them to create meaningful relationships with their healthcare professionals and possibly other significant persons in their lives. This in turn may facilitate a process of change and growth.

A search of various resources (Chandler, 2005; Delta Society, 1997; Fine, 2000), reveal that AAT has most widely been researched in the United States and European countries. AAT has also most widely been used with regards to children displaying physical handicaps and mental health disorders such as anxiety and depression, although this is still a relatively new area of research. Literature reviews have found little to no research with regards to the use of AAT therapy and specifically EAP with adolescents with a diagnosis of CD in South Africa. This research has attempted to overcome some of these weaknesses in prior research and add to the very limited existing body of literature on EAP.

Despite the limited availability of research work done in this field, Kohanov (2001), does suggest that EAP has been highly effective in assisting people "...reintegrate mind and body, increase awareness of unconscious behaviour patterns, and develop the self-confidence, stress management, and assertiveness skills that lead to increased success..." (p. xviii). Some of her work has proven effective in assisting Vietnam War veterans, sex addicts, substance abuse victims and adolescent boys with anger management problems (Kohanov, 2001).

The psychotherapeutic benefits that EAP has shown in other studies to yield increased self-confidence, improved communication, anxiety reduction, impulse modulation, improved boundaries, and decreased isolation amongst others (Cumella, 2003).

As previously mentioned, there is little to no literature on the use of EAP with conduct disordered adolescents from a psychodynamic object relations perspective. This study hopes to add to the body of literature available on this topic. This research also hopes to add value through offering an in-depth and descriptive analysis of the EAP sessions. Lentini and Knox (2008), furthermore, suggest that

more research regarding EAP and specific outcomes with regards to cognitive, emotional, behavioural, and objective physiological variables is needed, and this research hopes to provide this.

The outcome of the study may also add value by contributing to the construction of effective early interventions for aggressive, defiant, and hostile adolescents, which may assist in the prevention of violent behaviour in adolescents and possibly in the future adult population as well.

This study presented an objective to assist social workers, psychologists, psychiatrists, and other mental health individuals that work with adolescents diagnosed with conduct disorder in better understanding the pathology as well as ways in which to effectively treat and deal with them.

Lastly, it is hoped that this research will add value for the actual adolescent themselves and allow them to change their behaviour allowing for more meaningful and constructive relationships with more effective object-relations in the future.

### **1.5. Overview of the study**

This research consists of thirteen chapters with the appendices and references included at the end of the research.

**Chapter 1**, the current chapter gives an overview of the orientation, motivation, as well as the aims and objectives of the study. **Chapter 2** presents the current and relevant literature pertaining to adolescents, conduct disorder, animal assisted psychotherapy, as well as equine assisted psychotherapy (EAP). **Chapter 3** presents the paradigmatic point of departure of the research, namely that of psychoanalyst Melanie Klein's psychodynamic theory of object relations. The research methodology as well as the data collection and analysis are discussed in **Chapter 4**, namely that of both quantitative and qualitative research methods.

**Chapter 5**, presents the research findings and discussion of Participant A. **Chapter 6**, presents the research findings and discussion of Participant B. **Chapter 7**, presents the research findings of Participant C. **Chapter 8**, and **Chapter 9**, present the research findings of Participant D and F respectfully. Unfortunately, Participant E dropped out of the study. **Chapter 10**, presents the quantitative data section of the research section and **Chapter 11**, provides an integration of the results obtained from the preceding five chapters. This chapter incorporates the participant's experiences and provides an interpretation and contextualisation of the findings with the relevant literature and within an object-relations context. Lastly, the research is concluded in **Chapter 12**, with an evaluation of the study including any limitations and recommendations for future research.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1. Introduction**

*“The ways that animals are treated and the rules governing human-animal interactions are metaphors for how the children should be treated. Children learn about human morality by reflecting upon the moral principles inherent in the treatment of animals. Without an ethic of human-animal interaction, there is no therapy in the larger sense....”*

(Chandler, 2005, p. 121)

This literature review will firstly outline and discuss adolescence and disruptive behaviour disorders with specific reference to conduct disorder (CD). CD is a DSM 5 diagnostic category – the fifth and latest edition of the Diagnostic and Statistical Manual for psychiatry and used by clinical psychologists (American Psychiatric Association, 2013). The second section of this chapter discusses Animal-Assisted Psychotherapy (AAT) and more specifically Equine Assisted Psychotherapy (EAP). The specific use of horses in therapy and how the therapy is facilitated is also discussed.

#### **2.2. An Overview of Adolescence**

This section focuses specifically on adolescence: the meaning of adolescence/an adolescent, the development of adolescence as well as normal adolescent behaviour versus delinquent adolescent behaviour as a thorough understanding of adolescence is central to this research.

##### **2.2.1 Defining adolescence**

It is firstly important to define what is meant by the term adolescence. Adolescence is a broad term describing a human developmental stage that encompasses a wide range of developmental, emotional, and cognitive changes (Zastrow & Kirst-Ashman, 2013). The specific age group referred to by the term adolescence varies in the literature. This research will focus on adolescents between and including the ages of 13 years to 17 years 11 months.

The World Health Organisation (2017) describes adolescence as the period in human growth and development that occurs after childhood and before adulthood, typically between the ages of 10 and 19 years old. It is characterised by tremendous developmental growth and critical transitions. There are many biological changes and the onset of puberty during adolescence marks the

beginning of adulthood (World Health Organisation, 2017). Some key developmental areas during adolescence include the beginning of the process of acquiring financial independence, the development of an identity, and the acquisition of skills (World Health Organisation, 2017). This period is also a time of considerable risk for the development of mental illness due to the vast developmental changes (emotional, physical and cognitive), during which familial, peer and social factors play an important role (World Health Organization, 2017).

Abercrombie, Hill, and Turner (2000), refer to adolescence as a period characterized by individual crisis, echoing the theory of Erikson, who referred to this as the developmental stage of identity formation vs. identity diffusion (Erikson, 1973). They argue that many psychiatric and behavioural problems have their greatest incidence and onset in adolescence, thus making them an important group to focus research on. Furthermore, the effect of the transition from home to school and subsequently to work and the emotional distress that it may bring is a large focus for this group (Abercrombie, *et al.*, 2000).

### **2.2.2 Normal adolescent behaviour**

Certain behaviour in adolescence is regarded as normal for this developmental stage. However, what type of behaviour is regarded as normal and what warrants further intervention is important to discuss. An ability to defend oneself against verbal or physical attacks is part of an innate tendency to survive (Buitelaar, *et al.*, 2012). Aggressive behaviours such as hitting, pushing, biting, slapping, kicking and spitting are universal behaviours in young children. However, as children grow older, most learn to inhibit these behaviours and to socialise more agreeably (Buitelaar, *et al.*, 2012).

With the beginning of puberty during early adolescence or even late childhood, a whole array of different behaviours is expected (Sisk & Zerhr, 2005). These behaviours are defined as 'normal' depending on how the adolescent navigates them (Quevedo, Benning, Gunnar, & Dahl, 2009). The behaviour should not become consistent and should not impact the adolescent's ability to perform at school, socially with their peers and within society. Once this behaviour impacts their ability to perform in these areas, it may have become problematic and pathologized (Berenbaum, Beltz, & Corley, 2015).

### **2.2.3 Delinquent adolescent behaviour**

Certain behaviours in adolescence are not considered age appropriate and start to cause distress to both the adolescent as well as their family and the community around them (Nightingale & Fischhoff, 2001). Acts of violence and aggression may be displayed that become harmful to others as well as themselves (Fischhoff, Downs, & De Bruin, 1998). This group of adolescents are a

highly psychiatrically vulnerable population that are in dire need of services (Steiner *et al.*, 2011). In addition, this group of adolescents is at-risk to more maladaptive developmental trajectories and increased criminal recidivism as well as what is known as the ‘cycle of violence’ in criminological literature (Steiner *et al.*, 2011). Essentially the literature suggests that these adolescents constantly get involved in violent and aggressive activities in a never-ending cycle.

The study of aggression from a psychiatric/scientific perspective is a relatively modern one, beginning in the 20<sup>th</sup> century with the work of August Aichhorn (Steiner *et al.*, 2011). Aichhorn argued that the intra-psychic world as described by Freud could be used as an explanatory tool for the social/criminal acts witnessed amongst delinquency. Aggression has been defined as a very general term used to describe a wide variety of acts that involve attacking, and hostility which can be motivated by fear or frustration, a desire to produce flight or fright in others as well as a tendency to push forward ones ’own will and desires (Reber & Reber, 2001). Highly traumatic events (parental death/abusive parenting/threats to their own lives), social isolation and displacement have been found to contribute towards aggressive behaviour (Steiner *et al.*, 2011).

Treatment is essential to assist in the breaking of this cycle (Fischhoff, Downs, & De Bruin, 1998). Psychiatrists and mental health care professionals are in the best position to contribute towards the disruption of ‘the perpetuation of acts of aggression from generation to generation by providing effective treatment of these pathologies’ (Steiner *et al.*, 2011, p. 21). However, treatment is not always readily accessible, nor are mental health care professionals always willing to assist these youths due to what is viewed as their poor prognosis (Bernstein, 2000; Webster-Stratton, & Reid, 2010).

Many delinquent youths will receive a diagnosis of Oppositional Defiant Disorder (ODD), Conduct Disorder (CD) or Antisocial Personality Disorder (18 years onwards) (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). These diagnoses will be explored further below except for antisocial personality disorder as it falls outside of the specified age range for the purposes of this research.

### **2.3 Disruptive Behaviour Disorders**

Behavioural disorders commonly referred to as Disruptive Behaviour Disorders (DBD), are known as the most common psychiatric disorders amongst children and adolescents (Kronenberger & Meyer, 2001). Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) are the two disorders that fall under this umbrella term. Both ODD and CD diagnosis share the common characteristics of disobedient and disruptive behaviour as well as the breaking of societal norms (Kronenberger & Meyer, 2001). The introduction of these diagnostic labels (ODD and CD) has



achieved an important step in the scientific/medical approach to delinquency as they separated diagnosis and treatment from adjudication (Steiner *et al.*, 2011). In addition, these diagnostic labels permitted early identification as well as treatment and preventative intervention outside the confines of the juvenile justice system (Steiner *et al.*, 2011).

### **2.3.1. Oppositional Defiant Disorder (ODD)**

The essential feature of oppositional defiant disorder is a persistent and frequent pattern of an angry/irritable mood and argumentative/defiant behaviour which may be confined to one setting, frequently the home (American Psychiatric Association, 2013).

According to the American Psychiatric Association (2013) the following diagnostic criteria as set out in the DSM 5, needs to be fulfilled in order to make a diagnosis of oppositional defiant disorder:

- A. A pattern of angry/irritable mood, argumentative/defiant behaviour, or vindictiveness lasting 6 months as evidenced by at least four symptoms from any of the following categories and exhibited during interaction with at least one individual who is not a sibling.

#### **Angry/Irritable Mood**

- 1. Often loses temper
- 2. Is often touchy or easily annoyed
- 3. Is often angry and resentful

#### **Argumentative/Defiant Behaviour**

- 4. Often argues with authority figures or adults
- 5. Often actively defies or refuses to comply with requests from authority figures or with rules
- 6. Often deliberately annoys others
- 7. Often blames others for his/her mistakes/misbehaviour

#### **Vindictiveness**

- 8. Has been spiteful or vindictive at least twice within the past six months.
- B. The disturbance in behaviour is associated with distress in the individual or others in his/her immediate social context or impacts negatively on social, occupational, educational, or other important areas of functioning.

- C. The behaviours do not occur exclusively during the course of a psychotic, substance abuse, depressive or bipolar disorder. Criteria are not met for disruptive mood dysregulation disorder.

Furthermore, current severity needs to be specified:

*Mild:* Symptoms are confined to one setting,

*Moderate:* Some symptoms are present in two settings,

*Severe:* Some symptoms are present in three or more settings.

The American Psychiatric Association (2013), also states that the persistence and frequency of these behaviours should be used to distinguish behaviour that is within normal limits, from behaviour that is pathological. For children, younger than 5, the behaviour should occur most days for a period of more than 6 months. For individuals, older than 5, the behaviour should occur once a week for a period of more than 6 months.

### **2.3.2. Conduct Disorder (CD)**

Conduct disorder (CD) is a frequently occurring psychiatric disorder that is characterised by a persistent and often relentless pattern of aggressive and non-aggressive behaviours (Buitelaar *et al.*, 2012). The behaviour of an individual diagnosed with CD is often difficult to cope with for many members of society. Buitelaar *et al.*, (2012), suggest that the behaviours associated with CD lead to a considerable burden for the patients, their family, as well as society, often with considerable expense to the government. Conduct disorder has been reported to have a prevalence of 1 to 16% of the population, with most studies, although mostly American, indicating a population rate of approximately 5% (Sadock & Sadock, 2005). A review of the various literatures indicates that this rate is still the current prevalent rate. It is more prevalent amongst boys than girls (American Psychiatric Association, 2013).

According to conventional guidelines and methods of describing CD, the DSM-IV-TR, is probably the most trusted and widely used guideline. However, with the release of the DSM-5 in May 2013, this research will refer to the DSM-5. It is important to note that the diagnostic criteria for CD has remained unchanged in the DSM-5. There is instead, the introduction of a new specifier: callous-unemotional type (CU) (Buitelaar *et al.*, 2012), which is of importance.

CD is a disorder that results in impaired social or academic performance/functioning in a child or adolescent (Sadock & Sadock, 2005). It can sometimes be a difficult disorder to diagnose because, as already discussed, some oppositional and defiant behaviour is often developmentally appropriate for children and adolescents. However, children and adolescents with CD are often

impaired themselves by the severity and frequency of their disruptive behaviours (American Psychiatric Association, 2013). Longitudinal studies have found that adolescents diagnosed with CD suffer from both short-term and long-term impairments, mental and physical health problems, accidents and injuries, legal difficulties, incarceration, as well as premature mortality (Lacourse *et al.*, 2010).

According to the DSM-5, a specific criterion needs to be met in order to make a diagnosis of CD in a child or adolescent. These are listed below, and this criterion will be used for the purposes of the selection of participants for the study (American Psychiatric Association, 2013):

- A. A repetitive and persistent pattern of behaviour in which the basic rights of others or major age-appropriate societal norms or rules are violated, as manifested by the presence of three (or more) of the following criteria in the past 12 months, with at least one criterion present in the past 6 months;

**Aggression to people and animals**

1. often bullies, threatens, or intimidates others
2. often initiates physical fights
3. has used a weapon that can cause serious physical harm to others (e.g., a bat, brick, broken bottle, knife, gun)
4. has been physically cruel to people
5. has been physically cruel to animals
6. has stolen while confronting a victim (e.g., mugging, purse snatching, extortion, armed robbery)
7. has forced someone into sexual activity

**Destruction of property**

8. has deliberately engaged in fire setting with the intention of causing serious damage
9. has deliberately destroyed others' property (other than by fire setting)

**Deceitfulness or theft**

10. has broken into someone else's house, building or car
11. often lies to obtain goods or favours or to avoid obligations (i.e., "cons" others)
12. has stolen items of nontrivial value without confronting a victim (e.g., shoplifting, but without breaking and entering; forgery)

**Serious violations of rules**

13. often stays out at night despite parental prohibitions, beginning before age 13 years

14. has run away from home overnight at least twice while living in parental or parental surrogate home (or once without returning for a lengthy period)
15. is often truant from school, beginning before age 13 years.

- B. The disturbance in behaviour causes clinically significant impairment in social, academic, or occupational functioning.
- C. If the individual is age 18 years or older, criteria are not met for antisocial personality disorder.

Disruptive behaviour disorders are often comorbid with other disorders such as substance abuse/dependence, mental retardation, autism, Post Traumatic Stress Disorder (PTSD), Attention Deficit Hyperactivity Disorder (ADHD) and mood disorders (Steiner *et al.*, 2011).

Although the above diagnostic list is comprehensive and understandable, making a diagnosis of CD appear relatively easy Buitelaar *et al.* (2013), argues that some symptoms of CD are covert and of low frequency and may go unnoticed or be concealed and thus easily underreported. Thus, it is important to have the adequate training and knowledge with regards to CD as well as actively probing during the interview(s) with the adolescent as well as collateral sources such as parents/legal guardians and teachers.

CD is comprised of subtypes as outlined below.

#### 2.3.2.1. *Childhood onset (before age of 12 years)*

This subtype of CD was present in the DSM-IV-TR and has been retained in the DSM 5. The difference between childhood-onset CD and adolescent-onset CD is the presence of just one symptom before the age of 10 years (Buitelaar *et al.*, 2013). Childhood-onset CD is relatively rare as Buitelaar *et al.* (2013), states that many individuals usually present with antisocial behaviours in their adolescent years.

However, childhood-onset behaviour would appear to be associated with dysfunction. It has also previously been known as persistent antisocial behaviour and has been found to be associated with early family instability and dysfunction, cognitive and temperament problems as well as a strong genetic vulnerability (Buitelaar *et al.*, 2013).

#### 2.3.2.2. *Adolescent Onset*

This group is far more common, and the prevalence is higher. The American Psychiatric Association (2013) state that adolescent onset occurs when there are no symptoms characteristic of conduct disorder prior to the age of 10 years old.

### 2.3.2.3. *Subtypes*

DSM 5 has added specifiers to the diagnosis of CD which will be discussed below:

#### *Callous-unemotional (CU) type*

The DSM 5 added an additional subtype to the diagnosis of CD known as CD with a callous-unemotional presentation. An individual needs to meet two of the four symptoms over 12 months and in multiple relationships and settings to fit the criteria (Buitelaar *et al.*, 2013). In addition, these symptoms need to be assessed from a variety of sources (self-report and significant others). Buitelaar *et al* (2013) described the four symptoms as outlined below:

#### *A lack of remorse or guilt.*

The adolescent does not feel bad or guilty when he/she does something wrong. There is a complete lack of concern about any negative consequences for their behaviour. This excludes remorse shown when he/she has been caught out and is facing punishment/consequences.

#### *A callous lack of empathy.*

The adolescent disregards and is unconcerned about the feelings of others. These adolescents can present as cold and uncaring. In addition, the adolescent presents as more concerned about the consequences of his/her actions on him/herself rather than on others, even when his/her actions result in harm to others.

#### *No concern for poor/problematic performance at school/other important areas of his/her life.*

The adolescent would appear to not put in the effort necessary to perform well and tends to blame others for his/her poor performance. They struggle to take responsibility.

#### *A shallow or deficient affect.*

They do not typically express feelings or show emotions to others. However, when they do it is done in ways that appear shallow, insincere, or superficial or the expression is used for self-gain (manipulation or intimidation).

### 2.3.2.4. *The aetiology of Conduct Disorder*

There are several well studied reasons for the development of conduct disorder. As Sadock and Sadock (2005), state there is no single cause that has yet been identified for the development of conduct disorder.

The following section explores factors that place an individual at risk for developing conduct disorder which are divided into biological, psychological, and sociological factors. In general, conduct disorder develops because of adverse environmental influences on a vulnerable individual at critical stages in their growth and development (Sadock & Sadock, 2005).

#### 2.3.2.4.1. *Biological factors*

There would appear to be possible genetic influences on the disorder as supported by the occurrence of cases within families. According to the American Psychiatric Association (2013), the risk of developing conduct disorder increases significantly in children with a biological parent or sibling that may also have conduct disorder. Research has shown that the disorder would appear to be common in children of parents with severe alcohol use, depressive or bipolar disorder, schizophrenia, or ADHD (American Psychiatric Association, 2013).

However, Sadock and Sadock (2005), state that there is more than likely no one gene or set of genes that are responsible for the development of the disorder. Genes that control specific features such as impulsivity, aggression and attention would appear to contribute towards the potential for the development of CD. Scheepers, Buitelaar, and Matthys (2011), argue that genetics and biological systems play a very large role in adolescents diagnosed with conduct disorder, callous-unemotional (CU) type. The heritability coefficient for aggression amongst 3 year olds is 69% and for antisocial behaviour amongst 5 year olds, it is 69% (Scheepers *et al.*, 2011). The effect of hereditary factors would appear to be larger in pre-schoolers than in school children, adolescents, and adults. Thus, genetic factors may play an important role in the initiation of the disorder rather than the maintenance of the disorder (Scheepers *et al.*, 2011).

Research on neurotransmitter differences, especially those that play a role in sympathetic arousal are of interest, but research is inconclusive. Interestingly, low resting heart rate is consistently associated with and predictive of antisocial behaviour in boys, especially with regards to aggression (Sadock & Sadock, 2005). Various MRI studies have found reduced amygdala reactivity in youth with conduct disorder CU traits (Scheepers *et al.*, 2011). In addition, the American Psychiatric Association (2013), states that structural and functional differences in the areas of the brain associated with affect regulation and processing, particularly frontotemporal- limbic connections that involve the brains ventral prefrontal cortex have consistently been noted in individuals with conduct disorder compared to those without. However, this is not diagnostic.

#### 2.3.2.4.2. *Psychological factors*

A consistent finding in studies is poor academic functioning as well as low IQ (Sadock & Sadock, 2005). Difficulties with executive functioning (the ability to anticipate and plan, inhibition of abstract responses as well as abstract reasoning) has been linked to the development of conduct disorder. This may also include a low verbal intellectual ability.

The presence of fearlessness and stimulation seeking in early childhood is also a predictive factor for later aggression (Sadock & Sadock, 2005), as well as a difficult, under-controlled infant temperament (American Psychiatric Association, 2013).

#### 2.3.2.4.3. *Sociological factors*

A lot of research has focused on the familial and social environments. Scheepers *et al* (2011), argue that environmental factors play a large role in the development of conduct disorder without callous unemotional traits. Furthermore, research has indicated that children exposed to maltreatment, harsh discipline and physical or sexual abuse are at a greater risk for developing antisocial behaviours (Sadock & Sadock, 2005). A study found that sexually abused children are 12 times more likely to develop antisocial behaviour.

An emphasis on the development of conduct disorder is placed on poor parenting and risk factors include neglect, rejection, lack of involvement, parental alcohol, and substance abuse as well as parental mental illness (Sadock & Sadock, 2005).

Marital discord, poverty, domestic violence, poor socioeconomic status, poor housing, exposure to violence (through movies, television, or physical fighting), and substance abuse (alcohol, drugs and over the counter medication), as well as exposure to antisocial peers are also considered risk factors for the development of conduct disorder (Sadock & Sadock, 2005). Further risk factors identified include early institutional living, frequent change of caregivers, large family size, and parental criminality (American Psychiatric Association, 2013).

#### 2.3.2.5. *Co-morbid and differential diagnosis*

When making a diagnosis of conduct disorder it is important to also consider any comorbid or differential diagnosis. The most common comorbid diagnoses include; attention deficit hyperactivity disorder, depression, substance abuse, oppositional defiant disorder, as discussed above, and intellectual disability. These are discussed in more detail below. This list is not exhaustive and some other comorbid disorders, not discussed here include bipolar mood disorder and intermittent explosive disorder.

### 2.3.2.5.1. Attention Deficit Hyperactivity Disorder (ADHD)

Children with ADHD may exhibit hyperactive and impulsive behaviour and thus become disruptive (American Psychiatric Association, 2013). When making a differential diagnosis, it is important to remember that children with ADHD often don't violate the rights of others.

ADHD and oppositional defiant disorder are both common in individuals diagnosed with conduct disorder and this comorbid presentation often predicts worse outcomes (American Psychiatric Association, 2013).

The diagnostic criteria for ADHD are discussed below as defined in the DSM 5 (American Psychiatric Association, 2013):

- A. A persistent pattern of inattention and or hyperactivity-impulsivity that interferes with functioning/development as characterised by (1) and/or (2):
  1. *Inattention*: Six or more of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with the developmental level and negatively impacts on social and academic/occupational activities:
    - a. Fails to give close attention to details or makes careless mistakes,
    - b. Difficulty sustaining attention in tasks or play activities,
    - c. Doesn't seem to listen when spoken to directly,
    - d. Doesn't follow through on instructions and fails to finish schoolwork, chores, or duties at the workplace,
    - e. Often has difficulty organising tasks and activities,
    - f. Avoids, dislikes or is reluctant to engage in tasks that require sustained mental effort,
    - g. Loses things necessary for tasks or activities,
    - h. Is often easily distracted by extraneous stimuli,
    - i. Is often forgetful in daily activities.
  2. *Hyperactivity/Impulsivity*: Six or more of the following symptoms have persisted for at least 6 months to a degree that is inconsistent with the developmental level and negatively impacts on social and academic/occupational activities:
    - a. Fidgets with or taps hands and feet,
    - b. Often leaves seat in situations when remaining seated is expected,
    - c. Often runs about or climbs in situations where it is inappropriate/feels restless,
    - d. Unable to play or engage in leisure activities,



- e. Often 'on the go' as if 'driven by a motor',
  - f. Talks excessively,
  - g. Blurts out an answer before a question has been completed,
  - h. Cannot wait their turn in a conversation/queue/line,
  - i. Often interrupts or intrudes on others.
- B. Several inattentive or hyperactive-impulsive symptoms were present prior to age 12 years,
  - C. Several inattentive or hyperactive-impulsive symptoms are present in two or more settings,
  - D. Clear evidence that the symptoms interfere with or reduce the quality of social, academic, or occupational functioning,
  - E. The symptoms do not exclusively occur during schizophrenia or any other mental disorder.

It needs to specify whether the symptoms are a combined presentation, predominantly hyperactive presentation, or predominantly hyperactive/impulsive presentation and if the severity is mild, moderate or severe.

#### 2.3.2.5.2. *Major depressive disorder (MDD)*

Irritability, aggression, and conduct problems can also occur in children or adolescents that have a major depressive disorder (American Psychiatric Association, 2013). In order for a differential diagnosis to be made it is important to distinguish the pattern of the behavioural disorders. Individuals with conduct disorder will display substantive levels of aggression or non-aggressive conduct problems without a mood disturbance. In cases where both criteria are met, both diagnoses are given and the disorders are thus comorbid (American Psychiatric Association, 2013).

The diagnostic criteria for depression is discussed below as defined by the DSM (American Psychiatric Association, 2013):

- A. Five or more of the following symptoms have been present during the same 2-week period and represent a change from previous functioning. At least one of the symptoms is (1) depressed mood or (2) loss of interest or pleasure,
  - 1. Depressed mood most of the day, nearly every day as indicated by either subjective report (feels sad, empty, hopeless) or observation (appears tearful or irritable),
  - 2. Markedly diminished pleasure or interest in all, or almost all, activities most of the day, nearly every day (subjective or objective account),
  - 3. Significant weight loss when not dieting or weight gain or a decrease or increase in appetite,
  - 4. Insomnia or hypersomnia nearly every day,

5. Psychomotor agitation or retardation nearly every day (mostly observable by others, not just subjective reports of feeling restless or being slowed down),
6. Fatigue or loss of energy nearly every day,
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day,
8. Diminished ability to think or concentrate or indecisiveness nearly every day,
9. Recurrent thoughts of death (not just fear of dying), suicidal ideation without a specific plan or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress/impairment in social, occupational and/or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or a medical condition.

D. The occurrence is not better explained by another mental illness, such as schizophrenia, delusional disorder or another psychotic disorder.

E. There has never been a manic or hypomanic episode.

#### 2.3.2.5.3. *Substance abuse*

Individuals abusing substances can become aggressive and irritable. However, in order to diagnose the conduct disorder, the presence of the irritability and aggression needs to be present without the presence of substances. If both symptoms co-exist, then both diagnoses are made. The presence of substance abuse with children/adolescents diagnosed with conduct disorder is relatively high.

Overall the diagnosis of a substance use disorder is a pathological pattern of behaviours related to the use of the substance (alcohol, illicit drugs, and over-the-counter medication). Symptoms include impaired control (taking the substance in larger amounts or over a period longer than intended, the individual may spend a great deal of time obtaining the substance and all of his/her energy is invested in the substance to the detriment of occupational activities), social impairment (withdrawal, social and personal problems), risky use (use of the substance in situations where it may be physically hazardous such as driving or when using machinery), and pharmacological criteria (tolerance – requiring a markedly increased dose of the substance to achieve the desired effect) (American Psychiatric Association, 2013).

The DSM 5 describes many different types of substance-related and addictive disorders and as such they will not be discussed for the purposes of this research. These include substance intoxication and withdrawal and substance-induced mental disorders.

#### 2.3.2.5.4. *Intellectual disability*

A diagnosis of conduct disorder is only given if the conduct behaviour noted is markedly greater than is commonly observed amongst individuals of comparable mental age and comparable severity of intellectual disability (American Psychiatric Association, 2013). A low intelligence, specifically with regards to verbal IQ, is often associated with behavioural concerns and conduct disorder (American Psychiatric Association, 2013).

According to the DSM 5, an intellectual disability (Intellectual Developmental Disorder) has the following diagnostic criteria (American Psychiatric Association, 2013):

- A. Deficits in intellectual functions, such as reasoning, problem solving, planning, abstract thinking, judgement, academic learning and learning from experience, confirmed by both clinical assessment and individualized, standardized intelligence testing.
- B. Deficits in adaptive functioning that result in failure to meet sociocultural and developmental standards for personal independence as well as social responsibility. These deficits limit functioning in one or more areas of daily life, such as communication, social participation, and independent living, across multiple environments such as home, school, work and the community.
- C. Onset of adaptive and intellectual deficits occur during a developmental period.  
Different severities need to be specified; mild, moderate, severe, or profound.

#### 2.3.2.6. *Previous and current methods used to treat Conduct Disorder (CD)*

The treatment of conduct disorder is a matter of significant public health and societal concern as it places significant burden on the patient, the family and immediate environment surrounding the family as well as having strong associations with adverse scholastic and work performances, relationships and engaging in risky and addictive behaviours (Buitelaar *et al.*, 2013). A number of various therapeutic approaches have been utilized in the treatment and management of disruptive behaviour disorders. Wenar and Kerig (2000) state that due to the developmental trajectory of CD, the continuity from childhood to adulthood, emphasising that it is a psychopathology entrenched in early development, there is an urgent need for prevention and treatment. Furthermore, it has been emphasised that a major difficulty in treating adolescents with CD, is comorbidity with other disorders and clinicians should be particularly alert for symptoms of other disorders (especially ADHD and depression) and treatment should include components for both/all disorders (Kronenberger & Meyer, 2001).

Buitelaar *et al.* (2013) argue that ideally for treatment to be effective it needs to be multi-modal, involve a family and social systems-based approach, address multiple areas of focus, and continue over extensive periods of time.

Some of the previous and the most commonly used treatment options are explored in further detail below:

#### 2.3.2.6.1. Medication/Pharmacotherapy

Pharmacotherapy is not recommended as the first line of treatment but should be considered in adolescents that have failed to respond to other types of treatment/interventions and that show escalating levels of dangerous aggression and violent behaviour (Buitelaar *et al.*, 2013). In addition, research indicates that the effectiveness of medication, especially certain types of medication, is inconclusive. Pharmacotherapy is usually most effective when administered in combination with other psychological/behavioural interventions.

Neuroleptics such as, Risperdal, Clozaril, Haloperidol, and Mellaril can be effective when excessive violent behaviour or agitation is the primary feature of CD (Buitelaar *et al.*, 2013; Kronenberger & Meyer, 2001; Sadock & Sadock, 2005). However, they do sometimes have worrisome side effects.

Stimulants, such as Ritalin, can also be used, especially when there is a co-morbid diagnosis of Attention Deficit Hyperactivity Disorder (ADHD). They are beneficial in the treatment of aggression when CD is comorbid with ADHD (Buitelaar *et al.*, 2013). Other types of medication such as antidepressants and mood stabilizers have been utilised, but more specifically when a co-morbid diagnosis exists or for the treatment of the aggression associated with CD (Buitelaar *et al.*, 2013; Kronenberger & Meyer, 2001).

In general, there is no single, widely used and accepted pharmacological treatment for CD and it is common practice that multiple medications are used (Kronenberger & Meyer, 2001). In addition, Buitelaar *et al.*, (2013), argue that non-medical psychosocial interventions are recommended as the primary option for treating CD. However, there is a role for medication in the treatment of any comorbid syndromes as discussed above (Buitelaar *et al.*, 2013). Unfortunately, not all psychosocial and psychological treatments have been proven to be beneficial.

#### 2.3.2.6.2. Cognitive Behavioural Therapy (CBT)

This psychotherapeutic approach has dominated treatment approaches to treating adolescents that present with CD (Kronenberger & Meyer, 2001; Wenar & Kerig, 2000). This model addresses the adolescent's thoughts and behaviours with regards to three primary deficits suggested to have been

found in adolescents with CD: social relationships, problem solving and anger management (Kronenberger & Meyer, 2001). However, this model fails to address the underlying relationship and the poor attachment that the adolescent often has with his/her primary caregiver.

#### *2.3.2.6.3. Behavioural Programmes*

Another psychotherapeutic approach that has played an important role in the treatment of CD and other behavioural disorders is that of the behavioural programmes. According to McDiarmid and Bagner (2005), behavioural programmes have historically played a central role in the treatment and management of adolescents and children with disruptive behaviour disorders. Typically, behavioural programmes involving authorities and based either at home or at school are also one of the most commonly used treatment approaches (Kronenberger & Meyer, 2001). Home based programmes often involve psychoeducation for the parents themselves especially around parental behaviour and concepts such as rewards and punishment as well as some information around the diagnosis of CD itself (Kronenberger & Meyer, 2001).

#### *2.3.2.6.4. Systemic/Ecosystemic Therapy*

In systemic family therapy, the behavioural problems displayed by the adolescent are viewed in the context of the functions that they serve within the family. Thus, the goal of the family therapy, involving all members of the family, is to assist the family members communicate and problem-solve in more meaningful and less maladaptive ways that allow them to meet these needs more satisfactorily (Wenar & Kerig, 2000). These processes and interventions aimed at the family dynamics therefore reduce the acting out behaviour of the adolescent. However, there is little research available on the effectiveness of this type of intervention.

#### *2.3.2.6.5. Parent Management Training (PMT)*

This form of intervention teaches the parents consistent parenting, the role of positive and less harsh discipline techniques, monitoring the child as well as the importance of positive feedback (Buitelaar *et al.*, 2013; Forgatch & Patterson, 2010). These types of programmes are usually effective in decreasing aggressive, non-compliant and oppositional behaviour. However, parental stress, psychopathology as well as a lack of motivation and perseverance can become problematic in the implementation of this intervention (Buitelaar *et al.*, 2013; Forgatch & Patterson, 2010). In addition, research (Buitelaar *et al.*, 2013) has shown that the efficacy of PMT has been limited to younger children (8 years old) (Stratton & Taylor, 2001).

#### 2.3.2.6.6. *Anger Management*

Anger management programmes can be used to address the adolescent's anger outbursts and emotionally related behaviour difficulties as well as assisting them in containing their own anger and emotional states through the teaching of skills (Lochman, Boxmeyer, Powell, Barry, & Pardini, 2010). These interventions can be delivered at a group or individual level (Murryhy, 2010). Kronenberger and Meyer (2001), suggest that there are typical components of an anger management programme. These include psychoeducation, goal setting, arousal awareness, situational awareness, cognitive awareness, and anger control strategies which include relaxation and distraction techniques, self-talk, anticipation of consequences and assertion training. Problem-solving and social skills training techniques can also be incorporated into anger management programmes (Kronenberger & Meyer, 2001; Lochman *et al.*, 2010; Murrihy, 2010).

#### 2.3.2.6.7. *Inpatient Treatment/Hospitalization*

Hospitalisation can become necessary for adolescents that display severe behavioural difficulties such as the level of harm that the adolescent presents to him/herself or others. Kronenberger & Meyer (2001), suggest that adolescents that present with a diagnosis of CD as well as a comorbid diagnosis of depression (Capaldi, 1991; Capaldi & Kim, 2014) need to be evaluated for self/injurious or suicidal behaviour. Additionally, adolescents with CD continuously place themselves in dangerous positions (through thrill seeking behaviour, stealing, acquiring drugs etc.) becoming a danger to themselves, and may also become a danger to others through threats, predatory behaviour or revenge seeking (Capaldi & Kim, 2014; Kronenberger & Meyer, 2001). Sometimes the environment in which an adolescent diagnosed with CD is in may be dangerous due to physical, verbal, sexual or emotional abuse and short-term inpatient care can assist in the management of not only the adolescents acting out behaviour, but also the home environment can be attended to (Kronenberger & Meyer, 2001).

The inpatient hospitalisation of the adolescent, along with adolescents struggling with similar behaviours, allows a new behavioural plan to be implemented targeting compliance, the following of rules and promotion of prosocial behaviour through the use of rewards and privileges (Kronenberger & Meyer, 2001). However, it is often the case that these adolescents are difficult to contain within a hospital or residential care environment and they are often discharged within a couple of days (Case, Olfson, Marcus, & Siegel, 2007; Penzerro & Lein, 1995).

#### 2.3.2.6.8. *Structured Environments*

These types of environments would be places such as a youth development centre where a structured and consistent environment is offered to adolescents with a diagnosis of CD. Sadock & Sadock (2005), suggest that an environmental structure that provides support along with rules and consistent consequences, such as a youth development centre, can assist in controlling a variety of problematic behaviours displayed by CD adolescents. Specialised programmes are suggested to be designed to contain and manage these youth (McIntyre, 1993). These environments are especially beneficial if the child/adolescent lives in a family that is especially chaotic or abusive and would then benefit from being removed and placed in such a placement centre (Frensch & Cameron, 2002).

#### 2.3.2.6.9. *Psychodynamic psychotherapy*

A review of the various literature (*Evidence Based Practices*, 2001; Kazdin, & Weisz, 1998; Kronenberger & Meyer, 2001; McDiarmid & Bagner, 2005; Sadock & Sadock, 2005; Wenar & Kerig, 2000), has not suggested that psychodynamic therapy is useful when working with adolescents with a diagnosis of CD. This research challenges this presumption when psychodynamic therapy is conducted in conjunction with the EAP. Thompson (2002) however suggests that in the instance of violent children and adolescents, psychodynamic theory is uniquely positioned to understand their violent behaviour. Furthermore, there exists a connection between understanding and forgiving and in order to be able to understand and forgive a willingness to conform to social expectations and be a productive member in society should be the result (Thompson, 2002).

Interventions with adolescents diagnosed with CD are necessary and should show behavioural change. Kronenberger and Meyer (2001), report that the diagnosis of CD may predict later chronic substance abuse and overall poor quality of adult life. CD is associated with a high death rate, unemployment, marital conflict, and poor interpersonal relationships as well as financial instability (Kronenberger & Meyer, 2001).

While studies in AAT are increasing globally (Chandler, 2005), studies conducted in South Africa on AAT remain few. What can be found are studies using younger child participants and focussing more on children with physical disabilities (Naidoo, van den Berg, & Hayes, 2006). In addition, studies have been conducted exploring animal affiliation and its effects on patients (Odendaal, 2000), or ideas around the animal-human bond as in the effects of pet ownership (Lubbe & Scholtz, 2013; Odendaal, 2002). The effect of Equine Assisted Psychotherapy (EAP) on adolescents diagnosed with CD in South Africa has not been adequately researched. Therapeutic

work with adolescents, who present with the above-mentioned symptoms, may be possible with the use of animals and more specifically horses, being horses, offer a genuine, non-judgemental, and real relationship that no human could offer. As Winston Churchill once stated, “the outside of a horse is good for the inside of a man.” (Chandler, 2005, p. 128).

The next section will focus on the use of animals in psychotherapy, Animal Assisted Therapy and more specifically on Equine Assisted Psychotherapy.

## **2.4. Animal Assisted Therapy (AAT)**

This section focuses on descriptions, definitions and information pertaining to animal assisted therapy (AAT). Equine assisted psychotherapy (EAP) is a form of AAT.

### **2.4.1. Defining AAT**

The available literature on AAT provides a vast source of definitions relevant to this type of therapy that are important to understand as a basis for this study.

Animal Assisted Therapy (AAT) has been defined as a goal directed activity in which an animal that meets specific criteria is used as an integral part of the psychotherapeutic treatment process (Lentini & Knox, 2008). Fine (2010) distinguishes between AAT and other animal assisted activities such as recreational, animals as companions, hospital visits and so on. The latter are informal, unstructured and without evidence of effectiveness (Fine, 2010; Smith-Osborne & Selby, 2010). An example of a psychotherapy session utilizing AAT would be the trained psychotherapist including an animal, such as a dog, in the therapy session. Animal assisted therapy (AAT) has also been defined as a process utilizing the “animal-human” in the therapeutic process (Delta Society, 1997). Furthermore, animal-assisted therapy has been defined by Pet Partner’s (2018) as a “goal-orientated, planned, structured and documented therapeutic intervention...”.

Furthermore, AAT is not a style of therapy like cognitive behavioural therapy (CBT) or psychodynamic psychotherapy, but rather involves a registered therapist working from his/her paradigm of choice and utilizing an animal that is present for part or all the therapy sessions. Through the client’s interactions with the animal the therapist is able to obtain information about the client and devise further activities in order to enhance change (Delta Society, 1997).

### **2.4.2. The different uses of animals and animal assisted activities**

Animals such as dolphins, cats, and dogs as well as horses have been used for a multitude of different therapeutic reasons as indicated by various studies (Fine, 2010; Smith-Osborne & Selby, 2010; Davies & Collins, 2015; LaFleur, 2015). Examples of this form of animal assisted activity are



dogs being taken to old age and nursing homes, people swimming therapeutically with dolphins, and rabbits, cats, and hamsters being used in individual psychotherapy sessions. This type of activity not only assists in the individual's rehabilitation but has also been found to be effective in increasing self-confidence and self-efficacy (Chandler, 2005). Physical disabilities that can be included in treatment include multiple sclerosis, head injuries with concomitant physical impairments, spinal cord injuries, scoliosis, and cerebral palsy (Chandler, 2005).

Hippotherapy has been described as the use of horses to improve neuro-motor function (Children's Therapy Foundation; Zadnikar & Kastrin, 2011). It is usually provided by trained physical and occupational therapists and is based on the idea of transfer of movement from the horse to the patient (Smith-Osborne & Selby, 2010; Zadnikar & Kastrin, 2011). This type of animal assisted activity differs importantly from equine assisted psychotherapy (EAP), a form of AAT (Fine, 2010). During hippotherapy the patient mounts and rides the horse (Zadnikar & Kastrin, 2011). EAP involves activities with the horse which may include non-mounted activities such as observing horses in a pasture, catching a horse, putting a halter on, and leading a horse, grooming, bathing, talking to the horse, building obstacles, and leading the horse (Lentini & Knox, 2015). In contrast, therapeutic riding, incorporates horseback riding (the actual mounting of the horse) in order to promote cognitive, physical, emotional, and social well-being for individuals who have special physical needs (Lee, Dakin, & McLure, 2016). This type of equine assisted activity would involve a horse specialist and possibly the use of a physiotherapist as well and is helpful for children with cerebral palsy and Down's syndrome.

As this research focuses on the use of horses, it is important to define and explore the different approaches currently in use with regards to equines. Relevant literature and studies indicate that horses are being used in a variety of contexts and in a variety of therapeutic mediums (Davies & Collins, 2015; LaFleur, 2015; Wach, 2014). Lee, *et al.* (2016) define four different approaches to equine-based mental health interventions which vary in terms of their goals; Equine assisted learning (EAL) and equine facilitated learning (EFL) focus more on learning goals, whilst equine assisted psychotherapy and equine facilitated psychotherapy address treatment goals such as treating depression, and/or anxiety etc. There is often confusion amongst these different forms of modalities as they share many similarities. Carey (2016) provides a differentiation between these approaches by the qualification of the facilitators which, in the case of EAP and EFP are those with a qualification in mental health, whilst in EAL and EFL the facilitators typically hold a qualification in group facilitation and coaching. This research focuses on equine assisted psychotherapy and the treatment of conduct disorder in adolescents, specifically from a psychodynamic perspective.

### **2.4.3. *Animal Assisted Therapy and Juveniles***

Meta studies have shown that animal assisted therapy (AAT) may be an effective intervention for troubled adolescents (Fine, 2010; Nimer & Lundahl, 2007; Odendaal, 2000; Smith-Osborne & Selby, 2010). Chandler (2005) reports that the juvenile detention centre of Denton County in Texas has thoroughly incorporated AAT into their Post Adjudication Program. All the juveniles involved in the program are repeat offenders with theft and drug possession as the most common offenses (Chandler, 2005). In addition, many of the juveniles have the opportunity to participate in equine assisted therapy programmes at a therapy centre. Chandler (2005), goes on to report that there are several successful equine therapy programmes designed to assist troubled adolescents across the United States of America. These troubled adolescents are paired with horses and are responsible for all aspects of their care, including grooming, feeding, exercise and cleaning of their stables. The good effects of such programmes are reflected in this comment, “When I came here, I had an anger problem....Working with horses has really helped me out. It’s given me a good perspective on animals, on how to treat them properly” (Chandler, 2005, p. 137). Meta studies completed on equine assisted programmes include a systematic review by Selby and Smith-Osborne (2013). This meta study indicated some evidence of biopsychosocial benefits. However, their recommendation is that further studies need to be conducted to establish effective treatments.

A literature review conducted by O’Haire (2013) whereby 14 studies were reviewed specifically focusing on autism spectrum disorders indicated that AAT improved multiple areas of functioning such as increased social interaction and communication as well as decreased problematic behaviours. Furthermore, it was concluded that as a concept, AAT is useful, but that more research is required (O’Haire, 2013).

### **2.5. *Equine Assisted Therapy (EAP)***

Equine Assisted Psychotherapy (EAP), is a form of AAT and it is a planned psychotherapeutic treatment using the horse as an integral part of the therapeutic process (Lentini & Knox, 2008) as previously mentioned. It is a fairly new, innovative, and emerging approach to mental health treatments (Lee et al., 2016). There are a number of organisations that have emerged in this field locally and internationally including, but not limited to the Equine Assisted Growth and Learning Association (EAGALA), the Federation of Horses in Education and Therapy (HETI), the Equine Association of Guided Education (EGEA) and EPONA (Carey, 2016) as well as locally the Equine Assisted Psychotherapy Institute of South Africa (EAPISA). EAPISA was a fundamental component of this research. Equine assisted psychotherapy (EAP) involves activities with the horse which are designed to coordinate with the overall psychotherapeutic treatment of the patient/client (Fine,

2010). Furthermore, EAP, is designed to be short-term, intensive, and experiential (Pointon, 2005). The sessions that last between an hour and an hour and a half are facilitated by a team comprising of a therapist (clinical or counselling psychologist or social worker) and a horse specialist (Pointon, 2005). Smith-Osborne and Selby (2010) refer to Equine facilitated psychotherapy (EFP) as ““experiential psychotherapy that includes equine(s)” ... delivered by a licensed mental health professional in conjunction with a credentialed equine professional” (p. 294).

The experimental nature of EAP is especially important when working with adolescents. It allows adolescents, individuals in a very critical period of development, to experiment with their behaviour, try out new ideas and behaviours and examine whether they were more or less effective than behaviours applied beforehand (Wilson, Buultjens, Monfries, & Karimi, 2015). The horse allows for a genuine and honest answer with regards to how these behaviours can affect others around them. This is insight that may not be gained during traditional talk-therapy due to the interference of counter-transference. Non-talk based therapies can actually enhance children’s well-being (Dunlop & Tsantefski, 2017).

This type of therapy is not focused on riding skills, but is more about the activities, including the catching and grooming of the horse that take place on the ground with limited equipment (Pointon, 2005). EAP is designed to boost skills like non-verbal communication, assertiveness, leadership and problem-solving and can be employed particularly powerfully with eating disorders, substance abuse problems, depression, and behavioural difficulties (Pointon, 2005).

It is also important to remember that ‘EAP is not activity driven but process driven’ (EAP Practice). Since EAP happens around an activity with the horses, this can be hard to remember. The therapy is not about the activity or the content that the client brings to the sessions, but rather the process around what the client brings. As Mandrel (2006), states it is more important how the client handles the process and the experience is more valuable than the content.

Since the EAP sessions happen around a current activity being performed, EAP focuses on the ‘here and now’ (EAP Practice). Horses allow the client to ‘see’ what is going on in the present moment (the here and now) in the current environment as they are affected by the current context (EAP Practice). The process is experiential and hands-on (Ewing, MacDonald, Taylor, & Bowers, 2007). The size and power of the large animal is used in the therapeutic context which facilitates a social learning experience which is physical in nature (Ewing et al., 2007). AAT, and thus EAP, generally is seen to be consistent with other types of psychotherapy (Fine, 2010) such as Gestalt psychotherapy, systems theory, and interactional analysis.

EAP is a team approach involving the client, a qualified, registered counsellor/psychologist/social worker, horse specialist, also known as an equine specialist, and the horse(s).

Furthermore, it includes a sequence of interactive horse activities for the purposes of individual or group problem-solving, goal setting, awareness, and trust as well as processing (Mandrell, 2006). The activities with the horses are designed to coordinate with the overall psychotherapeutic treatment of the patient/client (Fine, 2010).

Furthermore, EAP is a non-judgemental and client-centered approach assisting clients cope with change and face life's challenges/struggles "through the use of team-building activities with horses" (Mandrell, 2006, p. iv). It is non-threatening in nature. In addition, EAP is not a paradigm in itself, but rather a form of psychotherapy, that attaches itself to an already recognised form of psychotherapy such as cognitive behavioural therapy, systems theory, gestalt, or psychodynamic psychotherapy.

EAP involves many principles. One of the 'biggest' principles of EAP is observable behaviour (Mandrell, 2006). The EAP team observes the client's behaviour/interaction with the horses as well as the horse's non-verbal behaviour and reflects on this. This allows everyone involved to better understand and recognise their patterns of interacting within relationships (Mandrell, 2006). These patterns of interacting may include rules i.e. rules of inclusion or exclusion and through observing the client's behaviour, these interactional styles, and rules of relating will become clear. They can then be reflected and processed, which will enable change to occur. Thus, the nature of the relationships in EAP is interactional. Therapeutic goals and alleviation of the presenting complaint are achieved through the use of the information that is gained through the interactions/the 'space' between the client and the horse.

As the therapist and horse specialist it is important to remember that one also forms part of the system/have an impact on the relationships within the system; one is also a participant in the system. Thus, the therapist also has an impact on the client's interactional style as everything he/she does is a form of communication (verbal or non-verbal) and one cannot not communicate (Mandrell, 2006). The therapist cannot simply observe behaviour, as a participant he/she also has an impact on the system. Even the context (environment) has an impact on the client and his/her interactional style.

### ***2.5.1. Advantages of EAP***

There are various benefits and advantages of EAP. These benefits are usually long-term and can generally be generalised. Mandrell (2006) describes a few, in depth, which are listed below:

- An opportunity is created to practice new skills and learn how to transfer them back to 'real life situations': This allows individuals to develop insight and skills and transfer them to their real-life;

- All aspects of the person are involved in order to generate change: EAP engages the whole person (the physical, emotional, and spiritual parts) in a natural environment that is suited to holistic healing;
- EAP provides the individual with a non-threatening and motivating learning environment: The client is encouraged to explore their true selves in a challenging, accepting, conscious and supportive environment,
- EAP assists in empowering clients through giving them a sense of control: Clients come to feel that they can deal with anything that their environment presents to them. This is in part due to the realisation that they cannot control a horse and through relinquishing this illusion of control, they acquire more internal control and thus an increase in self-confidence.
- EAP reveals an ability within the client to make their own decisions and take responsibility in their life; working with the horses enables clients to identify and access their own inner abilities for healing.
- EAP assists in breaking down defence barriers: As the focus of the sessions is on activities with the horse(s), it is possible that the client is distracted by these activities, which aids the therapist in getting a more authentic picture of the client. Furthermore, genuine and consistent behaviour is required when working with horses, for success as they can quickly distinguish between lies and authentic behaviour;
- EAP enhances problem-solving skills: EAP activities are designed to help the client think outside of his/her standard means of operation and mirror the client's feelings or thoughts e.g. "I can't do this/I have tried everything", encouraging them to problem-solve.
- It teaches empathy, responsibility and patience: In the arena, the client becomes aware of behaviour that impacts others as well as any safety concerns. As EAP is a team approach, other individuals in the arena must be thought about and patience may need to be developed.
- It provides immediate cause and effect situations: Horses are constantly taking care of their basic needs and thus operate on an immediate cause and effect basis. The client can immediately see the results (effect) of their behaviour on another (horse).

- It assists in building trust in relationships: As EAP activities involve a lot of teamwork and communication, the client develops trust. Furthermore, some level of trust is necessary in the horse.
- EAP stimulates creativity: Clients need to become creative in their problem-solving abilities otherwise they will not be very successful.
- Decreases feelings of hopelessness: A core belief of EAP is “there is always more than one way to do things” (Mandrell, 2006, p. 34). This encourages the client to problem-solve and seek new choices thus feeling empowered.
- Assists in improving self-concept: When the client accomplishes the activities, their confidence will improve, and they start to believe in their own value.
- Increases the client’s internal locus of control: During the course of EAP the client will become aware of what he/she can control and what they can’t i.e. the horses. This enables them to take responsibility for their actions, thus improving their internal locus of control.
- EAP is captivating and holds an individual’s attention: Working with horses can maintain your client’s attention and interest as the horses will continuously re-involve the client in an activity thus minimising the possibility that the client may become uninvolved or disengaged, a possibility in traditional ‘talk-therapy’;
- Lessons on an emotional level are conveyed: Intense emotions can be generated during the EAP sessions which can be raw. The context of the EAP sessions allows these emotions to be safely explored.
- EAP promotes change in the client from dysfunctional to functional patterns: The activities encourage people to explore and try new ways of coping that are more functional in nature.

### ***2.5.2. Disadvantages of EAP***

There are very few disadvantages discussed in the literature on the use of EAP. In which case, it may be more pertinent to discuss the disadvantages more relevant to South Africa.

- Horses are not easily accessible to all members of the population, with some people not having ever seen a horse before;
- EAP is expensive and is currently only accessible to patients in the private sector. Government facilities do not provide EAP in South Africa;

### ***2.5.3. Historical Overview of AAT and EAP***

The relationship between animals and humans has for many decades been known to provide meaningful relationships (Kakacek, 2007). According to research, even ancient civilizations have used animals in treatment goals and the first documented case was in England in 1966 (Kakacek, 2007). Kakacek (2007), further states that this case utilized cats and dogs as relaxation techniques for the mentally ill. As discussed above, numerous studies have since confirmed the advantages of the human-animal relationship and have concluded favourably in its use for patients with a mental illness. Animals have long influenced the development of psychological theories as the case of the famous Pavlov clearly illustrates. The use of animals, in Pavlov's case, a dog, in the development of therapeutic techniques based on the conditioned response theory could be formulated. As early as 1942 a pilot study was conducted at an Army convalescence hospital in the United States of America (Kakacek, 2007). These patients were exposed to animals in order to assist with their recovery and the results of the study found that the patients reported less anxiety (Kakacek, 2007).

With regards to the use of horses as therapeutic mediums, this too has been recognized for hundreds of years. Pointon (2005), suggests that its roots lie in the 18<sup>th</sup> century where horseback riding was recommended in Germany to reduce attacks of hysteria and hypochondria. Since the 1950's horseback riding has been recognized in Europe and the United States of America as a form of therapy to benefit people with physical disabilities (Pointon, 2005). However, it is only in the past few decades that the psychotherapeutic dimension of horseback riding has begun to be fully explored (Pointon, 2005).

For many years' humans, have drawn considerable benefit from their relationships with animals. Animals have made it possible for humans to accomplish essential and vital functions such as food, protection, and the generation of resources such as transport (Chardonens, 2011). Furthermore, animals have also long been recognised for their therapeutic benefits (Burgon, 2011). They have been used for over 300 years in mental health interventions and have been shown to have both physiological effects as well as improve children's social networks and reduce anxiety, increasing self-esteem (Holmes, Goodwin, Redhead, & Goymour, 2012). However, horses would appear to have perhaps been far more helpful in psychotherapy than any other animal. Horses have been recorded through history as healing agents and have had a long relationship with humans (Burgon, 2011).

### ***2.5.4. The Development of AAT and EAP in South Africa***

One of the first institutes for EAP, the Equine Assisted Psychotherapy Institute of South Africa – EAPISA was developed in South Africa in 2007 by the clinical psychologist Kim Kidson (Equine

Assisted Psychotherapy Institute of South Africa, 2017). Although, this field of work is relatively new, new organisations with qualified Equine Assisted Psychotherapy (EAP) therapists can be found all over South Africa, despite the lack of South African Research on this type of therapy. An example is the Mizpah Farm Retreat in the Kwa-Zulu Midlands.

## 2.6. Why horses?

*“Horses are honest, they typically do not come with a lot of emotional baggage, and they do not invest energy in “looking good” and in trying to be something they are not.”*

(Chandler, 2005, p. 110).

Why horses? What is the benefit and value of using horses in psychotherapy? This section will explore these phenomena in more detail as well as comparing the use of horses to other animals in psychotherapy and the value that horses add to our lives.

The mere presence of horses in the therapeutic milieu can contribute towards peace, serenity, confidence, and the development of trust (Bachi, Terkel, & Teichman, 2011). Horses are excellent therapeutic facilitators, especially where there is an objection to ‘going to a psychologist’. During the therapeutic process, the horse is utilised as agents of change, or objects, to allow for the processes of development, learning and growth within the client (Wilson, Buultjens, Monfries, & Karimi, 2015). They are non-judgemental and project love, acceptance, and the Rogerian concept of unconditional positive regard (Bachi *et al.*, 2011). Furthermore, they can assist, especially in South Africa, a country with 11 official languages, to overcome the limitation of language as their medium of communication is non-verbal (Wilson *et al.*, 2015).

Whittlesey-Jerome, Schultz, and Tomaka (2016), state that anecdotal evidence has shown that most male adolescents respond favourably to horses and that males can benefit from caring for animals. Through caring for and nurturing an animal, male adolescents can experience giving as well as receiving nurturance, a skill not necessarily encouraged in certain cultures (Whittlesey-Jerome *et al.*, 2016). Furthermore, anecdotal evidence also suggests that female adolescents respond to horses in a positive way and that girls tend to define themselves in terms of relationships (Whittlesey-Jerome *et al.*, 2016). Thus, the use of horses with the type of population that this research involves is ideal.

Chandler (2005), states that horses instinctively mirror human’s attitudes, emotions, and behaviours without allowing baggage to interfere. Thus, horses reduce the countertransference in psychotherapy (projection of one’s own thoughts/feelings/attitudes onto the client – to be further discussed in Chapter 3). A horse also encourages dialogue to be created between the client and the



horse as they may appear less threatening than talking directly to a therapist thus encouraging and fostering the therapeutic relationship. Horses offer both emotional and physical comfort and thus the development of trust and confidence, something that the therapist as a human-being is not always able to provide (Wilson *et al.*, 2015).

The honesty of horses and their genuineness force the client to interact in the same manner (Mandrell, 2006.). In addition, horses are also experts at non-verbal body language and communication, which enables them to highlight the client's incongruence and areas of difficulty. Roberts (2001), states that horses communicate through their body language. The horse is a prey animal and its highly-developed sense of smell and eyesight plays an important role in their communication (Roberts, 2001). Through being able to read and determine what their body language is communicating with us, they add valuable information to the therapeutic sessions. Each part of the horse, such as their eyes, mouth, tail, neck, ears, position of feet as well as the noise that they make communicates something with the human. For example, a highly-held head could possibly indicate tension, fear, or excitement. However, the position of the head would need to be interpreted with the rest of the body parts/body language. All of these separate parts that make up the horse can also be viewed as a whole, also communicating with the human.

Many of the benefits of using horses in psychotherapy are similar to those of AAT. However, horses have additional qualities, when compared to other animals, partly due to their large size and power as well as their inherent vulnerability and unique characteristics (Burgon, 2011). Mutual body language exchanges (such as grooming, petting etc.) fosters a deeper emotional connection, supporting the growth of a meaningful relationship as horses will seek the affection of someone who caresses them by getting physically closer (Bachi *et al.*, 2011).

Mandrel (2006), further suggests that the activities with the horses provide a metaphor for life experiences as well as relationships and allow tools for success to be developed (improved work ethic, responsibility, assertiveness, communication, and healthy relationships). Furthermore, the participant is given the opportunity to try out different behaviours and receive valuable feedback from the horse with regards to these behaviours (Mandrell, 2006).

When compared to cats, horses are more social animals as they form part of a herd. Cats have been described as independent, not easily swayed, or manipulated and self-reliant (Mandrell, 2006), and exist independent of humans and others. Horses foster relationships, whereas a cat's responses lead to isolation and loneliness. Mandrell (2006), argues that cats often think impulsively and usually only of themselves. Traits that can be problematic when mirrored in humans and that do not allow for a relationship whereby change can be fostered to occur.

Dogs are similar to horses in that they offer unconditional love and acceptance without judgement. They have also been used for years for therapy such as assisting humans with impaired

sight (guard dogs), impaired hearing and to alert their owner when they are at risk of an epileptic seizure (Mandrell, 2006). Although dogs have similar qualities to horses that are useful in psychotherapy, fundamentally they are predators which mean that their natural reaction when fear is present is to attack and be on the defensive (Mandrell, 2006). This is very different to the fight or flight response of the horse where usually the horse runs when under attack. In addition, dogs usually automatically give the human the dominant, leadership position (Mandrell, 2006). This detracts from the therapeutic benefit of allowing the participant the opportunity to grow and develop trust and respect.

In addition, Roberts (2001), suggests that horses are both flight and herd animals and that their phenomenon of advancing and retreating is an essential part of the communication process. Horses have strong social bonds as they are members of a herd and herd behaviour is based on cooperation with each horse having a 'place' and a leader (usually an older, wiser mare) (Burgon, 2011). This makes them highly suitable for therapeutic work (Bachi *et al.*, 2011). Through the process of domestication, horses have come to view humans as part of their herd (in some respects) which would appear to provide the underlying basis for the bond between humans and horses (Bachi *et al.*, 2011). The observation of the dynamics and interactions amongst the herd when running free in a paddock enables mirroring (of both the other horses as well as a human in a therapeutic interaction). This is facilitated by the therapist and used as a catalyst in the treatment process (Bachi *et al.*, 2011). However, it is important for the human to take on the leadership role. For successful EAP, it is important to select an appropriate horse. Like each human is unique with their own memories, life experiences and behaviours, so are horses. Bachi, *et al.*, (2011), argue that herd dynamics are associated with life-cycle processes such as courtship, coupling, birth, friendship, rejection and abandonment, injury, and death. The psychotherapeutic process allows these topics in relationships to be addressed as per their appearance/perception to the client. Trauma, primary experiences, and perceptions that have been consolidated in the cognitive and emotional mapping of the client are thus allowed to be explored and processed (Bachi *et al.*, 2011).

An additional comparison and value of using a horse to another animal, is that they (the horse), is highly sensitive to others in their surroundings and have the ability to provide feedback (Bachi *et al.*, 2011). A horse has the ability to induce interactions during the course of therapy that facilitate the processing of significant difficulties. Horses are also relatively flexible on a behavioural level which allows them to adapt to persons/situations as well as to sense the person and respond to them (Bachi *et al.*, 2011), which other animals such as dogs and cats are not able to do.

Horses can also be particularly helpful in certain areas. Bachi *et al.*, (2011), suggest that association with the horse as powerful, noble, intuitive, strong, and large improves the development

of a positive self-image. It allows aggression to be redirected in a creative and positive manner. Furthermore, the gentle nature of a horse facilitates a sense of freedom and openness, which is particularly important with regards to clients with negative social stigma (Bachi *et al.*, 2011).

The connection that a human creates with a horse also has significant value. Bachi *et al.*, (2011), argue that a connection to animals (horses) especially during old age and childhood can positively affect the human personality and allow for the development of internal and interpersonal skills. This is in part due to the nature of the relationship and bond that we form with the horse. Just interacting with a horse adds value to an individual's life. Metaphorically, when a person cares for and invests in a horse they are investing and caring for themselves (Bachi *et al.*, 2011). Furthermore, it is argued, that by merely standing next to a horse at 'eye-level' a sense of relaxation, openness and confidence can be achieved (Bachi *et al.*, 2011). The mere presence of horses in therapy can contribute to serenity, confidence, and the development of trust (Bachi *et al.*, 2011). Through the mere grooming of a horse the encouragement of dialogue between the individual/client and the horse is created. This space is intimate, private, and unique to each and every individual.

### **2.6.1. *The language of the horse/equine***

*“The body language of horses offers profound lessons  
for communication between humans.”*

(Roberts, 2001, p. 32).

In order to fully grasp the concept of EAP, it is vitally important to understand how a horse communicates and how this communication can be used therapeutically. The horse is a visual thinker and has an extraordinary ability to sense the intentions of those around them (Roberts, 2001). Roberts (2001), states that horses communicate through their body language. Through being able to read and determine what their body language is communicating with us, they add valuable information to the therapeutic sessions.

There are parallels between the way in which horses and humans perceive the world around them and record information (Roberts, 2001). By understanding these parallels, we can understand how humans communicate.

In order to survive in the wild, a horse must be aware of everything around him/her. They must always be on their guard and aware of every element of their environment (Roberts, 2001). Horses startle at the slightest thing such as a bush or dog. The horse will always be aware of that object. Similar to how the human is always aware of a traumatic event or distractibility. A

distractible child is at a grave disadvantage in the classroom and often misunderstood. Similar to a horse, a distractible child may have his/her attention drawn off by some minor detail. However, a horse's distractibility is also an advantage. Many people need to multitask and be aware of a lot of things around them, thus allowing them to do so (Roberts, 2001).

Roberts (2001), describes the notion of advancing and retreating. A horse's first reaction to a predator is to flee, using speed to escape from danger. When the attack has been avoided, the horse will stop and look back in order to reassess its situation. A horse will retrace his/her steps to the area of the attack in order to determine the nature of the predator, keeping track of its presence and appraising any current threat (Roberts, 2001). This is known as advance and retreat and is an essential part of the communication process. Humans also advance and retreat. Furthermore, when a horse decides to approach the human out of his/her own volition, he/she is communicating that they would like to enter into a relationship with the human. This is the process of 'join-up'. The process of 'join-up' is vitally important to understand in the EAP process. A horse 'joins-up' with you when they feel that you are congruent and would like to be submissive to you, in a partnership. The horse will approach you, head down and neck bowed with licks and chews (when the horse looks like he/she is eating something).

The first gesture that predators make whilst stalking their prey is to lock eyes with them (Roberts, 2001). Eye contact signals interest and communicates commitment as well as maintaining communication. According to Roberts (2001), the lack of eye contact can be interpreted in many ways; it may demonstrate a lack of self-esteem, and/or sincerity, and the presence of confusion and/or fear. With horses when a human looks away, they are passive and if they stand square and eye to eye, they may be defiant.

## **2.7. The therapeutic setting**

In EAP great significance is placed on the physical setting in therapy (Bachi *et al.*, 2012). A typical setting where EAP takes place involves the stable, the lunging arena, a dressage arena and a show jumping arena or open paddock.

This setting can allow for interpretation in various ways and an example is a client that is approaching a stable can hide the fact that they are in therapy, which as Bachi *et al.*, (2012) state is useful for adolescents in psychotherapy as they are also struggling with identity formation and may struggle with being labelled a patient. Furthermore, the location may have symbolic meaning, or a horse stable can be experienced as homely, intimate, and protective.

The setting also provides various equipment for use in the activities with the horses. This equipment includes jumping poles, tyres, fences (which are useful for the projection of difficulties

related to boundaries), numbers and letters, old coke bottles, rope, halters, lead reins, grooming kits, and other miscellaneous items that you might find on a farm/in a stable, or that is introduced by the therapists. In addition, there are also the natural surroundings, which can be a very relaxing, non-threatening environment promoting openness. Psychotherapy carried out in a different environment to the traditional one (an office or hospital setting) may enable different aspects of the client to emerge and be expressed (Bachi *et al.*, 2012).

As previously discussed, it is important to select the appropriate horse according to the client as well as the presenting problem. For example, a horse that acts out a lot by kicking and biting, may not be ideally suited for an adolescent that is very anxious and depressed. This may be challenging especially if the client does not know horses and is wary of them. However, this can be used therapeutically.

## **2.8. The use of EAP with behavioural disorders**

As previously mentioned, there is very little data/research on both the use and efficacy of EAP with adolescents that struggle with behavioural disorders/conduct disorder, more specifically from a psychodynamic object relations perspective. A literature search revealed studies on the use of EAP from a Gestalt perspective (Lac, 2014) as well as a client-centred perspective (Rogerian), but none could be found from a psychodynamic perspective. Furthermore, the Equine Assisted Psychotherapy Institute of South Africa practices EAP from an Interactional Pattern Analysis (IPA) paradigm. Lentini and Knox (2015) argue that although the use of EAP has expanded over the past three decades and a number of books, studies and other literature has been published, there is little consensus in the field regarding best practices. Furthermore, EAP has not been established as evidence-based treatment for any disorder of childhood or adolescence (Lentini & Knox, 2015).

In their study, Lee *et al.*, (2016) reviewed the current literature available on EAP. They reviewed 24 qualitative and quantitative empirical studies (4 published and 20 unpublished), including articles published in peer-reviewed journals as well as research presented in dissertations. They concluded that additional research is needed to explore the effectiveness of EAP for different clinical populations such as autism, trauma, substance abuse and risk for social and academic failure. Thus, this research attempts to fill some of the gap in research with focusing on a specific clinical concern, that of adolescents diagnosed with conduct disorder and more specifically from an object-relations perspective, which will be discussed further in Chapter 3.

However, a literature review revealed some studies such as Whittlesey-Jerome *et al.*, (2016), state that in a study (Ewing *et al.*, 2007), of children 10 to 13 years of age, clinicians saw improvements in emotional disorders when using equines in therapy. Furthermore, in five different

studies reported by MacDonald amongst at-risk children and youth from the ages of 11 to 17 years, two were favourable for EAP. The first study found significantly higher self-esteem and the second found lower scores on aggression. Two studies failed to find significant results and the last found a significant increase in aggression possibly related to issues around termination or the process of having to start dealing with difficult emotions (Whittlesey-Jerome *et al.*, 2016).

A further study amongst 3<sup>rd</sup> to 8<sup>th</sup> grade students by Trotter *et al* (2008) found that EAP was effective in preventing and resolving emotional and behavioural issues. When this group was compared to a group that had received conventional 'talk' therapy, the results indicated that whilst both interventions were effective, the group that underwent EAP showed greater improvements in self-awareness, the ability to recognise dysfunctional patterns of interaction and behaviour as well as the development of positive relationships (Whittlesey-Jerome *et al.*, 2016). Kruger (2012) cites a study by Schultz whereby a control group receiving talk therapy was quantitatively compared to those receiving EAP and analysed the outcomes on psychosocial functioning for at-risk adolescents. The study found that those participating in traditional talk therapy did not demonstrate the statistically significant change in functioning that was established by the EAP group. In a study conducted by Kruger (2012) on a six-month trauma focused EAP intervention for children and adolescents, significant changes were obtained on scores as obtained on the Child and Adolescent Functional Assessment Scale (CAFAS). These indicated a noticeable improvement on their trauma related symptoms.

Thus, EAP provides treatment opportunities for at-risk youth and children with histories of neglect, abuse and eating disorders who may not necessarily choose or benefit from traditional, one-on-one talk therapies (Lentini & Knox, 2015; Grimm, 2015). This is also illustrated by the results of the study conducted by Boshoff, Grobler, & Nienaber (2015) which indicated that EAP improved that participant's subjective well-being, problem focused coping as well as emotional focused coping. However, this study was not from a psychodynamic perspective. In addition, EAP can also be a useful treatment option for adolescent development and trauma especially in the context of family welfare services (Wall, Higgins, & Hunter, 2016) and parental substance use (Dunlop & Tsantefski, 2017). This research specifically focuses on adolescents from a child welfare society\facility.

## **2.9. Safety and EAP**

Safety is a very important aspect in all activities of EAP. This involves both the physical and emotional safety of the horses, the clients, and the professionals. In order to ensure optimum safety, it is essential that both professionals need to be fully qualified in their role i.e. horse/equine

specialists need to have undergone all the relevant training and the counsellor/social worker/psychologist also needs to be appropriately qualified and registered with the Health Professional Council of South Africa.

It is important that prior to the onset of any EAP sessions, the client signs consent and indemnity forms. These forms should address the various aspects of safety and confidentiality and allow the client to be made aware of his/her rights and give consent to participate in the EAP activities.

Generally, the horse specialist would primarily be concerned with physical safety and all of the risks and dangers associated with the horses and the counsellor/social worker/psychologist concerned with emotional safety as these are their areas of expertise. It is very important that a client comes to no harm on both a physical and emotional level, that confidentiality is assured and that the client feels as emotionally safe as possible. Mandrell (2006) comments that a horse professional's safety knowledge must consider both the horses' physical make-up and skeletal structure (e.g. recognising sharp/protruding bones that may come into contact with the human/client's body).

However, it is recommended that both specialists have an understanding and awareness of the concepts as outlined below.

### ***2.9.1. Physical Safety***

The client's physical safety needs to be taken into consideration when planning activities with the horses. This involves thinking about any potential risks/dangers and discussing them with your clients (Mandrell, 2006). It is also very important to invest in safety equipment i.e. the right kind of shoes and courses i.e. CPR courses. It is also essential for the horse specialist (as well as the psychologist) to know the horses, to know if the horse will kick or bite and when. The client should be allowed time to get to know the horse and practice certain activities such as picking up hooves in order to minimise the possibility of injury. In addition, it is important to be aware of the horses' skeletal make-up as well as the horse's common movements. It is important that the correct professionals are used; "The horse professional should be a skilled horse person" (Mandrell, 2006, p. 99). From the onset and prior to starting any EAP sessions, it is important that all professionals involved as well as the client is appropriately dressed and wears the appropriate dress code. Closed, hard shoes will lessen the injury if a horse accidentally stands on you. It is also best if pants are worn, sunblock is used (as the activities take place outside) and an appropriate top is worn (EAPISA provides golf shirts – at the client's cost). For example, a boob tube would be inappropriate. Safety

in the environment is also crucial. All equipment should be stored appropriately; the horses should be in the correct stalls/fields with the appropriate fencing.

It is very important, that if an incident happens, to remain calm and professional and not get emotional/emotionally involved. This will allow the professional to best attend to the situation. Mandrell (2006), further states that if the professional reacts in a panic, the client will more than likely also panic or freeze and focus on you (the professional), rather than the horse where her/his focus should be. It is imperative for the EAP professionals to observe the client's behaviour. In this way they can reflect on any risk-taking/dangerous behaviour and try to prevent further 'dangerous' behaviour. This also allows the professionals to become aware of their interactional style.

### ***2.9.2. Emotional Safety***

Emotional safety involves being aware of the emotional well-being of both the client and the horse. This aspect of safety is often overlooked and EAP professionals should address safety concerns with the client as they arise (Mandrel, 2006).

Prior to the commencement of any EAP sessions, the mental health professional (usually the counsellor/psychologist/social worker), must obtain a full background history which includes the client's full medical history. This enables the EAP team to be aware of any potential risks i.e. if the client has epilepsy and plan appropriately for them. This information will also allow the professionals to get an understanding of the client's exposure to horses and plan the type of horses to use. It is important to choose horses appropriate to presenting problem and client i.e. with conduct disordered adolescents it is possible that the horses can become uncontained, therefore, choose horses that are quieter.

It is also unnecessary to disclose excessive amounts of safety concerns to the client as this may create fears and anxieties within the client (Mandrell, 2006). Confidentiality (as discussed above) is also an important aspect of emotional safety. The counsellor/social worker/psychologist must also be aware of the emotional content of the EAP sessions and may need to contain the client or end the sessions depending on where 'the client is at' emotionally. For example, if the client displays bizarre, psychotic behaviour it may be in their best interests to not continue with the sessions.

It is also important that the horse(s) used during the EAP sessions are given an opportunity to rest and that the same horse is not used over and over. Careful attention needs to be paid to the horse's body language in order to look out for any signs of emotional distress or tiredness. Behaviour that is possibly out of the ordinary for that specific horse may signal that they need a rest.



It is important to remember that safety, both emotional and physical during the EAP sessions are continuous concepts to be aware of. Safety is on-going and is not just relevant some of the time.

## **2.10. Conclusion**

This chapter has focused on the concept of adolescence and an in-depth understanding of conduct disorder has been provided to the reader.

Equine assisted psychotherapy has been defined, described, and explicated in detail thus allowing the reader to fully understand the concept as well as the purpose that horses play in psychotherapy and how we understand them. The literature review has provided a basis for the research to be understood.

The next chapter, **Chapter 3**, focuses on a discussion of the paradigmatic point of departure, namely Melanie Klein's psychodynamic object relations theory.

# **CHAPTER 3**

## **PSYCHODYNAMIC OBJECT RELATIONS THEORY:**

### **MELANIE KLEIN**

#### **3.1. Introduction**

This chapter will specifically explore and focus on the object relations theory of psychoanalyst Melanie Klein. Klein contributed greatly towards the development of the theory. Judith Hughes (1990) has outlined the development of object relations theory out of its earlier psychoanalytic roots to more modern object relations theories and psychodynamic interpretations of such.

The notion of object relations originated with a predecessor of Klein, Ferenczi, but was developed considerably by Klein and other British psychologists, her followers, including Winnicott, Guntrip, and Stuart (Hughes, 1990; Melanie Klein Trust, 2017; Rubens, n.d). Out of this Fairbairn, a contemporary of Klein, evolved his own interpretation of object relations and it is due to his work that it became well known in psychoanalytic and psychodynamic circles (Hughes, 1990). He outrightly rejected Freud's more biological theoretical constructs and emphasised that the infants need was not on getting the milk, but the actual experience of being nursed (McWilliams, 1994), a process, the mother-child relationship, that Klein also places emphasis on. Even in current research, (Buchele & Rutan, 2017) this process is still considered relevant. Buchele and Rutin (2017) argue that human beings have an innate drive to be in relationships and that any behaviour that is counter to this goal is considered a defence mechanism to protect themselves.

However, Klein's work is today most closely linked with the term "object relations theory" (Hughes, 1990). She focussed on the attachment between the early primary object and the young child (Spillius, 1988). It is important to note that Melanie Klein refers to the primary object as the mother (Ainsworth, 1969; Spillius, 1988), and both love and hatred are projected onto her, giving rise to the 'good' and the 'bad' object. Given the context in which the research has been undertaken, namely South Africa, and that many children are raised by their grandparents and "nannies" the term mother is used loosely in this research and is also used to refer to all of the above, the primary caregiver.

Furthermore, Klein's theory is vast and expansive. This chapter will provide a summary of the key points and concepts relevant to her theory and will also explore the concepts that have relevance to the nature of this research. Moreover, Klein's theory is mainly built on that of Freud (Hughes, 1990; Spillius, 1988) and thus many definitions and terms unique to Freud's psychoanalytic technique are referred to in the text.

### **3.2. Psychodynamic Object-Relations Theory**

The theory of object relations is made up of many different approaches, different views of the self as well as many different views of childhood development from many different contributors. The term object-relations is used to refer to theorists that have departed from the classical tradition of psychoanalysis such as Klein and Fairbairn, and theorists that have remained in the tradition of psychoanalysis, but have stretched its boundaries, such as Mahler, Jacobson, and Kernberg, (Mitchell, 1981). This research will focus exclusively on the contributions made by Klein.

Object relations theory can be defined as the theory of the relations between objects, namely human objects. Cashdan (1988), states that the ‘objects’ in object relations are human beings and reflects the relations with others. Furthermore, these relations may be internal or external, fantasised, or real but essentially centre around interactions with other human beings (Cashdan, 1988). Mills (2010) describes object relations similarly and adds that object relations is a theory of intrapsychic activity which is based on functional aspects of an experience and the internalisation of this. The emphasis of this theory (object-relations) is placed on what the main objects in the child’s life have been like, how they have been experienced and aspects of them internalised as well as how internal images and representations of them live on in the unconscious lives of adults (McWilliams, 1994). Mitchell (1981) goes on to state that the term object was the term chosen by Freud to designate the target of the drives, the “other”, “real or imaginary” toward the drive is directed. It is the vehicle through which gratification is either obtained or denied (Hughes, 1990; Mitchell, 1981; Spillius, 1988). The actual concept “object-relations” stems from the psychoanalytic instinct theory and the ‘object’ of an instinct is the agent through which the aim is achieved, and the agent is the other person (Ainsworth, 1969).

### **3.3. Melanie Klein’s theory of Object-Relations**

Melanie Klein is one of the most significant theorists within psychoanalysis over the past 70 years (Mitchell, 1981), although Gomez (n.d) describes her as a tragic figure due to her own personal life of loss and turmoil. She was a child psychotherapist and contemporary of Freud (Cashdan, 1988). Klein opened an entire new realm of clinical investigation in terms of applying object-relations theory to her work with children. In addition, in more recent literature, Vulevic (2018) Klein is acknowledged for establishing a system of communication and a specific vocabulary for the analytic process, which is still in use today.

Klein’s theory of an object was developed from her notion that the mental life of a child and an adult consists of a complex tapestry of *phantasised* (Spillius, 1988) relations between the self and others, both within the imaginary world of internal objects as well as the external world (Greenberg

& Mitchell, 1983). According to Spillius (1988) Klein deliberately spelled *phantasy* this way to distinguish it from the more common English word *fantasy*. She construed of phantasy somewhat differently from the Freudian sense, in that for her they refer to the unconscious drives which interact with the external world in such a way that the child develops into the adult and defences are formed (Spillius, 2001). Thus, the way in which the child incorporates phantasies are central to the child's further development and this includes importantly, the relationship to the primary object in terms of future relationships (Spillius, 2001). The way in which the child relates to this object characterises all of his/her future relationships and he/she 'projects' onto this object his/her feelings, thoughts and behaviours directed towards the primary attachment figure (Hughes, 1990). Only later in life does the child's images of objects take on aspects of the real objects that they represent in the real world. Prior to this, a child's sense of an object is made up of images and 'memory traces' of breasts, penises, the womb, and babies (Greenberg & Mitchell, 1983). Klein also distinguishes between good and bad objects. The bad object is created because of a projection of the death instinct onto it. The death instinct is comprised of the threat of destruction from the inside. This may result in hostility and aggression towards the bad object, especially if the infant has no experience of a good object. The good object is a projection of the child developing a belief of kindly and loving figures (Greenberg & Mitchell, 1983). Furthermore, the analysis of transference is an important aspect in Klein's technique (Klein, 1953). Klein believes that one is able to help the patient by taking his\her desires and anxieties in the transference interpretations back to where they originated, namely in infancy and in relation to his\her first object (Klein, 1953). Furthermore, the Kleinian notion of transference is centred on the relation with the internal object (Bianchedi, De Moreno, De Urman, & Zysman, 2003). The transference is the application to the new object, in this research the horse, of the model of the relationships established with introjected objects (Bianchedi *et al*, 2003).

However, Klein's concept of an object was harshly criticised. A lot of criticism was received especially around her sense of objects having no real connection to real people and also that she did not acknowledge the diversity of formulations and provide a compelling synthesis (Greenberg & Mitchell, 1983).

Up until Klein started her work, very little psychoanalytic work had been done with children (Cashdan, 1988). Klein's work evoked a great deal of controversy in part due to the assumption that she made that child analysis was to be conducted in exactly the same way as an adult one, except that the analysis of verbal association was to be supplemented by the analysis of play (Klein, 1975). Children have limited conceptual and verbal skills and were previously not able to make use of psychoanalytic techniques. This is contradictory to the work of Freud that focused on adult analysis and very little on children. Furthermore, Klein assumed that a transference was possible, adopting Freud's notion of transference, that a super-ego (although a more rudimentary one than Freud), was

present, and that no moral or educational pressure should be placed on the client by the analyst (Klein, 1975).

Aguayo and Salomonsson (2017) argue that Klein's observations, although possibly not very valid due to the lack of a scientific nature, gave unique insights not only into her as a person, but into psychoanalysis. The available methods today, such as infant research, infant observation as well as parent-infant psychotherapy lends itself to more valid and reliable analysis (Aguayo & Salomonsson, 2017).

Furthermore, through these processes and adding to the concept of object relations more is known about infant's emotional reactivity, their ability to communicate (non-verbal cues) as well as their sensitivity to their mother's sensual attributes and possible post-natal depression (Aguayo & Salomonsson, 2017).

The Oedipus concept, a term coined by Freud and referring to a struggle over illicit pleasure and fear of punishment, was changed by Klein into a struggle for power and destruction and the fear of retaliation (Greenberg & Mitchell, 1983), and sets in as early as the second half of the first year of life. Libidinal impulses do not become problematic until the later stages of the Oedipus complex, long after the infant's earlier relations to the parents have become established. The child thus feels anxiety and guilt as a result of aggressive fantasies that accompany libidinal impulses. Furthermore, Greenberg and Mitchell (1983), argue that in Klein's theory the child's emotional life centres around paranoid anxiety (the fear of destruction of the self from the outside).

In her writings, Klein (1989), suggests that *pavor nocturnus*, which appears at 18 months old, is a neurotic working over of her Oedipus conflict. Klein's work illustrated that a small child's early feelings of anxiety and guilt have their origin in aggressive tendencies connected to the Oedipus conflict and that very young children experience intense feelings of guilt. Klein continues by suggesting that children and young people suffer from a more acute anxiety than adults, and thus we need to gain access to their anxiety and unconscious sense of guilt. Klein's focus and interpretation of unconscious anxiety, which is based on unconscious phantasy, was a characteristic specific to her technique (Klein, 1975).

### ***3.3.1. The history of Melanie Klein***

Melanie Klein was actually born Melanie Reizes in 1882 in Austria (Klein, 1975). She was the fourth and youngest child born to non-practicing Jewish parents. Her family was described as very united, held together by strong ties of love and her childhood setting was a very intellectual one. Her life was, however, marked by tragedy and sadness when both her favourite sister died and later also her

older brother whom she had enormously admired (Klein, 1975). This tragedy of loss was repeated when one of her own sons was killed in a climbing accident.

Melanie Klein was about 14 years old when she decided that she wanted to study medicine. With the help of her brother she quickly learnt the necessary Latin and Greek, needed at that time. However, these prospects ended, when she became engaged at 17 and married four years later in 1903 (Patel, 2016). Melanie Klein mothered three children.

She returned to her professional career during the first world war. She was inspired by a book by Freud and started analysis with Ferenczi in Budapest, who encouraged her to specialise in the analysis of children (Klein, 1975). At the time this was an unknown field with only some analysis by Freud, namely, 'Little Hans', having been conducted. Anna Freud also entered this field, but in a different direction.

In 1921 after the war, Klein went to Berlin to continue her work with children, under Dr Karl Abraham and introduced significant and new concepts into the field of analysis (Klein, 1975). Dr Abraham unfortunately passed away in 1924 and in 1926 Klein went to London to continue her work under Ernest Jones. During her time in Berlin, Melanie's husband was in Sweden and their allegedly unhappy marriage was terminated. Klein stayed in London until her death in 1960 after a successful career treating both adults and children as well as conducting self-analysis. Many of Klein's published works are as a result of the analytic observations made both on herself and her patients (Klein, 1975).

### ***3.3.2. Klein's theory of the mother-child relationship***

Almost entirely all of Freud's formulations about human behaviour, personality, and development were constructed out of childhood reminiscences of adult patients. Klein began to remedy this situation. Klein developed a technique in which children could express themselves through toys and play allowing the meaning of their play to be analysed (Melanie Klein Trust, 2017). Cashdan (1988), stated that Klein incorporated psychoanalytic techniques into her therapies with children, in an attempt to clarify the connections between childhood experiences and adult personality. Klein used play therapy (using dolls, clay, drawings, and other non-verbal techniques) in order to gain access to the inner world of the child (Geleerd, 1963). She also came to the conclusion that a child needs sessions of consistent frequency and duration (Geleerd, 1963). Klein's findings indicated that children devoted more time and energy to constructing their interpersonal world than to trying to control libidinal impulses and that children are driven by a need to control feelings directed at significant others in their lives (Cashdan, 1988). This was known as the "internal object world" of the child, a world of human relationships (Cashdan, 1988).

Klein became mostly interested in the mother-child relationship and she postulated that this relationship forms the prototype for all other significant relationships in the child's life. Klein believed that the core of the self is tied to the infant's first and most fundamental object relation, which is the relationship with the mother (Cashdan, 1988). Klein's theory is postulated around the early months of infancy and the psychotic anxieties that are related to it (Gomez, n.d.). Raphael-Leff (2003) explains that the mother\primary caregiver acts as a containing object for the infant and the need for this in an infants unintegrated state produces a frantic search for a light, a voice, a smell representative of the object and hold the parts of the personality together.

A point in Klein's theory that is perhaps of a more controversial nature is that Klein believed that this relationship had its origins even before the child was born (Cashdan, 1988). Thus, an unplanned child, a child whose pregnancy was unwanted, may struggle with feelings of feeling unwanted and have an underlying sense of rejection and no sense of belonging. A mother who was physically, verbally, or emotionally abused during the pregnancy may determine how the child responds to the outside world (i.e. aggressively and possibly also abusively). Klein is referring to a collective unconscious and the mother exists as an archetype in the mind of the child (Cashdan, 1988). It is this primal maternal image of the mother that guides the child's interaction with the primary caretaker.

### ***3.3.3. Klein's theory of positions***

Klein expanded her theory to include various "positions". These positions are Klein's way of depicting significant developmental stages through which the child passes. She referred to them as positions and not phases/stages because the change signifies that the child begins to experience his/her object relationship from a different position, a different point of view (Segal, 1979). These developmental stages are not defined in terms of psychosexual growth, but rather the psychological growth of the child in terms of love-hate relationships (Cashdan, 1988). It is important to note that even though Klein used psychiatric terms to describe the various positions, they are normal developmental progressions and describe the child's attempts to deal with significant real and representational figures rather than biological impulses (Cashdan, 1988). Furthermore, these positions (primitive mental states) have an impact on the adult life (Melanie Klein Trust, 2017).

These positions were derived from the conflict that exists between preservative (loving) and destructive (hateful) feelings, and between a desire to protect those close to the child and a malicious wish to destroy them (Cashdan, 1988). These positions are types of interpersonal stances along which the child organised experiences whereby "each position represents a developmental stepping stone along a continuum of love and hate and describes the way that object relations originate and mature."

(Cashdan, 1988, p. 6) and develop during the oral stage of development (Rosenbluth, 1965). Klein's notion of positions, whereby someone might view himself and his/her relationships with the world, constituted a significant shift within psychoanalytic thinking and allowed an understanding of developmental possibilities in relation with prevailing mental states (Waddell, 1998).

Klein developed two positions, the paranoid-schizoid position and the depressive position as described in detail below.

### *3.3.3.1. The paranoid-schizoid position*

This position spans the first three or four months of the infant's life and characterises the infant's first encounters with the world (Cashdan, 1988). Klein (1950), writes that this first position is marked by persecutory anxiety, both from external and internal sources. External sources being the experience of birth which is felt as an attack on him/her as the infant is taken away from the security of the mothers' womb. It also encompasses internal sources such as the perceived threat to the organism. Freud argued that this anxiety arises from the death instinct whereas Klein (1950), described this anxiety as occurring from the fear of annihilation, rather than the fear of death. She suggests that it is this fear that is the primary cause of anxiety. Klein (1950) describes her concept of persecutory anxiety as relating to dangers that threaten the ego and a manifestation of mental development in earliest infancy (Geleerd, 1963).

This position is also characterised by splitting. This splitting is as a result of the individual turning his destructive impulses towards his ego, resulting in parts of his ego temporarily going out of existence. This leads to a dispersal of emotions and an unconscious phantasy of the annihilation of this part of his/her personality (Likierman, 2001).

It is during this phase that the child first comes into contact with his/her first object, the breast, more specifically a part-object. (Cashdan, 1988). Thus, the infant, during this period, only views the mother as a part-object. Rosenbluth (1965) describes this position as the problem of an immature, unintegrated, and fleetingly integrated and then disintegrated ego that relates to part objects that is split into persecutory or ideal.

If this position is not successfully navigated, the child becomes an adult that is stuck in this position and constantly feels persecuted and attacked.

### *3.3.3.2. The depressive position*

This is the second position and begins in the second quarter of the first year, extending until the beginning of the second year (Melanie Klein Trust, 2017). This position is marked by depressive anxiety which is described by Klein (1950), as dangers felt to possibly threaten the loved object,



primarily through the subject's aggression. It arises through synthetic processes in the ego and as a result of growing integration, love and his\her violent destructive inner world can be reconciled into a whole (Geleerd, 1963). Accordingly, both the good and bad objects come closer together in the brain of the infant (Klein, 1950). Some integration occurs in this position and although important, persecutory anxiety has diminished. Crucial developmental milestones such as weaning are important in this position (Aguayo & Salomonsson, 2017).

Segal, analysed by Klein, a co-worker and one of the first psychiatrists to analyse psychotic patients using Kleinian concepts (1979), describes the depressive position as the beginning of the child's perception of his/her mother as a whole object. Furthermore, this position is characterised by rapid psychological growth and the reversal of splitting (Cashdan, 1988). As the child can now view the mother as a whole and not part-object, they also come to recognise that both good and bad can come from her and that she is a fallible human being. The infant is now aware of feelings of love and hate and that the mother that they love is the one that they hated a few moments ago (Rosenbluth, 1965). During this period the child may be forced to acknowledge negative, often hateful, feelings towards its mother (Cashdan, 1988).

Segal (1979), further states that when the mother is viewed as a whole object, she can be loved as a whole object. The child turns to this whole object to relieve his/her persecutory fears and wants to introject her in order to be protected from inner and outer persecution. However, the mother is an object that is seen as exposed to constant danger and if she is felt as protecting the infant, she herself is exposed to their attack. In addition, the mother is now felt to be whole she is also a source of both the infant's gratifications as well as their frustrations and pain (Segal, 1979). Klein also views maturity as an increased capacity to live in this position (Waddell, 1998).

The infant's love for his/her mother is therefore very ambivalent and can easily be turned to hatred. The loved and needed mother is always in danger of being destroyed, not only by phantasised persecutors but also by the infant's own sadism and hatred (Segal, 1979). Furthermore, because the mother is loved and identified with, the loss of her is felt acutely. Segal (1979), goes on to explain that the ego arrives at a new position, the loss of the loved object. Once the object is loved as a whole, she can be lost as a whole. Klein (1950) suggests that the infant feels that he/she has lost this object, his/her first loved object the mother's breast, his/her first loved object at weaning time. This loss is felt both externally and as an introjected object and is due to the infant's hatred, aggression, and greed (Klein, 1950). Furthermore, deprivation of this contact with the loved object can wreak chaos on the individual's psyche and cause his\her ego to establish relationships with their internal objects, instead of real objects in the external world (Sistani, Hashim, & Hamdam, 2014).

This position marks the onset of what Klein termed 'depressive anxiety'. The weaning off the mother's breast accentuates the infant's depressive feelings and amounts to a stage of mourning

(Klein, 1950). Klein (1950), goes on to state that the suffering experienced by the infant in the depressive position, is bound up with an increasing insight into psychic reality and thus contributes towards a better understanding of the psychic world. Through a growing adaptation to reality and the infant's expanding range of object relations the infant becomes able to combat and diminish depressive anxieties and to some extent securely establish his/her good internalised objects, the helpful and protective aspect of the super-ego (Klein, 1950).

Destructive urges in the paranoid position are replaced with guilt. Although depressive anxiety is uncomfortable it replaces the persecutory anxiety of the previous position and the child comes to view the mother as whole, thus paving the way for more mature interrelating (Cashdan, 1998). This allows the capacity for reparation and the potential for establishing relationships based on more caring and preservation, rather than destructive impulses. Waddell (1998) describes the working through of the depressive position under prevailing love as the synthetization of the good and bad objects, a more integrated ego and hope for the re-establishment of the good object.

This position is repeatedly revisited and refined throughout childhood and intermittently throughout life (Melanie Klein Trust, 2017).

Klein argues that persecutory and depressive anxieties, if in excess, can lead to severe mental illness and mental deficiency in childhood (Likierman, 2001). Furthermore, it is these two forms of anxiety that provide the fixation points for paranoia, schizophrenic and manic-depressive illness later on in life.

#### ***3.3.4. Klein's theory with regards to children***

Klein's theory has particular relevance to children, and she places a lot of emphasis on the development of play therapy. She was a pioneer in the treatment of children and implemented several never-before used tools and techniques (Patel, 2016). Klein's writing focus mainly on the analysis of small children and the observation of mothers and infants. However, her theory did extend to adolescence and she fundamentally believes that adult and adolescent analysis is rooted in the fundamentals of child analysis. Klein (1989), writes that psycho-analysis had led to the creation of a new child psychology and her writings "The psycho-analysis of children" is a pioneering text and the foundations of object-relations theory (Harris, 2014). Psycho-analytic observations have taught us that children, in their early years, experience sexual impulses, anxiety, as well as disappointments (Harris, 2014).

With specific reference to this research, a horse, the arena and all the relevant equipment is symbolic of a play room. This is supported by Klein's view (1953) that toys are not the only requisites for a play analysis. It can be argued however, that Klein's view was a bit limited in that she perceived

psychoanalysis to only take place with simple toys such as animals, trees, little wooden men and women, trains, aeroplanes etc. All inanimate objects and her theory did not extend to include animate objects such as horses as this research proposes.

Klein (1953) argues that in order to psychoanalyse a child, one needs to understand and interpret the fantasies, feelings, anxieties, and experiences expressed by the play or if the play is inhibited, then the cause of the inhibition. She further believed that children are not just made up of instincts, but thoughts and feelings. The way in which individuals later perceive the world, their careers as well as other key objects are important for clinicians to understand (Harris, 2014), in terms of understanding and working with them. Hindle (2017) states that Klein's play technique still has relevance in modern day society, the setting, the use of play material and role plays as well as limit setting, an issue that still challenges child care providers, teachers, and parents.

Transference is described as the backbone to the psychoanalytic procedure (Klein, 1953), and according to Klein, can only be established and maintained if the client can feel that the analysis is something separate from his/her ordinary home life. The interpretation and analysis of the transference is one of the important points in her technique (Klein, 1953). Klein postulates that we are able to help the child by taking his/her anxieties in our transference interpretations back to where they originated, in infancy and in relation to his/her first objects.

Klein (1953) argues that symbolism is an essential part of the child's mode of expression and allows access to the child's unconscious. Similar to how Freud analysed dreams and thus allowing access to the individual's unconscious. The child's capacity to use symbols enables the child to transfer interests, fantasies, anxieties, and guilt to objects other than people (Klein, 1953). Her concept of projective identification is thus formulated, and she argued that it is an intrapsychic process and allows the subject's internal world of self and objects to be understood (Greenberg, 2018).

In more recent literature, Greenberg (2018) argues that there is interest and enthusiasm about projective identification, but this hinges on a dramatic shift in the understanding of the concept. Moving away from the traditional Kleinian understanding, projective identification became interpersonalised and was also understood from the object's response to the projections (Greenberg, 2018). It is no longer seen as simply a phantasy, but as a relational transaction that existed between two people and is central to development and emotional growth (Greenberg, 2018). Sherwin-White (2017) argues that Klein's main emphasis has been on the infant's emotional development of an inner world dominated by projections of phantasies onto the mother. Further, Klein did argue against Anna Freud's concept of primary narcissism and the thought process that until a baby is at least 6 months old it has no object relation through emphasizing the importance of the external environment (Sherwin-White, 2017).

Greenberg (2018) discusses enactment, a term not available during Klein's era, but which is referred to in more contemporary literature, which refers to the analyst's behaviour during the session is unavoidable and continuous, an important part of the process. In contrast, Klein believed that she could close herself off to projections. Klein's theory lent itself to the more modern day understanding of the object as part of the analytic couple and not in isolation (Greenberg, 2018).

### ***3.3.5. Klein's theory and adolescence/puberty***

One of the foundations of child analysis is that the child expresses its phantasies, wishes and behaviours and experiences in a symbolic way through the use of play and games (Klein, 1989). Adolescents have a better grasp of language and thus a better mode of expression. However, they too can express themselves symbolically and this is where the use of the horse is important as the horse contains the projections of these feelings, wishes and phantasies and as it has far less baggage than a human, can be far more effective.

Manifestations of anxiety and affect are much more acute in this period of puberty than in the latency period (Klein, 1989). Klein (1989) further writes that warding off and managing anxiety is executed with much greater success as an adolescent due to a more developed ego. Furthermore, the adolescent has developed his/her various interest and sporting activities aiding him/her in mastering that anxiety, of overcompensating for it or making it to himself and others. This is in part achieved by developing the attitude of defiance characteristic of puberty.

Adolescence is a phase characterised by physical, psychological, and developmental challenges. It is common that psychological difficulties and personality changes appear frequently in children at the onset of puberty (Klein, 1975). Through Klein's ongoing analysis and work she discovers that a fundamental part of the adolescent's development is the revisiting of the Oedipus complex, which aids in the joint development of psychical bisexuality and psychical puberty (Agostini, 2004). Klein (1989), further goes on to state that during the intensely emotional age of puberty (which this study focuses on), an acute degree of anxiety is once again seen which is expressed through resistances of a defiant and violent nature. However, this may cause the analysis/treatment to be ended due to negative countertransference. A certain amount of anxiety can quickly be resolved in children of all ages if the negative transference is treated and dissolved (Klein, 1989). Thus, according to Klein, it is possible to treat children that struggle with conduct disorder if the therapist can first dissolve and treat the negative transference. Furthermore, underlying the behaviour of these adolescents is an overwhelming anxiety.

Klein (1989) stated that the phantasy of an adolescent is more adapted to reality and he/she has stronger ego-interests thus making the phantasy content much less recognisable than in small

children. The content of his/her phantasies undergoes an alteration and becomes more about the impulse to prove his/her courage in the real world and the desire for competition with others becomes much more prominent (Klein, 1989).

#### *3.3.5.1. The male adolescent*

Klein (1975) describes the male adolescent at this stage of development as overwhelmed by his sexual maturation, momentous bodily changes as well as feeling at the mercy of wishes and desires that he cannot satisfy. She goes on to explain that some males, who may have had cheerful and trusting natures may become secretive and defiant and revolt against home and school, whilst some lose ambition and others may fail at school (Klein, 1975). Puberty is characterised by a host of conflicts which in extreme manifestations, as seen in this study, may result in criminal, violent behaviour, or suicidality.

It is important to consider what underlies these conflicts. Freud first emphasised the significance of infantile neurosis. Children who had previously appeared quite healthy can suffer serious breakdowns as a result of even moderate strains (Klein, 1975). Thus, the conflicts that the adolescent boy experiences at puberty can become overwhelming and cause a breakdown. The boy will experience infantile wishes and desires projected and linked towards his early objects such as his mother (Klein, 1975). Thus, every boy will show a passionate love for his mother and be in conflict/competition with his father. The incestuous nature of these wishes evokes severe social conformity and are thus repressed forming in the unconscious of the Oedipus complex (Klein, 1975). Existing in the fantasy life of all adults, according to Klein, is the male unconscious desire to kill his father and perform incest with his mother. Due to the tempestuous uprush of instincts during puberty, the male adolescent may experience even more difficulties and succumb to these desires possibly resulting in aggressive outburst and opposition and defiance towards authority figures.

Klein (1989), suggests that analysis during puberty is similar to that done with a small child, as instinctual impulses, and the unconscious as well as the phantasy life once again present, however in a richer and more acute form. Furthermore, the phantasy of the adolescent is more adapted to reality and has stronger ego-interests thus it is much less easily recognisable than in smaller children. Due to the adolescents' stronger relations to reality, the character of his/her phantasies undergoes alteration and the impulse to prove his courage and desire for competition is once again very prominent (Klein, 1989). As a small child the boy's desire to rival with his father for possession of his mother is accompanied by feelings of hatred and aggression as well as anxiety and guilt. The mechanisms of the adolescent child conceal these impulses better than that of a small child and takes on role-models of heroes and great men. This allows him to easier maintain his identity with these

objects as they are further removed from him and thus his aggression is directed towards other objects as it becomes split off from his father (Klein, 1989).

#### *3.3.5.2. The female adolescent*

Klein (1989) suggests that the onset of menstruation causes great anxiety in girls and becomes a visible sign that the interior of her body as well as the inner child that is contained therein are destroyed. The feminine position of the girl takes longer to develop than that of the male adolescent and is beset with various other complications. The masculine component within the girl is reinforced in her at puberty (Klein, 1989) and she may have an oppositional attitude of rivalry towards the opposite sex (the male). She experiences deep seated anxiety and guilt as a result of her feelings of aggression towards her mother leading her to reject the feminine role. Her fear of having her body destroyed by the mother leads her to refuse to adopt the position of woman (Klein, 1989) and possible identification with her father. The girl's feminine position may be exaggerated and pushed into the foreground as a way to defend against the masculinity (Klein, 1989).

#### *3.3.6. Klein's theory on the notion of the death instinct*

Klein's theory differed from Freud's theory of the death instinct. She postulated that we all have a destructive inner force that if left unchecked could lead to self-annihilation (Cashdan, 1988). An inner struggle between the forces of life and death was ultimately projected onto the world (Cashdan, 1988). Klein believed that a large part of the death instinct was projected onto external objects. Thus, this struggle is projected onto the horse in EAP and can be more easily worked with as the horse carries no emotional baggage that may interfere with this projection and the interpretation thereof. This development is responsible for Klein's early division of the world into good and bad. This can lead to a world filled with malevolent and destructive figures known as hating, bad objects (the death instinct) (Cashdan, 1988; Melanie Klein Trust, 2017). A child/adolescent diagnosed with conduct disorder lives in a world filled with many bad objects. The bad object is then projected onto the horse. This attitude to life renders the formation of relationships with these children challenging.

It is important to note that the child's world is not exclusively populated by bad objects, but rather by many objects, some good and some bad and that some of the child's libidinal energy is also projected outward to create good objects (Rubens, n.d).

All these objects, good and bad are re-introjected in order to produce an inner representational world of themselves that is split into destructive (bad) and benevolent (good) components (Cashdan, 1988). This dynamic interplay makes up Klein's view of the infant psyche. The child/adolescent constantly projects and introjects hateful feelings in an attempt to deal with innate destructive

impulses (Cashdan, 1988). It is possible that the internal psyche of a child diagnosed with conduct disorder is made up of more bad objects than good which they have internalised resulting in them struggling to view themselves as good. They then tend to act out these bad objects in problematic behaviours. The horse mirrors these behaviours back to them, but in a non-judgemental and accepting way, thus hopefully allowing the adolescent to internalise more of the good.

### **3.3.7. Klein's theory and deprivation**

As discussed in Chapter 2, the literature review, deprivation is a possible contributing factor to the development of conduct disorder and thus an important concept to discuss. Klein states that patients who feel deprived experience envy and this leads them to always imagine that someone else is always withholding and enjoying the satisfaction that is owing to them (Likierman, 2001). Envy is located at the centre of her theory (Bianchedi *et al.*, 2003). This may have been in the form of an experience of a mother who may have withheld her breast selfishly. Deprivation in South Africa is an undeniable factor of the children/adolescents that have grown up here. This can result in envy as Klein postulates. Klein describes excessive envy resulting from an unusual sense of helplessness or deprivation in infancy, especially in cases where feeding and nurture are felt to be faulty, unreliable, and out of control (Likierman, 2001). This leads the infant to believe that goodness is never within easy reach and thus promotes a breakdown in trust. This also triggers a sense of persecution, grieving, and envy.

Envy is singled out as one of the most fundamental and most primitive of emotions (Segal, 1979). It arises in early infancy and in its most primitive form is directed at the feeding breast. It is described as the angry feeling that a person possesses whilst watching another enjoying something desirable, often accompanied by an impulse to take it away (Melanie Klein Trust, 2017). Klein postulates that the love, care, and food received from the mother stir two opposite reactions in the infant: of gratification leading to love and the other of hostility and envy, based on the realization that the source of food, love and comfort lies outside oneself (Segal, 1979). These feelings are not just related to the physical feeding only. For an infant that is gratified, the breast is idealized and experienced as the fount of love, understanding and wisdom. However, for the ungratified infant, envy can be stirred by frustration and deprivation and thus when the infant is deprived, he/she assumes that the 'riches' that he/she attributes to the breast are exclusively enjoyed by the breast (Segal, 1979). This can result in anger and rage, which can be acted out throughout childhood and into adolescence, especially if the child is deprived over and over again.

### ***3.3.8. Klein's theory and conduct disorder***

Klein didn't specifically have a theory that related to the diagnosis of conduct disorder, but she did have theories around concepts that are also found in children diagnosed with conduct disorder as well as the development of an antisocial personality disorder, often found in individuals that have previously been diagnosed with conduct disorder.

Klein suggested that criminal tendencies are at work even in normal children and that there are a few factors which underlie what she termed as an asocial or criminal development in a child (Klein, 1975). She postulated that children would show asocial and criminal tendencies. They tend to act them out repeatedly in their childish ways exacerbated by a dread of a cruel retaliation from their parents as a punishment for their aggressive phantasies directed towards those parents (Klein, 1975). The childhood background on these individuals are often rife with insecurity and chaos and one can find virtually no consistent, loving, and protective family influences (McWilliams, 1994). Klein (1975), goes on to suggest that it is the overpowering strictness of the super-ego and not the lack of conscience that is responsible for the characteristic behaviour of asocial and criminal children, in part due to the absence of a sense of power at the developmentally appropriate times, thus propelling children to constantly seek confirmations of their omnipotence (McWilliams, 1994).

Initially the infant holds onto aggressive impulses and phantasies towards his/her parents' which is then projected onto them. This results in the infant/child developing a phantastic and distorted picture of the world around it (Klein, 1975). Due to introjection operating at the same time these unreal perceptions of the world become internalised resulting in the child feeling that he/she is being ruled by dangerous, aggressive, and cruel parents; the super-ego (Klein, 1975).

During the normal course of development, both sadism and anxiety diminish, and the child finds better and more social means for mastering his/her anxiety. In a child that could potentially develop into a child diagnosed with conduct disorder, he/she protects themselves against their fear of violent objects (introjected and external) by redoubling their attacks against them in their imagination (Klein, 1975). Their aim is to get rid of the objects and to silence the intolerable threats of his/her superego. Thus, a vicious circle is set up whereby the child's anxiety causes it to try and destroy its objects, thus increasing its anxiety, and thereby increasing its urges to try and destroy these objects. Klein (1975), argues that it is this vicious circle that underlies asocial and criminal tendencies in children.

Furthermore, children who develop behavioural difficulties have been indulged materially and emotionally deprived (McWilliams, 1994). These children also cannot acknowledge ordinary emotions because they associate them with vulnerabilities (McWilliams, 1994). McWilliams (1994)



also states that in their families of origin little emphasis was placed on the expressive and communicative functions of language instead, words were used to control.

### **3.3.9. Klein's theory and depression**

Depression according to Klein can be overcome through the diminishing of fears through happy experiences (Likierman, 2001). These emotions which also include grief and feelings of loss need to be overcome. Rosenbluth (1965) states that according to Klein, depression occurs as a result of an inability to face or cope with the conflicts that arise in the depressive position.

Likierman (2001), states that within the theory of object relations depression shares important elements with mourning and is as the result of early object loss which may be concrete and observable or internal and psychological (McWilliams, 1994). A major loss in the separation-individuation phase as well as a family atmosphere where mourning is discouraged are major factors in the development of depressive dynamics in an individual (McWilliams, 1994).

Furthermore, depression was rooted in a metaphorical loss, which is brought about by the patient's phantasy attacks on a strongly resented object (Likierman, 2001). It is important to note that whilst this event may have resulted in less anger and hatred an important crucial event leads to depression. The participant's central relationship is viewed as hostile, although completely indispensable to him/her (Likierman, 2001). The patient attempts to gain mastery of the object by introjecting it. Unfortunately, through this process, known as displacement (the moving of the feelings and thoughts from reality onto the psychic process), the participant redirects his/her feelings onto his/her own ego resulting in a depressive deterioration and lowered sense of self (Likierman, 2001).

McWilliams (1994) agrees with the notion that depression shares elements with mourning as it is in part, as a result of multiple object losses as well as painful, premature experiences of separation from a love object.

### **3.4. Critique of Melanie Klein's theory**

Solnit, Neubauer, Abrams, and Dowling (1999), comment that contemporary Kleinians rely a lot on themselves and their keen clinical sensitivity, thus not waiting for many of the patient's free associations. Their main concern is to interpret quickly and accurately. However, although their inference of patient's inner lives may be correct, the eagerness of their interventions does not allow for extensive observations by the analyst or the patient. Solnit *et al.*, (1999) go on to further state that "there is little of the rich array of possible hypotheses about unconscious mental life that the analysing instrument provides for the analyst" (p. 112).

Furthermore, the contemporary Kleinians are further critiqued in saying that the predominant use of projective identification and counter transference analysis necessitates that the analyst's understanding of the patient relies more on his idiosyncratic intuitive rather than inferences derived from a standardised method (Solnit *et al.*, 1999). Psychodynamic psychotherapy has often been criticised for the difficulty with regards to measuring the results and Solnit *et al.*, (1999), argue that the accuracy or the validity of the data cannot be appraised by other psychoanalysts, and that it is very hard to generalise.

Furthermore, Greenberg and Mitchell (1983), argue that Klein's depiction of the relationships that dominate emotional life (paranoid-schizoid position, depressive position, and envy) are powerful and do constitute her greatest contribution towards clinical psychoanalysis. However, they are presented as constitutional and as a direct and predetermined result of the nature of the drives, particularly of constitutional aggression.

In Klein's understanding of the parental figures, she often refers to them as loving and nurturing figures and real-life features such as a depressed mother, a mother's deprivation or dislike of the child do not appear in formulations of internal object relations (Greenberg & Mitchell, 1983). Thus, her theory is very difficult to apply to aggressive, hostile adolescents (conduct disordered adolescents), as previously discussed in Chapter 2, major contributions towards the development of this pathology is neglect, deprivation, abuse, and conflict.

### **3.5. Conclusion**

This chapter has provided a summary of Melanie Klein's object-relations theory with specific focus on adolescence and conduct disorder. It also outlined the importance of the mother-child relationship, which is central to her theory and outlined her concepts of different positions, the death instinct, deprivation as well as her conceptualization of depression. All of which are important constructs to consider in the development, management and treatment of children that present with conduct disorder.

Although Klein's theory does not necessarily depict a very clear development of conduct disorder, her theory does describe the development of aggressive and hostile tendencies as well as behaviour that may be criminal such as stealing and the harm of others (symptoms of conduct disorder) and can be applied to the understanding and treatment of conduct disorder in adolescents.

The next chapter, **Chapter 4**, discusses the research methodology that was used in this research as well as the process used in obtaining the participants, the data collection as well as the procedure used for the analysis of the data.

## **CHAPTER 4**

### **RESEARCH METHODOLOGY, INVESTIGATION AND PROCEDURE FOLLOWED**

#### **4.1. Introduction**

The methodology for this research was a mixed methods approach and thus both quantitative and qualitative research methodologies were used in the collection of the data which is expanded upon in the chapter below.

Furthermore, this chapter also explores the procedure that was followed in this research. The objectives of the research are discussed as well as the process that was involved in the recruitment and selection of the research participants with specific reference to the criteria for inclusion and exclusion. The process whereby the data (interviews, EAP sessions and psychometric instruments - the 6-18 year CBCL Youth Checklist and the MMPI-A) was collected and analysed will also be further outlined and discussed in this chapter. From here on the 6-18 year CBCL Youth Checklist will be referred to as the CBCL.

#### **4.2. The nature of qualitative and quantitative research methodology**

The combining or mixing of qualitative and quantitative methodologies is not a unique or new phenomenon to counsellors/researchers (Frels & Onwuegbuzie, 2013), and recently, there has been an increase in the demand for a mixed methods approach in research (Palinkas, Horwitz, Green, Wisdom, Duan, & Hoagwood, 2013). Furthermore, both forms of data are used in practice and are a necessary part of the profession. Schedler (2010), argues that both qualitative and quantitative methods are useful for examining effective change and outcomes, which this research proposed to explore. Thus, researching the effectiveness/outcomes of EAP with adolescents diagnosed with conduct disorder and whether the desired effect, namely emotional connection, and behavioural modification, has been achieved, was best researched using a mixed methods approach.

It is important to explore and understand what is meant by quantitative and qualitative research methods and how they either complement or contrast each other.

The main focus of qualitative research is concerned with the interpretation of subjective meaning, the description of social context and the privilege of lay knowledge. The focus of qualitative research rests in three main areas: language as a means to explore the

process of communication, the description and interpretation of subjective meanings, as well as theoretical meanings (Fossey, Harvey, McDermott, & Davidson 2002). Quantitative research, however, is more focused on the collection of the data and transforming it into statistics generally for the purpose of external statistical generalisations (Frels & Onwuegbuzie, 2013).

Patton (2002) describes the data collection for quantitative data as requiring the use of standardized methods that allow the experiences of individuals to fit into predetermined response categories. This research used the standardized self-report checklist, namely the CBCL as well as the standardized personality assessment, the Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A). The measuring instruments, test items and survey tools are the focus and means by which the objectives of the study were achieved. In contrast to qualitative data collection, the researcher is detached from the data collection process (Patton, 2002).

In contrast, qualitative research is a broad term that describes several research methods which rely on the collection, analysis, and interpretation of nonmathematical data (Whitley & Crawford, 2005). The child and adolescent interview, background histories, clinical observations, and the transcriptions from the EAP sessions will form the qualitative data for this research.

Furthermore, qualitative research methods are used to explore and obtain depth of understanding, as well as explaining life experiences and events (Denzin & Lincoln, 2017; Patton, 2002) whilst quantitative research methods are used to test and confirm hypothesis and obtain breadth of understanding (Palinkas *et al.*, 2013).

However, Allwood (2012) states that the distinction between qualitative and quantitative research is abstract, very general and of little value. The distinction may restrict creativity in the development of new research methods as well as create confusion and unnecessary work. Thus, it may not be necessary to focus on the differences but rather on how each research methodology complements each other.

The table below, Table 1, Qualitative and Quantitative Research methods, provides a summary of the processes involved in qualitative and quantitative research as well as the outcomes (Johnson & Christensen, 2008; Lichtman, 2006).

*Table 1*  
*Qualitative and Quantitative Research Methods*

	<b>Qualitative Research</b>	<b>Quantitative Research</b>
<b>Objective</b>	In – depth/rich outcomes	Generalizable
<b>Size of group</b>	Smaller & not randomly selected	Larger & randomly selected
<b>Type of data collected</b>	Words, images, objects	Numbers & statistics
<b>Form of data collected</b>	Interviews, open-ended responses, field notes, reflections, and observations	Precise measurements using structured & validated data-collection instruments
<b>Type of data analysis</b>	Identify themes and patterns	Identify statistical relationships
<b>Objectivity/Subjectivity</b>	Subjectivity is expected	Objectivity is important
<b>Results</b>	Specialised findings that are less generalizable	Generalizable findings
<b>Scientific method</b>	Exploratory or bottom-up; the researcher generates a new theory/hypothesis from the data collected	Confirmatory or top-down; the researcher tests the theory with data
<b>View of human behaviour</b>	Dynamic, social & situational	Regular & predictable
<b>Focus</b>	Wide – angle lens; examines breadth & depth	Narrow-angle lens; tests specific hypothesis
<b>Research outcome</b>	Narrative report with descriptions and quotations	Statistical report with correlations & statistical significance

As this research was a mixed methods approach, and more specifically, a qualitatively dominant mixed methods design, the above-mentioned designs were combined in this research and are further explored in more detail in the rest of this chapter. Johnson, Onwuegbuzie and Turner (2007) describe a qualitatively dominant mixed methods approach as one in which the researcher relies on a qualitative view of the research and concurrently recognise that the addition of quantitative data would likely benefit and add value to the research.

According to Leech and Onwuegbuzie (2007) there are six mixed method designs, as listed below (Doyle, Brady & Byrne, p. 182, 2009):

- Partially mixed concurrent equal status design,

- Partially mixed concurrent dominant status design,
- Partially mixed sequential equal status design,
- Partially mixed sequential dominant status design,
- Fully mixed concurrent equal status design,
- Fully mixed concurrent dominant status design.

According to the above-mentioned methods, this research is considered a *partially mixed sequential dominant design*. This is due to the fact that the qualitative and quantitative data collection was done separately and only mixed at the data interpretation phase. Furthermore, each stage of data collection was done sequentially, once the previous phase was completed. Initially, the quantitative data in the form of questionnaires was collected, thereafter the researcher interviewed each participant. Once these two phases were completed, the participants engaged in the EAP sessions, which were transcribed and formed the qualitative data. Only once all the participants had completed the EAP sessions were the last quantitative assessments administered, once again in the form of questionnaires. Each phase of the research took a few months. The total time required for the data collection was about 18 – 24 months. This research was qualitatively dominant.

### **4.3. Aim of the study**

The aim of this research was to research the effectiveness and outcomes of EAP with adolescents diagnosed with conduct disorder that are between the ages of 13 years and 17 years 11 months.

More specifically the focus of this study was on EAP as this is a relatively new form of psychotherapy emerging in the field of psychology and its effectiveness with regards to specific population groups and diagnosis is still to be determined. EAP will refer to the use of psychotherapy with horses, as previously discussed in Chapter 2.

Furthermore, this study specifically aimed to study the effectiveness and outcomes that EAP has on the emotional and behavioural aspects of adolescents diagnosed with conduct disorder. The results were considered from an object relations perspective as discussed in Chapter 3.

The specific objectives of the study are outlined below:

- To source participants diagnosed with conduct disorder from the local child welfare society that fulfil the criteria for inclusion in this study;
- To obtain background histories and collateral information on all participants from the social worker(s) at the child welfare society;
- To verbally complete a child and adolescent interview with each participant (Appendix D);
- To obtain questionnaires, the CBCL and the MMPI-A, as completed by the adolescents prior to the start of the EAP sessions and more than six months after the completion of the EAP sessions for both the control and experimental groups;
- To obtain CBCL protocols as filled out by the adolescent's teacher prior to the start of the EAP sessions and more than six months after the completion of the EAP sessions for both the control and experimental groups;
- To obtain CBCL protocols as filled out by the adolescent's parents/legal guardian prior to the start of the EAP sessions and more than six months after the completion of the EAP sessions for both the control and experimental groups;
- To conduct six sessions of EAP with each adolescent in the experimental group;
- To transcribe the EAP sessions verbatim and include non-verbal behaviour where appropriate. These transcriptions form part of the raw data;
- To analyse these transcribed sessions by means of thematic analysis as discussed further in the chapter;
- To analyse the quantitative data of the research (the CBCL and the MMPI-A) per a Wilcoxon Signed Rank Test as discussed further on in this chapter;
- To draw conclusions pertaining to the effectiveness of EAP as an alternative method of psychotherapy for adolescents diagnosed with CD;
- To make recommendations and suggestions regarding the future treatment of adolescents diagnosed with conduct disorder,
- To make recommendations and suggestions regarding future research in this area.

The procedure through which the above-mentioned objectives were achieved will be addressed in the section outlined below.

#### **4.4. The procedure that was followed in the study**

This section explores the procedure that was followed in this research with specific focus on the sourcing of the participants, the process involved in the administration of the psychometric instruments (the CBCL and MMPI-A) as well as the process involved in the EAP sessions and the transcription of these sessions. The method used for the data analysis is also described.

##### ***4.4.1. The research participants***

Participants were selected through purposive selection according to specific inclusion and exclusion criteria, which will be discussed later in more detail. They were randomly assigned into the control group and the experimental group, once the criteria for inclusion and exclusion was achieved. Wilson, Buultjens, Monfries, and Karimi (2015) suggest that a randomised controlled trial with the use of control groups and usual care groups to which the adolescents are randomly assigned is needed in future research to quantify the psychosocial aspects of EAP.

All participants had to have previously received a diagnosis of conduct disorder, which was verified by the researcher through the initial interview, the questionnaires as well as the clinical observations and collateral information.

Permission was obtained from the local child welfare society in order to conduct the research as the participants were sourced through them. Informed consent forms (Appendix B) were obtained from the legal guardians of the adolescents and the adolescents completed assent forms giving their assent to participate in the study (Appendix C). These forms also included indemnity with regards to working with the horses and the safety of the participants.

In addition, permission was also obtained from EAPISA (Equine Assisted Psychotherapy Institute of South Africa) to perform the study and utilize their resources (stables, horses, land, and equipment).

##### ***4.4.1.1. Inclusion and exclusion criteria for participation in the study***

The research participants were chosen according to the following inclusion criteria:

- Participants were between 13 years 0 months and 17 years 11 months old;
- They were either female or male;
- They were of different ethnic and cultural backgrounds;



- They all had a prior diagnosis of conduct disorder as made by a qualified psychiatrist and/or clinical psychologist, which was confirmed by the researcher;
- Participants were referred by the auxiliary social worker at the child welfare society, as this ensured that a specific population was targeted, enabling effective purposeful sampling;
- They were able to speak English fluently enough to participate;

Exclusion criteria for participation in the study:

- The adolescents/participants were not previously in psychotherapy and/or treatment with the clinical psychologist or the horse specialist who conducted the research.

Participation in the study was voluntary and the participants were allowed to withdraw at any time without any harm or repercussions to themselves. This was the case with Participant E who decided to withdraw willingly from the research.

#### *4.4.1.2. Recruiting the participants*

The purposive sampling method was used to recruit participants in line with the inclusion and exclusion criteria as listed above. Participants were recruited by the auxiliary social worker at the child welfare society. They were identified from a list that the auxiliary social worker had of children with behavioural difficulties (diagnosed with conduct disorder that was confirmed by the researcher) that was obtained from the relationship with their pilot project at a school in the area as part of their community outreach programme. The area in which the community outreach programme was conducted was predominantly a coloured area and thus the majority of the participants were coloured. Both a control and an experimental group was chosen. The process is outlined below.

Palys (2008), describes purposive sampling as a strategic choice about whom, where and how the researcher does their research. Thus, the researcher's sample is tied to their objectives. The type of purposive sampling used in this research is both criterion and theory-guided sampling. This implies that specific participants were chosen for the research based on meeting certain criteria (Palys, 2008). Furthermore, because this research is following a more deductive and theory testing approach, participants that embody theoretical constructs are chosen, for e.g. those that display conduct disorder symptoms or whose primary relationship with their object can be explored according to Melanie Klein's theory.

There is an overlap between criterion and theory-guided sampling. The use of sampling strategies, such as purposive sampling, is used in order to select information-rich cases. However, Palinkas, *et al* (2013), argues that there are no clear-cut guidelines for conducting purposive sampling in a mixed methods approach and that the process needs to be based on the objectives and impact that the researcher wishes to achieve.

#### **4.4.2. Data Collection**

Due to developmental factors and complexities of measured constructs the gold-standard for assessing adolescents is multi-method incorporating methods such as interviews, the use of psychometric instruments, clinical observations and background information, multi-informant from the adolescent, parents, teachers, and peers as well as multi-construct (Sistere, Massons, Perez, & Ascaso, 2014).

In accordance with the gold-standard this research involves multi methods including the child and adolescent background interview, the background histories as obtained by the social worker, the CBCL protocols (as filled out by the participant, the teacher, and the parent; pre- and post-test) and MMPI-A as well as the transcripts of the EAP sessions for the experimental group.

The data was collected over a period of time due to various constraints. These constraints included delays due to school holidays, tests, and examinations, as well as constraints around planning such as transport and obtaining the adolescents as some were truant. 15 adolescents for the EAP sessions (the experimental group) and 15 adolescents for the control group were chosen through purposive sampling. The 15 children that were selected as part of the control group were involved in a structured programme coordinated by the child welfare society.

Once all the participants were chosen, they, and their legal guardians, were informed about the nature and purposes of the research as well as confidentiality. Their consent and assent to participate in the study was obtained. During these interactions, the researcher determined if based on their language capabilities they were suited to participate in the study. Once this was achieved, dates and times were set for the child and adolescent interview to be undertaken for the individuals undergoing the EAP sessions. These interviews were conducted on a Monday morning over a period of two weeks.

Once the interviews were conducted, the assessment procedures were completed over a period of four days spread over approximately four weeks and then dates were discussed

and set for the participation of the EAP sessions. This involved the collaboration of the auxiliary social worker, the horse specialist, the clinical psychologist as well as the school teachers and the principal. The selected participants attended EAP sessions at EAPISA (Equine Assisted Psychotherapy Institute of South Africa), a South African stable situated in the south of the Gauteng Province. The owner of the farm, the director of EAPISA has specific horses, equipment and arenas that are geared towards EAP. Once the EAP sessions were completed the same procedure as previously discussed was followed for the post-test data collection.

Out of the 14 participants chosen for the EAP sessions (Group A – the experimental group) only seven (50%) of them completed both the CBCL and MMPI-A. Thus, only seven children were used for the EAP sessions. Out of those seven children, one withdrew and the other one was excluded due to language difficulties. The data collected from the other seven children was moved into the control group (Group B) in order to create a greater probability of data being obtained as well as a greater curve to which to compare the data obtained from Group A.

Twelve children participated in the collection of the data (Group B, the control group) out of 15 requested. Also, only seven (58.3%) of these children completed both the CBCL and the MMPI-A. From Group B, two children dropped out of the study due to being placed in foster care or going through a process of adoption.

Collection of the data presented with many challenges. The data (child and adolescent interview, CBCL and MMPI-A) were collected at a primary school in a location on the East Rand whereby the researcher would go through to the school on allocated dates that had been organised with the school and the child welfare society. The school was involved in a collaboration with the child welfare society and had given permission to the child welfare society for their resources to be used as part of this research and to partake in the research. In addition, the researcher met with the principal of the school prior to the start of the collection of the research data and obtained his assent and cooperation to participate in the research. An auxiliary social worker from the child welfare society was present for all the assessment dates. There were difficulties with regards to resources such as an office space as well as language difficulties with the school with regards to organisation. Often the children were late, truant, or absent thus placing restrictions on the data collection.

Upon completion of the collection of the child and adolescent interview as well as the pre-test CBCL and MMPI-A, dates and times were set for the EAP sessions. These were

done on a Monday morning at a stable yard in the south of Johannesburg. The child welfare society bought the children to the farm where the assessor/clinical psychologist met with the horse specialist and the sessions were conducted. Each session was between 30 and 40 minutes long and each participant was meant to complete six sessions of EAP.

#### ***4.4.3. Psychometric instruments***

Information for the research was collected from a variety of resources. The quantitative methods used were formal assessment procedures, namely the CBCL and a personality assessment, the Minnesota Multiphasic Personality Inventory-Adolescent version (MMPI-A) which was completed on all the participants by a clinical psychologist qualified to perform such assessments and only valid protocols were used in the study. Invalidity was determined by the guidelines as set out by the MMPI-A and the CBCL. These assessments were performed prior to the EAP sessions and again more than 6 months afterwards. The parents, caregivers and teachers were properly instructed on how to complete the checklists. They were re-administered six months afterwards according to the guidelines for the re-administration of the MMPI-A as well as to not allow the adolescents' time to regress and capture the possible changes in therapy. These assessments were administered in a group. Although this is not preferable with the use of the MMPI-A, due to time, it is necessary. However, although it was done in a group setting, everyone had their own question sheet and the questions were read out to them. The clinical psychologist was present for the duration of the time that it took to complete the assessment.

##### ***4.4.3.1. The 6-18 Child Behaviour Checklist – Youth Checklist (CBCL)***

This version of the CBCL is a self-report questionnaire and is also known as a component of the Achenbach System of Empirically Based Assessment (ASEBA) (Domenech, Ezpeleta, & Lacalle, 2012). The ASEBA system is one of the most widely used assessment systems for the assessment of dimensional psychopathology in school-age children (Sistere *et al.*, 2014). This system is based on the observation of children in the United States of America epidemiological studies and comprises of different versions of child, teacher, and parent instruments, according to the age of the child and allowing for multi-informant assessment (Braet, Callens, Schittekatte, Soyez, Druart & Roeyers, 2011). It is a dimensionally based assessment characterised by a bottom-up approach (Braet *et al.*, 2011). This was achieved

through obtaining scores for specific descriptors of children's functioning. The initial items were based on reviews of clinical research literature and professional consultations. Items were revised based on the findings in psychiatric case studies and feedback received from different informants (Braet *et al.*, 2011). The CBCL is one of the most important instruments of the ASEBA system.

Furthermore, the CBCL assesses competencies and psychopathology (both behavioural and emotional) in both children and adolescents (Sistere *et al.*, 2014). Thus, making it the ideal questionnaire for this study as it will be examining behavioural difficulties. Mazefsky, Anderson, Conner, and Minshew (2011) state that the CBCL is widely used in mental health services, medical settings, schools, public health agencies and in training programmes.

The checklist designed for ages 6 – 18 years was used for the purposes of this study. There are three different forms/scales that can be filled out; one for the youth/child, known as the CBCL, one for the teacher, known as the Teacher's Report Form (TRF) and one for the caregiver of the child. These questionnaires are similar in nature and for the purposes of this study and consistency, only one type was handed out to the youth/child, teacher, and caregiver, namely the CBCL. Literature on psychological measurements highlights the value of including multiple informants, particularly parents with regards to youth assessments (Bernstein, Chorpita, Ebesutani, & Nakamura, 2008).

The CBCL self-report consists of 113 items which assess emotional and behavioural difficulties that have occurred over the last six months. There are three response options: 0 = not true, 1 = sometimes true and 2 = very true/often true (Sistere *et al.*, 2014). Thus, it is relatively easy to understand and respond to. By identifying syndromes, the researcher was able to identify patterns of problematic behaviour and learn more about the causes, risk and protective factors, effective interventions, and outcomes for each syndrome (Achenbach & Rescorla, 2001).

This checklist possesses DSM-orientated and empirically based syndrome scales which have been constructed through expert clinical judgement to match selected categories for behavioural and emotional problems as described in the DSM-IV i.e. affective, anxiety, somatic, attention-deficit/hyperactivity, oppositional and conduct scales (Bernstein *et al.*, 2008). The Empirically Based Syndrome scales were originally obtained through factor analysis and the items were grouped into the following eight categories: Anxious-Depressed, Withdrawn-Depressed, Somatic complaints, Social problems, thought problems, Attention

problems, Rule-breaking behaviour and Aggressive behaviour which are also grouped into two higher order factors/global groupings, internalising (internal) and externalising (external). (Sistere *et al.*, 2014). These items were further grouped under the DSM-IV. For example, items that cover generalised anxiety, separation anxiety and specific phobias are assigned to the Anxiety problems DSM-Orientated scale (Sistere *et al.*, 2014).

The internal scales reflect problems with the 'self' such as anxiety, withdrawn/depression, and somatic complaints. The external scales represent conflicts with other people and expectations for children's behaviour such as rule-breaking, aggressive and attention problem syndromes (Achenbach & Rescorla, 2001).

The following symptoms are measured by these scales and some can be related to DSM orientated scales, although not a diagnosis on their own (Achenbach & Rescorla, 2001):

- *Anxious/depressed*: fears and anxiety, nervous, tense, tearfulness, feelings of feeling unloved and worthless, self-consciousness, feelings of guilt and suicidal ideation. This syndrome can be related to anxiety disorders such as generalised anxiety disorder (GAD);
- *Withdrawn/depressed*: sad, withdrawn, prefers to be alone, secretive, shy, timid, refuses to talk and engage, would rather be alone, lacks energy. This scale can be related to depression.
- *Somatic complaints*: nightmares, feeling dizzy, overtired, aches, pains, nausea, eye and skin problems, stomach aches and vomiting. This syndrome can be related to somatic disorders in the DSM;
- *Social Problems*: too dependent, lonely, jealous, gets teased, speech problems, clumsy, speech problems, not liked;
- *Thought problems*: twitching, picking of skin, strange ideas, strange behaviour, seeing things, hears things, repeats acts, sleep talks or walks and has difficulty sleeping;
- *Attention problems*: fails to finish, can't concentrate, can't sit still, confused, daydreams, impulsive, inattentive, fidgety, disruptive, impulsive, and poor school performance. This scale can be related to attention deficit hyperactivity disorder (ADHD) and attention deficit disorder (ADD);
- *Rule-breaking behaviour*: drinks alcohol, breaks rules, lies, cheats, lacks guilt, has bad friends, prefers older children, runs away, sets fires, sexual problems, steals at

home and outside the house, uses profanities. This scale can be related to the DSM diagnosis of Conduct Disorder (CD) or Oppositional defiant disorder (ODD):

- *Aggressive behaviour:* argues a lot, mean to others, destroys their own and other things, disobedient at home and at school, gets into fights, threatens, has a temper, loud, suspicious, demands attention and sulks.

Only the syndrome scales of the CBCL protocols were analysed. This is because the researcher was researching the change in behaviour and symptoms and these scales are more reflective of the behaviour and symptoms experienced by the adolescents.

#### 4.4.3.2. *The Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A)*

The MMPI-A was developed from the Minnesota Multiphasic Personality Inventory (MMPI), a personality assessment, which has a long history of being used with adolescents and was the most widely used objective assessment tool for adolescents (Baum, Archer, Forbey & Handel, 2009). However, the MMPI was originally created for the use of adults in mind, and thus had adult's norms which when used with adolescents could provide misleading and/or questionable results. Thus, a decision was made to create a revised edition of the assessment specifically for adolescents and with adolescent norms (Baum, *et al.*, 2009). It has become the most frequently used self-report tool amongst adolescents.

The MMPI-A is a 478-item multiscale personality inventory that requires a seventh-grade reading level and is usually used on adolescents between the ages of 14 – 18 years (Rogers, Hinds, & Sewell, 1996). Although it is possible to administer the inventory to adolescents that do not necessarily have this level of schooling. This, however, may be a limitation to the results and the researcher needs to interpret the results with caution.

The MMPI-A can be used to diagnose as it possesses DSM-IV-TR orientated scales i.e. anxiety, somatoform, oppositional. As the MMPI-A measures baseline functioning with regards to certain personality traits/psychopathology (conduct disorder, depression etc.), comparing the results after approximately six months (before and after the EAP sessions), the outcomes of the EAP sessions in terms of changing behaviour measured on the scales were measured as well as any change in relational styles.

This research focused on the analysis of the basic profile and the core scales of the MMPI-A. Thus, the following validity and content scales were discussed qualitatively as well

as compared quantitatively; Infrequency (F1), Defensiveness (K), Lie (L), Hypochondriasis (Hs), Depression (D), Hysteria (Hy), Psychopathic deviate (Pd), Masculinity-femininity (Mf), Paranoia (Pa), Psychasthenia (Pt), Schizophrenia (Sc), Hypomania (Ma) and social introversion (Si). Framingham (2016), expands and explains these scales in depth;

### *Validity Scales*

- F – This scale is intended to detect unusual or atypical ways of answering the test items e.g. if a person were to randomly fill out the test questionnaire. Furthermore, it taps into several strange thoughts, peculiar experiences, feelings of alienation and isolation as well as several unlikely or contradictory beliefs. If an individual answers too many of the F scale items incorrectly, it will invalidate the entire test.
- K – This scale is designed to identify psychopathology in individuals who would otherwise have profiles within the normal range. Individuals who score high on this scale are seen as being defensive.
- Lie (L) – This scale has been developed to identify individuals that are deliberately trying to avoid answering the questionnaire honestly. Individuals that score high on this scale are often trying to make themselves look better than they really are.

### *Content Scales*

- Hypochondriasis (Hs) – This scale measures a wide variety of vague and non-specific complaints about bodily functioning. Furthermore, this scale measures poor physical health and gastrointestinal difficulties.
- Depression (D) – This scale measures clinical depression, characterised by poor morale, lack of hope in one's future and a general dissatisfaction with one's life.
- Hysteria (Hy) – This scale primarily measures five components – poor physical health, shyness, cynicism, headaches, and neuroticism.
- Psychopathic Deviate (Pd) – This scale measures general social maladjustment and the absence of strongly pleasant experiences.
- Masculinity-Femininity (Mf) – This scale measures interest in vocations and hobbies, aesthetic preferences, activity-passivity, and personal sensitivity. It also measures how rigidly a person conforms to stereotypical masculine or feminine roles.



- Paranoia (Pa) – This scale measures interpersonal sensitivity, moral self-righteousness, and suspiciousness. Some of the items on this scale acknowledge the existence of paranoid and delusional thoughts.
- Psychasthenia (Pt) – This scale measures a person’s inability to resist specific actions or thoughts, regardless of their maladaptive nature, also referred to as obsessive compulsive disorder. Furthermore, this scale taps into abnormal fears, self-criticism, difficulties in concentration as well as guilt.
- Schizophrenia (Sc) – This scale measures bizarre thoughts, peculiar perceptions, social isolations, poor familial relationships, difficulties with regards to behaviour, concentration and impulse control, sexual difficulties as well as disturbing questions related to self-worth and self-identity.
- Hypomania (Ma) – This scale measures milder degrees of excitement, characterised by an unstable mood, psychomotor excitement, flight of ideas, over activity, grandiosity, and irritability.
- Social introversion (Si) – This measures the social introversion and extroversion of an individual. An individual scoring high on the introversion scale may feel uncomfortable in social interactions and may withdraw. They may also have limited social skills.

#### ***4.4.4. The child and adolescent psychiatric interview***

The Child and Adolescent Psychiatric interview (Appendix D) was conducted with each participant in the experimental group and undergoing the EAP sessions. This involved the asking and answering of carefully selected and constructed questions which were relevant to the adolescent in order to enhance the qualitative data obtained.

Frels and Onwuegbuzie (2013) state that interviews are one of the most common ways of collecting data in qualitative research because they provide opportunities for the researcher to collect meaningful and rich data and that they are perhaps more relevant to the field of counselling/therapy.

Questions pertaining to the child’s experience of horses were also included and the process of the EAP sessions as well as safety issues were discussed.

This information did not only assist with the process of therapy, but also added value to the qualitative research findings.

#### ***4.4.5. Equine Assisted Psychotherapy Sessions (EAP)***

The standard process for EAP was followed for the purposes of this research. This process involves an initial interview with the participant followed by sessions in the arena with the horse specialist, clinical psychologist, and the horse. This study, unlike most other published studies, specifically focused on the use of psychodynamic psychotherapy in collaboration with EAP. As mentioned, the EAP sessions were performed by a qualified clinical psychologist as well as a qualified horse specialist. Each professional had undergone specialised training in EAP. Specific horses were chosen to participate in the EAP depending on the participant and the presenting problem. The horses were chosen by the horse specialist who knew them well and knew their behaviour. For example, a calm and placid horse was chosen as it was more suited to adolescents that may act out aggressively or who may be very anxious.

The sessions took place at a stable yard in the South of Johannesburg, with prior approval from EAPISA, as previously mentioned.

Each EAP session had a particular activity designed by the horse specialist, in collaboration with the clinical psychologist. The particular activity as well as the purpose of the activity is described in detail for each participant in the relevant chapter. Only the participant entered the arena with the horse. The clinical psychologist and horse specialist remained outside, to assist with objectivity.

The EAP sessions were between 30 and 40 minutes long and each participant was to undergo 6 sessions of individual EAP. They were conducted every Monday morning at the farm in the South of Johannesburg where the psychologist met with the horse specialist. The children were transported to the farm by the auxiliary social worker from the child welfare society in two different groups. To make the sessions more manageable, the participants were split into groups of three so that only three sessions were conducted on a Monday. Each participant had their own individual session of EAP. Thus, the psychologist and horse specialist were each involved in approximately 3 hours of EAP every Monday morning for a period of 12 weeks. This process allowed not only the researcher and horse specialist a chance to rest, but more importantly gave the horses a chance to recuperate. After the first group of three had completed their six sessions, the second group of three participated in the EAP sessions.

With the legal guardian's consent and the participants assent, each session was tape recorded with the use of an electronic tape recorder. This data was stored according to the University of Pretoria's, Faculty of Humanities data storage policy.

The following safety measures were important to take into consideration during the EAP sessions and were discussed with the participant during the child and adolescent interview, prior to the EAP sessions;

- Each participant needed to wear appropriate clothing (long trousers and a T-shirt) as well as sunblock and a hat,
- Each participant needed to wear closed shoes to protect themselves should a horse stand on their feet,
- Emotional safety, such as confidentiality was discussed.

#### **4.5. Data analysis**

The following section focuses on the data analysis of both the quantitative and qualitative data.

##### ***4.5.1. Quantitative Data-Analysis***

Once the data was obtained it was statistically analysed using the Wilcoxon Signed-Rank test which was used to compare scores. Upon completion of the CBCL, the raw data was analysed with the assistance of a research psychologist that is experienced and fluent in statistics from the University of Pretoria. The MMPI-A was sent to Jopie Van Rooyen (a company specialising in psychometric assessments) to be analysed and a basic profile report was obtained which was then analysed with the Wilcoxon Signed Rank test.

##### ***4.5.1.1. The Wilcoxon Signed-Rank test***

Many statistical methods require that assumptions are made about the format of the data to be analysed (Whitley & Ball, 2002). Thus, parametric methods of analysis are used. However, there are situations when transformed data may not satisfy the assumptions and, in these cases, it would be inappropriate to use traditional (parametric), methods of analysis such as the t-test (Whitley & Ball, 2002). The Wilcoxon Signed-Rank test is an alternative to the sign test as well as the  $t$  test of the difference between two dependent means (Minium, King, & Bear, 1993). It is also considered a nonparametric method which requires very limited

assumptions to be made about the data (Whitley & Ball, 2002). Furthermore, it is more powerful than the sign test because it weighs the size of a difference between pairs of scores (Minium, King, & Bear, 1993), and is used when a comparison is made between two independent groups such as pre-test and post-test results (Whitley & Ball, 2002). Furthermore, a Wilcoxon Signed Rank test also uses additional information about the difference. This test is also referred to as the Mann-Whitney test (Whitley & Ball, 2002).

With regards to interpreting the output from a Wilcoxon Signed Rank Test, there are two things that are important; the Z value and the associated significance levels which are presented as Asymp. Sig (2 tailed).

The following five steps are followed in performing the Wilcoxon Signed Rank Test (Whitley & Ball, 2002);

- *Step 1*

The null hypothesis is stated and particularly the hypothesized value for comparison.

- *Step 2*

All observations are ranked according to their increasing order of magnitude, ignoring their sign. Any observations that are equal to the hypothesized value are ignored. If two observations have the same value, regardless of their sign, they are given the average ranking.

- *Step 3*

A sign (+ or -) is allocated to each observation according to whether or not it is greater or less than the hypothesized value.

- *Step 4*

The following are calculated:

$R_+ = \text{sum of all positive ranks}$

$R_- = \text{sum of all negative ranks}$

$R = \text{smaller of } R_+ \text{ and } R_-$

- *Step 5*

An appropriate  $P$  (significance level) value can be calculated.

If the significance level, symbolised by a  $p$  is equal to or less than 0.05 then you can conclude that the difference between the two is statistically significant (a 5% level of significance was used). The effect size is actually the main finding of the quantitative study. A  $p$  value informs the reader whether an effect size exists, but it does not reveal the size of the effect (Sullivan & Feinn, 2012). With regards to interpreting results, both the  $p$  value and the effect size are essential results to include.

When interpreting the  $p$  value, if the significance level, symbolised by a  $p$  is equal to or less than 0.05 then you can conclude that the difference between the two is statistically significant. This is based on the assumption of a null hypothesis which states that there is no difference between the pre- and post-test. However, one sample mean will nearly always be greater than the other. Therefore, the researcher must employ a statistical significance test to determine the probability of a difference between the sample means occurring by chance when the null hypothesis is true (Maher, Markey, & Ebert-May, 2013). The researcher may decide to reject the null hypothesis based on the results and the basis for this rejection is provided by the  $p$  value. The  $p$  value is the output of statistical significance testing (Maher *et al.*, 2013). Furthermore, the  $p$  value represents the probability of the observed data given that the null hypothesis is true. A low value of  $p$ , typically below 0.05 leads researchers to reject the null hypotheses (Maher *et al.*, 2013). Furthermore, the smaller the value of  $p$ , the larger the treatment effect.

An effect size symbolised by an  $r$  is an extra explanation of the  $p$  value and conveys to the reader how large the impact of the  $p$  value is. Reporting only the  $p$  value for an analysis is not adequate enough in order for readers to fully understand the results (Sullivan & Feinn, 2012). Maher *et al.*, (2013), state that a useful statistical tool is the effect size which measures the strength of a treatment response or the relationship between variables. An effect size provides a scale-free measure that reflects the practical meaningfulness of the difference or relationship between variables (Maher *et al.*, 2013). Effect size and statistical significance testing are complementary to each other and both need to be considered. Furthermore, Sullivan and Feinn (2012), state that an effect size is the magnitude of the difference between groups. An absolute effect size is the difference between the average/mean outcomes in two different intervention groups.

An effect size symbolised by an  $r$  is an extra explanation of the  $p$  value and conveys to the reader how large the impact of the  $p$  value is. A  $r$  value between 0.1 and 0.3 is a small

effect size, a  $r$  value of between 0.3 and 0.5 is a medium effect size and any  $r$  value 0.5 upwards is a large effect size.

With regards to effect sizes of the CBCL, the following is taken into consideration:

0.1 to <0.3 is considered a small effect size

0.3. to <0.5 is considered a medium effect size

0.5 and upwards is considered a large effect size

The following table, Table 2, Ranges of the Syndrome Scales illustrates the normal and clinical ranges for the CBCL.

*Table 2*

*Ranges of the Syndrome Scales: Normal and Clinical Ranges of the CBCL – Girls and Boys (Other problems do not have normal range or clinical range scores).*

**Normal Range**

Syndrome	Boys 6-11	Boys 12-18
Anxious/Depressed	0-10	0-9
Withdrawn/Depressed	0-5	0-7
Somatic Complaints	0-6	0-5
Social Problems	0-9	0-8
Thought Problems	0-6	0-7
Attention Problems	0-12	0-13
Rule Breaking Behaviour	0-6	0-12
Aggressive Behaviour	0-16	0-16
Internal A	0-11	0-13
External B	0-15	0-18
Total	0-48	0-51

Syndrome	Girls 6-11	Girls 12-18
Anxious/Depressed	0-10	0-10
Withdrawn/Depressed	0-6	0-7
Somatic Complaints	0-6	0-6
Social Problems	0-8	0-8

Thought Problems	0-6	0-6
Attention Problems	0-10	0-10
Rule Breaking Behaviour	0-6	0-10
Aggressive Behaviour	0-15	0-16
Internal A	0-13	0-14
External B	0-14	0-15
Total	0-48	0-44

### Clinical Range

Syndrome	Boys 6-11	Boys 12-18
Anxious/Depressed	11-26	10-26
Withdrawn/Depressed	6-16	8-16
Somatic Complaints	7-22	6-22
Social Problems	10-22	9-22
Thought Problems	7-30	8-30
Attention Problems	13-20	14-20
Rule Breaking Behaviour	7-34	13-34
Aggressive Behaviour	17-36	17-36
Internal A	12-64	14-64
External B	16-70	19-70
Total	49-240	52-240

Syndrome	Girls 6-11	Girls 12-18
Anxious/Depressed	11-26	11-26
Withdrawn/Depressed	7-16	8-16
Somatic Complaints	7-22	7-22
Social Problems	9-22	9-22
Thought Problems	7-30	7-30
Attention Problems	11-20	11-20
Rule Breaking Behaviour	7-34	11-34
Aggressive Behaviour	16-36	17-36
Internal A	14-64	15-64

External B	15-70	16-70
Total	49-240	45-240

The following tables, Tables 3 & 4, explain the ranges that were used for the interpretation of the MMPI-A (Butcher *et al.*, 1992):

*Table 3*  
*Interpretation guidelines for the Validity scales*

L	60 – 64 Cautionary Statement	65 + Possibly Defensive	
K		65 + Possible defensive test taking attitude	
F	80 – 89 Problematic response pattern	90+ Invalidating response pattern	110+ Carelessness or faking bad

*Table 4*  
*Interpretation guidelines for the Content Scales*

	<b>Insignificant</b>	<b>Moderate elevations</b>	<b>Clinically significant</b>
<b>Hs</b>	0 – 59	60 - 64	65 +
<b>Depression (D)</b>	0 – 59	60 - 64	65 +
<b>Hy</b>	0 – 59	60 - 64	65 +
<b>Pd</b>	0 – 59	60 - 64	65 +
<b>Masculinity-Femininity (Mf)</b>	0 – 59	60 - 64	65 +
<b>Paranoia (Pa)</b>	0 – 59	60 - 64	65 +
<b>Pt</b>	0 – 59	60 - 64	65 +



<b>Schizophrenia (Sc)</b>	0 – 59	60 - 64	65 +
<b>Ma</b>	0 – 59	60 - 64	65 +
<b>Social Introversion (Si)</b>	0 – 59	60 - 64	65 +

#### ***4.5.2. Qualitative data analysis***

This section explores the method used for the analysis of the qualitative data. Upon completion of the EAP sessions, each session was transcribed verbatim from the electronic tape-recordings of the sessions. Schedler (2010), argues that examination of session recordings is helpful in determining outcomes and effectiveness. Where appropriate, non-verbal behaviour was included in the transcriptions, using brackets and italics. The researcher noted this non-verbal behaviour at the time that it occurred, in a little note book, in order to ensure that the non-verbal behaviour corresponded with the verbal description. The auditory tape recordings as well as the transcripts of the sessions formed the raw data for this research and was utilised for the data analysis. The raw data was stored appropriately per the policy at the University of Pretoria.

##### ***4.5.2.1. Thematic analysis***

Thematic analysis is a type of qualitative analysis that is used to analyse classifications and present themes (Boyatzis, 1998). Thematic and content analysis are known as two separate approaches, however, because the division and boundaries between the two has not been established, the terms are often used interchangeably and the similarities and differences between the two can be confusing (Vaismoradi, Turunen, & Bondas, 2013), thus the term thematic content analysis. Thematic analysis has been described as an ‘independent qualitative descriptive approach’ that identifies, analyses and reports patterns and themes within data, identifying common threads that extend an entire interview, set of interviews (Vaismoradi *et al.*, 2013). Alhojailan (2012) describes thematic analysis as a comprehensive process whereby researchers can identify numerous cross references between the data and the researchers evolving themes.

The thematic analytic approach of Braun and Clark was used in this study. Clark and Braun (2016) state that their own approach is flexible and organic allowing coding to evolve through the process. In order for this to take place themes need to be conceptualised as real

and identifiable in the world. “They are offered to the reader as a compelling and coherent reading of data, rather (more or less) accurate identification of a decontextualized or pre-existing truth” (Clarke & Braun, 2016, p.740). This process assists with reliability, as Clarke and Braun (2016) state that if themes can be captured, recognised, and noticed they would pre-exist the analytic and interpretative approach of the researcher and thus not be inferred.

The aim of this approach is to analytically examine narrative material by breaking the text into relatively small units of content (codes) and submitting them to descriptive treatment (Vaismoradi *et al.*, 2013). Thematic analysis allows for a qualitative, detailed, and nuanced analysis of the data, whereas, content analysis allows for the analysis of data qualitatively as well as being able to quantify the data (Vaismoradi *et al.*, 2013). Furthermore, it provides flexibility for approaching the research in two different ways; namely inductive and deductive (Alhojailan, 2012).

The researcher read and reread the transcript of the EAP sessions until a sense of the whole and potential themes was identified. According to Braun and Clarke (2006), there are six steps in thematic analysis which were followed during the analysis of the data and are discussed in more detail below. Clarke and Braun (2013) describe this process as a recursive process, rather than a linear model, where one cannot proceed without completing the prior phase.

- *Step 1 – Familiarising yourself with the data*

The transcription of the data and the reading, and rereading of the data in an attempt to immerse yourself in the data and note down initial ideas and potential themes.

Nowell, Norris, White and Moules (2017) describe this phase as engaging with the analysis as a “faithful witness to the accounts in the data” (p. 5), being vigilant and honest about any of their pre-existing thoughts, beliefs and developing theories. The researcher should document any theoretical and reflective thoughts that develop and make notes about any ideas that may develop for coding which can be returned to in subsequent phases (Nowell, Norris, White, & Moules, 2017). This is the process that the researcher followed in the thematic analysis.

- *Step 2 – Generating initial codes*

This step involved the coding of interesting features of the data systematically across the entire data set and collating the data as relevant to each code. Thus, it allows the researcher to simplify and focus on specific characteristics of the data (Nowell, Norris, White, & Moules,

2017). It can only take place once the researcher has read and fully familiarised themselves with the data and what is in the data (Nowell *et al.*, 2017). This allows for the capturing of diversity and provides the foundation for the conceptualisation of possibly significant patterns of meaning (shared) (Clarke & Braun, 2016).

Using thematic analysis, it is possible to link the various concepts and opinions of the participants and compare them with the data that has perhaps been gathered at different times with different participants (Alhojailan, 2012). This step is a theorising activity and requires the constant revisitation of the data, a process of reflection (Nowell *et al.*, 2017).

- *Step 3 – Searching for themes*

Nowell *et al.* (2017) state that this step only occurs once all the data has initially been coded and a list of different codes has been identified across the data set. This involves sorting through all the potentially relevant codes into themes.

Themes are identified by bringing together fragments of ideas, that may appear meaningless when viewed alone (Nowell *et al.*, 2017). A theme needs to capture something that is important in relation to the overall research question and once identified, themes are significant concepts that link large amounts of the data together. The first place to start when looking for themes, is with a few pre-defined codes that would help guide the analysis, thus themes and sub-themes may emerge. Codes should not be abandoned at this point and can be placed in a “miscellaneous” folder until it is determined where they may best fit (Nowell *et al.*, 2017). Detailed notes of this process should be kept.

Various procedures such as tables, templates, code manuals or mind-maps can be used to generate themes, as long as they are consistent (Nowell *et al.*, 2017). The researcher employed the use of mind-maps to generate themes.

- *Step 4 – Reviewing themes*

This step involved generating a thematic map which involved checking if the themes work in relation to the coded extracts as well as the entire data set.

Nowell *et al.* (2017) states that during this step, inadequacies in the initial coding phase will be identified and new codes may be inserted, a code may be deleted, or some themes may collapse into each other. Furthermore, some themes may need to be refined and ultimately the data within themes should be clear and consistent with a clear distinction between the themes. This can be an ongoing process.

- *Step 5 – defining and naming the themes*

This step involved generating clear definitions and names for each theme. It also involved ongoing analysis for reviewing the specifics of each theme and the overall ‘story’.

Clarke and Braun (2016) suggest that the names of the themes need to be catchy and immediately give the reader a sense of what it is about. There may be overlapping between the themes and it is advisable to consult with outside experts to determine if the themes are clear and comprehensive enough (Nowell *et al.*, 2017), which was followed through with this research through consultations with my promoter. This step can only be considered finalised once all of the data and coding has been scrutinised twice (Nowell *et al.*, 2017).

- *Step 6 – Producing the report*

This is the final opportunity for analysis and involves the selection of vivid, compelling, extract examples and relating them back to both the research question and the available literature thus producing a ‘report’ of the analysis.

The write-up of the report needs to be concise, coherent, logical and an interesting account of what the data contains within as well as across themes. Direct quotes from participants are an essential part of this step and extensive passages of quotation can be included (Nowell *et al.*, 2017). This step needs to remain credible and trustworthy through a discussion of all the relevant results (unexpected as well as those that did not correspond with the main explanations) as well as using the results to build a convincing explanation (Nowell *et al.*, 2017).

Furthermore, the paradigmatic point of departure for the sessions is Melanie Klein’s psychodynamic object relations as discussed in Chapter 3 and the analysis of the data into themes will also rely heavily on the features of psychodynamic object relations. According to Shedler (2009), seven features distinguish psychodynamic therapy from other therapies, which has been determined by empirical examination of actual session recordings and transcripts. These seven distinctive processes and features will be outlined below as they are an important part of the data analysis (Shedler, 2009);

1. The focus on affect and expression of emotion: psychodynamic psychotherapy encourages the exploration and discussion of the full range of the patient’s emotions. The therapist helps the patient describe and put words to feelings (difficult and troubling feelings) that the patient may not necessarily want to acknowledge. There is

also a recognition that emotional insight is important and different from intellectual insight.

2. Exploration of attempts to avoid distressing thoughts and feelings: Individuals are involved in many avoidance techniques (missing sessions, arriving late or being evasive) to avoid aspects of experiencing that are troubling. Psychodynamic psychotherapy actively focuses on and explores these avoidances.
3. Identification of recurring themes and patterns: Psychodynamic psychotherapists work is to explore and identify recurring themes and patterns in patient's thoughts, feelings, self-concept, relationships, and life experiences. Sometimes individuals are aware of these patterns and unable to change them or sometimes they may require the therapist to help them understand self-defeating and self-sabotaging patterns of behaviour in order to change them.
4. Discussion of past experiences (developmental focus): this is related to the identification of recurring themes and patterns and is the recognition that past experiences, especially our early experiences of attachment figures affects our relation to and our experience of the present. The relationship between past and present is explored and the way in which the past has an impact on the present.
5. Focus on interpersonal relations: Heavy emphasis is placed on the patient's relationships and interpersonal experiences (the patient's object-relations). Difficulties often arise when problematic interpersonal relations interfere with the individual's ability to meet emotional needs.
6. Focus on the psychotherapy relationship: The therapeutic relationship is an important and meaningful interpersonal relationship. The repetitive and maladaptive themes in the individual's life often play out in the therapeutic relationship. This transference and countertransference provides a unique opportunity for the themes and patterns to be explored in the therapy.
7. Exploration of wishes and phantasies: Psychodynamic psychotherapy encourages patients to speak freely thus encouraging the patient to discuss dreams, desires, fears, worries, and daydreams providing a rich source of information for the therapist to work with.

#### 4.5.2.2. *Personal reflexivity*

The researcher was both the clinical psychologist conducting the EAP sessions as well as the researcher. Due to the dual role, that the researcher undertook, it was important to keep a personal research field diary in which any comments, bias and possible non-objectivity could be diarised and discussed with her promoter in order for any potential bias and judgement to not interfere with the research outcomes.

Furthermore, in accordance with thematic analysis, the researcher would have had to bracket any of her persona biases. Bracketing is the setting aside of the researchers own biases and judgement. This is a traditionally phenomenological term but is applicable to qualitative studies and especially where judgements or bias may be present. It is well accepted as a way to enhance rigour in multiple qualitative research methodologies (Peters & Halcomb, 2015). Simon (2011) argues that one's personal experiences and cognitive biases cannot be fully set aside when doing research, it is important to engage in a process of bracketing. The researcher also had to abstain from presupposition and/or judgements about the phenomena under research. This is termed Epoché. The aim is thus to "enable the researcher to describe the "things" themselves and set aside our natural attitude or all those assumptions we have about the world around us." (Yuksel & Yildirim, p. 6, 2015).

It is important to note that there are varying positions around bracketing (Peters & Halcomb, 2015). It can also merely mean curiosity – the acknowledgement that there is something additional and unknown to be discovered, and bracketing can occur at different phases of the research (Peters & Halcomb, 2015).

The researcher and clinical psychologist does believe that she was able to maintain clear and consistent boundaries during this process. In addition, she only undertook one role at a time, either that of researcher or that of psychologist. This was possible through the completion of the EAP sessions before the start of the research.

#### **4.6. The validity and reliability of the mixed methods research approach**

Evaluating the validity of a qualitative study requires the reviewer to distinguish between researcher's errors during the data analysis (Vaismoradi *et al.*, 2013).

Qualitative data has been criticised in that it lacks the rigour and scientific credibility associated with the traditionally accepted quantitative analysis. Credibility, dependability, conformability, and transferability (providing as thick a description of the phenomenon as possible) are the most common measures to achieve validity and rigour in qualitative studies

(Vaismoradi *et al.*, 2013) and were followed in the process of this research. Dependability was ensured through the use of Guba's technique of the inquiry audit (Lincoln & Guba, 1985). This involves the collection and analysis of information in order to acquire the research findings that is examined and confirmed by a supervisor. This ensures the correction of any of the researcher's biases.

Practically, to improve rigor in both approaches, the researcher is encouraged to keep a personal research diary, (Vaismoradi *et al.*, 2013), which in the case of this research was done. One of the best ways for judging the quality of findings is whether new insights have been provided into the phenomenon being studied (Vaismoradi *et al.*, 2013).

The 6 – 18 year CBCL and the MMPI-A are considered a valid and reliable measure of psychopathology for this research and add value to the study as a diagnostic tool. A research study conducted in an Iranian community found that the CBCL is reliable in most multicultural communities (Tehrani-Doost, Shahrivar, Pakbaz, Rezaie, Ahmadi, 2011).

Furthermore, many studies have illustrated a high rate of reliability between the scales of the CBCL and actual psychological diagnosis (Mazefsky, Anderson, Conner, & Minshew, 2011). Sistere *et al.*, (2014), reported that the DSM conduct problems scale makes a notable contribution to the diagnostic clarification of DSM Disruptive Behaviour Disorders according to the results of their study. However, a clinician must be careful in usually it on its own as a diagnostic tool and with most assessment procedures needs to be used in conjunction with collateral information as well as clinical observations. Nakamura, Ebesutani, Bernstein and Chorpita (2009) reported that on the DSM orientated scales of attention deficit hyperactivity disorder, oppositional defiant disorder as well as conduct disorder there was a positive correlation with their respective convergent validity criterion measures. Further results from this study suggest that there is acceptable internal consistency for the scales of the CBCL as well as excellent convergent and divergent validity (Nakamura *et al.*, 2009). Embregts (2000) did however find that the checklists of the CBCL for psychopathology amongst youth that present with mild mental retardation may not always represent a reliable checklist.

The MMPI-A clinical scales have been shown to have high long-term stability (Pope & Butcher, 2006) and the assessment instrument has been used extensively in the study of delinquents and a number of clinical studies (Pope & Butcher, 2006). A number of studies have focused on establishing the reliability and validity on the MMPI-A content scales (Handel, Archer, Elkins, Mason & Simonds-Bisbee, 2011). These studies have found evidence for incremental validity on a number of content scales in predicting a variety of

intra test criteria (Handel *et al.*, 2011). Furthermore, in a study conducted by Forbey and Ben-Porath provided evidence for the validity of the content scales on the MMPI-A (Handel *et al.*, 2011). According to the study conducted by Handel *et al.*, 2011, the scores obtained on the MMPI-A showed evidence of convergent validity and discriminant validity. Validity evidence varied by scale and gender

#### **4.7. Ethical considerations**

There are certain ethical considerations that needed to be taken into consideration. Both the rights of the participants as well as the horse(s) need to be considered and it was ensured that they were protected from harm, both emotionally and physically, at all times.

The following are the ethical considerations that were taken into consideration whilst undertaking the research;

- Ethical clearance was obtained from the Higher Degrees Committee of the Faculty of Humanities at the University of Pretoria before the commencement of the study;
- Prior approval from the child welfare society was obtained in order to source participants;
- Prior approval from EAPISA (Equine Assisted Psychotherapy Institute of South Africa) was also be obtained in order to utilise their resources and conduct the research,
- Informed consent was obtained from the legal guardians of the participants in order to participate in the research (as they are younger than 18 years of age);
- Informed assent was obtained from the participants prior to the conduction of the research,
- These consent and assent forms also included an indemnity with regards to working with the horses,
- Confidentiality was maintained and the study did not mention any of the participants' names or specific information that could potentially lead to the identification of the individual or horse;
- The participants as well as the child welfare society will be given the opportunity to receive feedback with regards to the research findings once the manuscript is finalised;
- Counselling, debriefing and/or psychotherapy was made available to the research participants where needed and when necessary. This was done in conjunction with the



child welfare society whereby they could be referred for further intervention if deemed necessary. Furthermore, the social workers at the child welfare society were involved in the process, given constant feedback about the welfare of the participants with their assent and could contact and follow-up with the participants if deemed necessary;

- Furthermore, full reports will be given to the child welfare society;
- First aid/medical assistance was made available to the research participants where needed and if necessary. This was done in conjunction with the child welfare society;
- The participants were given the opportunity to withdraw from participating in the study at any point during the course of the study with no harm or consequences coming to them;
- The researcher was also the clinical psychologist involved in the EAP sessions and thus steps were taken (such as keeping a research diary as well as consultation with the researcher's promotor from the University) to ensure that objectivity was ensured, and the dual role remained ethical;
- The horse's wellbeing was always taken into consideration and they were not over utilised, with rest periods in between sessions allowed. Furthermore, the same horse was not always used for each participant and the horse specialists is trained to identify any signs of fatigue or discomfort in the horses and thus the therapy could have been stopped.

#### **4.8. Conclusion**

This chapter explored both the quantitative and qualitative research methodologies as a mixed methods approach as used in this research. The focus of this chapter was more on the practical aspects of this research, namely the process that was used in the collection of the research data as well as the selection of the participants, the data collection, and the method of analysis.

The various steps involved in the data analysis were explicated as well as the validity and reliability of the research methods.

The next chapter, **Chapter 5**, introduces the reader to the first participant, Participant A. This chapter explores Participant A's background history, child and adolescent interview, the results of the pre- and post-test CBCL protocols and MMPI-A as well as the intra-individual analysis of the EAP sessions and conclusions.

## **CHAPTER 5**

### **RESEARCH RESULTS: PARTICIPANT A**

#### **5.1. Introduction**

The following chapter presents the research findings of Participant A. It includes relevant background history regarding Participant A, the child and psychiatric interview, the researcher's impressions, the results of the CBCL and MMPI-A (both pre-test results as well as post-test results after the EAP sessions) as well as a summary and thematic analysis of the transcripts of the EAP sessions.

Participant A was the only female participant in the study that underwent the EAP sessions.

#### **5.2. Relevant Background History**

Participant A was reported, by the auxiliary social worker from the local child welfare, to be born on the 23<sup>rd</sup> July 2002 and is reportedly in Grade 7 at a local government primary school in a low socio-economic area. She is currently residing with her biological mother (30 years old) and maternal grandmother. It was reported that her biological father is living with another woman and her children. She alleged that she has a good relationship with her father even though they are not staying together. It was further reported that her biological mother is allegedly using drugs and alcohol and is often drunk. When the auxiliary social worker arrived at her house, her mother was found drunk. She is apparently not providing for Participant A, and Participant A is being looked after by her maternal grandmother.

Participant A's maternal grandmother reported that she is stubborn, does not obey house rules, is allegedly not able to assist with house chores and is apparently too lazy to wash her underwear.

The teacher reported that Participant A is an 'average performer' and that she is happy with her school work.

It was also further reported, by the auxiliary social worker, that Participant A had recently started her menstruation and that she was allegedly very uncomfortable with the process as she would 'bleed' on her panties and then hide them or throw them away. It also appeared as if no one had informed her of puberty and what that means and the changes that the body goes through.

#### **5.3. Child and Adolescent Psychiatric Interview**

Upon interview, Participant A stated that she is a 14 year old, Coloured adolescent female. She is predominantly Afrikaans speaking, but also speaks English. She spoke English fluently enough to participate in the study. She stated that she is currently in Grade 6 at a local primary school in a low

socio-economic area, although this contradicts the information obtained from the auxiliary social worker.

She reported that she lives in a low socio-economic area with her maternal grandmother, her 12 year old half-brother and her maternal Uncles (23 and 9 years old). She reported that her 23 year old Uncle is currently in prison and that her mother also resides on the property at the back in a 'shack'. She stated that her mother is HIV+, although she is currently not very sick. Participant A further reported that she hardly sees her father and they have a poor relationship even though he also lives in the same area as her. She does not know her paternal grandparents and her maternal grandfather passed away in 2010 from complications resulting from a gunshot wound.

Participant A stated that her relationship with the members of her household was good, except for her brother, who she fights with a lot, and stated sometimes takes her stuff. She stated that there were no problems at home.

Furthermore, Participant A stated that no one in the household is working and they allegedly survive off the grant money that her grandmother receives. Participant A reported that the house she lives in only has two rooms and she shares a room with her grandmother.

During weekends, Participant A enjoys walking around the township and playing games at the game shops, with her friends. When she can afford it, she also enjoys going to the next closest city to run cross-country. Her favourite television programme is "7de Laan" (a locally produced popular soap opera) and she enjoys netball, swimming and running. She would like to be a doctor and Will Smith is her role model. Her three wishes are to have food on the table every day, for her grandmother to live until she is older and for a big home and to be a great mother one day. She would take her brother with her on an island holiday.

Participant A reported that school was 'good' and there were no problems. Her favourite subject is Afrikaans and she doesn't dislike any of her subjects. She reported that she gets along with all her teachers. She stated that she only has three friends and sometimes gets bullied at school (she gets laughed at, spoken about behind her back and gets her hair pulled). She doesn't have a boyfriend.

She further reported that she sometimes does not eat and would get hungry, feeling faint and dizzy. She stated that she does not eat breakfast and lunch as there is no money for food. She occasionally eats bread at school and has pap with soya mince for dinner. She reported that she goes to bed at 20:30 and has middle insomnia, often feeling tired in the morning, possibly due to hunger. She stated that she has no nightmares or dreams.

Participant A does worry a lot and especially worries what would happen if something happened to her granny, whom she is very close to, or if she passed away. She reported that she does sometimes feel sick and has a lot of headaches and feels dizzy at times. Although she reported a lot

of symptoms related to anxiety, Participant A did not report any fears or phobias. However, some of her symptoms, may also be due to hunger.

She stated that she does get angry and would then cry and go to bed. This happens when her granny shouts at her or when her uncle fights.

No history of epilepsy, seizures and/or psychotic symptoms were reported or elicited. She denied any conduct disorder features.

Participant A stated that she had never been around horses and that she is unfamiliar with them. She further stated that she was happy to be working with horses. All physical and emotional safety aspects were discussed with her.

#### **5.4. Researchers impressions of Participant A**

Participant A presented as a fairly groomed, coloured female adolescent. During the initial interview and assessment process, her mood was slightly low and she had a blunted affect. She presented as withdrawn and quiet and would only occasionally speak out or ask questions. Her thought form and content was normal, however, her speed was a bit slow. She was considered psychotic and suicidal. Her judgement and reliability was considered poor with very little insight.

Furthermore, during most of the EAP sessions she presented with a low mood, and was very withdrawn and disconnected. Her affect was blunted and it was very difficult to create a sense of rapport with her. She required a lot of motivation and encouragement in order to participate in the EAP sessions and almost seemed to do so reluctantly. Although she appeared to enjoy working with the horses, she did so with very little effort. She also did not interact much with the other children and spoke very little. She presented as anxious and hesitant and seemed very unsure of herself.

Participant A would appear to be very passive in nature. When asked why she felt that she was referred for the EAP sessions, she was very vague, and didn't seem to really know, and stated that she needed to do the sessions because the school had told her to. She seems to just do what she is told, however, with possible underlying resentment. She also appears to have a very external locus of control and as previously mentioned, poor insight into her behaviour.

She cooperated and participated fully with the assessment procedure as well as the EAP sessions. Throughout the whole process she presented as very quiet and withdrawn. She was experienced like this by both the researcher as well as the horse specialist.

## 5.5. Results of the MMPI-A (Pre-Test)

### *Validity Scales*

The results of the MMPI-A were deemed **valid** and therefore interpretable. However, due to specific elevated results on the validity scales the test results should be interpreted with caution. She scored high on the *FI* (Infrequency; T-score = 95) Scale which may indicate that she attempted to fake bad as well as the *L* (Impression management; T-score = 75) Scale which may also indicate that she attempted to present herself in as favourable light as possible. These results are contradictory and could possibly indicate that Participant A may be maladjusted and is trying naively to cover up problems. It may also indicate that she responded carelessly or inconsistently.

The configuration of the validity scale is F-L-K in a linear line with F at the top and going down. According to Duckworth and Anderson (1986) when the L and K are moderately elevated and the F is markedly elevated it is indicative of random marking of the test. However, it is also possible that the pattern is produced by the “All false” or “Negative response set” which indicates that most of the questions may have been answered false (Duckworth & Anderson, 1986).

Her high scores on both scales indicate that she responded to the test items in a very defensive and guarded manner. However, it is important to note that she may not necessarily have deliberately responded in this way, and these results may also indicate a subconscious cry for help/need for assistance with her difficulties.

### *Clinical Scales*

Participant A scored moderately high on the *Hypomania* (Ma) and high on the *Social Introversion* Scale (Si).

Individuals that score high on the Hypomania scale illustrate an abnormally high level of enthusiasm and energy which may lead to antisocial acts or irrational manic behaviour. She may also be predisposed to feeling irritable and experience a sense of grandiosity and elevated mood. Some adolescents also display a flight of ideas, egocentricity and cognitive and behavioural over activity. Individuals that score high on the Ma scale, may become restless and excited and stir up excitement just for the sake of it.

Furthermore, Participant A would appear to significantly struggle with relationships and may tend to withdraw, as illustrated by her high score on the Si scale. She may also have a low self-esteem. Research has shown that girls who score high on this scale, may have a predisposition towards eating problems, weight gain, depression, suicidal ideation and few friends (Butcher *et al*, 1992). In addition they may present as withdrawn, timid, shy, fearful and physically weak.

## **5.6. Summary of EAP sessions and therapeutic process**

Participant A undertook 5 out of 6 sessions of Equine Assisted Psychotherapy (EAP) at the stables. Unfortunately, one session had to be cancelled and was unable to be made up due to examinations and then school holidays. Her sessions lasted approximately 30 – 40 minutes per session and were facilitated by the researcher who is also a qualified Clinical Psychologist and the horse specialist.

The following section describes the activities that were used for Participant A, their purpose as well as a summary of the therapeutic process of each session. Most of the activities were specifically designed to assist her in dealing with relationships, as this had been identified as one of her core difficulties.

### ***5.6.1. Meet and Greet***

As this was the first session of EAP as well as Participant A's first time at the farm, it was decided by the clinical psychologist and horse specialist to allow Participant A time to meet and spend time with the horse in whichever way she felt possible. Horse A was placed in a small lunging arena and with all of us standing outside, she was instructed to go meet Horse A, spend some time with her and when she felt comfortable to go into the ring with her.

The purpose and focus of the activity is on relationship building as well as social skills and communication.

Participant A was initially very fearful and anxious of meeting with the horse and didn't even manage to go into the arena during the first session. She spent the entire first session outside of the arena and only managed to go into the arena and greet the horse on the third session. She was exceptionally scared that the horse would hurt her even though she was reassured that we wouldn't give her a horse that would kick or bite her. The horse also showed her, through her non-verbal body language, such as remaining calm and completely focused on her, that she wanted her to come and greet her and spend time with her. She did, however, manage to touch the horse through the wooden fence.

The process of the session was focused on her anxiety as well as her fear of creating relationships, rather than the fact that she was unable to complete the instruction.

### ***5.6.2. Meet and Greet***

Although this was the second session, it was also a session focused on meeting the horse and the same instructions that were given in Session 1 were given in Session 2. Initially a large, brown horse, Horse A, was used for her sessions, which was changed for the second session to a much smaller, grey pony, Horse B. It was felt that the size of the horse was far too intimidating and as she had shown that she

struggles to form relationships, it was felt that it may be less intimidating for her to work with a smaller pony and more possible for her to potentially create a relationship.

Participant A tends to want a relationship, but struggles with boundaries (may go into the horse's personal space), as soon as she receives a relationship from the other side, she pulls away as illustrated by her walking away from the horse when the horse would come to her. Very much a push and pull process. During this session it was also clear that Participant A has unmet needs, which was mirrored by the horse (the horse spent a lot of time eating the grass on the side of the arena, thus fulfilling a need of hers). Again, Participant A illustrated a fear of relationships.

### ***5.6.3. Catch and groom***

During this session Participant A was initially instructed to go into the arena and spend some time with Horse B. Once she was more comfortable with Horse B she was then given a grooming kit and instructed to spend time with Horse B by grooming her. The grooming kit is full of various brushes and tools that are used in fully grooming a horse. The focus of this activity is on relationships, communication, and social skills, problem-solving (how to groom a horse and what each tool is for) as well as boundaries. Once again the session is focused on the process and not on whether or not she completes the activity.

Participant A really struggled to form a relationship and spend quality time with the horse. She showed very minimal effort in her grooming and was again very anxious and hesitant. The horse seemed to try to force her to create a relationship with her and again Participant A illustrated difficulties with regards to boundaries (she would often walk behind the horse putting herself at risk of getting kicked) and unmet needs (the horse would go off eating, fulfilling a need, and ignore her. This also illustrated to the team that she has needs that she needs to fulfil). There were also times during the session where she perceived Horse B as rejecting her.

### ***5.6.4. Build how you feel***

This session was undertaken in the large arena. Horse B was present in the arena and next to the arena was a pile of objects such as poles, cones, old "Coke" bottles, balls, jumping poles, tyres, plastic letters and numbers as well as upright poles. Participant A was asked to build how she felt using any of the resources that were provided next to the arena. Participant A was told that she can include Horse B if she likes and was provided with a halter in order to catch her if necessary.

Participant A built a structure that seemed to represent a soccer field. She proceeded to kick the ball around and knock over letters and numbers. Each letter and number seemed very strategically placed. Horse B was mostly situated at the opposite end of the arena and did not seem to pay any

attention to Participant A. In addition, Participant A did not invite Horse B into her space that she had created.

In addition, a photo was taken at the end of the session with Participant A and Horse B as a memento for her and something tangible that she can take home with her to remember the sessions by.

The therapeutic process of this session was characterised by unmet needs (the horse would often do what she wanted to) as well as a need to be vulnerable. Her avoidance was very evident as well as the difficulty that she has in building relationships. Her disconnection from the horse was again very evident and she didn't even include the horse in her activity.

#### ***5.6.5. Catch, halter and groom***

This activity involves taking the halter, catching the horse in a large arena, putting the halter onto the horse and grooming the horse using the grooming kit. The grooming kit was filled with various brushes in order to fully groom a horse from head to toe. This activity once again focuses on relationships, boundaries, communication skills as well as problem-solving and trust as you need to trust a horse in order to thoroughly groom it (i.e. pick up a horse's feet, walk behind the back of the horse). It is important to note that Participant A was provided with these objects but was rather told to do whatever she wants in order to say goodbye and end of the EAP sessions.

During this session, Participant A became very involved with Horse B, grooming her and paying attention to her, although the disconnection and distance in the relationship was still very evident as she kept her distance and seemed to groom the horse at arm's length. Horse B was also very distracted with meeting her own needs and a push-and-pull relationship was very evident as both of them would get close to one another and then move away. It was also evident from the session that Participant A struggles with boundaries as she often placed herself in compromising positions, such as walking behind the horse and standing too close risking being stood on, and interestingly, Horse B would often stop and sniff at other horse's droppings which is highly indicative of setting boundaries.

At the end of the session, Participant A was given her photograph and was given an opportunity to say goodbye to Horse A. It did not seem particularly hard for her to say goodbye to the horse as she merely patted the horse and said goodbye.

The next section focuses on the intra-individual analysis of the EAP sessions.



## 5.7. Intra-Individual analysis of the transcript of the EAP sessions

The following section is an intra-individual analysis of the 5 EAP sessions where specific themes are highlighted and presented to the reader.

The following five themes were identified, which will be discussed in more detail: relationships, (which was sub-divided into trust, rejection, disconnection, boundaries and lack of effort), feelings, perception of the environment, as well as unmet needs.

Below follows the detailed thematic analysis with specific reference to the above-mentioned themes.

### 5.7.1. Relationships

Participant A would appear to really struggle to form relationships. This was evident right from Session 1 throughout the five sessions. As mentioned, she would appear to significantly struggle with relationships and may tend to rather withdraw from them.

The horse was changed from Horse A, a large, brown horse, to Horse B, a small grey pony, which did appear to help, but she would appear to really struggle to create a connection and take a long time to do so:

- **Horse specialist:** “Okay so we’ve got the small horse again for you today. Because we remember you don’t really like working with the bigger ones. Okay, so looks to me like she’s standing there waiting for you to come say hallo. So when you ready I’d like you to go in greet her and just become comfortable with her. It’s now the third session and you still a little bit anxious...so spend some time with her and become more comfortable with her before I give you the next instruction. Okay?” (*Silence 13 seconds*) (*Birds chirping*) (*Writing noise*)
- **Horse specialist:** “Okay my sweetheart, so there’s Horse B, there’s a halter on the floor, there’s brushes there, there’s all this stuff if you want to use it. This is your time with Horse B so you can go in and do whatever you want to with her for the next half an hour. Okay. Totally up to you. You can use this stuff you can use that, you can use that. You can do whatever you want to.”  
**Participant A:** “Okay.” (*Silence 18 seconds*)  
**Pauline:** “Interesting.” (*Participant A walked up to the horse.*)  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** “She’s actually taking stuff to do something with Horse B. (*Silence 8 seconds*) Again.”  
**Horse specialist:** (*Too windy to hear*).  
**Pauline:** (*Sound of agreement*) “Cause last week she ignored her hey...”  
**Horse specialist:** “Totally”  
**Pauline:** (*Too windy to hear*) (*Silence 4 seconds*) “Now she wants to spend time with her. And again she’s eating.”  
**Horse specialist:** “Looking after herself.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “It’s actually quite sad that it cost this girl three sessions to become involved, cause now at the end she’s very involved but it’s almost a little too late. (*Writing noise*)  
**Pauline:** “Ja. But I think that’s maybe what happens to her it’s too late then she doesn’t understand why the people have already like...”  
**Horse specialist:** (*Sound of agreement*).

She even wanted one of us to go with her to “assist” her in creating a relationship with the horse and did not have the courage/trust to do it herself;

- Horse Specialist:** “I noticed how interested she is with you.”

**Participant A:** “Are you gonna stand next to me?”

**Horse Specialist:** “Pardon?”

**Participant A:** “Are you gonna stand next to me?”

**Horse Specialist:** “I can. Her name is Horse A.”

**Participant A:** “Horse A?”

**Horse Specialist:** “Uh...ha”

**Participant A:** “Jo, must I just hold on to you?”

**Horse Specialist:** “Look how she’s moving closer to you. (*Silence 5 seconds*) It’s almost as though she’s saying: ‘Please touch me.’”

**Participant A:** “Can you touch it? Let me just see?”

**Pauline:** “What’s that like to see Horse Specialist touch her?”

**Participant A:** “Like the horse is friendly.”

**Pauline:** “Okay, so maybe the horse is friendly?”

**Participant A:** “Mmmm, ... Horse A...ne?”

**Pauline:** “Um...Hu. (*Silence 9 seconds*) It’s hard to trust that maybe the horse is friendly.”

**Participant A:** “Jo, I’m so scared man.”

She also appeared very fearful that she was going to get hurt or injured by Horse B if she did attempt to create a relationship;

- Horse Specialist:** “Okay my sweet heart? So, this is Horse A, her name is Horse A. So I’d like you to go and meet her and then when you feel comfortable you can go in to the circle with her. And I’d like you to spend some time with her and just bond with her a little bit.”

**Participant A:** “Is it not going to hurt me?”

**Horse Specialist:** “So remember you are working with a live animal, so she...she can kick, she can step on your toes, she can bite, not necessarily that she is going to so you need to look after your own safety as well. Okay. So when she moves watch out for your toes, I see you are wearing closed shoes which is good. Uhm... But horses... she won’t generally just bite or kick, but just lookout for your safety. Okay? So you can go and greet her and when you feel comfortable you can go in and spend some time with her.”
- Participant A:** “She’s not gonna bite me, if I greet her?”

**Pauline:** “You seem very worried about going to greet her.”

Only towards the end of the EAP sessions, did Participant A seem to have created some sort of a relationship with Horse B;

- Pauline:** “Okay. Hallo”

**Participant A:** “Hallo”

**Pauline:** “Today is our last session with Horse B and here at the farm. Okay it’s the last Monday. I wonder what that’s like for you.” (*Very windy*)

**Participant A:** “It’s a little bit sad.”

**Pauline:** “A little bit sad. Ja. It is a bit sad. Why is it sad for you?”

**Participant A:** “Cause I’m not gonna see Horse B anymore.”

**Pauline:** “Ja. So it sounds to me like we hear you made a relationship with Horse B then if you say it is sad to say goodbye.”

**Participant A:** “Yes.”

Horse B mirrored her difficulty creating relationships and the lack of effort that she showed in putting into creating relationships as well as the constant push (closeness) and pull (abandonment/rejection) she projects onto relationships;

- Horse specialist:** “But she walks away and then comes back.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “Then tries to put the halter on and Horse B walks away again. But not far, a few steps, very aware of her.”  
**Pauline:** “She’s walking right behind her. Where she can get kicked”. (*Silence 15 seconds*) (*Horse nays*)  
**Horse specialist:** “Horse B’s making her work for this.” (*Laughs*)  
**Pauline:** “But she’s always done that hey. That’s a pattern with her.”  
**Horse specialist:** “If you want me come and get me.” (*Silence 5 seconds*)  
**Pauline:** “And Horse B getting quite frustrated. (*Silence 27 seconds*) (*Birds chirping*) Okay. She’s doing identical hey to what Participant F just did.”  
**Horse specialist:** “It’s a pity with them.”  
**Pauline:** “Although it’s a lot easier. (*Silence 5 seconds*) They copy each other. (*Silence 7 seconds*) But there is with her that very much that like push and pull of a relationship. “
- Pauline:** “...against actually developing a relationship.”  
**Horse specialist:** “Straight to the gate and out.” (*Silence 9 seconds*)  
**Pauline:** (*To participant*) “You finished? (*Silence 10 seconds*) We noticed you, you climbed out a lot. You come, when you finish you come to the gate and you climb straight out and you come stand here by us and you leave Horse B there.”  
**Horse specialist:** “And I noticed how she standing...”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “... there looking at you. So exactly how you left her that’s how she’s standing. It’s almost like she’s waiting for...”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “...you again.”  
**Pauline:** “I almost get the sense that she’s kind of like what we were walking around...”  
**Horse specialist:** “What now?”  
**Pauline:** “...like what now, why’d you leave?” (*Silence 9 seconds*)  
**Participant A:** (*Sighs*)  
**Pauline:** “It’s hard to spend time with.” (*Silence 7 seconds*)  
**Horse specialist:** “We noticed how you put the halter on, and well done for getting it on, and then you walked her, then you changed, turned around and walked again. And she stopped over here. And she stopped and she wouldn’t move and she forced you to come back to her. And you patted her and you loved her and played with her hair and you tried to walk again and she wouldn’t move and that made you come back to her again. And you patted her and you loved her and you played with her hair. And she seemed to enjoy that. Look how she’s licking and chewing now. So she seemed to enjoy that. And only after the second time that you came back to her, when you walked the third time she walked with you. So she was almost forcing you to spend time with her.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “And even now she standing there you, you’ve climbed out again. But she’s standing there licking and chewing. She’s not gone back to eat.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “She’s waiting for you.”  
**Participant A:** “Okay, joh.”  
**Horse specialist:** (*Soft to Pauline*) “Picks up the lead rain and walks, doesn’t go that way.”  
**Pauline:** “She’s just like no”  
**Horse specialist:** “Nice try. (*To participant*) See same pattern again. You climbed in you picked up the lead rain and you tried to walk with her and she wouldn’t walk and she forced you to come back to her. And again.”  
**Pauline:** “So she wants you to spend time with her. (*Silence 11 seconds*) (*Soft to horse specialist*) doing what she wants.”  
**Horse specialist:** “Now she’s got the best of both worlds.”  
**Pauline:** “Ja. (*Laughs*) (*Silence 4 seconds*) she’s quite stubborn hey?”

The theme of relationships was further broken down into smaller sub-themes; trust, rejection, disconnection, boundaries and lack of effort, which will be discussed below;

### 5.7.1.1 Trust

It was really hard for Participant A to trust all three of us; the psychologist, the horse specialist as well as the horse and trust that she would be safe and that we would not harm her;

- **Pauline:** “Your heart is beating? (*Birds chirping*) Maybe it’s hard to trust the horse and to trust we’re not going to put you in a situation where you’re going to get hurt. Ja”
- **Participant A:** “I’m scared.”  
**Pauline:** “You feeling scared?”  
**Participant A:** “Uh ha.”  
**Pauline:** “What are you scared of?”  
**Participant A:** “She’s gonna bite me”  
**Pauline:** “That she going to bite you, okay. I can see it is really hard for you to trust the horse and to trust that Horse Specialist and I are going to put you in a situation where you’ll be safe. (*Silence 15 seconds*) I wonder if you feel like that often. Do you get scared often? You do?”
- **Participant A:** “Can Participant F come first and then he can, he can just tell me if it was fine when he went inside maybe I’ll feel safer.”  
**Pauline:** “That’s okay, cause we’re gonna do Participant F just now and then you’re gonna come back again.”  
**Participant A:** “Ja.”  
**Pauline:** “But the whole time you were busy here, I was thinking that it must be really hard for you trust people and animals.”

Even the horse gave her reassurances that it was okay and that she wanted to be her friend:

- **Horse Specialist:** “So remember we won’t put you in a situation where the horse is going to bite you or hurt you. And if I look at how she looks now she looks pretty relaxed. She looks like she is waiting for you to go and greet her, because she is standing here by the gate.”  
**Participant A:** (*Sighs*)  
**Horse Specialist:** “See what she is doing there with her mouth? Can you see? She... it looks like she is chewing something, look, but there is nothing in her mouth. That’s her way of telling you it’s okay, you, you can trust her, she can trust you.”
- **Pauline:** “I wonder if that is what’s happening with Horse B, if you in the way (*Silence 13 seconds*) or maybe like Horse Specialist said perhaps you need to do more to get her attention.”  
**Participant A:** “I’m still scared she’ll bite me.”  
**Pauline:** “Okay.”  
**Horse specialist:** “I don’t think she looks like she’s gonna bite you. Remember I said last week horses will always give signs first before they do something. So she’ll always give you a warning sign if she was gonna bite you.”  
**Pauline:** “Maybe because you scared she’s gonna harm you, you scared to make a relationship with her.”  
**Participant A:** “Yes.”
- **Horse Specialist:** “So she looks very patient, Uhm, and she could go and stand anywhere in this ring but she’s standing here by the gate. Looks like she’s waiting for you. And while you and Pauline have been speaking she did that thing again with her mouth. And that like I said is called a lick and chew, and horses do that to us and they do that to other horses when they feel comfortable, when they feel trusting, when they feel okay.”  
**Participant A:** “So it’s just gonna greet me?”  
**Pauline:** “I wonder what that feels like for you that she is calmly waiting for you. What do you think about what Horse Specialist said?”  
**Participant A:** “I think it’s true.”  
**Pauline:** “You think it’s true? Okay. And how, tell me how does that make you feel?”  
**Participant A:** “Uhm I feel a bit that the horse believes in me.”  
**Pauline:** “You feel a bit that the horse believes in you? Okay. So maybe you’re feeling a bit more confident?”  
**Participant A:** “Ja.”  
**Pauline:** “Good. Do you sometimes feel that people don’t believe in you? Ja. That must be really hard hey?”  
*Participant A nods* “Ja.”

Her inability to trust is also evident at home, especially through her hiding of her panties and feeling unsure and fearful to ask for help as discussed in the background history.

### 5.7.1.2. Rejection

Participant A would appear to feel easily rejected;

- **Horse specialist:** “So there she stopped eating and she moved a little closer here. Now she’s coming right to you. Or just moved to another spot to eat.” (*Silence 6 seconds*)  
**Pauline:** “What happens if you interrupt people when they eating.”  
**Participant A:** “My parents yell at me.”  
**Pauline:** “They yell at you. Are you may be worried that we gonna yell at you, or that she’s like you said gonna bite you, she’s gonna get cross and she’s gonna bite you?”  
**Participant A:** “Kick me.”  
**Pauline:** “Kick you?” (*Writing noise*)  
**Horse specialist:** “Did she kick you before when you went to her?”  
**Participant A:** “No.”  
**Pauline:** “So maybe she won’t do that then? (*Plane flying past*) But it’s also hard to trust that she’s not gonna hurt you and that it’s gonna be okay with her if you say to her hey you know spend some time with me. (*Silence 49 seconds*) (*Wind noise*) (*Truck hooting*)”
- **Horse Specialist:** “So something else caught her attention and she walked away a little bit and now she’s come back to here and she’s smelling the droppings. Investigating her boundary. And then she’s making a bout and focusing on you.”  
**Pauline:** “So I wonder what it’s like for the horse to go away and come back. (*Silence 8 seconds*) It’s not easy. Ja...”

### 5.7.1.3. Disconnection

Participant A seemed to create a lot of distance in the relationships, which was mirrored in the horse;

- **Horse specialist:** “And she doesn’t feel like paying attention to her. Head through the fence, rather eating the grass.”  
**Pauline:** (*Sound of agreement*) (*Silence 8 seconds*)  
**Horse specialist:** (*Too soft to hear*) (*Silence 18 seconds*) (*Sound of sun beetles*) (*Construction work noise*)  
**Pauline:** “Very hesitant.”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** (*To participant*) “And? I see you’ve come back?”  
**Participant A:** (*Very softly*) “Yes.” (*Silence 11 seconds*)  
**Pauline:** “It’s almost if you not sure if you want to spend time with her, and now you hiding away from me.” (*Someone sniffs*)  
**Participant A:** “Yeah.”  
**Pauline:** “What you thinking, can you tell us what you thinking?”  
**Participant A:** “I’m just wondering...”  
**Pauline:** “You wondering...?” (*Someone sniffs*) (*Silence 12 seconds*) Maybe you too scared to tell us what you thinking?”  
**Participant A:** “Yeah.”
- **Pauline:** “Okay. So you know how to, to look after your frustrations. And play with the ball. And you knocked all those, what were they, targets? You knocked them down. (*Silence 8 seconds*) One of the things we also noticed is whilst you were busy building you didn’t pay attention to Horse B at all. There she was.”  
**Horse specialist:** “I don’t even think you went to go say hallo to her hey? You focused on building. (*Silence 11 seconds*) And you were focused on your building and what you were doing and she was focused on herself and eating grass. And there was a point where you started kicking and you were kicking quite hard and I don’t know if you noticed how she got a fright over here. While she was coming closer to you and then you kicked quite hard and she got a little bit of a fright. Then she was quite focused on you for a long time. She stood here. Did you notice? She stood here in the corner and she watched you...”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “...and she watched you for a long time. And then she went back to eat again. So you were extremely focused on yourself and what you were doing and she was focused on herself and what she needed.” (*Silence 4 seconds*)  
**Pauline:** “...maybe sometimes that happens at home and at school. You do your thing and everyone else does their thing. And you don’t really interact with each other or connect anywhere.”  
**Participant A:** “No.”  
**Pauline:** “That must be quite lonely. Ja. But even when she stopped and she was watching you, you didn’t, you didn’t do anything you just carried on. So maybe relationships are really, really, really hard for you.”

And it's hard to connect with animals or with Horse B or with people. (*Silence 10 seconds*) And I know it's even hard to stand here with us and talk with us about it."

**Participant A:** "It is."

**Pauline:** "Ja. It's not easy. (*Silence 8 seconds*) Perhaps sometimes when you get angry people move away from you (*Very windy*)"

**Participant A:** (*Too windy to hear*)

**Pauline:** "No. okay. Cause we noticed Horse B moved away. When you kicked so hard. And like Horse specialist said Horse B got a fright and she moved away and she stood in the corner here and she watched you. She didn't come close. (*Silence 12 seconds*) (*Construction vehicle*) But I think it's really, really hard to talk about this stuff and it's much easier to go and to actually do something. Like you were building. And kicking. And that's the first time in the four sessions that we've seen you that you've been so involved. Hey. You really seemed to enjoy that."

**Participant A:** "Yes."

#### 5.7.1.4. Boundaries

Participant A seemed to lack boundaries and would place herself in positions that could potentially be harmful and dangerous;

- **Horse specialist:** (*Softly to Pauline*) "She's anxious and petrified and then goes and touches the horse on the bum."  
**Pauline:** "No sense of boundaries."
- **Pauline:** "We noticed that you went in and you touched her right on her bum. I was wondering what you think could have happened?"  
**Participant A:** "Uh." (*Silence 6 seconds*)  
**Pauline:** "Cause even though we won't put you with a horse that gonna kick or bite or anything like that, sometimes we just need to think about what might happen. So maybe, I know you were quite anxious and worried, so maybe next time we must be a bit more careful. Look what she's doing."  
**Horse specialist:** "See she's laying down and she's rolling and that shows us that she feels quite safe with you." (*Silence 15 seconds*)  
**Pauline:** "What do you think?"  
**Participant A:** "I think, Uhm, she's right."  
**Pauline:** "You think she's right, Ja. So even thou maybe the way you approached her was a bit worrying she's still very friendly, she still feels safe with you, she still wants to be you friend." (*Silence 16 seconds*)
- **Horse specialist:** "Joh Horse B getting a big fright there." (*Silence 11 seconds*) (*Very windy*)  
**Pauline:** "Did Horse B stand on her foot?"  
**Horse specialist:** "I'm trying to see if like she stood her out of her shoe. And she's just disregarding it."  
**Pauline:** "Ja. There's like no..."  
**Horse specialist:** "Emotion."  
**Pauline:** "Ja."  
**Horse specialist:** "No showing pain not even showing a face. Probably so petrified three weeks ago."  
**Pauline:** "Yes that's a good point cause there almost..."  
**Horse specialist:** "I got a fright."  
**Pauline:** "Ja (*Both laugh*) And it looks like she stood on her. And she looked down and she just walked towards Horse B and carried on brushing her."  
**Horse specialist:** (*Said together with Pauline*) "Carried on."  
**Pauline:** "And she was exactly like you say she was petrified that something like this would happen and..."  
**Horse specialist:** "and now disregards it." (*Silence 22 seconds*)  
**Pauline:** "Horse B is walking away now." (*Silence 11 seconds*)  
**Horse specialist:** "But she walks away and then comes back."  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** "Then tries to put the halter on and Horse B walks away again. But not far, a few steps. Very aware of her."  
**Pauline:** "She's walking right behind her. Where she can get kicked." (*Silence 15 seconds*) (*Horse nays*)

#### 5.7.1.5. Lack of effort

Participant A did not put much effort into creating a relationship with Horse B, possibly because of her fear, but she also did not seem to try very hard;

- Horse specialist:** I noticed that even though you were there with Horse B, she wasn't really paying attention to you."

**Participant B:** "Yeah."

**Horse specialist:** "She was much rather paying attention to the grass and eating the grass than you. But I also noticed you didn't do much to get her attention."

**Participant A:** "It's like I don't want her to stop her from eating."

**Horse specialist:** "You don't want to stop her from eating?"

**Pauline:** (*Sympathetic sigh*) Are you maybe worried that you like interfering with what she's doing?"

**Participant A:** "Yeah."

**Pauline:** (*Sound of agreement*) "Maybe sometimes it feels like that with other people as well, well with other people. Like you somehow in the way."

**Participant A:** "Yeah." (*Silence 7 seconds*)

**Pauline:** "I wonder if that is what's happening with Horse B, if you in the way (*Silence 13 seconds*) or maybe like Horse specialist said perhaps you need to do more to get her attention."

**Participant A:** "I'm still scared she'll bite me."

It is possible that due to the lack of effort that she puts into relationships, she ends up actually being neglected/unseen and unheard and then feels rejected;

- Pauline:** (*To participant*) "You seem very frustrated. And helpless. Like she's gone back to eating now you missed your opportunity. (*Softly to Horse specialist*) She seems so deflated."

**Horse specialist:** (*Sound of agreement*) (*Silence 7 seconds*)

**Pauline:** (*To participant*) "That must have been very upsetting (*Sympathetic sigh*) (*Silence 12 seconds*) I wonder what would have happened if you'd let Horse B know that you actually around a bit more forcefully." (*Silence 7 seconds*)

**Horse specialist:** "Did you notice how it seemed like she was almost ignoring you, hey?"

**Participant A:** (*Sound of agreement*) (*Simultaneously with Pauline*)

**Pauline:** (*Sound of agreement*)

**Horse specialist:** "So she walked passed she stopped and she scratched her leg and she just carried on walking. Almost like you weren't there." (*Silence 6 seconds*)

**Pauline:** "Does that feel like that happens a lot? No?"

**Participant A:** "Not really."

**Pauline:** "Not really, okay (*Silence 17 seconds*) (*Wind noise*) It's almost like it's really hard for you to make it known to Horse B that you are actually here, and you, you also have a need." (*Silence 38 seconds*) (*Wind noise*)

**Horse specialist:** "So there's another opportunity for you that she stopped eating (*Silence 13 seconds*) and still the opportunity is there."

**Pauline:** "You seem really scared. Maybe you don't trust yourself enough to go and take the opportunity, Ja." (*Silence 11 seconds*) (*Horse nays*)

**Horse specialist:** "And there I noticed she stopped eating again. (*Silence 5 seconds*) Sound like she's calling other horses, did you hear that?"

**Pauline:** "So do you think it would be fair to say that maybe she wants company, she wants a relationship?"

### 5.7.2. Feelings

Participant A voiced that she often felt scared and fearful:

- Participant A:** "I'm scared."

**Pauline:** "You feeling scared?"

**Participant A:** "Uh ha"

**Pauline:** "What are you scared of?"

**Participant A:** "She's gonna bite me"

**Pauline:** "That she going to bite you, okay. I can see it is really hard for you to trust the horse and to trust that Horse specialist and I are going to put you in a situation where you'll be safe. (*Silence 15 seconds*) I wonder if you feel like that often. Do you get scared often? You do?"
- Pauline:** "What's that like to see Horse specialist touch her?"

**Participant A:** "Like the horse is friendly"

**Pauline:** "Okay, so maybe the horse is friendly?"

**Participant A:** "Mmmm, Horse A ne?"

**Pauline:** "Uhm. (*Silence 9 seconds*) It's hard to trust that maybe the horse is friendly."

**Participant A:** "Jo, I'm so scared man."

**Pauline:** (*Sympathetic sigh*)

**Horse Specialist:** “See how she leans out the whole time? (Silence 9seconds) and chasing the flies away and then back to us again. And then she’s doing the lick and chew again.”

**Participant A:** (*Scared moans*)

**Pauline:** “Sometimes things are scary, Ja. I can see you are feeling very anxious and worried, and scared.”

**Participant A:** “Ja (*Whispered*). Can you do it again please?”

She was very fearful of the horses and seemed very concerned that the horse would somehow hurt her;

- **Pauline:** “Maybe we can just stand here and just talk a bit and Horse Specialist can tell us what’s going with the horse, okay. Maybe you can tell us a bit about what scares you?”  
**Participant A:** “Yes.”  
**Pauline:** “What sort of things scares you?” (*Construction vehicle noise*)  
**Participant A:** “It’s just that, I’m scared if I go in there the horse will kick me or something.”
- **Horse specialist:** “I noticed how when you went in and you started brushing her she was quite enjoying it did you see how she stretched her neck right down and then she was looking at you and she was standing still she was enjoying it. And then it was almost like something changed because then she walked away from you and she came and ate. And then you brushed a little bit more then she moved away from you again. So something inside of you must have changed for her to change her behaviour.”  
**Pauline:** “Do you know what that was?”  
**Participant A:** “Uhm, scaredness...”  
**Pauline:** “Scaredness. Okay. And that’s something that we’ve been talking about for a while now that you scared of her. What, what made you feel scared?”  
**Participant A:** “Uhm, the way she was kicking.”

Even despite reassurances, she still felt very fearful;

- **Horse Specialist:** “Okay my sweet heart? So this is Horse A, her name is Horse A. So I’d like you to go and meet her and then when you feel comfortable you can go in to the circle with her. And I’d like you to spend some time with her and just bond with her a little bit.”  
**Participant A:** “Is it not going to hurt me?”  
**Horse Specialist:** “So remember you are working with a live animal, so she...she can kick, she can step on your toes, she can bite, not necessarily that she is going to so you need to look after your own safety as well. Okay. So when she moves watch out for your toes, I see you are wearing closed shoes which is good. Uhm... But horses... she won’t generally just bite or kick, but just lookout for your safety. Okay? So you can go and greet her and when you feel comfortable you can go in and spend some time with her.”
- **Horse Specialist:** “So did you see how she put her head through here and she was eating the grass and it just makes me think you saying how extremely scared you are and how nervous you are. She is the exact opposite. She’s relaxed, she’s calm, and she’s comfortable. She even lets her guard down and she eats. So its two opposites, you very nervous and very scared and she’s showing you it’s okay, she’s comfortable, she is calm.”

Her fear stayed with her right through out Session 1 and only towards the end of the session, there was a glimmer that she was starting to feel more comfortable although it reappeared in Session 2;

- **Pauline:** “Okay. So maybe in just kind of finishing up a bit you can tell us what this was like for you?”  
**Participant A:** “It was like scary for me...”  
**Pauline:** “Scary...”  
**Participant A:** “...and then to touched the horse I was feeling a bit better.”  
**Pauline:** “Okay, so you felt a bit more comfortable when you touched her, maybe that’s why she was a bit more relaxed. So sometimes thing are scary and hard. Cause it seemed to me she was very welcoming, and Horse Specialist said she was looking for you.”  
**Horse Specialist:** “Lots of licking and chewing, and like I said she can go anywhere in this ring but she stood here by the gate welcoming you, looking at you. Patiently waiting for you.”



- **Horse specialist:** “So you see I got a smaller horse for you today. Cause I remember last time you were a little bit worried about the horse’s size. So now I’ve got a cute little small one and her name is Horse B. Okay. So last time you didn’t manage to go in with the horse, remember you were a little anxious a little bit afraid. So this time I would like you to, because she’s smaller, make your way into the ring and make friends with Horse B.” (*Writing noise*)
- **Horse specialist:** (*Softly to Pauline*) “She’s anxious and petrified and then goes and touches the horse on the bum.”

Participant A’s anxiety is so prominent that even at the beginning of Session 3, she still presented as anxious and worried;

- **Pauline:** “You feeling good. You look a bit anxious. Bit worried. Maybe you still feeling a bit scared or unsure? (*Silence 5 seconds*) (*Someone sweeping*) Ja... Okay. I’m gonna give you to Horse specialist, and horse specialist will give you an instruction again. Okay?”

However, it would appear that sometimes her feelings are too hard for her and she denies them, even when she is objectively anxious;

- **Pauline:** (*Mid-sentence*) “...back. How are you doing?”  
**Participant A:** “I’m fine.”  
**Pauline:** “You fine, okay. You seem a little bit anxious, a little bit worried (*Silence 5 seconds*) (*Writing noise*) you feeling a bit worried? No, okay. Okay. Should we start?”

Participant A also displayed some symptoms of depression during the EAP sessions:

- **Horse specialist:** “That’s what’s lacking in this girl is effort.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “Like don’t you feel tired working with her.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “You feel like...joh...” (*Silence 8 seconds*)  
**Pauline:** “Ja, I definitely think there’s a depression. But also there’s that intense like guardedness...”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** “...against actually developing a relationship.”

### 5.7.3. Perception of the environment

Participant A perceives her environment as extremely hostile and dangerous;

- **Participant A:** “Ai jo, maybe it’s because I’m scared for dog and cat and that’s why I’m scared of the other animals also.”  
**Pauline:** “Okay (*Sympathetic sigh*). And why are you scared of a dog and a cat?”  
**Participant A:** “Cause a cat will scratch me and a dog will bite me.”  
**Pauline:** “Okay. Okay.”  
**Participant A:** “That’s why I don’t like them.”  
**Pauline:** “So sometimes what I’m hearing you say is that the world is quite scary. Ja. Ja. And even when the horse wants you to go say hallo and says to you come say hallo to me it’s scary.”
- **Horse specialist:** “While I was watching her the whole time while you were in there with her it didn’t look like she’s gona kick you at all. It actually looked like she enjoyed you grooming her. She didn’t look tense or anxious or upset at all. She looked extremely relaxed and comfortable and even now she’s calm, she’s laying down, she’s rolling and that shows comfort. Doesn’t show she’s tense or ready to kick or bite.” (*Silence 32 seconds*) (*Horse nays*)  
**Pauline:** “I wonder what you thinking. (*Silence 21 seconds*) I can see that it’s really hard for you to talk to us to tell us what’s going on. (*Silence 4 seconds*) Maybe you worried about what we might say. Maybe you worried what we might think. Maybe you worried cause I’ve got the voice recorder. (*Silence 16 seconds*) We not here to judge you. And everything that goes on the voice recorder is gona be confidential no one’s gona know who you are. There’s no names no nothing. (*Silence 4 seconds*) I think it’s really, really hard to trust us and, and the horse. That she’s not gona kick you and we not gona hurt you. (*Silence 29 seconds*) What would you like to do now? (*Silence 8 seconds*)”

#### 5.7.4. Unmet Needs

There was also a strong theme of deprivation and unmet needs. Horse B mirrored this very nicely, through almost making sure that she met all of her own needs, thus emphasising Participant A's deprivation;

- **Participant A:** "Looks like she's very hungry..."  
**Pauline:** "Looks like she's very hungry. (*Sound of agreement*) (*Silence 6 seconds*) (*Construction work noise*)" Maybe sometimes you get quite hungry, Ja. (*Sniff*) and what happens when you're hungry?"  
**Participant A:** "I just tell my parents."  
**Pauline:** "Okay good" (*Silence 9 seconds*) (*Wind noise*)  
**Horse specialist:** "It looks to me like Horse B looks after herself."  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** "You know what I mean by that? You think she's hungry, she's doing what it takes to satisfy her hunger. So she's eating."  
**Participant A:** (*Sound of agreement*)  
**Horse specialist:** "See so she, she's got a need and she's fulfilling it, make sense?"  
**Participant A:** "Yes."  
**Horse specialist:** "She's doing whatever it takes to make sure she's okay." (*Silence 5 seconds*) (*Wind noise*)  
**Pauline:** "Maybe that's something you struggle with a bit to look after yourself. No"  
**Participant A:** "Not really."  
**Pauline:** "Not really, okay (*Silence 6 seconds*) I think that sometimes it's hard to ask when you need something. And Horse B is not even asking she's just going." (*Silence 15 seconds*) (*Writing noise*)
- **Pauline:** "You don't, you don't know. I'm wondering that even though she's eating, if you went and spent more time with her, then maybe that relationship (*Silence 3 seconds*) that question would turn from a maybe to a yes. But I know it's hard to spend time with her." (*Silence 12 seconds*) (*Writing noise*)  
**Participant A:** "I'd like to stand with her but I don't want to disturb her while she's eating"  
**Pauline:** (*Sympathetic sigh*)  
**Horse specialist:** "And what if I told you she has the rest of the day to go and eat as well?" (*Pauline gives soft chuckle*) (*Silence 9 seconds*)  
**Pauline:** "Perhaps it's really hard for you to ask her for her attention."  
**Participant A:** "Yes."  
**Pauline:** "You like 'I'm here now, please can you pay some attention to me now, you can go eat just now.'" (*Silence 21 seconds*)
- **Pauline:** "But maybe then you put yourself out, cause then you don't get the opportunity to do what you want to do, cause you so focused on her." (*Silence 13 seconds*)  
**Horse specialist:** (*Soft chuckle*) Look how she's scratching her neck on the pole. Did you see? So again that shows me that she's looking after her own needs. She's itchy she got, she scratched herself. She might seem a bit hungry she's eating. She's looking after what she needs."
- **Horse specialist:** "now even though Horse B is eating she's still..."  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** "...brushing, touching."  
**Pauline:** "Ja she's still spending time with her. I mean that is a need of hers. As scared as she is of relationships she needs them. Same as Horse B really making a meal of that piece of grass." (*Laughs*)

And unfortunately it would appear that when she does ask for her needs to be met, she receives a very negative response;

- **Participant A:** "I'd like to stand with her but I don't want to disturb her while she's eating."  
**Pauline:** (*Sympathetic sigh*)  
**Horse specialist:** "And what if I told you she has the rest of the day to go and eat as well?" (*Pauline gives soft chuckle*) (*Silence 9 seconds*)  
**Pauline:** "Perhaps it's really hard for you to ask her for her attention."  
**Participant A:** "Yes."  
**Pauline:** "You like 'I'm here now, please can you pay some attention to me now, you can go eat just now.'" (*Silence 21 seconds*)  
**Horse specialist:** "So there she stopped eating and she moved a little closer here. Now she's coming right to you. Or just moved to another spot to eat." (*Silence 6 seconds*)

**Pauline:** “What happens if you interrupt people when they eating?”  
**Participant A:** “My parents yell at me.”  
**Pauline:** “They yell at you. Are you may be worried that we gonna yell at you, or that she’s like you said gonna bite you, she’s gonna get cross and she’s gonna bite you?”  
**Participant A:** “Kick me...”  
**Pauline:** “Kick you...” (*Writing noise*)  
**Horse specialist:** “Did she kick you before when you went to her?”  
**Participant A:** “No.”  
**Pauline:** “So maybe she won’t do that then? (*Plane flying past*) But it’s also hard to trust that she’s not gonna hurt you and that it’s gonna be okay with her if you say to her hey you know spend some time with me?” (*Silence 49 seconds*) (*Wind noise*) (*Truck hooting*)  
**Horse specialist:** “So there was a nice opportunity for you that you wouldn’t have stopped her from eating, because she stopped eating herself and she walked right passed you. And you didn’t take that opportunity to build a relationship with her.” (*Silence 8 seconds*)  
**Pauline:** “I wonder why not. (*Silence 30 seconds*) I get a sense that relationships are really, really hard, and scary as well.”

Participant A really struggles to look after herself and meet her needs, as mirrored in Horse B’s behaviour;

- **Pauline:** “And she’s (*Horse B*) also always eating.”  
**Horse specialist:** (*Sound of agreement*) (*Silence 6 seconds*) “It’s a theme that comes up, vulnerability and self needs. Looking after yourself.” (*Silence 11 seconds*)  
**Pauline:** “But she doesn’t thou. I mean like leaving her jersey at home.”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** “Cause she would have been outside.” (*Silence 9 seconds*)
- **Horse specialist:** (*Soft chuckle*) Look how she’s scratching her neck on the pole. Did you see? So again that shows me that she’s looking after her own needs. She’s itchy she got, she scratched herself. She might seem a bit hungry she’s eating. She’s looking after what she needs.”

Although she denied this, at times and became defensive;

- **Horse specialist:** “It looks to me like Horse B looks after herself.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “You know what I mean by that? You think she’s hungry, she’s doing what it takes to satisfy her hunger. So she’s eating.”  
**Participant A:** (*Sound of agreement*)  
**Horse specialist:** “See so she, she’s got a need and she’s fulfilling it, make sense?”  
**Participant A:** “Yes.”  
**Horse specialist:** “She’s doing whatever it takes to make sure she’s okay.” (*Silence 5 seconds*) (*Wind noise*)  
**Pauline:** “Maybe that’s something you struggle with a bit to look after yourself. No”  
**Participant A:** “Not really.”

## 5.8. Results of the MMPI-A (Post-Test)

### *Validity Indices*

Participant A’s profile was deemed valid. However, it is important to note that she scored high on all three validity scales, which indicates that her responses to the MMPI-A to be interpreted with caution.

Participant A scored high on the *F1* (Infrequency scale; T-score = 72) scale, indicating that she may have attempted to portray herself in as negative a light as possible, “faking bad”. She also scored high on the *L* (Impression management; T-score = 85) scale which indicates that she may have attempted to deny any flaws or weaknesses, “fake good” which is in stark contrast to the *F1* scale.

However, her score was higher on the L scale. Furthermore, she scored high on the K (Correction scale T-score = 74) scale indicating a possible defensive manner of reporting.

Further interpretation of the configuration which was triangular, with L at the top and both F and K below indicates that she may try to deny problems and present herself in a more positive light (L or K > 60). It is also possible that Participant A subconsciously may be seeking help, a possible “cry for help”.

### *Clinical Scales*

Participant A had a moderately elevated score on the *Hypochondriasis (HS)* scale indicating a slight tendency towards a preoccupation with regards to health and illness. Individuals that score high on this scale may present with a variety of physical complaints. Elevations on this scale are also related to personality and behavioural difficulties. It is also possible that she may not be performing very well at school, reporting academic problems as well as family problems especially with regards to financial difficulties and marital discord.

Furthermore she score high on the clinical scales of *Depression (D)*, *Hysteria (Hy)* and *Paranoia (Pa)* indicating a prominence of these syndromes. A high elevation on the Depressive scale may indicate that she experiences general feelings of unhappiness with her life, feelings of discouragement and helplessness as well as feelings of despondency, apathy and excessive sensitivity. Furthermore, it is possible that she may not be doing well at school, experience worsening of arguments at home. Female girls that score high on this scale may be socially withdrawn, have no to few friends, somatic complaints as well as a low self-esteem. This was corroborated by the findings from the thematic analysis as well as clinical observations.

Elevated scores on the Hysteria subscale indicate that Participant A may express her anxiety through somatising and physical symptoms as corroborated by her moderately high score on the Hypochondriasis scale.

Lastly, a high score on the Paranoia subscale indicates that she might feel suspicious, persecuted and may present as rigid. High scores on this scale are associated with aggressive acting-out and argumentative behaviour. Furthermore, there are a number of negative behavioural correlates associated with elevations on this scale such as school problems (failing and suspension) as well as arguments and disagreements with parental figures.

## **5.9. Quantitative analysis of the results of Participant A’s CBCL**

The following section focuses on the quantitative analysis of the pre- and post-test CBCL that were filled out by Participant A, her teacher, and her parents.

### ***5.9.1. Analysis of the teachers CBCL***

Below follows the analysis of the protocols of the CBCL Youth that were filled out by the teachers.

#### *Syndrome Scales*

The higher the score on the syndrome scales, the worse the child is doing or the higher the pathology. Thus an increase in the scores indicates that that particular area is going worse for the child; there is an increase in that particular syndrome. With regards to the syndrome scales, the participant's behaviour either falls within the normal or the clinical range. The clinical range was worked out according to the 98<sup>th</sup> percentile. This was done for the South African context and indicates that the participant will need to score higher than average before his/her behaviour is considered clinical.

There are 9 syndrome scales: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviour, aggressive behaviour and other problems.

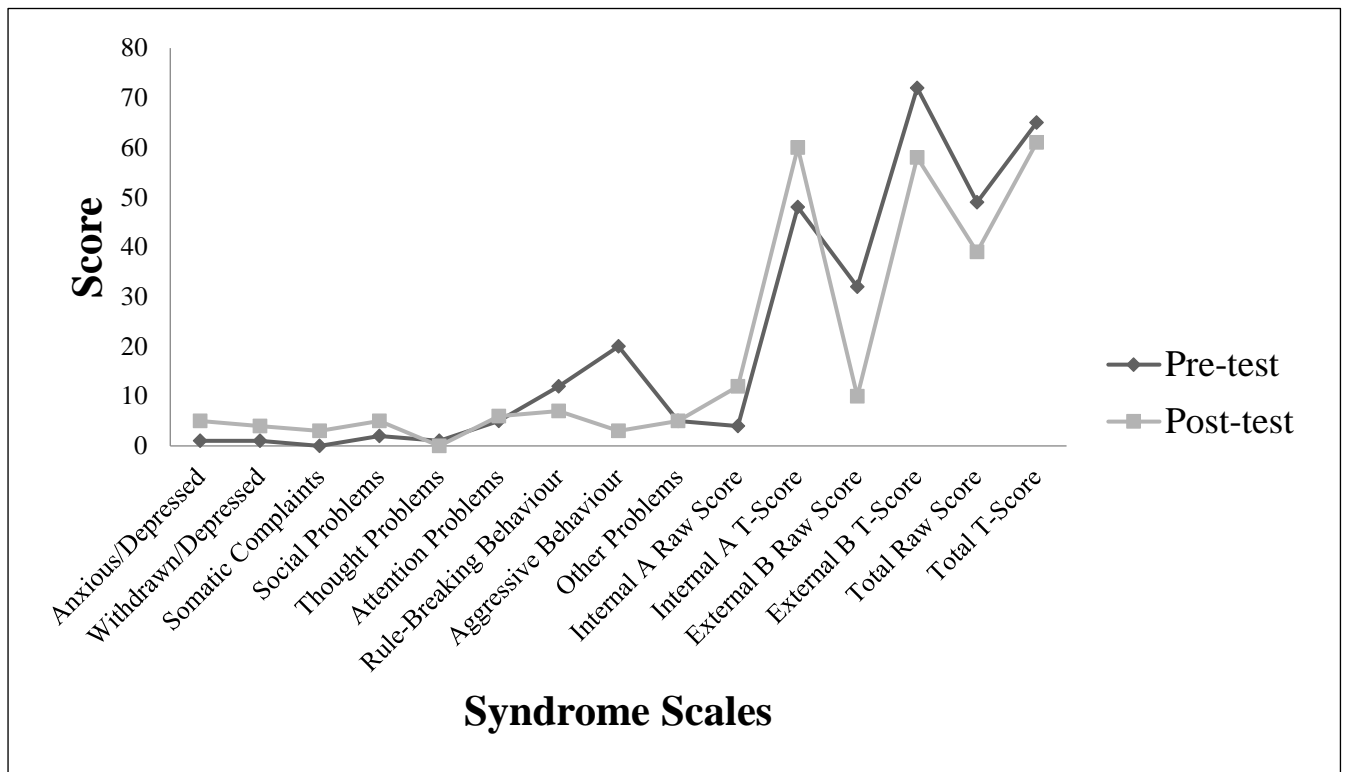
As shown below in Table 5, Teacher CBCL syndrome scales and Table 6, Scores of the syndrome scales, Participant A showed an increase in anxious/depressed behaviour (from 1 to 5 – normal range) after the EAP sessions. She also showed an increase in withdrawn/depressed behaviour (from 1 to 4 – normal range), somatic complaints (from 0 to 3 – normal range), attention problems (from 5 to 6 – normal range) as well as social problems (from 2 to 5 – normal range).

The table also shows that Participant A showed a decrease on the following scales; thought problems (from 1 to 0 – normal range), rule-breaking behaviour (from 12 to 7 – from clinical to normal range), aggressive behaviour (from 20 to 3 – from clinical to normal range).

Participant A's score on the scale "Other problems" stayed the same at 5.

With regards to the T-scores, Participant A's internal score increased from 48 to 60 (normal range), her external T-score decreased from 72 to 58 (from clinical to normal range) and her total T score (overall syndrome scale) decreased from 65 to 61 (from clinical range to normal range)

*Table 5*  
*Participant A's Teacher CBCL Syndrome Scales*



*Table 6*  
*Total Scores of the Syndrome Scales*

	Pre-test	Post-test
Anxious/Depressed	1	5
Withdrawn/Depressed	1	4
Somatic Complaints	0	3
Social Problems	2	5
Thought Problems	1	0
Attention Problems	5	6
Rule-Breaking Behaviour	12	7
Aggressive Behaviour	20	3
Other Problems	5	5
Internal A Raw Score	4	12
Internal A T-Score	48	60
External B Raw Score	32	10
External B T-Score	72	58
Total Raw Score	49	39
Total T-Score	65	61

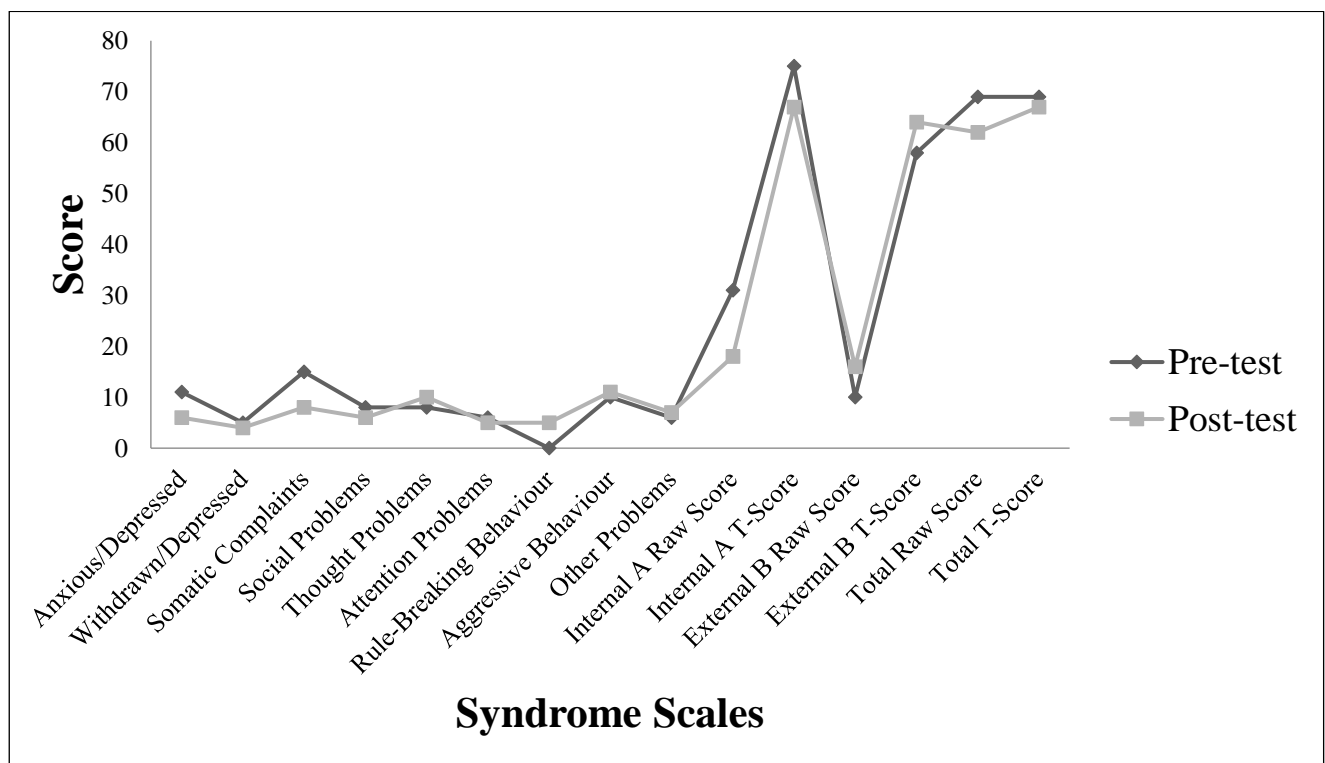
### 5.9.2. Analysis of the youth CBCL syndrome scales

According to Table 7, Youth CBCL Syndrome Scales, Participant A showed an increase in thought problems (from 8 to 10 – normal range), rule-breaking behaviour (from 10 to 11 – normal range), aggressive behaviour (from 10 to 11 – normal range) as well as other problems (from 6 to 7). However, it is important to note that none of these increases fell within the clinical range.

Participant A showed a decrease in the following scales; anxious/depressed (from 11 to 6 – from clinical to normal range), withdrawn/depressed (from 5 to 4 – normal range), somatic complaints (from 15 to 8 – both in the clinical range), social problems (from 8 to 6 – normal range) as well as attention problems (from 6 to 5 – normal range).

With regards to Participant A’s overall T-scores, she showed a decrease in her internal T-score (from 75 to 67 – clinical range), an increase in her external T-score (from 50 to 64 – normal to clinical range) and a decrease on her overall total T-score (from 69 to 67 – clinical range).

Table 7  
Participant A’s Youth CBCL Syndrome Scales



*Table 8*  
*Total Scores of the Syndrome Scales*

	Pre-test	Post-test
Anxious/Depressed	11	6
Withdrawn/Depressed	5	4
Somatic Complaints	15	8
Social Problems	8	6
Thought Problems	8	10
Attention Problems	6	5
Rule-Breaking Behaviour	0	5
Aggressive Behaviour	10	11
Other Problems	6	7
Internal A Raw Score	31	18
Internal A T-Score	75	67
External B Raw Score	10	16
External B T-Score	58	64
Total Raw Score	69	62
Total T-Score	69	67

### **5.9.3. Analysis of the youth and teacher CBCL's**

This section focuses on the overlap between both the teacher and youth CBCL protocols.

#### *Syndrome Scales*

As illustrated in Table 9, Participant A's Youth and Teacher CBCL Syndrome scales as well as Table 10, Scores of the Syndrome Scales, the teacher and youth scores are not in "agreement for the majority of syndromes". In the majority of the scores when the teacher scores showed a decrease, the youth scores would increase and vice-versa.

However, both the teacher and youth indicated an increase in somatic complaints as well as social problems. The total T-scores were also similar, but for the youth it stayed the same during the pre-and post-tests, whilst the teacher indicated a small decrease during pre- and post-tests.



Table 9  
Participant A's Youth and Teacher CBCL Syndrome Scales

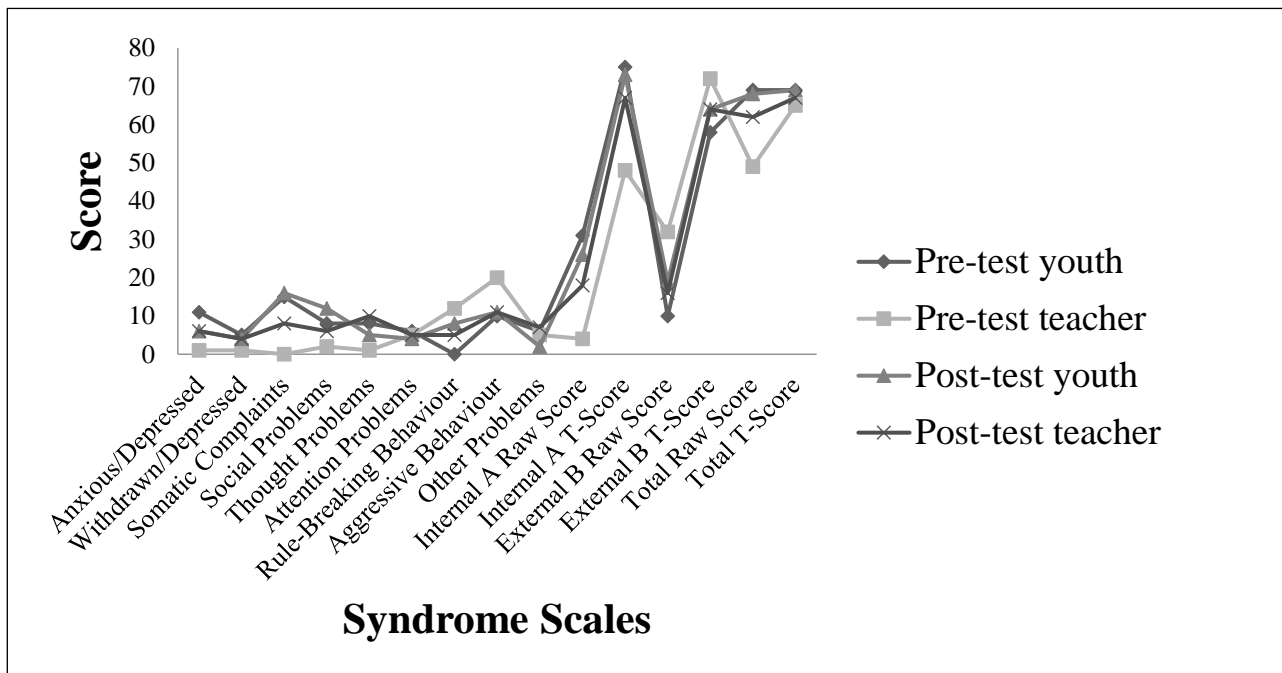


Table 10  
Total Scores of the Syndrome Scales

	Pre-test youth	Pre-test teacher	Post-test youth	Post-test teacher
Anxious/Depressed	11	1	6	6
Withdrawn/Depressed	5	1	4	4
Somatic Complaints	15	0	16	8
Social Problems	8	2	12	6
Thought Problems	8	1	5	10
Attention Problems	6	5	4	5
Rule-Breaking Behaviour	0	12	8	5
Aggressive Behaviour	10	20	11	11
Other Problems	6	5	2	7
Internal A Raw Score	31	4	26	18
Internal A T-Score	75	48	73	67
External B Raw Score	10	32	19	16
External B T-Score	58	72	64	64
Total Raw Score	69	49	68	62
Total T-Score	69	65	69	67

The next section focuses on the quantitative analysis of the pre- and post-test MMPI-A.

## **5.10. Quantitative analysis of the results of Participant A's MMPI-A**

Below in Table 11, Participant A's Pre- and Post-test MMPI-A scores, follows the quantitative analysis of the pre- and post-test data from Participant A's MMPI-A.

The scores on this section were worked out according to the T scores obtained. The higher the score, the worse that the child is doing. Thus an increase in the score represents an increase in pathology.

### **5.10.1. Validity Scales**

With regards to the validity scales, the Infrequency (F1) scores decreased significantly, in the pre-test, from a score of 95 (serious concerns about the possibility of an invalidating response style) to 72 in the post-test, which can be viewed as insignificant.

The Lie (L) scores increased from the pre- to the post-test (from 75 to 85) and can be interpreted as a defensive style of answering.

The scores for the Defensiveness scale (K) increased from 44 in the pre-test to 74 in the post-test. This is indicative of a possible defensive test taking attitude.

### **5.10.2. Clinical Scales**

The following results were obtained on the clinical scales.

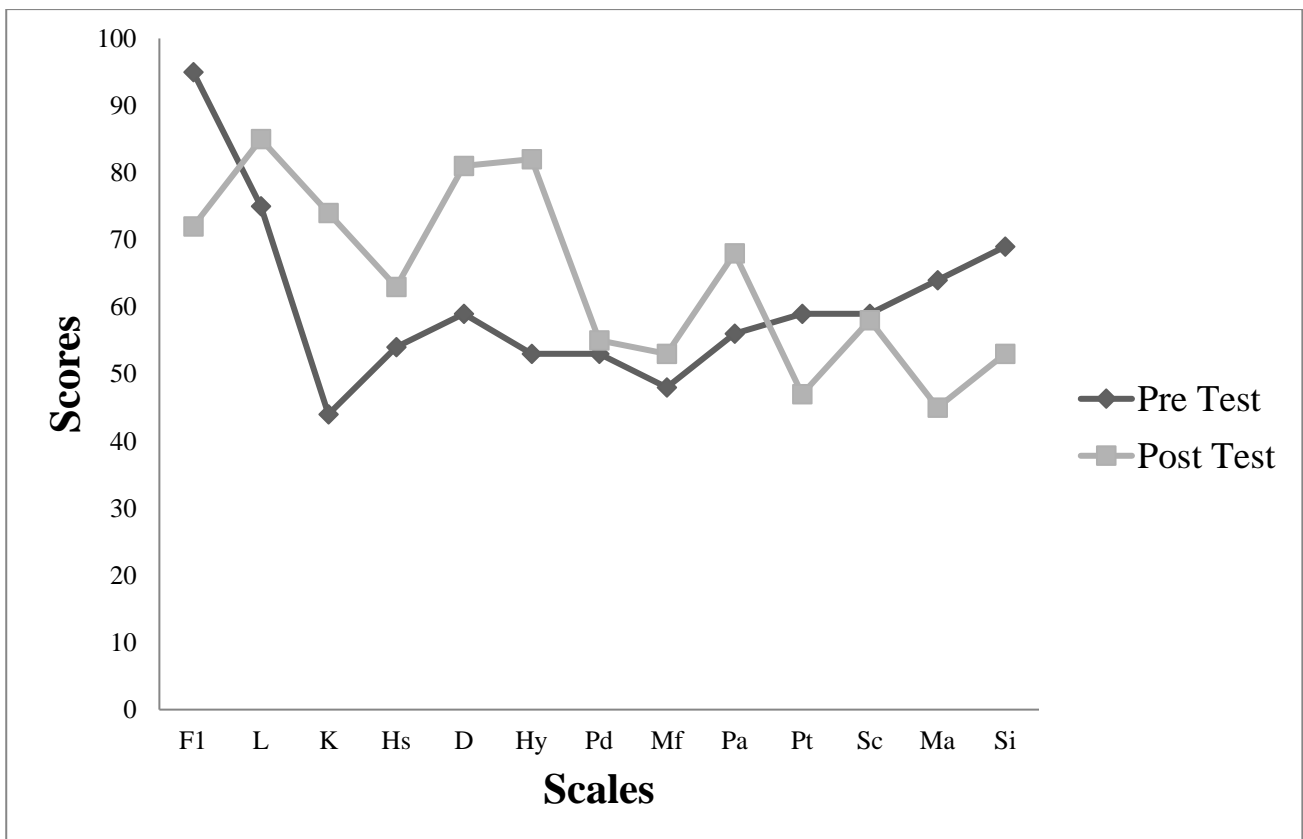
The following scales showed increases:

- The Hypochondriasis (Hs) scale increased from insignificant (54) in the pre-test to moderate elevations in the post-test (63). This is a significant increase.
- The scores for the Depression (D) scale increased significantly from the pre-test (59 - insignificant) to the post-test (81 – clinically significant).
- Scores on the Hysteria (Hy) scales also increased significantly from the pre-test results (53 – insignificant) to the post-test (82 – clinically significant).
- For the Psychopathic deviate scale (Pd) a slight increase from the pre-test (53 – insignificant) to the post-test (55 – also insignificant).
- The Masculinity-Femininity (Mf) scales were both insignificant although they did increase from the pre-test (48) to the post-test (53).
- Lastly, the Paranoia (Pa) scores also increased from the pre-test (56 – insignificant) to post-test (68 – clinically significant). This increase was significant.

Participant A showed decreases in the following four scales:

- For the Psychasthenia scale (Pt) her score decreased, although insignificantly, from the pre-test (59) to the post-test (47).
- On the Schizophrenia (Sc) scales scores decreased from 59 on the pre-test to 58 on the post-test. A very slight decrease.
- On the Hypomania (Ma) scale there was a significant decrease from the pre-test (64 – moderately elevated) to the post-test (45 – insignificant result).
- Lastly, on the Social Introversion scale (Si) there was also a significant decrease in the scores from the pre-test (69 – clinically significant) to the post-test (53 – insignificant).

*Table 11*  
Participant A's Pre- and Post-test MMPI-A scores



*Table 12*  
*Summary of MMPI-A scores*

	Pre-Test	Post-Test
Infrequency (F1)	95	72
Lie (L)	75	85
Defensiveness (K)	44	74
Hypochondriasis (Hs)	54	63
Depression (D)	59	81
Hysteria (Hy)	53	82
Psychopathic Deviate (Pd)	53	55
Masculinity-Femininity (Mf)	48	53
Paranoia (Pa)	56	68
Psychasthenia (Pt)	59	47
Schizophrenia (Sc)	59	58
Hypomania (Ma)	64	45
Social Introversion (Si)	69	53

### **5.11. Discussion**

Participant A, the first participant in this research, was a female, coloured 14 year old adolescent. She would appear to be from a very deprived and impoverished background and unfortunately, very little background information was able to be obtained about her. She underwent 5 sessions of EAP sessions at the farm. Below follows a summary and discussion of the research results.

Analysis of the data as well as the psychiatric interview indicate that Participant A presents with symptoms of depression and it is possible that she is really acting out her sadness in an aggressive and oppositional manner. However, it is also important to note that she may have both depression and conduct disorder as co-morbid disorders. Klein postulates that aggressive behaviour is caused by the infant's fear of annihilation and thus their need to protect themselves and the resulting acting out behaviour. Participant A would appear to view objects as persecutory and hostile, as a result of her early infant experience of her primary object. From the background history obtained, it would appear that her mother is not very emotionally or physically 'available' to her and thus she may perceive her mother as an object unable to fulfil her basic needs and desires and thus hostile. As this relationship, according to Klein, forms the basis for all future relationships, Participant A may perceive all of her relationships as harsh, untrustworthy and hostile. Her high paranoia scores on the MMPI-A, which according to object relations theory is indicative of a projection of her inner thoughts and feelings as well as her transference, indicate that Participant A perceives the world as untrustworthy, hostile and persecutory. This was also evident through the thematic analysis of the EAP sessions and her difficulty creating relationships particularly evident through her initial fear of the horse and fear that

the horse would hurt her despite numerous reassurances. Her elevated Si scale on the MMPI-A corroborates difficulties with regards to relationships that was also noted in the researcher's impressions of her.

Participant A would also appear to experience difficulties with regards to rejection and was very fearful that the horse would reject her. She has already experienced her primary object relation as rejecting and thus perceives all objects and further object relations as rejecting according to Klein. Through the process of EAP she was able to experience a loving, non-judgemental relationship from the horse that was not rejecting and thus a therapeutic catharsis.

She also presents with symptoms of anxiety. Her anxiety and withdrawn nature, which is also corroborated by her high score on the paranoia (clinically significant) and hypochondriasis subscales of the MMPI-A was evident in her relationships through the disconnection, difficulty with regards to trust and lack of effort in establishing relationships. Clinically she was noted to be very anxious and Klein (1975) postulates that anxiety is as a result of a fear of annihilation and relates to the paranoid-schizoid position whereby the infant feels persecutory anxiety from both her internalised sense of her object as well as from perceived external sources. Participant A would appear to still be in the paranoid-schizoid position of psychological development, which needs to be re-negotiated through psychotherapy.

In addition, Participant A would appear to have unmet needs. This was illustrated by the horse constantly eating the grass on the side of the arena and addressing her own needs rather than paying attention to Participant A. This was also corroborated by the auxiliary social worker who told the researcher that she had recently started menstruating and instead of asking for help, rather hid her soiled panties away. According to Klein, (1989) the onset of menstruation causes great anxiety and that the 'children' contained in her internal world are being destroyed. This can result in aggressive acting out tendencies as a result to protect herself as well as higher depressive scores and as illustrated by the MMPI-A.

According to the Teacher's syndrome scale of the CBCL, Participant A showed some increases, although not necessarily enough to fall within the clinical range. This is important to note as it may show an increased awareness of her difficulties and improved insight. According to this scale, the teacher reported a decrease in her aggressive behaviour and as it would appear that Participant A showed a lot of symptoms of depression, it is possible that her acting out behaviour has decreased in lieu of dealing with her depression and that her aggression was perhaps masking her depression. The teacher also reported a decrease in rule-breaking behaviour which can be linked to the theme of boundaries. The thematic analysis shows that Participant A struggled with boundaries and it would almost seem to appear that the EAP may have illustrated to her the importance of boundaries which may have possibly had an impact on her rule-breaking behaviour.

The analysis of the teacher and youth CBCL showed contradictory results, however they both indicated an increase in somatic complaints as well as social problems. The increase in somatic complaints may be due to an increased awareness of her anxiety which is expressed through somatic concerns. As previously indicated, through the EAP sessions, Participant A became acutely aware of her difficulties with regards to building relationships.

The MMPI-A quantitative analysis shows us that her defensive manner of reporting increased and it is possible that she may be becoming aware of more dysfunctional patterns of behaviour and have a need to try and hide them. However, her infrequency score decreased significantly, which indicates that she was better able to respond to the test.

She reported far more symptoms on the MMPI-A after her EAP sessions than before and this could possibly also be due to increased awareness and insight of her difficulties.

## **5.12. Conclusion**

Thematic analysis of Participant A's transcripts of the EAP sessions revealed several themes. A core theme for her was that of relationships. Klein's theory is based on the analysis of the relationship between the infant and their primary care giver (object) and thus this is a fundamental theme to this research. The theme of relationships was further broken down into smaller subthemes that included: trust, rejection, disconnection, boundaries, and lack of effort. She stated that she only has 3 friends and struggles with relationships at home. However, she was able to create a relationship with the horse. Although this relationship mirrored her feelings towards her object, there was more room for change and growth in this relationship as it was non-judgemental and working in a more Kleinian manner allows for the adolescents phantasies and emotions to emerge without disapproval or judgement.

With regards to the results of the quantitative analysis, Participant A illustrated more increases than decreases although not statistically significant. 6 of the scales on the MMPI-A increased and overall mostly increases were reported on the CBCL protocols.

Thus, it is evident that the EAP sessions led to changes in her thinking, feeling and behaviour.

The next Chapter, **Chapter 6**, focuses on the research findings of Participant B.

## **CHAPTER 6**

### **RESEARCH RESULTS: PARTICIPANT B**

#### **6.1. Introduction**

This chapter introduces Participant B to the reader and explores the findings of the research results. This includes a background history, a child and adolescent psychiatric interview, the findings of the initial and post-treatment 6-18 CBCL and MMPI-A as well as an intra-individual analysis of the transcripts from the EAP sessions.

#### **6.2. Relevant Background History**

It was reported that Participant B was born on the 17<sup>th</sup> January 2001 and is 15 years old. He is currently in Grade 7 at a local government primary school in the area. It was further reported that he resides with his single mother (45 years old) and his younger brother (5 years old). He also has an older sister (23 years old) who reportedly lives with her boyfriend. His parents were separated and his biological father had remarried. His biological father allegedly passed away in 2011 and his biological mother is currently employed and is the sole provider for the household.

Participant B spends time with his paternal aunt on weekends.

Apparently he argues a lot with his mother for spending time with children that are older than him as well as his smoking. Participant B denied smoking stating to his mother that he has stopped. His mother also reported that he cries a lot whenever they talk about his father.

According to Participant B's class teacher, he was described as a problematic and uncontrollable child who abuses substances (weed). He is allegedly regularly absent from school without valid reasons and he allegedly shows little interest in his class work. The principal of the school reported that Participant B often bunks school and is hardly ever in class. He further reported that they experience constant difficulties with his behaviour as he is often caught lying and is manipulative. The principal reported that Participant B leaves for school at 07:10am and his mother leaves for work at 07:15am. Participant B then returns home once his mother has left. The principal stated that he had been absent for more than 40 days the previous term.

#### **6.3. Child and Adolescent Psychiatric Interview**

Participant B is a 16 year old, coloured male. He is right handed and reported that although he is Muslim, he does attend a Christian church. He is currently in Grade 7 at a local government primary school in the area.

He stated that he currently resides in a local low-socioeconomic area with his biological mother, younger half-brother (5 years old) and half nephew (4 years old). His older half-sister is reportedly living in a different province with her boyfriend and is at university. His biological father passed away in 2011 due to unknown causes. His parents were separated and his mother currently has a new partner. He further stated that his maternal grandfather passed away in 2008 and his maternal grandmother is also living in another province. According to Participant B, his paternal grandmother also lives in a low socio economic area nearby and he occasionally goes to visit her, although he hasn't seen her in a while and misses her. He has a paternal Uncle that was in a local prison for a few years, allegedly due to "fighting".

Participant B reported that he fights a lot with his half-sister and acknowledged that he can lie. He also reported that his mother hits him. Participant B further stated that he doesn't really have a relationship with his brothers and his relationship with his father was distant prior to his death, which he struggled with.

Participant B further reported that he likes school although he is sometimes scared to come to school because he allegedly gets "slapped" by the teacher and they make jokes. He stated that they do this because he hits other children, makes a lot of noise and bunks classes which he denied and doesn't know why they would say these things about him. He further stated that the principal has accused him of fighting and being absent all the time and wanted to suspend him. His favourite subjects are Mathematics and Technology and he dislikes Life skills and Afrikaans. He has failed Grade 1 and 2 allegedly because his mother became very ill and she went back home to her home province for 2 years. During this time he stayed with his grandmother. He reportedly walks to school by himself every day.

He enjoys soccer and cricket and participates in athletics (100 metres). He apparently doesn't have any friends at school and has only one friend at home. He stated that he doesn't like friends and stays in his yard, sweeping, and helping to cook. He further went on to state that people throw stones at the house and make jokes about him. He apparently gets bullied at school and other children take his money, hit him, swear about his mother and the teachers make fun of him.

Participant B reported that he feels sad every day coming to school because he gets hit and people do bad things to him. He does feel angry and then wants to go and sleep. He also stated that he does get nervous and that people make him nervous. He doesn't always eat breakfast as there isn't always money, but he does get hungry. He eats bread and juice at lunch time and his mother sometimes brings dinner from work. He reported that he sleeps well, although he does feel tired in the mornings and worries about coming to school because of how the teachers will treat him and of being bullied.



Participant B has suffered a severe head injury. In 2009 he was hit by two cars whilst crossing the road and spent 3 months in the local government hospital. He also allegedly broke his leg and hand and goes to the local government hospital for treatment and medication for headaches and pain. He reported no epilepsy and/or seizures. He did state that he “see’s” sangoma’s in his dreams. No symptoms of psychosis were reported or elicited.

Participant B denied using drugs and alcohol, bunking, lying, fighting and stealing upon direct questioning although it is important to note that he did report it earlier on in the interview.

He has allegedly never been around horses and stated that he loves animals: “If I had an animal, I would treat him like a person.”. All safety issues around the psychotherapy with the horses were explained to him, including correct clothing to wear.

#### **6.4. Researchers Impressions of Participant B**

Participant B presented as a male, coloured adolescent with a flat mood and blunted affect. He was fairly groomed in his school clothes during the initial interview and when he attended the EAP sessions he was very well groomed in very fashionable clothing. He made very poor contact, although he did make eye contact. He was considered very concrete with a possible intellectual disability. He had a monotonous tone of voice with a slow thought form and normal content. He was considered apsychotic and asuicidal.

Participant B seemed to place himself in the victim role, taking no responsibility for his behaviour with a very external locus of control. He presented as very guarded and manipulative and has questionable reliability and validity with poor judgement.

#### **6.5. Results of the MMPI-A (Pre-Test)**

##### *Validity Indicators*

Participant B’s profile was valid although due to the elevated *Infrequency* (F1) score should be interpreted with caution. This indicates that Participant B attempted to portray himself in a bad light and was considered to be “faking bad”. Thus, some of his clinical symptoms may have been exaggerated.

His L and K scores were below that which is considered significant.

##### *Clinical Syndromes*

Participant B scored high on: *Hypochondriasis* (Hs), *Paranoia* (Pa) and *Schizophrenia* (Sc) subscales indicating a prominence of these disorders.

This indicates that he may have a preoccupation with regards to his health and illnesses and may have a lot of physical complaints. Personality and behavioural descriptors are also related to an elevation on the Hypochondriasis scale. It is also likely that boys with elevations on this scale are unlikely to be doing well especially in academic settings and may report family problems. He may also present as suspicious, rigid, morally self-righteous and distrustful. He may also have a higher predisposition towards dropping out of school.

Furthermore, he may present with disturbances of thought, mood and behaviour, be socially isolated and experience difficulties with impulse control and concentration. High scores on the Schizophrenia scale indicate that he is more likely to have poor academic achievement and to drop out of school. He may also have impaired reality-testing. The high Sc elevation is also indicative of conflict with parents, behavioural problems and a possible history of sexual abuse. Furthermore, a high Sc elevation does not necessarily indicate a diagnosis of Schizophrenia, but rather behavioural problems.

He scored moderately high on *Psychasthenia (Pt)* and *Hypomania (Ma)* indicating a presence of these syndromes.

It is possible that due to the elevated score on the Pt scale, Participant B may have physical complaints, problems with regards to his concentration, restlessness, obsessive thoughts, anxiety and some feelings of inferiority. High scores on this scale were related to a history of sexual abuse in boys, although this was not indicated in his background history.

High scores on the Ma scale indicate that he may be prone to antisocial acts or irrational manic behaviour. He may become restless and stir up excitement for the sake of excitement. There is also a correlation between this scale and substance abuse/use. This was corroborated by the background history. Participant B may experience poor motivation for psychotherapy, may not be willing to explore his feelings and may be hypersensitive to criticism as well as perceived criticism.

## **6.6. Summary of EAP sessions and therapeutic process**

Participant B unfortunately only had three sessions of EAP. He was truant and after session 3, the social workers could not locate him either at home or at school in order to continue with the sessions. There was also a large gap (few weeks) between session 1 and session 2, once again due to truancy as well as examinations and school holidays.

The following is a description of the activities that were undertaken during the EAP sessions as well as their purposes and the therapeutic process.

### **6.6.1. Meet and Greet**

This activity took place over two sessions; Session 1 and Session 2 due to the large gap between the sessions as well as a change in the horse used. The horse was changed as it was felt that a different horse would be more suited to Participant B. The focus of this activity is on building a relationship with the horse. This activity usually takes place in a smaller space such as the small arena or even the stable if the individual is particularly scared or anxious and essentially involves the meeting of the horse and establishing some sense of a relationship with the horse. The individual may choose to enter the arena/stable and stroke the horse and just spend time establishing a bond and a relationship with the horse.

Participant B initially struggled to go into the arena and “meet” with the horse. He presented as very anxious and hesitant and it took him 12 minutes before he felt comfortable enough to go into the arena with the horse. Even then, when he entered he backed away when the horse approached him. Thus he would appear to really struggle to make relationships and approaches them with caution. His anxiety was mirrored by the horse as she was also not very calm and the position of her neck and head was often tense and stiff.

### **6.6.2. Catch, halter and groom**

This activity took place in session 3 and involved the actual catching of the horse and putting a halter on the horse. The purpose of this activity is once again building a relationship with the horse as well as boundaries and interpersonal style. A lot can be observed and processed based on how the individual undertakes the task. It is also important to note that it is not necessarily important that the participant correctly halts the horse as long as the horse is not in any discomfort or pain.

It was evident from this session that Participant B seemed to really struggle with boundaries and communication. He was noted to be very impulsive and just ran straight into the arena, into the horse’s space, not even waiting for the instructions of the activity to be given. He also seemed to struggle with poor social skills and interactions were almost forced as noted by him pushing and shoving the horse around. The horse responded by walking away or pushing back against him. Furthermore, he also had no regard for the horse’s safety and would put the halter on covering her eyes and placing his fingers very close to her mouth.

The focus of the grooming part of the activity is on building a relationship, boundaries, social skills and communication. The participant is given a grooming kit with a variety of brushes and grooming tools with which to groom the horse. Once again it is important to focus on the process around the grooming and not on whether or not they do the activity “right”.

The next section is the thematic analysis of the EAP sessions.

## 6.7. Intra-Individual Analysis of the transcripts of the EAP sessions

Participant B undertook 3 sessions of EAP at a farm yard with Pauline Mawson and a Horse Specialist. After the three sessions he was not able to be found in order to complete the sessions. There was a gap of a few weeks between session 1 and session 2 and the horse was also changed.

The following three themes were identified which will be discussed in more detail below; Relationships (divided into subthemes of trust, boundaries as well as dependency and needs). Feelings and Erratic Behaviour.

### 6.7.1. Relationships

Participant B seemed initially very scared of the horse and to build a relationship with her;

He really seemed to lack the social skills to develop and build relationships and could sometimes be very aggressive:

- **Pauline:** “I don’t know I almost get a sense like when he calls her, almost disrespectfully, she doesn’t come. But when he goes and almost...”  
**Horse specialist:** “...Spends time with her then she comes.”  
**Pauline:** “Then she comes, Ja.”  
**Horse specialist:** “It’s like when he expects her to come, she doesn’t. But work on the relationship and she will...”  
**Pauline:** “...and she will come, Ja.” (*silence 7 seconds*)  
**Horse specialist:** “Look how she’s standing there waiting for him.”  
**Pauline:** (*Sound of agreement*) (*To participant B*) “Participant B, you know what we noticed, when you spend time with her she comes with you. When you just call her she, she doesn’t. So maybe relationships you need to work on them, they don’t just happen. (*Softly to Horse specialist*) Okay so he’s going back.”  
**Horse specialist:** (*Sigh*) “He understands it.”  
**Pauline:** “Ja. But very superficially, Ja. Okay.”
- **Pauline:** “Not as forceful. But it’s almost sad hey. Like you can see he want’s that relationship.”  
**Horse Specialist:** “Just doesn’t know how to get it.”  
**Pauline:** “Ja.”  
**Horse Specialist:** “Like when you asked him his answer was I don’t know.”
- **Horse Specialist:** “He hasn’t asked us what’s her name.”  
**Pauline:** “But it’s like he doesn’t know how to build a relationship he doesn’t know what to do. Very like, poor like social skills. (*Silence 47 seconds*) And she doesn’t seem very interested.”  
**Horse Specialist:** “Not at all. She’s interested in herself and the grass and that’s it. (*Silence 12 seconds*) And he doesn’t seem to be putting in any more effort.”  
**Pauline:** (*Sound of agreement*) “Hasn’t asked for help. Nothing. (*Silence 7 seconds*) (*To participant*) Participant B, what’s going on?”  
**Participant B:** “Don’t know.”  
**Pauline:** “You don’t know.”  
**Horse Specialist:** “I noticed how she’s very much interested in the grass and not in you really. Even when you came in here you tried to get her attention by pulling her towards you and she pulled away and she went to go eat.” (*Silence 3 seconds*)  
**Pauline:** “Perhaps that’s really frustrating. (*Silence 4 seconds*) How do you think you can maybe spend time with her while she’s eating? You don’t know. Okay. What if you just go up her and you just pat her and talk to her and just spend some time with her. Do you think that might work? (*Silence 8 seconds*) (*To horse specialist*) He’s got very poor social skills.”

He was however, able to build some sort of relationship with the horse;

- **Horse specialist:** “Can you see in her how she softened a bit?”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “Even her jaw is more relaxed.”

**Pauline:** “Okay. O yes, yes Ja. Now I see  
**Horse specialist:** “Earlier her head was high her whole body just looked tense besides the back leg. Now she’s even closing her eyes a little bit.” (*Silence 7 seconds*)  
**Pauline:** “So should we give him a minute, and then...”  
**Horse specialist:** “...Okay.”  
**Pauline:** “...maybe we can like reflect a bit on this how she keeps him there. I think that’s all I’m gonna say.”  
**Horse specialist:** “To spend time with him.”  
**Pauline:** “Ja, and then she got more relaxed.”  
**Horse specialist:** “And it’s quality time.”  
**Pauline:** “Yes.”  
**Horse specialist:** “He’s not just there for the sake of being there. He’s spending time with her.”  
**Pauline:** “Yes, Ja” (*Silence 39 seconds*) (*Wind noise*) There you can see he’s putting the effort in.”

- Participant B:** “I wish I could have a horse.”  
**Pauline:** “You wish you could have a horse, Ja. Why do you wish you could have a horse?”  
**Participant B:** “It’s nice.”  
**Pauline:** (*Sound of agreement*)  
**Participant B:** “Have fun with it.”  
**Pauline:** “Have fun. Do you have an animal at home? Nothing. So why a horse and not a dog or a cat?” (*Silence 14 seconds*) What’s so special about, about a horse?”  
**Participant B:** “It’s quiet, feels like a dog.”  
**Pauline:** “Okay, how’s it different then a dog?”  
**Participant B:** “A dog barks...”  
**Pauline:** (*Sound of agreement*)  
**Participant B:** “...A horse is fast, it has big legs.”  
**Pauline:** “Okay. Well maybe there’s a part of you that relates better to a horse, then to a dog.”  
**Participant B:** “I, I don’t like dogs.”  
**Pauline:** “You don’t like dogs, okay. What don’t you like about dogs?”  
**Participant B:** “They’re biting, Ja I think they barking, Ja that’s what I think.”  
**Pauline:** (*Sound of agreement*) “So they annoying, Ja. And maybe you can’t sit with a dog like you is, stood with her and did the mane and stroked her. I noticed, Horse A, did something?”  
**Horse specialist:** “Now?”  
**Pauline:** “Ja.”  
**Horse specialist:** “Did you see how she was yawning now...now?”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “So she did her lick and chew first, remember the thing where she looks like she’s chewing something and that means what, can you remember? That means she accepts you, she, she’s comfortable and then she started yawning. Did you see she did two or three yawns (*Pauline gives soft giggle*) what could that mean?”

And the more effort he put in, the better the relationship got;

- Horse Specialist:** “Making a plan climbing through the fence to get the halter on her.” (*Silence 3 seconds*)  
**Pauline:** “Cause it was at the end of the session last week that he started making an effort.”  
**Horse Specialist:** (*Sound of agreement*)  
**Pauline:** “So maybe he wants to carry that on. (*Silence 42 seconds*) She’s very stubborn hey.” (*Silence 8 seconds*)  
**Horse Specialist:** “She’s definitely the pony that teaching you carry on ...”  
**Pauline:** “Persevere. O he’s put the halter down now. (*Silence 4 seconds*) O he’s got the grooming stuff out okay. So then I’ll just groom you.”  
**Horse Specialist:** “Which is the goal at the end of the day anyway.”  
**Pauline:** (*Sound of agreement*) (*silence 10 seconds*) “But even though he carried on it’s almost seemed like kind of he, lost some hope.”  
**Horse Specialist:** “Ja.”  
**Pauline:** “That she’s not responding to him. But she did in the beginning there. (*Silence 11 seconds*) He’s doing the tail.”  
**Horse Specialist:** “He’s all over hey. Puts the effort in.”

### 6.7.1.1. Trust

Participant B really struggled to trust that the horse wasn't going to hurt him and that she wanted to make a relationship with him;

- **Horse specialist:** "Okay so we're going to be working with Horse A today. So I'd like you, if you feel comfortable, to step into the ring and make friends with her. If you want to, we gonna stand on the outside, if you want to, you can stand on the outside and make friends from this side. So while you're working I want you to think what you like about her, what you don't like about her, if there is anything, did she remind you of anyone."  
**Pauline:** "Participant B, I see you backed off there? (*Silence 5 seconds*) It's almost like you got scared. (*Silence 6 seconds*) Tell us about that, why, why, why did you get scared?"  
**Participant B:** "It is nothing."  
**Pauline:** "Nothing? Okay"  
**Horse specialist:** "So she approached you and you backed off?"  
**Pauline:** "Maybe you felt a little bit scared of her? Ja. I wonder what you were worried she would do."  
**Participant B:** "Maybe she can kick me."  
**Pauline:** "Maybe she can kick you? Okay. What else might she do?"  
**Participant B:** "I don't know."  
**Pauline:** "So at the moment you just think she, she'll kick you, she'll hurt you. Okay." (*Birds chirping*)  
**Horse specialist:** "If I'm looking at her body language and the way she's standing, she looks pretty relaxed, pretty calm. She doesn't look like she's gonna kick or bite or anything actually." (*Silence 14 seconds*)  
**Pauline:** "I see you walked close then you backed away again. So maybe you're very unsure about meeting her? (*Silence 51 seconds*) (*Wind noise*) (*Movement of paper*) I wonder what happened there. You were stroking her then you backed off quickly."  
**Participant B:** "My blood, my blood."  
**Pauline:** "Your blood? What happened to your blood?"  
**Participant B:** "It move fast."  
**Pauline:** "Okay so got, you got a bit anxious? Your heart started beating faster and you got very worried and moved away quickly." (*Silence 6 seconds*)
- **Pauline:** "Do you sometimes notice everything around you? No? Do you feel you don't notice things that happen?"  
**Participant B:** "Umm."  
**Pauline:** "Okay. But you noticing her quite a lot. (*Silence 6 seconds*) (*Softly to Horse specialist*) He's also terrified."  
**Horse specialist:** (*Sound of agreement*) (*silence 7 seconds*)  
**Pauline:** "Okay..."  
**Horse specialist:** "But wants to..."  
**Pauline:** "Ja. (*Silence 13 seconds*) So he's also not trusting..."  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** "...that she's not, gona hurt him. (*Someone sniffs*) (*Silence 8 seconds*) One hand in the pocket."  
**Horse specialist:** "Stretching over the fence."  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** "When she moves closer he moves away." (*Bird chirping*)  
**Pauline:** (*Sound of agreement*) (*silence 13 seconds*) "I see you smiling but you also shacking your head. What you, what you thinking Participant B? (*Silence 13 seconds*) Now you've moved a bit closer to her, leaning on the fence." (*Silence 15 seconds*)  
**Horse specialist:** "It's very interesting to me how pat..., patient she is with you. She's patiently standing here. She could move away and go stand anywhere else in the ring but she's here by you." (*Silence 8 seconds*)  
**Participant B:** "Won't she bite?"  
**Horse specialist:** "Remember we'd never put you in a situation with a horse that will just kick or bite. (*Silence 8 seconds*) (*Buzzing of insect flying past*) (*Softly to Pauline*)

However, towards the end of the third session, Participant B was able to start trusting Horse A;

- **Pauline:** "O my goodness he's brushing it. (*the horses hoof*) (*Silence 5 seconds*) Is that like how you supposed to do that? Okay."  
**Horse Specialist:** "He's making sure it's clean properly. You know like when you shine a shoe..."  
**Pauline:** "...O yes ja."  
**Horse Specialist:** "And look how easily she's giving her legs (*Silence 8 seconds*) Sjoh."  
**Pauline:** "I've never seen a kid do that hey. Clean their hooves."

**Horse Specialist:** “And you know for a horse to lift their legs up and give someone their legs they trust the person. And she didn’t fight it at all.”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “Just check....And the way he starts with the back legs.”  
**Pauline:** “Ja that’s also trusting. (Silence 5 seconds) But what I also find interesting is he just walked straight behind her.”  
**Horse Specialist:** (*Sound of agreement*)  
**Pauline:** “So even thou he’s quite confident about her, her feet he also has no regard for safety.”  
**Horse Specialist:** “Ja.” (*Silence 6 seconds*)

### 6.7.1.2. Boundaries

Participant B really struggled with boundaries and to respect personal space;

- Pauline:** “Ja. (*Silence 7 seconds*) And now he’s just sitting with her (*Silence 8 seconds*) Checking her out what’s going on (*Silence 8 seconds*) O he almost got stood on...”  
**Horse Specialist:** “...His feet.” (*Silence 3 seconds*)  
**Pauline:** “But then there’s also that that no sense of boundaries hey. Like you said she’s right, he’s right in her space.”  
**Horse Specialist:** “Even when he rubs...he play rubs her face he rubs her eye.”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “...if someone was rubbing my eyeball I would also get upset.”  
**Pauline:** “Ja. I wouldn’t be surprised if she smacked him, kicked him. (*Silence 26 seconds*) (*Construction vehicle*) And again he’s like watching the Adison tractor.” (*Silence 5 seconds*)
- Pauline:** “That’s also a word, he seems a bit intrusive. Like not much respect for...”  
**Horse specialist:** “...Ja.”  
**Pauline:** “Her space, his space. And in the beginning he didn’t want to go into that space.”  
**Horse specialist:** “And as he grows up that’ll be a problem for him. Not respecting...”  
**Pauline:** “Ja”  
**Horse specialist:** “...people’s boundaries and stuff”  
**Pauline:** “I think it might already be”  
**Horse specialist:** (*Sound of agreement*) “It’s, it’s a feeling I get as well.
- Pauline:** “Ja. (*Silence 7 seconds*) And now he’s just sitting with her (*Silence 8 seconds*) Checking her out, what’s going on (*Silence 8 seconds*) O he almost got stood on.”  
**Horse Specialist:** “His feet.” (*Silence 3 seconds*)  
**Pauline:** “But then there’s also that that no sense of boundaries hey. Like you said she’s right, he’s right in her space.”  
**Horse Specialist:** “Even when he rubs he play rubs her face he rubs her eye.”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “If someone was rubbing my eyeball I would also get upset.”  
**Pauline:** “Ja. I wouldn’t be surprised if she smacked him, kicked him. (*Silence 26 seconds*) (*Construction vehicle*) And again, he’s like watching the Adison tractor.” (*Silence 5 seconds*)

And didn’t seem able to understand that this might make the horse feel uncomfortable and tense;

- Pauline:** “Okay well he’s spending time with her.”  
**Horse specialist:** “But again invasively.”  
**Pauline:** “Ja.”  
**Horse specialist:** “See how she moved away some more?”  
**Pauline:** “Ja.”  
**Horse specialist:** “And lifted her head away from him.” (*Silence 31 seconds*) (*Buzzing of insect*)  
**Pauline:** “He hasn’t walked as far away and he’s gone back now.”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** “She’s got her leg up there?”  
**Horse specialist:** “Ja, so the back looks quite relaxed”  
**Pauline:** “Okay.”  
**Horse specialist:** “But the front, her head held high, looks quite tense.”

At times even placing himself in danger due to his disregard for personal space;

- **Pauline:** “Ja, that’s also trusting. (*Silence 5 seconds*) But what I also find interesting is he just walked straight behind her.”  
**Horse Specialist:** (*Sound of agreement*)  
**Pauline:** “So even though he’s quite confident about her, her feet, he also has no regard for safety.”

### 6.7.1.3. Dependency and unmet needs

Participant B would appear to have a lot of unmet needs which were mirrored through the horses behaviour and her actually taking care of her needs;

- **Horse Specialist:** “You must maybe ask him, is he really looking after himself making sure that her needs are met. Why doesn’t he look after himself?”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “Does he?” (*Silence 6 seconds*)  
**Pauline:** (*To participant*) “Participant B we noticed now you’re just standing with her and you’re giving her, her space and we noticed she’s really eating a lot and she’s really looking after herself.”  
**Horse Specialist:** “She wants to eat so that’s what she’s doing. It’s she’s looking after her own needs.”  
**Pauline:** “We wondered do you look after your needs. Do you look after yourself?”  
**Participant B:** “Yes.”  
**Pauline:** “You do. How do you look after yourself? What do you do?”  
**Participant B:** (*Spoke to soft to hear*)  
**Pauline:** “Sorry, we couldn’t hear you.”  
**Participant B:** “Eating well.”  
**Pauline:** “You’re eating well, what else? (*Silence 3 seconds*) Cause a person doesn’t just need food hey, they need other things as well. So what else do you do?”  
**Participant B:** “Make sure I bath.”  
**Pauline:** “You’re not sure.”  
**Horse Specialist:** “No make sure he baths.”  
**Pauline:** “O sorry make sure he baths, okay.”  
**Horse Specialist:** “So physically looks after himself.”  
**Pauline:** “Ja. Does anyone else look, does anyone else look after you?”  
**Participant B:** “It’s only my mum.”  
**Pauline:** “Only your mom. So maybe sometimes it get a bit lonely and maybe mom doesn’t always have time for you.”  
**Participant B:** “She has.”  
**Pauline:** “She has time?”  
**Participant B:** “Yes.”  
**Pauline:** “When does she have time?”  
**Participant B:** “During the weekends.”  
**Pauline:** “On the weekends.”  
**Participant B:** “Yes.”  
**Pauline:** “Joh did you see what she did?” (*Horse pushed him out of the way.*)  
**Horse Specialist:** “She came back to eat this side and just pushed you out the way.” (*Silence 8 seconds*)  
**Pauline:** (*To Horse specialist*) “I’m sure he doesn’t get noticed.”
- **Horse Specialist:** (*Sound indicating she did not hear*)  
**Pauline:** “I’m sure he does not get noticed. And he just gets pushed out the way.”  
**Horse Specialist:** “Only on weekends.”  
**Pauline:** “Yes.”  
**Horse Specialist:** “But there is five other days of the week.” (*Silence 3 seconds*)  
**Pauline:** (*To participant*) “Participant B I wonder if sometimes it feels at home you don’t always get noticed. (*Silence 4 seconds*) Maybe sometimes at home during the week there isn’t time for you?”  
**Horse Specialist:** “Do you sometimes feel like you just get pushed out the way. Like she pushed you? No.”  
**Pauline:** “We also know it’s very hard for you to talk about this stuff, hey. Perhaps it makes you feel sad? No. (*Silence 4 seconds*) Cause what she’s telling us is she’s just doing her own thing. She’s not really focusing on you, she’s not really interested in you. And she’s telling us that that happens in other places as well. Cause what happens here is an example of what happens at home or at school or other places. With friends. So she’s telling us that you do get ignored. She’s telling us that you do get pushed out the way.”



(*Silence 5 seconds*) What can you do to change that? (*Silence 4 seconds*) You don't know. (*Silence 7 seconds*) Cause sometimes it takes us to put in a little bit of effort to change things. So maybe you need to show her you do care about her and that you are interested in her." (*Silence 15 seconds*)

### 6.7.2. Feelings

Participant B experienced some emotions that he really struggled to voice, but were mirrored by the horse;

- **Pauline:** "She's got her leg up there?"  
**Horse specialist:** "Ja so the back looks quite relaxed."  
**Pauline:** "Okay."  
**Horse specialist:** "But the front, her head held high, looks quite tense."  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** "It's a little mixed emotions there."

He also seemed to feel very scared and anxious, especially of the horse and even got very panicky;

- **Pauline:** "I see you walked close then you backed away again. So maybe you very unsure about meeting her? (*Silence 51 seconds*) (*Wind noise*) (*Movement of paper*) I wonder what happened there. You were stroking her, then you backed off quickly"  
**Participant B:** "My blood, my blood."  
**Pauline:** "Your blood? What happened to your blood?"  
**Participant B:** "It move fast."  
**Pauline:** "Okay, so got, you got a bit anxious? Your heart started beating faster and you got very worried and moved away quickly." (*Silence 6 seconds*)
- **Participant B:** "I'm scared."  
**Pauline:** "You got scared? (*Silence 21 seconds*) (*Softly to Horse specialist*) "Still holding on to the fence." (*Birds chirping*)  
**Horse specialist:** "And won't let go" (*Dog barking*) As soon as she takes a few steps he jumps back out again."  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** "You can see how he desperately wants to be with her but he's...."  
**Pauline:** Participant B you seem very unsure if you should go in with her. But what Horse specialist and I were just saying was how much you want to be with her. Like you want to be inside with her, but you very unsure. So sometimes things can be really scary and you don't know what to do (*Silence 31 seconds*) (*Writhing noise*) (*Plane flew past*) (*Softly to Horse specialist*) "trying again."

Which lessoned the more time he spent with her;

- **Participant B:** "I don't feel scared anymore."  
**Pauline:** "You don't feel?"  
**Participant B:** "Afraid."  
**Pauline:** "O, you don't feel scared any more. Sorry I didn't hear the word scared. Okay. So it felt good to spend some time with her and you got to know her a little bit and you're not scared with her, of her. Cause, what we also noticed, is she stopped following you. It's like she forced you to come back to her and spend time with her."  
**Horse specialist:** "And when you went back to her and you spent time with her, you started plaiting her hair, she relaxed quite a lot. Throughout the session she's been a little bit, like you've been scared you say, or you've been anxious is another word, she's been a little bit anxious and on guard and aware. And when you went back to her and you started plaiting her mane she started relaxing a bit."  
**Pauline:** "So maybe when you spend time with her she's more relaxed and you felt more relaxed. So maybe she's not what you thought she was in the beginning, hey? How was today for you?"

### 6.7.3. Erratic Behaviour

Participant B's conduct disorder symptoms were evident during the EAP sessions and he would come across very aggressively;

- **Pauline:** "He's just like pushing her and shoving her around."

**Horse Specialist:** (*Sound of agreement*) “Very like in her space.”

- **Pauline:** “And she’s walking away. But she’s stopped eating.” (*Silence 7 seconds*)  
**Horse Specialist:** “There he’s got her attention a little bit. But forcefully.”  
**Pauline:** “Ja.”  
**Horse Specialist:** “So she picks her head up she walks away from where she was eating, then he grabs her neck, then she fights a little bit, then she gives in.”  
**Pauline:** (*Discontent noise*)  
**Horse Specialist:** “Very cheeky, very pushy from her, hey?”  
**Pauline:** “But he’s quite pushy. I think I would also get upset.”  
**Horse Specialist:** “Ja.” (*Silence 5 seconds*)  
**Pauline:** “It’s like he forces the interaction and she’s like no, it’s not gonna work that way.” (*Silence 49 seconds*)  
**Horse Specialist:** “And then he gives up. She goes back to eating and he goes back to standing, hanging on the fence staring at her. (*Silence 8 seconds*) And there he’s touching her again. Right in her space.”  
**Pauline:** “A bit gentler though...”  
**Horse Specialist:** (*Sound of agreement*)  
**Pauline:** “Not as forceful. But it’s almost sad hey. Like you can see he wants that relationship.”  
**Horse Specialist:** “Just doesn’t know how to get it.”  
**Pauline:** “Ja.”
- **Horse specialist:** “He’s quite also, uhm, also aggressive. Like the way he grabs her face, and grabs her neck and...”  
**Pauline:** “...I also thought that just now. Thought he, he almost seemed a bit aggressive the way he touched her.”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** Like initially he was scared and it was almost like too much”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** “But she didn’t walk away.”  
**Horse specialist:** “No she’s handling it properly. Look how she’s following him” (*Silence 6 seconds*)  
**Pauline:** There is something about him thou that’s a bit, uhm, I don’t know what the word is.”  
**Horse specialist:** “Disturbing?”  
**Pauline:** “Yes.”  
**Horse specialist:** “He’s a bit disturbing.”  
**Pauline:** “Disturbing, yes”  
**Horse specialist:** “I also feel a bit like...”  
**Pauline:** “...you don’t want to be around him?”  
**Horse specialist:** “...by yourself, umm”  
**Pauline:** “Yet she hasn’t walked away. She’s, like you said, she’s followed him the whole way around the arena”  
**Horse specialist:** “But she’s following him, but not calm and relaxed. She’s very...”  
**Pauline:** “Okay yes.”  
**Horse specialist:** “...alert at this moment”

It is also possible that Participant B may have ADHD as noted in the EAP sessions. He was very impulsive at times as noted in Session 3;

- **Pauline:** “Okay, so welcome back today. Okay, the reason I called you back out, is because you must just wait for both of us, okay, don’t just go and run and do what you want to with her. You must just be careful of that. Okay, but I can see you’re excited.”  
**Participant B:** “Yes.”
- **Pauline:** “Yes. (*Silence 4 seconds*) But that’s also interesting how he starts something, stops goes to something else comes back to it later. In terms of his thought processing centre. I’m wondering if this child is struggling with a bit of ADHD.”  
**Horse Specialist:** “Cause it looks like it he’s too here then there, then here then there.”  
**Pauline:** (*Sound of agreement*) “Very impulsive as well. Okay I’ll put the halter on you now. (*Silence 4 seconds*) And now he’s maybe a bit forceful.”  
**Horse Specialist:** “Still lacks those social skills.”  
**Pauline:** “Yes.”
- **Horse Specialist:** “But there again no dis, no regard for her eyes or anything. Forcing it on, fighting.” (*Silence 3 seconds*)  
**Pauline:** “And then it falls off.” (*Silence 3 seconds*)

**Horse Specialist:** “So he didn’t have, he didn’t take time to look at it, sus it out, think about it, he got it and just went. Now she’s eating from the grass.” (*Silence 17 seconds*) (*Tractor noise*) (*Wind picked up*)

## **6.8. Results of the MMPI-A (Post-Test)**

Participant B did not complete a post-test MMPI-A and on both occasions that the assessor tried to assess him, he was truant. Therefore, there are no post test results.

## **6.9. Quantitative analysis of the results of Participants B’s CBCL**

This section focuses on the quantitative analysis of the CBCL and the MMPI-A.

### ***6.9.1. Analysis of the parent and teachers CBCL***

Only one CBCL was filled out by the teacher and none by the parent (pre EAP intervention) and only one CBCL was filled out by the parent, post EAP intervention). The teacher did not complete the CBCL post-EAP as she stated that he was always absent and could not accurately comment on his behaviour.

Thus no analysis of the parent and teacher CBCL could be performed as there were no forms to compare.

### ***6.9.2. Analysis of the youth’s CBCL***

#### *Syndrome Scales*

The higher the score on the syndrome scales, the worse the child is doing or the higher the pathology. Thus an increase in the scores indicates that that particular area is going worse for the child; there is an increase in that particular syndrome. With regards to the syndrome scales, the participant’s behaviour either falls within the normal or the clinical range. The clinical range was worked out according to the 98<sup>th</sup> percentile. This was done for the South African context and indicates that the participant will need to score higher than average before his/her behaviour is considered clinical.

There are 9 syndrome scales: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviour, aggressive behaviour and other problems.

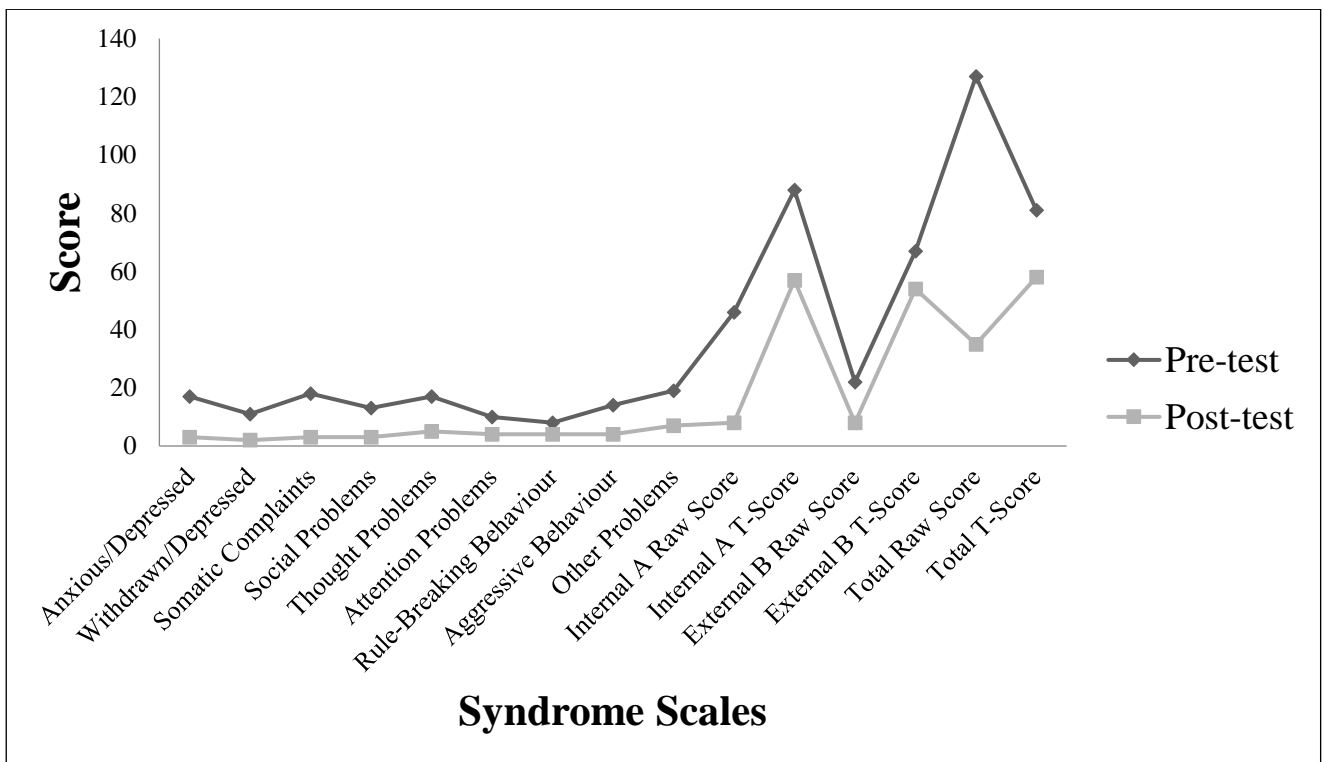
As shown in Table 14, Participant B’s Youth Syndrome Scales and Table 15, Scores of the syndrome scales, his internal A T-score decreased from 88 to 8 (from clinical to normal range). His external B T-score also decreased, from 67 to 54 (from clinical to normal range) and his total T-score – overall syndrome scale – decreased from 81 to 58 (from clinical to normal range).

Participant B showed a decrease in all areas:

- He decreased in anxious/depressed behaviour (17 to 3 – from clinical to normal range)

- A decrease for withdrawn/depressed behaviour (from 11 to 2 – clinical to normal range)
- Somatic complaints decreased from 18 to 3 (clinical range to normal range),
- Social problems decreased from 13 to 3 (clinical range to normal range),
- Thought problems decreased from 17 to 5 (from clinical range to the normal range)
- His attention problems decreased from 10 to 4 (both in the normal range),
- His rule-breaking behaviour decreased from 8 to 4 (both in the normal range),
- His aggressive behaviour also decreased from 14 to 4 (also both in the normal range),
- Other problems also decreased from 19 to 7 (normal range).

*Table 13*  
*Participant B's youth syndrome scales*



*Table 14*  
*Total Scores of the Syndrome Scales*

	Pre-test	Post-test
Anxious/Depressed	17	3
Withdrawn/Depressed	11	2
Somatic Complaints	18	3
Social Problems	13	3
Thought Problems	17	5
Attention Problems	10	4
Rule-Breaking Behaviour	8	4
Aggressive Behaviour	14	4
Other Problems	19	7
Internal A Raw Score	46	8
Internal A T-Score	88	57
External B Raw Score	22	8
External B T-Score	67	54
Total Raw Score	127	35
Total T-Score	81	58

#### **6.10. Quantitative analysis of the results of Participant B's MMPI-A**

Participant B did not complete a post-test MMPI-A. He did not show up for the scheduled three sessions in order to complete the assessment and when finally located by the social workers he stated that he did not want to take part in the assessment.

#### **6.11. Discussion**

Participant B was a male, coloured adolescent of 16 years of age. He would appear to be from a very impoverished background and very little background information was available on him. Furthermore, he was often experienced to be truant and therefore missed a lot of EAP sessions, only attending 3 out of the 6 sessions. School also reported difficulties with his attendance and he was often truant from school. Below follows a summary and discussion of the research results obtained.

He presented as very blunted, with a “gangsterish” attitude and was noted to be street-smart. Furthermore, he also presented as very demotivated and disinterested to participate in the assessments and EAP sessions.

Analysis of the data, a high Ma scale on the MMPI-A as well as the thematic analysis of the transcripts of the EAP sessions (erratic behaviour) showed that Participant B may display antisocial acts such as stealing, lying and theft and may also show behavioural problems. This was also clinically noted and is in keeping with the diagnosis of conduct disorder. His high Sc score is also indicative of

behavioural difficulties. Furthermore, the countertransference was one of feeling a bit afraid and anxious/nervous to be around him for fear of what he may do and thus possibly rejecting him. According to Klein's object relations theory, children display criminal tendencies, such as stealing, and act them out repetitively as a result of fearing a cruel retaliation from his parental figures. Unfortunately his behaviour would appear to result in rejection and thus he may feel justified with regards to his difficulties with trust and his view that objects are hostile and persecutory, resulting in more problematic behaviour. In addition, Participant B may view the loss of his father as persecutory in nature and almost as some sort of punishment and thus his behaviour. Furthermore, the relationships with his parents would not appear to be very close.

Furthermore, Participant B illustrates difficulty with regards to establishing relationships, especially with trust and has poor boundaries and social skills. This was also corroborated by his high Schizophrenia and Paranoid score on the MMPI-A. Per Klein, participant B would thus still be in the paranoid-schizoid position. It would appear that his view on the world is one of fear and distrust and he has a strong need to protect himself. He would appear to constantly be acting out against his fear of evil objects and this behaviour has been labelled as conduct disorder. He would also appear to view other objects as hostile and persecutory increasing his anxiety and thus increasing his behavioural difficulties as he doubles his attempts to destroy these objects. He may have withdrawn from the EAP sessions as the horse and the process was possibly viewed as too hard and too hostile for him and the continuation of the therapeutic process could have resulted in the triggering of an uncontrollable rage and thus more behavioural difficulties that may not be able to be contained.

Analysis of the results as well as the elevated Ma scale, indicates that he may have ADHD, a common comorbid diagnosis. Thus he may benefit from treatment in the form of psychopharmacology.

All of Participant B's score on the Youth CBCL decreased after his EAP sessions. Although his reliability and validity is questionable, it is possible that the EAP mirrored for him a sense of a relationship and that he did not need to act out aggressively in that relationship.

## **6.12. Conclusion**

Participant B's results are very limited, in that due to his truancy, the full scope of results was not able to be obtained. Also compliancy with regards to the completion of the CBCL protocols was also poor. Thus the results obtained may not be a full assessment of Participant B. This is in keeping with his behavioural difficulties and the diagnosis of conduct disorder.

Qualitative analysis of Participant B's EAP session revealed themes with regards to relationships, particularly trust, boundaries, dependency and unmet needs, feelings as well as erratic behaviour.

The next chapter, **Chapter 7**, focuses on the research results of Participant C.

## **CHAPTER 7**

### **RESEARCH RESULTS: PARTICIPANT C**

#### **7.1. Introduction**

This chapter introduces Participant C to the reader and explores the findings of the research results. This includes a background history, a child and adolescent psychiatric interview, the findings of the initial and post-treatment MMPI-A and CBCL, as well as an intra-individual analysis of the transcripts from the EAP sessions.

#### **7.2. Relevant Background History**

Very little background history was able to be obtained on Participant C, allegedly due to poor informants and thus, unfortunately, very little is known about his presenting problem and background.

The auxiliary social worker reported that Participant C was born in 2002, is 13 years old and is currently in Grade 5 at a local government primary school in the area. He further reported that his biological mother passed away in 2012 (cause unknown). He is residing with his biological father who currently does not hold any form of formal employment, but does find employment in casual jobs around the community. They allegedly live in a shack at the back of his paternal aunt's yard.

Participant C's family allegedly reported that he steals a lot in the house and lies frequently, especially towards his elders. It was further reported that Participant C was expelled from school in 2015 due to his ill-discipline (alleged theft). The auxiliary social worker reported to the assessor that Participant C's father was at school a few days prior to the start of the research, complaining about his behaviour. It was reported that Participant C is very 'naughty', doesn't listen, doesn't obey rules and was allegedly stealing and abusing drugs.

#### **7.3. Child and Adolescent Psychiatric Interview**

Upon interview with the researcher, Participant C stated that he is a 13 year old, Coloured adolescent male. He is fluent in English and is currently in Grade 5 at a local government primary school. He is right handed and reported that he was a Christian.

He reported that he resides in a low socio-economic area with his biological father, older biological brother, and older half-brother as well as his older half-sister and her 8-year-old son. He stated that he lives in the 'Zozo' hut on his maternal grandmother's property and she resides in the house. He further reported that his biological mother had passed away when he was in Grade 5 due to illness. His father sells snacks at a school down the road in order to make money and that



financially they are struggling. He stated that things were bad at home and that sometimes there was no food.

He also stated that he gets along with his family although there was sometimes conflict with his father when they fought. He could not elaborate on what they fought about.

Participant C enjoys playing soccer on the weekends. His favourite television programmes are 'Dragon Ball Z', '7de Laan' and 'Generations', a local South African programme. When he grows up he would like to be a policeman so that he can look after his family, especially if someone hurts them. His three wishes were to own a bicycle, own a car and own a house. He stated that he would take his father with him on a holiday and later changed his mind to his best friend.

Participant C reported that he enjoys school, although he finds it very hard. He especially struggles with Mathematics and Afrikaans. He reported that he gets a lot of homework and his father helps him with it. His favourite subject is Technology and he dislikes Mathematics.

He stated that he has many friends both at home and at school. He stated that he gets bullied when he doesn't want to give his peers money and gets slapped on the head. He also stated that he gets bullied by a "guy that smokes dagga".

Furthermore, Participant C reported that he feels both happy and angry most days. He gets hungry every day as there is not always money for food. He also stated that he does not always sleep well as he shares a bed with his father and gets woken up by his father's movements. He reported bad dreams of people killing and hurting his family.

Participant C stated that he doesn't worry and no psychotic symptoms were reported or elicited. There is no history of head injuries or epilepsy.

He did report that he smoked dagga every weekend since July 2015, but has recently stopped. He also reported that he has previously drunk alcohol, although stated that it was only once. He also acknowledged that he lies and sometimes steals, stating that he steals books. He denied truancy or getting involved in any fights.

Participant C has never been around horses or ponies. He stated that he was excited to be working with the horses. All safety procedures were explained to him.

#### **7.4. Researchers impressions of Participant C**

During the interview, Participant C presented as a fairly groomed, adolescent male with scars on his face. He was euthymic with a restricted affect. At times he was fidgety and seemed to get distracted easily. He also appeared to get easily bored. Although he made fair eye contact, he made poor contact and poor rapport. He was a psychotic and suicidal. His intellectual ability was judged to be between low average to average.

During the EAP sessions, Participant C presented as fairly groomed in his school clothes with a euthymic mood and reactive affect. His clothes were slightly tatty and you could see that they had been worn well. He did appear to be anxious and would often laugh, seemingly to hide his anxiety. He was initially very anxious and fearful of the horse. He seemed to try to portray a “gangsterish” attitude and walked around the farm very oppositional and with his hands in his pockets. He was at times, very impulsive and really struggled to talk about his emotions. He also presented as very street smart. He was also considered manipulative and could be very charming, hiding his initial anxiety well. Throughout the sessions, he made poor contact and rapport, creating distance between himself and the assessor/“therapists”. The sessions were conducted in English even though his first language is Afrikaans, he was fluent enough in English. At times, he was difficult to hear.

His reliability and judgement was considered questionable and he has very little to no insight, as well as poor ego-strength.

On one of the research days, Participant C did not arrive and it was reported by the auxiliary social worker that he had been expelled from school due to theft. He was also nowhere else to be found in the township.

## **7.5. Results of the MMPI-A (Pre-Test)**

### *Validity Indicators*

The results of the MMPI-A were deemed *valid* and could therefore be interpreted. However, Participant C scored high on the *Faking Bad* (F) and *Lie* (L) scales. This indicates that his results needed to be interpreted with caution and that he attempted to portray himself in both a good light as well as in as bad a light as possible.

### *Clinical Syndromes*

Items that are of clinical significance include: *Depression* (D), *Paranoia* (Pa) as well as *Schizophrenia* (Sc). This indicates that Participant C may feel hopeless, apathetic and experience feelings of discouragement and despondency. He may also present as suspicious, rigid, morally self-righteous and distrustful. He may also have a higher predisposition towards dropping out of school. Furthermore, he may present with disturbances of thought, mood and behaviour, be socially isolated and experience difficulties with impulse control and concentration. High scores on the Schizophrenia scale indicate that he is more likely to have poor academic achievement and to drop out of school. He may also have impaired reality-testing. The high Sc elevation is also indicative of conflict with parents, behavioural problems and a possible history of sexual abuse. Furthermore, a high Sc elevation does not necessarily indicate a diagnosis of Schizophrenia, but rather behavioural problems.

Areas of moderate significance include: *Hysteria (Hy)* and *Hypomania (Ma)*. This indicates that Participant C may have somatic concerns and deny problems as well as a need for social acceptance and approval. He may also express his anxiety through somatization (physical complaints). High scores on the Hy scale are also indicative of problems at school. High scores on the Ma scale indicate that he may be prone to antisocial acts or irrational manic behaviour. He may become restless and stir up excitement for the sake of excitement. There is also a correlation between this scale and substance abuse/use. This was corroborated by the background history where it was indicated that Participant C abuses weed. Participant C may experience poor motivation for psychotherapy, may not be willing to explore his feelings and may be hypersensitive to criticism as well as perceived criticism.

Thus, behavioural difficulties, suspiciousness, feelings of helplessness and anxiety as well as somatic complaints are prominent with Participant C.

## **7.6. Summary of EAP sessions and therapeutic process**

The following is a description of the activities that were undertaken during the EAP sessions as well as their purposes. Participant C was initially given a more directive activity to undertake, however, the sessions were not necessarily focused on whether or not he completed the activity, but rather on the process that unfolded:

### **7.6.1. Meet and greet**

Session 1 focused on building a relationship with the horse. This activity usually takes place in a smaller space such as the small arena or even the stable if the individual is particularly scared or anxious and essentially involves the meeting of the horse and establishing some sense of a relationship with the horse. The individual may choose to enter the arena/stable and stroke the horse and just spend time establishing a bond and a relationship with the horse.

Participant C initially thought that he was going to ride the horse. He seemed a bit anxious and hesitant when the researcher told him that the purpose of EAP was on activities with the horse and not on riding the horse. He was also very anxious that the horse would harm him. However, this hesitation was contrasted by poor boundaries and impulsivity as he would just walk straight into the arena and right up into the horse's space. The horse even appeared to need some reassurance from the researcher and horse specialist. However, the horse did start to relax with him and also gave him a lick and a chew which indicates the horse's submissiveness and feeling comfortable. This was however, only after Participant C had shown some compassion through stroking and caressing the horse.

### **7.6.2. Catch and halter**

This activity took place in session 2 and involved the actual catching of the horse and putting a halter on the horse. The purpose of this activity is once again building a relationship with the horse as well as boundaries and interpersonal style. A lot can be observed and processed based on how the individual undertakes the task. It is also important to note that it is not necessarily important that the participant correctly halts the horse as long as the horse is not in any discomfort or pain.

Participant C approached this task impulsively with seemingly little concern for his or the horse's safety and boundaries by just rushing into the arena and into the horse's space and also by walking right behind the horse. However, he also showed a connection with the horse in this session which was also noticed when he stroked her and she calmed down from previously being restless and pacing a lot. The relationship was also characterised closeness and distance as shown by the horse almost pushing him over, out of the way, and also being preoccupied with the new born foal in the next field and then by giving licks and chews.

### **7.6.3. Build a space for you and the horse**

This activity is focused on a few processes such as boundaries, relationships as well as personal space and social skills. This activity takes part in the big arena and the participant is asked to build a space with a variety of objects such as poles, tyres, cones, coke bottles, balls, uprights and any other object found in the arena. They are then asked to describe their space and guide the horse into their space.

Participant C illustrated difficulties with regards to relationships as he initially didn't even approach the horse and seemed pre-occupied with building his object. He also excluded the horse from his process and his structure and she mirrored his attitude and anger by also seemingly to not pay him much attention. It was interesting to note that there was no space for the horse in his object. It was also during this session that he broke one of the items used to build his structure by just throwing it and seemingly not showing much regard for other people's property.

### **7.6.4. Build your feelings**

This activity was focused on feelings. The idea is to allow the participants a tangible way in which to build how they are feeling, which is a task that they struggle with. This activity takes place in the big arena and they are allowed to build a structure using poles, old coke bottles, tyres, cones, balls and any other object provided or found in the arena. Part of this task is to establish their relationship with the horse and to see if they include the horse or not. Once again, the session is not task focused, but rather on the process that unfolds.

It was during this session that Participant C decided that he wanted another horse, another friend. He almost seemed to want to control the relationship and once again, the theme of relationships being hard was reflected in this session as he seemed to reject Horse A by ignoring her and wanting a “new” horse. The session previously had to be cancelled and thus he may have felt rejected by the researchers as well as the horse. He also really struggled to express his emotions and even stated that the activity was hard.

#### **7.6.5. Halter and groom (Two horses)**

Participant C decided that he would like another horse and as a result it was important to again establish his relationship with the new horse as well as the old horse.

This activity was very non-directive and involved the catching, haltering and grooming of either one or both horses and the focus was on relationships, social skills, boundaries as well as communication. It was interesting to note how he either included or excluded the horses and what this meant to him.

Once again, the theme of relationships emerged, and Participant C would take the horses and move them away from the researchers to the opposite side of the arena. He seemed to have control over the horses in this session as they did exactly as he wanted and walked very neatly next to him. He also seemed to show a disregard for their safety as he would leave the lead rein for them to step on and potentially hurt themselves. During this session, his disregard for other people’s property was also evident as he would sit and swing on the tape around the arena. The horses mirrored that they did not like this through putting their ears back and becoming restless. Participant C didn’t really connect much with Horse D during this session as was illustrated through not spending much time with her and patting her etc.

#### **7.6.6. Build an obstacle**

This session, session 6, focused on a culmination of all the sessions as it was the last session and involved building an obstacle in the big arena from objects such as jumping poles, uprights, cones, balls, coke bottles and any other object found around the arena. The participant was asked to build an obstacle, any obstacle and describe that for us. It was also his choice as to whether or not he wanted to include the horse.

Participant C built an obstacle that he named “Bullies” which he indicated that he struggles with at school. However, he did not ask for help or involve the horses in his space, thus struggling with communication, relationships as well as trust.

He also did not go and spend some time with the horses. Rejection and relationships was once again a theme for him in this session

Next follows the thematic analysis of the EAP sessions.

### 7.7. Intra-Individual analysis of the transcript of the EAP sessions

Participant C undertook 6 sessions of EAP at the stable yard accredited by EAPISA with Pauline Mawson and a Horse Specialist. The same horse was used for all six sessions, except for session 5 where an additional horse was added.

The following five themes were identified, which will be discussed in more detail below: Relationships, which was further broken down into themes comprising of abandonment and rejection/push and pull, trust, communication, lack of effort, boundaries, disconnection and then feelings, mirroring/counter-transference, erratic behaviour and power/control.

#### 7.7.1. Relationships

The theme of relationships was the most prominent theme for Participant C. Participant C would appear to really struggle with relationships, both to create as well as to maintain them and a large focus of the sessions was on building relationships;

- **Horse specialist:** "Okay have you ever worked with a horse before?"  
**Participant C:** "No."  
**Horse specialist:** "Have you ever touched a horse before? Never? Okay so when you ready you can go inside this arena..."  
**Participant C:** (*Laughed*)  
**Horse specialist:** "... and make friends with that horse when you're ready."  
**Participant C:** "Is she gonna kick me?"  
**Horse specialist:** "Okay so horses they can kick they can bite and the can step on your toes. Because they live animals. But you need to be aware of your safety (*Writing noise*) But I can tell you that I'm not gonna make you go in here with a horse that's going to hurt you."

Even in Session 2, he needed to be encouraged to build a relationship with Horse A;

- **Horse Specialist:** "Okay, are you ready for the next step? (*Silence 4 seconds*). You can go and find a spot in this arena where ever you feel comfortable. I'd like you to please groom her for us."  
**Participant C:** "What is this? Must I brush her?"  
**Horse Specialist:** "That's a grooming kit, you gonna use those brushes to groom her. And while you grooming her I want you to focus on building a relationship with her. (*Silence 4 seconds*)"

Most of his relationships would appear to lack depth and are mostly superficial in nature as illustrated by his rather large amount of friends;

- **Pauline:** "Do you have a lot of friends at school?"  
**Participant C:** "Ja."  
**Pauline:** "Not just one friend?"  
**Participant C:** "The whole class is my friends."  
**Pauline:** "The whole class?"  
**Participant C:** "Ja." (*Silence 6 seconds*)  
**Pauline:** "That's a lot of friends to have."

**Participant C:** "Twenty nine. Boys and girls."  
**Pauline:** "Sjoh girls and boys."  
**Participant C:** "Ja."  
**Pauline:** "Sounds to me like you very popular hey."  
**Participant C:** (*Chuckles*)

Also after only 4 sessions he decided that he wanted another horse. Perhaps so that he can reject Horse A before she rejects/leaves him;

- **Horse Specialist:** "This week."  
**Pauline:** "Want a new friend?"  
**Participant C:** "Jab, ja."  
**Pauline:** "Okay. So maybe we give you a new friend."  
**Participant C:** "Boring to have only one friend."  
**Pauline:** "Boring?"  
**Participant C:** "You must have lot of friends."  
**Pauline:** "Okay. But don't you have a better relationship if you only have one friend?" (*Horse nays*)  
**Participant C:** "No."  
**Pauline:** "No?"  
**Participant C:** "Must have, ouch, lot of friends."

Participant C did seem able to create some sort of a relationship with the horse although it may have been more superficial in nature;

- **Horse Specialist:** "What's she doing? She's licking her lips and she's chewing hey? That is her way of telling us that she feels save with you. That she's okay and that she wants to be your friend." (*Silence 7 seconds*)  
**Pauline:** (*To Horse Specialist*) "Aww he said I also want to be your friend."  
**Horse Specialist:** (*Sound of agreement*)  
**Pauline:** "Sweet. (*Silence 5 seconds*) And that thing she did there with her lips?"  
**Horse Specialist:** "Must be a little fly there or something."  
**Pauline:** "O, okay." (*Silence 5 seconds*)  
**Horse Specialist:** "See she's shaking her head." (*Silence 9 seconds*)  
**Pauline:** "But he's not so cocky now."  
**Horse Specialist:** (*Sound of agreement*) "Since I said that he is it's like he's toned down a bit. (*Silence 17 seconds*). There's another lick and chew."  
**Pauline:** "I actually I wonder what's going on with him that now she's being a bit more submissive and interested, cause she took a step towards him now."
- **Horse Specialist:** "When you went in, I don't know if you saw how she was jumping around and moving around because there's a baby foal this side."  
**Participant C:** "Yes."  
**Horse Specialist:** "So she was a little bit excited from that. And you touched her and you calmed her down nicely. And now she's focused on you. And there's a lick and chew. Can you remember what that means?"  
**Participant C:** "Yes."  
**Horse Specialist:** "What does that mean?"  
**Participant C:** "It's comfortable."  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** "Fantastic."  
**Pauline:** "Maybe you also feel comfortable with her. (*Silence 3 seconds*) I see you giving a lick and chew."  
**Participant C:** "Yes."  
**Pauline:** "So you..."  
**Participant C:** "At least she understands that I'm comfortable."  
**Pauline:** "Okay. You think she understands? So you're also comfortable with her?"  
**Participant C:** "Yes."  
**Pauline:** "And you like being around her?" (*Silence 6 seconds*)

Even though the relationships may have lacked depth he really struggled to say goodbye and terminate on the last session indicating that he does have an ability to create a relationship and does feel the loss even though he is very defensive about it;

- Pauline:** (*Sound of agreement*) (*To participant*) “We’ve done a lot together over these past six weeks hey?”

**Participant C:** “Ja. Joh.”

**Pauline:** “Ja. And it’s, it’s, maybe it’s sad. And it’s hard to say goodbye.”

**Participant C:** “Goodbye, ja. (*Silence 4 seconds*) I’ll never ever, ever see her again, ne?”

**Pauline:** “Well I think what we can do is we can say goodbye for now.”

**Participant C:** “Ja, ja.”

**Pauline:** “Ja. It’s not about never ever.”

**Participant C:** “You do think I can come visit her, ne?” (*Silence 3 seconds*)

**Pauline:** “I can hear that you would like to come and visit her. And that you gonna miss her very much.”

**Participant C:** (*Sound of agreement*) “So much.” (*Silence 3 seconds*)

**Pauline:** “So perhaps you’ve managed to establish a relationship with Horse A? Maybe you can make relationships outside as well.”

**Participant C:** “Ja.”

**Pauline:** “Like at home and at school.”

**Participant C:** (*Sound of agreement*) “At library, my books.” (*Silence 3 seconds*)

**Pauline:** “Ja. (*Silence 5 seconds*) Is there anything you wanna add before we say goodbye?”

**Participant C:** “Ja, take her for a round.”

**Pauline:** “For a round.”

The theme of relationships was further divided up into themes of trust, abandonment and rejection/push and pull, lack of effort, communication, boundaries and disconnection which will be discussed in further detail.

#### 7.7.1.1. Trust

Participant C would appear to have difficulties with trust. He really struggled to trust the horse as well as the Clinical Psychologist and Horse Specialist as illustrated below:

- Horse specialist:** “Have you ever touched a horse before? Never? Okay so when you’re ready you can go inside this arena...”

**Participant C:** (*Laughed*)

**Horse specialist:** “... and make friends with that horse when you’re ready.”

**Participant C:** “Is she gonna kick me?”

**Horse specialist:** “Okay so horses they can kick, they can bite and they can step on your toes. Because they’re live animals. But you need to be aware of your safety. (*Writing noise*) But I can tell you that I’m not gonna make you go in here with a horse that’s going to hurt you.”

**Participant C:** “Will you go first?”

**Horse specialist:** “See. the horses we work with are pretty safe, but you need to be aware.”

**Participant C:** “I can see you back track. So you know her.”

**Pauline:** “So maybe it’s hard for you to go in and trust that we’ve given you a horse that’s not gonna hurt you. You want to see us do it first?”

**Participant C:** “Ja.”

**Pauline:** “Why’s that. Why do you want us to do it first?”

**Participant C:** “I never touch a horse before.”

It’s extremely hard for him to trust, and he becomes very guarded, as illustrated in Session 3;

- Pauline:** “Ja. it is hard. What makes that hard?”

**Participant C:** “Joh. (*Silence 3 seconds*) I’m scared.”

**Pauline:** “Okay. So maybe that’s what the orange cones represent, hey? Stay out I’m scared.”

**Horse Specialist:** “Stick to myself.”

**Pauline:** “Ja you gonna keep to yourself. And like you said there is no space for Horse A inside your structure, like you keep your secrets to yourself.”

**Participant C:** “Ja. But I could always take her, but my time is finished.”

**Pauline:** “You could, but that would also mean that you must trust Horse A, hey? Cause maybe that’s what’s hard about letting your secrets out, is that means you’ve got to trust the person with your secrets.”

**Participant C:** “Must I talk to Horse A my secrets?”

**Pauline:** “If you want to.”

**Participant C:** “No.”

**Pauline:** “Why not? What’s she gonna do with your secrets?”



**Participant C:** “Nothing.”

**Pauline:** “Well exactly. She’s not gonna tell anyone else is she? She’ll probably just listen. (*Silence 5 seconds*) Maybe sometimes...”

### 7.7.1.2 Abandonment and rejection/Push and pull of relationships

Participant C was very cautious of the relationship that he had created with Horse A and almost seemed fearful that she would leave him;

- **Participant C:** “O every ... every Monday when I come we must...I want her to be here. Or it’s gonna be someone else?” (*Silence 4 seconds*)  
**Pauline:** “Where I can hear that you really want to spend time with her.”  
**Participant C:** “Ja.”  
**Pauline:** “And that she’s important.”  
**Participant C:** “What’s her name again?”  
**Pauline:** “Horse A”  
**Participant C:** “Horse A.” (*Silence 7 seconds*)  
**Pauline:** “It sounds to me like you’re starting to make a relationship with her. But one of the things I’m wondering about is, you’re still on the outside of the arena. You haven’t gone in, you haven’t spent more time with her since she, she moved around.”  
**Participant C:** “So must I also walk around?”  
**Pauline:** “Well it’s up to you. You can do whatever you want to do to make friends with her.”  
**Participant C:** “So you’re the other one who’s coming also in here?”  
**Pauline:** “No.”

Participant C really struggled with closeness and would sometimes, perhaps purposively create distance, almost as a way to protect himself before he could feel rejected by the horse;

- **Pauline:** “I can’t hear. But I think it’s also why he’s making that distance, because it keeps us out.”  
**Horse Specialist:** (*Sound of agreement*) “Look at that.” (*Silence 5 seconds*) (*Construction vehicle*)  
**Pauline:** “Now he’s climbed up onto the fence. A bit closer.” (*Silence 3 seconds*)  
**Horse specialist:** “It almost looks like he’s lost in her, hey?”  
**Pauline:** (*Sound of agreement*) (*Silence 4 seconds*)  
**Horse Specialist:** “Look at that. (*Silence 17 seconds*) Another lick and chew from her.” (*Silence 9 seconds*)  
**Pauline:** “Now she’s walking away.”  
**Horse Specialist:** “But with her head on the ground.”

However, Horse A seemed to be very aware of his disconnection and would attempt to create a relationship with him, as well as bring him closer to the Clinical Psychologist and Horse Specialist in order to form a relationship with us;

- **Participant C:** “Looks she’s following me.”  
**Pauline:** (*Sound of agreement*) (*Silence 8 seconds*) (*To participant*) “And just now you were all the way on the other side and you’re here. We’re all together now.”  
**Participant C:** “Ja.”  
**Pauline:** “You’re closer to us now. Ja”  
**Horse Specialist:** “I mean she’s right here as well.”  
**Pauline:** “It’s almost like she brought you this side, hey? (*Silence 6 seconds*) We noticed how relaxed she was and how you were talking with her and caressing her and stroking her. What was that like for you?”  
**Participant C:** “Fun.”  
**Pauline:** “Fun. Okay.”  
**Participant C:** “Touch her.”  
**Pauline:** (*Inquisitive sound*)  
**Participant C:** “She wants you to touch her.”  
**Pauline:** “She wants me to touch her?”  
**Participant C:** “Ja. No she wants me to touch her.”

In session 2, it was still very evident that Participant C wanted to create distance;

- **Pauline:** (*Sound of agreement*) “But he also it was interesting he took her away from us.”  
**Horse Specialist:** (*Sound of agreement*)  
**Pauline:** “Like I’m gonna go away...”  
**Horse Specialist:** “Ja.”  
**Pauline:** “... from you guys. Do my own thing.”

And this was a continuous theme throughout the sessions;

- **Pauline:** “Well we’re running out of time for today. But that’s maybe something to think about for next time. That maybe you need to pay more attention to her. And that maybe you can trust her. And like all these orange cones that are here I think it’s how guarded you are. How scary it is to trust people and to let them know your secrets. (*Silence 5 seconds*) (*To horse specialist*) He’s not interested at all now.”  
**Horse Specialist:** (*Sound of agreement*) “...not interested.”  
**Pauline:** “Cause it’s too hard to talk about.”  
**Horse Specialist:** “Just turns his back and walks away. Like she came through here turned her back and walked away.” (*Silence 5 seconds*)  
**Pauline:** “Jis for these kids to talk it’s very hard. (*Silence 6 seconds*) Do you want to add anything? Cause I think we’re being shut out now. (*To participant*) Participant C we know it’s very hard to talk about these things hey.”  
**Participant C:** “Which things?”  
**Pauline:** “Well like your secrets. And not wanting to let people into your space. It’s much easier to walk away.”  
**Participant C:** “Which people?”  
**Pauline:** “Which people would you let into your space?”  
**Participant C:** “Anybody.”  
**Pauline:** “Anybody?”

### 7.7.1.3. Boundaries and communication

Participant C clearly had great difficulty with regards to boundaries. He seemed to feel that they did not exist and really struggled with personal space often not even being aware of a boundary and crossing into the horse’s personal space;

- **Horse Specialist:** (*To Pauline*) “He’s very loud and out there hey?”  
**Pauline:** “Ja. And like in your face.”  
**Pauline:** “He’s having a fat conversation with her. (*Silence 16 seconds*) Look how he leans into her space he says he’s scared but then he’s right...”  
**Horse Specialist:** “Right in her space”  
**Pauline:** “Ja.” (*Silence 4 seconds*)

Even at times, risking his own safety, by walking under and behind the horse, so disregarding the boundary of safety;

- **Horse Specialist:** “Just hold this.”  
**Pauline:** “But again like a bit risky.”  
**Horse Specialist:** “Ja a risk, he makes a plan but safety isn’t a...”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “... factor.” (*Silence 11 seconds*) (*Writing noise*)

And being impulsive (Session 2) which can cause him to get into trouble;

- **Pauline:** “Okay. Could you have gone the other way around and come towards her from the front?”  
**Participant C:** “Yes.”  
**Pauline:** “Okay. Cause remember you also need to be very careful for your safety. Remember we chatted about that. And maybe try and not be so like impulsive like just do. Okay.” (*Dog barks*)

Participant C really struggled to communicate with Horse A. He did not seem to know how to communicate with a horse and almost seemed a disrespectful when he tried;

- Participant C:** “How do I call her?”  
**Pauline:** “How do you call her?”  
**Participant C:** “Ja”  
**Pauline:** “What do you think?” (*Silence 3 seconds*)  
**Horse Specialist:** (*To Pauline*) “Shows a hand signal. Huh?”  
**Pauline:** (*To participant*) “Okay so that didn’t work. So it’s almost like you’ve got to make a relationship with her so that she does come to you and she does listen to you.”  
**Participant C:** “What is her name?”  
**Pauline:** “Horse A.”  
**Participant C:** “Horse A” (*Silence 3 seconds*).

### 7.7.2. Feelings

Participant C did seem to have some ability to empathise with Horse A, although it would appear to have been very superficial and possibly even manipulative, for his own gain as seen in session 1;

- Participant C:** “There’s a lot of flies in her eyes.”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “You seem more bothered by the flies then what she does. Flies don’t seem to bother her much. (*Silence 8 seconds*) (*Talking to Participant C*)  
**Pauline:** “Perhaps a part of you is a bit worried about her eyes and that the flies bothering her. Or you feel that they bothering her.”  
**Participant C:** “Yes.”  
**Pauline:** “So it’s almost like you care about her and you want to take look after her.”  
**Participant C:** “Ja cause when I touch her, moves like this which means it’s a fly.”  
**Horse Specialist:** “There she’s licking and chewing again.”  
**Participant C:** “What does she says now?”  
**Horse Specialist:** “You know what that means. (*Pauline Chuckles*)  
**Participant C:** “Ja she’s comfortable with me.”

During the EAP sessions, it was evident that Participant C really struggled with a feeling vocabulary as well as expressing his feelings. Horse A would often mirror for him how he might be feeling, but he would often become very defensive;

- Pauline:** “It’s hard to talk about feeling upset hey. Maybe it made you feel a little upset when she just pushed you out the way.”  
**Participant C:** “No.”  
**Pauline:** “No? Okay.”  
**Horse Specialist:** “Did it maybe, do you know what the word frustrate means?”  
**Participant C:** “It seems that I know it but I don’t know it really.”  
**Horse Specialist:** “So frustrate means like a little bit agghhh!”  
**Participant C:** (*Laughs*)  
**Horse Specialist:** “Does that explain it?” (*Pauline laughs in background*)  
**Participant C:** “Yes.”  
**Horse Specialist:** “That’s what she’s showing me here when she paused like that is a little bit of aaggghhh! Frustration.”  
**Participant C:** “Want to get out of here? She also wants to get that side, ne?”  
**Horse Specialist:** “You think?”  
**Pauline:** “Cause I see she’s walked away now. You let go of her and she walked away. Maybe sometimes you feel frustrated.”  
**Participant C:** “At home ja.”  
**Pauline:** “At home. What happens at home that makes you feel so frustrated?”  
**Participant C:** “My brother.”
- Horse Specialist:** “Okay so you gonna go in. and you can spend some time with Horse A because you haven’t seen her for two weeks. And then I’d like you to use whatever is here and I want you to build for us how you feeling.”  
**Participant C:** “How I’m feeling?”  
**Pauline:** (*Sound of agreement*)

**Horse Specialist:** “So think about what you feeling inside. And then you gonna build it to show us how you feeling.”

**Participant C:** “Joh. That’s difficult.”

Participant C would also appear to constantly feel anxious, scared and unsafe;

- **Pauline:** “Okay. (*Car hoots*) So you’ve never done it before it’s completely new to you. What do you think it would be like to touch the horse? (*Dog Barks*)  
**Participant C:** “Joh, fun but then scared”  
**Pauline:** “Fun but scared?”  
**Participant C:** “Ja. (*Silence 3 seconds*) How do you call her?”

It was only with Horse A that he was able to feel safe;

- **Horse Specialist:** “So she’s laying down and she’s having a roll.”  
**Participant C:** “Playing.”  
**Horse Specialist:** “And to me that makes me believe that she feels she is safe in here with you.”  
**Participant C:** “I also feel that I’m safe in her. In here with her.”  
**Horse Specialist:** (*Sound of agreement*) “She’s feels she’s save enough do lay down and roll and she’s not gonna get hurt. Or she’s free enough to lay down and roll and she’s not gonna get hurt.”

It is possible, that with some effort and perhaps because it is with an animal that Participant C can show empathy;

- **Pauline:** (*To Horse Specialist*) “It’s so hard for him to talk about how he feels.”  
**Horse Specialist:** (*Sound of agreement*) (*Silence 5 seconds*)  
**Pauline:** “But his concerned about her and that’s what strikes me.”  
**Horse Specialist:** “Very, very concerned.”  
**Pauline:** “Cause these kids struggle to show empathy.”  
**Horse Specialist:** “Ja.”  
**Pauline:** “But he really seems to care about her.”  
**Horse Specialist:** “Goes and takes the lead rain off so she doesn’t fall.”

### 7.7.3. *Mirroring/Counter-transference*

Horse A was able to mirror how Participant C was feeling. She is able to mirror his feelings of rejection as well as disconnection and irritability even though he is unable to voice these things himself;

- **Horse Specialist:** “While he’s building she comes up to see what he doing, but last time she walked away.”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “This time she’s staying here.”  
**Pauline:** “But this time he acknowledged her. Last time he…”  
**Horse Specialist:** “He didn’t.”  
**Pauline:** “Even acknowledge her. No she’s not so happy.”  
**Horse Specialist:** “Quite weary of him. (*Silence 7 seconds*) Very inquisitive as well.”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “She comes here to smell it.” (*Silence 10 seconds*) (*Birds chirping*)  
**Pauline:** “She is quite weary of him hey.”  
**Horse Specialist:** (*Sound of agreement*)  
**Pauline:** “But he’s got all these like jagged things you know that would make her.”  
**Horse Specialist:** “and he’s using them quite abrupt.”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “He’s putting them down he’s making a noise.” (*Silence 3 seconds*)  
**Pauline:** “No sense he might scare her or, he just does.”

Although relationships are particularly difficult for Participant C he may feel empty and lonely and Horse A was able to mirror his unconscious need for a connection, for relationships;

- **Participant C:** “Look she’s talking again.”  
**Horse Specialist:** “Yeah look what she’s doing with her mouth. Remember what that’s called?”  
**Participant C:** “She wants to make friends with her.”  
**Pauline:** “With me?”  
**Participant C:** “Ja”  
**Horse Specialist:** “It’s called a lick and chew.”  
**Participant C:** “Lick and chew.”  
**Pauline:** “Why’d you think with me and not with you?” (*Silence 3 seconds*)  
**Participant C:** “Cause she’s making her lips while she’s standing there by you.”  
**Pauline:** “Okay. Does that maybe feel like that, that people wanna make friends with other people and not you?”  
**Participant C:** “And with me.”  
**Pauline:** “And with you.”  
**Participant C:** “Ja.”  
**Pauline:** “So you as well?”  
**Participant C:** “All of us.”  
**Pauline:** “Okay. So that’s very important hey?”  
**Participant C:** “Yes.”

#### 7.7.4. Erratic Behaviour

Participant C clearly illustrated symptoms of Conduct Disorder during the sessions which played out in the therapeutic process, even in the way in which he presented himself;

- **Horse Specialist:** (*To Pauline*) “This kid is sharp.”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “Very street wise hey?”  
**Pauline:** “Yes I was gonna say street wise ja. (*Silence 5 seconds*) “But now he’s like walked up to her all like...”  
**Horse Specialist:** “Gangsterish.”

He could become very impulsive at times;

- **Pauline:** “No he’s touching her. (*Silence 3 seconds*) He’s... he’s quite impulsive like he said he doesn’t wanna go in but then he almost like walked straight into the arena.”  
**Horse Specialist:** “Straight into her space.”

And seemed to find it extremely hard to let his defences down as seen in Session 1;

- **Horse Specialist:** (*To Pauline*) “This kid is sharp.”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “Very street wise hey?”  
**Pauline:** “Yes I was gonna say street wise ja. (*Silence 5 seconds*) “But now he’s like walked up to her all like...”  
**Horse Specialist:** “Gangsterish.”

It is also very evident that Participant C is involved with people that are involved in criminal activities, although he is very guarded against this;

- **Participant C:** “But not with my friends. I’m not sure when I’m safe with them. I’m sure. But not with friends I do not know. Friends I know well, my best friends I’m safe. Like in the class I’m safe. When I go out my house I’m safe. But not when I’m, how can I say it, when I’m in the bushes with wrong friends I’m not safe.”  
**Pauline:** (*Intrigued*) “Who’s the wrong friends, who’s the people you’re not safe with?”

**Participant C:** “Maybe person who smokes.”  
**Pauline:** *(Sound of agreement)*  
**Participant C:** “Alcoholics, Ja not safe with them.”  
**Pauline:** *(Sound of agreement)*  
**Participant C:** “With druggies. I’m safe with Horse A here.”  
**Pauline:** *(Sound of agreement)*  
**Participant C:** “With you, with my school Mr J. Ja.”  
**Pauline:** *(Sound of agreement)*  
**Participant C:** “And with my parents.”  
**Pauline:** “It sounds like those other, those other people are scary hey?”  
**Participant C:** “Who’s scary?”  
**Pauline:** “The people that smoke and alcoholics.”  
**Participant C:** “Ja.”  
**Pauline:** “They sound quite scary.”  
**Participant C:** “Ja. They’re scary. Only big people that can smoke. Not children.”  
**Pauline:** “What do they do that’s so scary?”  
**Participant C:** “They smoke.” *(Silence 3 seconds) (Writing noise)*  
**Pauline:** “Ja.”  
**Participant C:** “They mustn’t smoke.”  
**Pauline:** “So just that?”  
**Participant C:** “Ja. They’re under age.”  
**Pauline:** “Okay.”  
**Participant C:** “Only big people I understand.” *(Silence 4 seconds)*  
**Pauline:** *(Sound of agreement)*  
**Participant C:** “They can smoke but not use drugs.”  
**Pauline:** “What sort of drugs do they use?”  
**Participant C:** “I don’t know.” *(Silence 4 seconds)*  
**Pauline:** “Must be very scary.”  
**Participant C:** “What?”  
**Pauline:** “Being around them. *(Silence 3 seconds)* She’s come right up into your space.”

### 7.7.5. Power/Control

It’s very important for Participant C to have a sense of power and control. Even to the extent that he needs to control his relationships;

- Pauline:** “O. She must also have a new friend. Why must she have a new friend?”  
**Participant C:** “Us two.”  
**Pauline:** “Ja?”  
**Participant C:** “The two of us must make a new friend. Come and join our relationship.”  
**Pauline:** “O. Okay so you don’t wanna leave her behind? You wanna add to your friendship.”  
**Participant C:** “Ja.”

He would also appear to have a need to control his anxiety and his behaviour presents as obsessive compulsive at times;

- Horse Specialist:** “Very unaware of her.” *(Silence 27 seconds)*  
**Pauline:** “But he’s very organised. *(Silence 3 seconds)* Number letter number letter.”  
**Horse Specialist:** *(Sound of agreement) (Silence 4 seconds)*  
**Pauline:** “It’s interesting thou cause he’s quite impulsive. But when he builds something.”  
**Horse Specialist:** “He puts a lot of thought into it.”  
**Pauline:** “He’s very...Ja.” *(Silence 9 seconds)*
- Pauline:** “Like now go away. I’m gonna do my thing I want a new friend. *(Silence 46 seconds) (Birds Squawking)* What’s that in the middle it doesn’t make sense to me?”  
**Horse Specialist:** “E C S P 6 V” *(Saying out loud the letters\numbers on the cones)*  
**Pauline:** “And it’s right in the middle of nowhere. *(Silence 5 seconds)* Okay he’s taken that away.”  
**Horse Specialist:** “Now he’s putting it in the middle of the other side.”  
**Pauline:** “Oh.”  
**Horse Specialist:** “So again everything is even.”  
**Pauline:** *(Sound of agreement)*  
**Horse Specialist:** “Two three two three two.”

**Pauline:** (*Sound of agreement*)

**Horse Specialist:** “And even the numbers are on the left hand side and the letters are on the right hand side.”

**Pauline:** (*Sound of agreement*) “But they not in order thou. It’s not like 1 2 3.”

**Horse Specialist:** (*Sound of agreement*)

**Pauline:** “It’s just numbers. (*Silence 4 seconds*) But that’s also a sense I get from him, sometimes quite controlled and rigid, but then very chaotic at times as well.”

**Horse Specialist:** (*Sound of agreement*) “Cause there is a sense of control...but a sense of chaos.” (*Silence 5 seconds*) (*Construction vehicle*)

## 7.8. Results of the MMPI-A (Post-Test)

### *Validity Indices*

The results of the MMPI-A were deemed *valid* and could therefore be interpreted. However, Participant C once again scored high on the *Faking Bad* (F) and *Lie* (L) scales. This indicates that his results need to be interpreted with caution and that he responded in a defensive manner, attempting to portray himself in both a good light as well as in as bad a light as possible. However, he tended to try portray himself in a more favourable light.

Items of clinical significance included *Hysteria* (Hs). This indicates that symptoms of a somatic nature, denial of problems and the need for social acceptance and approval are still prevalent.

Items of moderate significance include *Hypochondriasis* (Hy), *Depression* (D) and *Paranoia* (Pa). There was a significant decrease in the score obtained on these scales. This indicates that symptoms of hopelessness, apathy and feelings of discouragement and despondency are still present, although to a lesser degree. Participant C may also still feel suspicious, rigid, morally self-righteous and distrustful and still be at-risk of dropping out of school. Furthermore, he may still present with disturbances of thought, mood and behaviour, be socially isolated and experience difficulties with impulse control and concentration.

## 7.9. Quantitative analysis of the results of Participant C’s CBCL

Below follows the quantitative analysis of Participant C’s CBCL:

### *7.9.1. Analysis of the parents and teachers CBCL*

Unfortunately no parent analysis was able to be obtained.

The analysis of the teacher’s CBCL indicated that his Internal T-score decreased from 70 to 64 (from clinical to normal range), his external T-score remained the same at 82 (clinical range) and there was a slight increase in his Total T-score from 76 to 78 (clinical range).

As illustrated by Table 16 and Table 17 there was an increase in the following syndromes:

- Social problems from 6 to 16 (from normal to clinical range),

- Thought problems from 6 to 11 (from normal to clinical range),
- Attention problems from 15 to 19 (both in the clinical range) and
- Aggressive behaviour from 30 to 34 (clinical range).

The following syndromes stayed the same:

- Other problems at 7 (normal range).

There was a decrease in the following syndromes:

- Anxious/depressed behaviour from 8 to 4 (both normal range),
- Withdrawn/depressed behaviour from 12 to 8 (both clinical range),
- Somatic complaints from 2 to 0 (both normal range) and;
- Rule breaking behaviour from 18 to 14 (both clinical range).

*Table 15*  
*Participant C's Parent and Teacher CBCL*

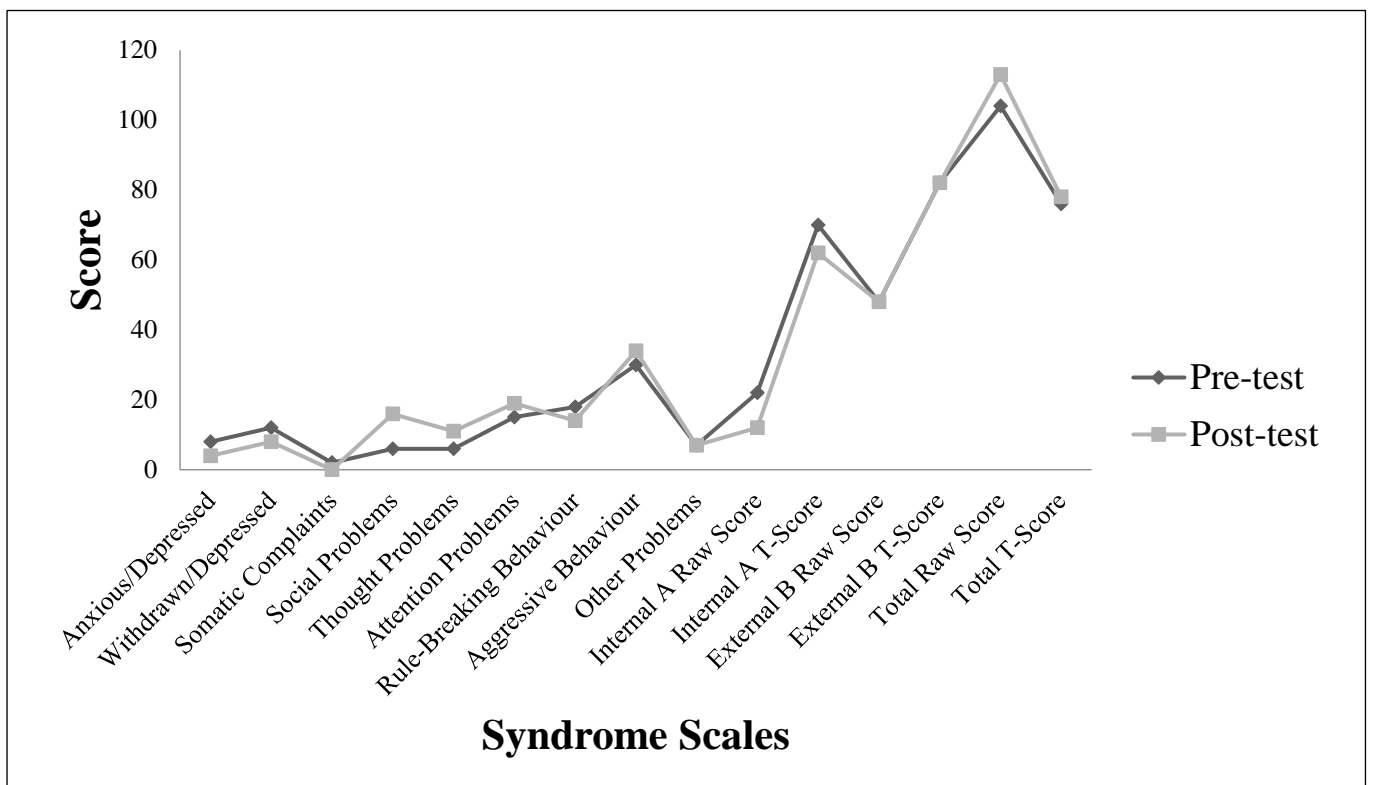




Table 16  
Total Scores of the Syndrome Scales

	Pre-test	Post-test
<b>Anxious/Depressed</b>	8	4
<b>Withdrawn/Depressed</b>	12	8
<b>Somatic Complaints</b>	2	0
<b>Social Problems</b>	6	16
<b>Thought Problems</b>	6	11
<b>Attention Problems</b>	15	19
<b>Rule-Breaking Behaviour</b>	18	14
<b>Aggressive Behaviour</b>	30	34
<b>Other Problems</b>	7	7
<b>Internal A Raw Score</b>	22	12
<b>Internal A T-Score</b>	70	62
<b>External B Raw Score</b>	48	48
<b>External B T-Score</b>	82	82
<b>Total Raw Score</b>	104	113
<b>Total T-Score</b>	76	78

### 7.9.2. Analysis of the youth CBCL

#### *Syndrome Scales*

The higher the score on the syndrome scales, the worse the child is doing or the higher the pathology. Thus an increase in the scores indicates that that particular area is going worse for the child; there is an increase in that particular syndrome. With regards to the syndrome scales, the participant's behaviour either falls within the normal or the clinical range. The clinical range was worked out according to the 98<sup>th</sup> percentile. This was done for the South African context and indicates that the participant will need to score higher than average before his/her behaviour is considered clinical.

There are 9 syndrome scales: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, though problems, attention problems, rule-breaking behaviour, aggressive behaviour and other problems.

Participant C's Internal A T-score decreased (78 – clinical to 73 – normal range). In contrast his External B-score increased slightly (from 63 – normal range to 64 – also normal range) and is total T-score decreased slightly (from 70 to 69, both within the normal range).

As shown in Table 18, Participant C showed an increase on the following syndromes:

- Social problems from 5 to 12 (normal to clinical range),

- Thought problems from 4 to 5 (both within the normal range),
- Attention problems from 3 to 4 (both within the normal range),
- Rule breaking behaviour from 7 to 8 (also both within the normal range).

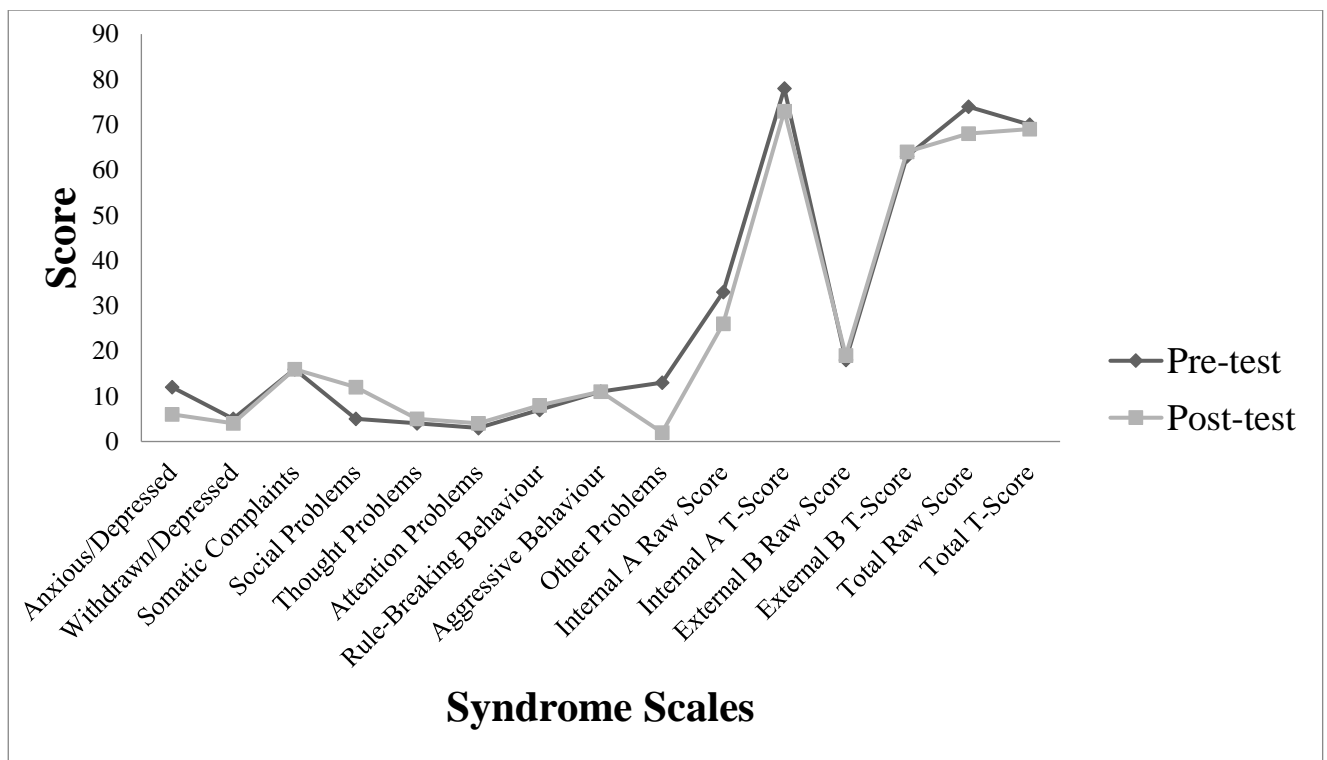
The following syndromes stayed the same:

- Somatic complaints at 16 (normal range), and
- Aggressive behaviour at 11 (normal range).

The following syndromes showed a decrease:

- Anxious/depressed behaviour from 12 to 6 (from clinical to normal range),
- Withdrawn/depressed behaviour from 5 to 4 (stayed in the normal range), and
- Other problems from 13 to 2 (stayed in the normal range).

*Table 17*  
*Participant C's Youth CBCL*



*Table 18*  
*Total Scores of the Syndrome Scales*

	Pre-test	Post-test
Anxious/Depressed	12	6
Withdrawn/Depressed	5	4
Somatic Complaints	16	16
Social Problems	5	12
Thought Problems	4	5
Attention Problems	3	4
Rule-Breaking Behaviour	7	8
Aggressive Behaviour	11	11
Other Problems	13	2
Internal A Raw Score	33	26
Internal A T-Score	78	73
External B Raw Score	18	19
External B T-Score	63	64
Total Raw Score	74	68
Total T-Score	70	69

### **7.9.3. Analysis of the teacher and youth CBCL**

This section is a discussion of the combination of both the analysis for the teacher and youth CBCL's and is shown in Table 19, Participant C's Teacher and Youth Syndrome Scales and Table 20, Total Scores of the Teacher and Youth Syndrome Scales.

It is evident that the views of the youth and teacher regarding behaviour are different. This may possibly be due to objectivity as well as context. The teacher only has a perception of the child as formed within the educational context.

In the pre-test both the youth and teachers scores indicated that he was in the clinical range for his internal A T-score. In the post-test both the youth and teachers scores indicated that social problems were an issue (in the clinical range).

The youths scores indicate that the main area of concern is somatic complaints (which did not change and is in the clinical range). While the teachers scores show that withdrawn/depression, attention problems, rule-breaking behaviour, aggressive behaviour, and his external B T-Scores remained in the clinical range during pre and post-test.

Table 19  
Participant C's Teacher and Youth Syndrome Scales

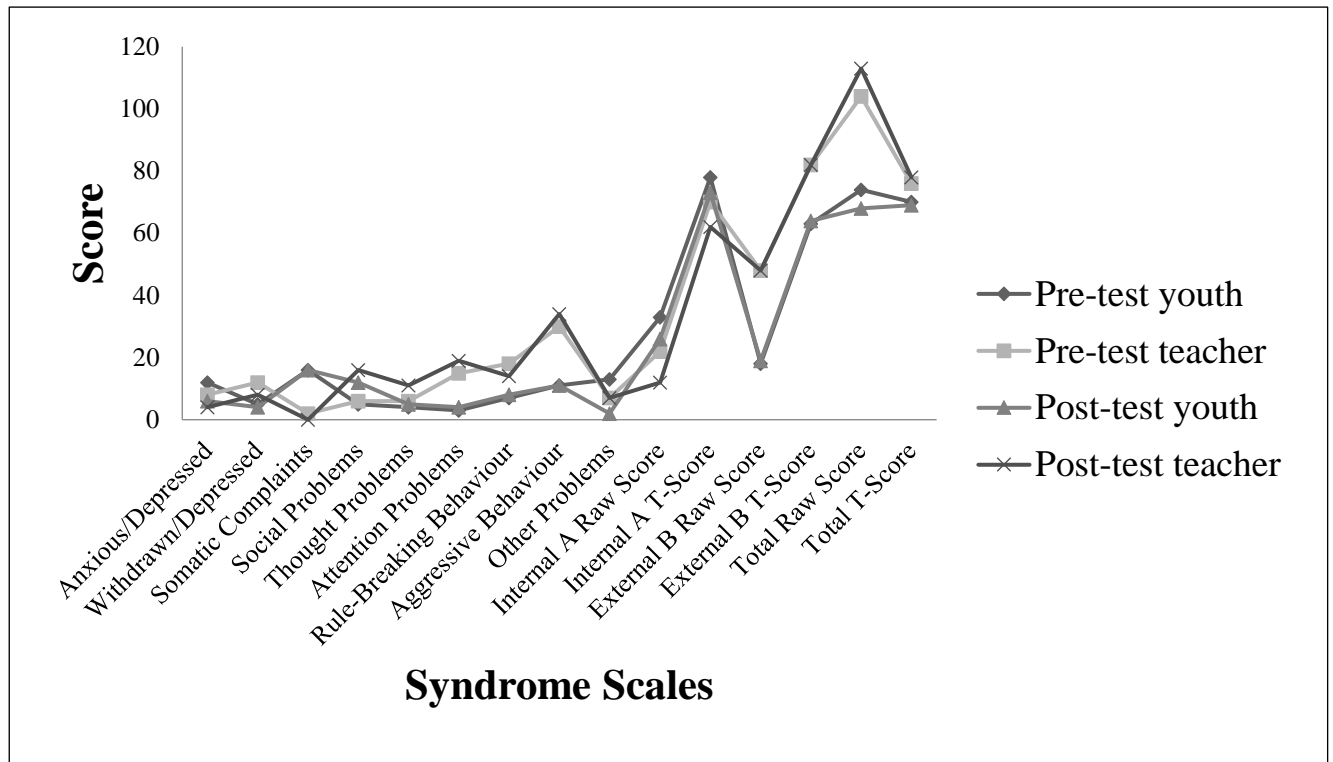


Table 20  
Total scores of the Teacher and Youth Syndrome Scales

	Pre-test youth	Pre-test teacher	Post-test youth	Post-test teacher
Anxious/Depressed	12	8	6	4
Withdrawn/Depressed	5	12	4	8
Somatic Complaints	16	2	16	0
Social Problems	5	6	12	16
Thought Problems	4	6	5	11
Attention Problems	3	15	4	19
Rule-Breaking Behaviour	7	18	8	14
Aggressive Behaviour	11	30	11	34
Other Problems	13	7	2	7
Internal A Raw Score	33	22	26	12
Internal A T-Score	78	70	73	62
External B Raw Score	18	48	19	48
External B T-Score	63	82	64	82
Total Raw Score	74	104	68	113
Total T-Score	70	76	69	78

## **7.10. Quantitative analysis of the results of Participant C's MMPI-A**

Below in Table 22 Participant C's Pre- and Post-test MMPI-A scores, follows the quantitative analysis of the pre- and post-test data from Participant A's MMPI-A.

The scores on this section were worked out according to the T scores obtained. The higher the score, the worse that the child is doing. Thus an increase in the score represents an increase in pathology.

### *7.10.1. Validity Scales*

With regards to validity scales, the Infrequency (F1) scores in both the pre- and post-test indicate that there were no problematic response patterns.

The Lie (L) scores for both the pre- and post-test could be interpreted as defensive and they increased from the pre-test, 76, to the post-test, 84.

For the defensiveness (K) scale, his scores decreased slightly from 59 to 57 and it was indicative of a none defensive test taking attitude.

### *7.10.2. Clinical scales*

The following results were obtained on the clinical scales:

Participant C showed an increase on the following scales:

- Hypochondriasis increased from 60 (moderate) to 65 (clinically significant),
- Hysteria (Hy) from 64 (moderate) to 76 (clinically significant),
- Psychopathic deviance (Pd) from 47 to 51 (insignificant),
- Masculinity-Femininity scales (Mf) from 54 to 59 (insignificant).

A decrease was obtained on the following scales:

- Depression (D) decreased from 69 (clinically significant) to 62 (moderate),
- Paranoia (Pa) decreased from 69 (clinically significant) to 63 (moderate),
- Psychasthenia (Pt) decreased from 51 (insignificant) to 46 (insignificant),
- Schizophrenia (Sc) decreased from 73 (clinically significant) to 56 (insignificant),
- Hypomania (Ma) decreased from 62 (moderately elevated) to 56 (insignificant),
- Social introversion (Si) decreased from 54 (insignificant) to 46 (insignificant).

Table 21  
Participant C's Pre- and Post-test MMPI-A scores

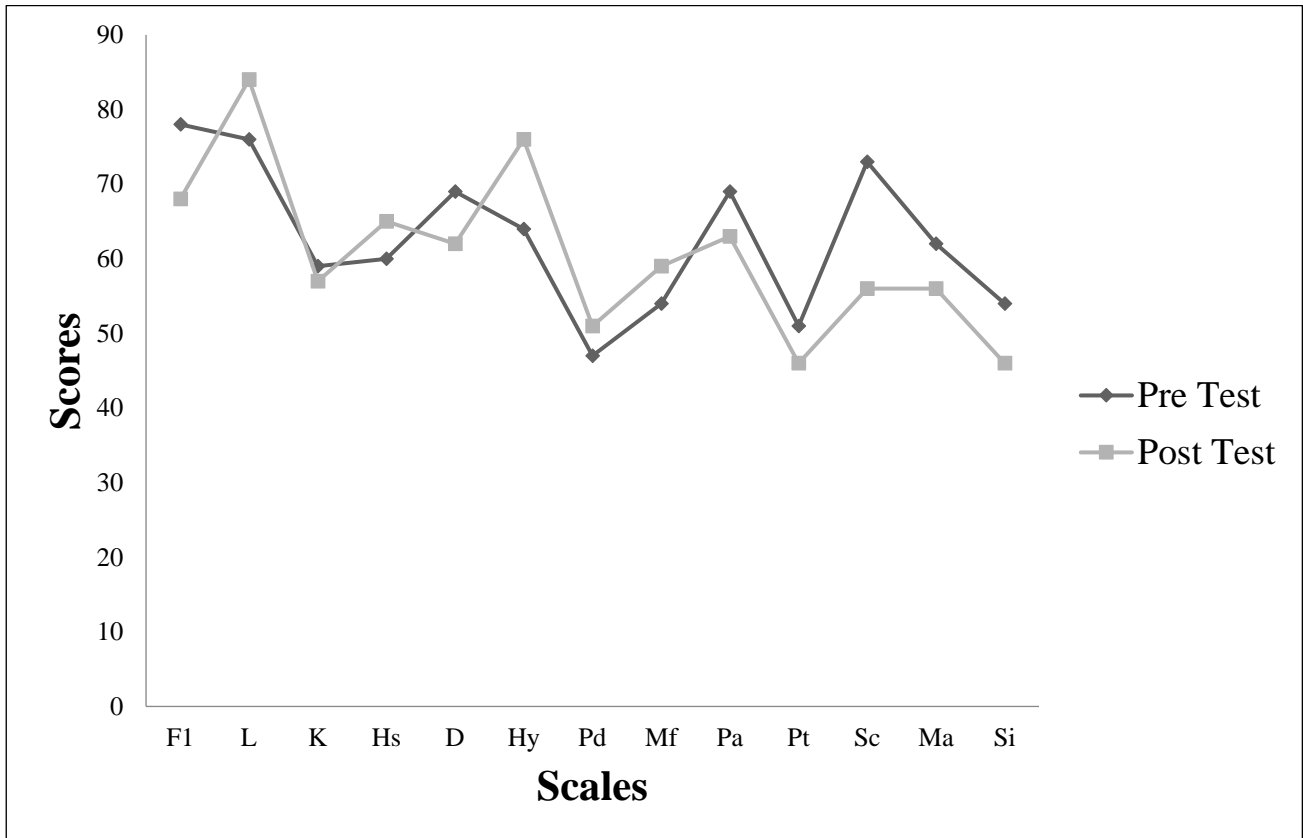


Table 22  
Summary of MMPI-A scores

	Pre-Test	Post-Test
<b>Infrequency (F1)</b>	78	68
<b>Lie (L)</b>	76	84
<b>Defensiveness (K)</b>	59	57
<b>Hypochondriasis (Hs)</b>	60	65
<b>Depression (D)</b>	69	62
<b>Hysteria (Hy)</b>	64	76
<b>Psychopathic Deviate (Pd)</b>	47	51
<b>Masculinity-Femininity (Mf)</b>	54	59
<b>Paranoia (Pa)</b>	69	63
<b>Psychasthenia (Pt)</b>	51	46
<b>Schizophrenia (Sc)</b>	73	56
<b>Hypomania (Ma)</b>	62	56
<b>Social Introversion (Si)</b>	54	46

### 7.11. Discussion

Participant C is a coloured, 13 year old male that underwent 6 sessions of EAP at the farm. Participant C is from a very impoverished background and his mother passed away in 2012. Very little background information was able to be obtained on him.

He presented with as very “gangsterish” and seemed to struggle to make a good rapport with the assessors, however he was able to create some sense of relationship with the horse. Relationships were a very prominent and important theme in the thematic analysis of his EAP sessions as well as feeling abandoned. Participant C was abandoned by his mother in 2012 when he was approximately 9 years old and not fully able to understand the finality of death. Relationships forms the core of Klein’s theory and her formulation of object-relations and thus his relationships with objects and perception thereof is fundamental in understanding Participant C’s diagnosis of conduct disorder.

Participant C may also be acting out his underlying rage and anger resulting from the various losses in his life. Klein (1975), suggests that the child has an intolerable fear of such dangers (death = the object being destroyed), and he responds by shifting his intolerable fears onto his external objects, which his immature ego then defends itself against by destroying the object and thus the

aggressive acting-out tendencies. Thus he would more than likely experience difficulties with regards to relationships, trust, boundaries as well as feeling rejected and abandoned by the object that he is defending himself against. All of these were themes identified through the thematic analysis of the EAP sessions. Furthermore, his rage towards the objects would be compounded by the “bullies” that he mentions and may almost feel like a justification for his actions. Klein placed a lot of emphasis on the analysis of countertransference in her theory and the countertransference was usually one of disdain and not wanting to be around Participant C as reflected by the horse. This would unfortunately end up in Participant C being rejected by others.

It is probable that Participant C has an overly developed super-ego and views not only his parents, but those around him as aggressive, cruel and dangerous. This would make it very difficult for him to develop relationships as was seen with the horse, especially if he views the horse as sadistic and dangerous due to his introjected distorted view of people as aggressive and dangerous.

With regards to the MMPI-A a quantitative comparison indicates that there was a decrease in the reporting of symptoms, although this is noted with caution due to the validity scales. Far less symptoms were reported post-test and although there was an increase in *Hysteria (Hy)*, most of the pathology had decreased, even if only by a few points. Of significance is the decrease reported in behavioural difficulties as noted by the decreased *Psychasthenia (Pt)* and *Schizophrenia (Sc)* scales.

His defensive style of reporting was consistent across both assessments, although he did have a tendency to try to portray himself in a more favourable light upon the second assessment, which may have obscured the results.

On the post-test results, no symptoms of *Schizophrenia (Sc)* and *Hypomania (Ma)* were reported on the MMPI-A with regards to the qualitative analysis. The quantitative analysis also indicated that there was a significant decrease in the scores obtained on the *Schizophrenia (Sc)* subscale, as mentioned above. It is possible that the EAP sessions improved insight into his behaviour, taught him rules, boundaries and structure and encouraged him to be more honest and authentic. Furthermore, it may have also assisted in moderating his mood. It is also possible that his instinctual impulses towards the objects were validated through the use of the EAP and thus resulting in less acting out behaviour.

Unfortunately no analysis of the parent CBCL protocols was possible and the quantitative analysis of the Teacher CBCL was fairly insignificant. The analysis of the Youth CBCL indicated that there was a significant increase on the social problems scale as qualitatively noticed although the anxious\depressed scale decreased possibly as a result of expressing and acknowledging feelings, thus allowing for them to be externalised rather than internalised.



Participant C would also appear to constantly feel anxious, scared and unsafe which was corroborated with the findings on the MMPI-A as well as the thematic analysis of the EAP sessions especially shown through his fear of relationships.

### **7.12. Conclusion**

Thematic analysis of Participant C's qualitative data revealed several themes with the theme of relationships the most prominent. Other themes included; trust, abandonment and rejection, boundaries and communication, feelings, mirroring and countertransference, erratic behaviour as well as power\control.

It is possible that the EAP sessions resulted in an improvement in Participant C's symptoms. Although it is also possible that he tried to portray himself in as favourable light as possible. It is evident from the thematic analysis that Participant C was able to create some relationship with Horse A and that possibly with more EAP sessions and over a longer period of time, he would be able to create a really meaningful relationship promoting behavioural and emotional change.

The next chapter, **Chapter 8**, focuses on Participant D.

## **CHAPTER 8**

### **RESEARCH RESULTS: PARTICIPANT D**

#### **8.1. Introduction**

The following chapter explores the findings of Participant D. This includes a background history, the adolescent psychiatric interview, the findings of the initial and post-treatment MMPI-A, as well as an intra-individual analysis of the transcripts from the EAP sessions. This chapter also includes the findings of the individual quantitative analysis of the CBCL and MMPI-A.

#### **8.2. Relevant Background History**

Participant D was referred for participation in the research by the social worker from the local child welfare, as he displayed several behavioural problems at school and at home and fit the criteria for a diagnosis of conduct disorder.

Unfortunately very limited background history was obtained on Participant D. According to the background history that was obtained, from the auxiliary social worker, he was born in 2001 and is currently a 15-year-old, Grade 7 learner at a local primary school. It was further reported that he resides with both his biological mother and father. He has three sisters and is the only boy in the family.

His teacher stated that he participates well in class, however, he was reported to be slow in completing the tasks/activities. He also appears to be in his 'own world' and does not always concentrate.

#### **8.3. Child and Adolescent Psychiatric Interview**

Participant D stated that he is a 15-year-old, male Coloured adolescent. He lives in a low socio-economic status area and is currently in Grade 6 at a primary school in the area, which is different to the background history obtained.

Participant D gave a different date of birth to that obtained from the background history, although still within the same year. He reported that he lives with his mother, father, and paternal grandmother, his three paternal Aunts and paternal cousin as well as his older sister (18 years), her child, and two younger sisters (8 and 5 years old). His paternal grandfather passed away when Participant A was in Grade 2. His maternal grandfather passed away the night before the interview. He reported feeling very sad about the loss of his maternal grandfather as he had raised him.

His father is the only one who is employed and they struggle financially. He reported that their house has 3 bedrooms and he shares a room with his three sisters and his cousin.

Participant D reported that school was fine, but that he does sometimes get bullied. He has previously failed Grade 4 and has failed both English and Afrikaans so far, this year (2015). He stated that the reason that he failed was because he didn't listen and played too much. He further reported that Afrikaans and Participant D reported that he does not participate in any sporting activities or extra murals. He also stated that he has no friends at school and sits by himself on the 'stoep' at break times. He only has one friend at home who he sees occasionally and plays football with. His mother apparently helps him with his homework.

Participant D reported that he eats well, twice a day (breakfast and dinner). He goes to bed at 20:00 and, although he struggles to fall asleep and wakes up during the night, he feels fine in the mornings. He also reported bad dreams although he stated that he has no worries. He stated that he does sometimes feel sad and cries especially when his mother allegedly hits him with a "sjambok". He stated that he never gets angry. He fears snakes. No medical conditions or head injuries were reported. Participant D denied any symptoms of Conduct Disorder although he did state that he sometimes lies to his friend and sisters.

He enjoys reading Afrikaans books and his favourite television programmes are Ben 10 and DragonBall Z. He enjoys playing with his cars of which he has two. When he is older he would like to be a policeman so that he can catch the bad people and his role model is Michael Jackson. His three wishes were to own a horse, have lots of toys and to be able to read better, especially in English. He would take his mother away with him for an island holiday.

Participant D stated that he has never ridden a horse, but has been around them before. He has stroked and fed them grass. He is looking forward to being with the horses. All the necessary safety precautions, including clothing attire, was explained to him.

#### **8.4. Researchers impressions of Participant D**

Participant D presented as a poorly groomed, coloured adolescent male who came to the EAP sessions in both school and casual clothes with poor hygiene. He had a few noticeable scars on his face. Although he made good eye contact on occasion, he made poor rapport with the assessor and was guarded. His mood was euthymic, but would sometimes become low especially when he spoke about death. He was at times anxious. He cooperated with the assessment process, although he did seem to become bored and restless. He had normal thought form, content and speed and was a psychotic and suicidal. He did appear paranoid and suspicious and would often look at what I was writing.

At times, it appeared as if Participant D was possibly exaggerating some aspects of the interview and the assessor wondered if he perhaps thought that the research was punishment.

During the EAP sessions, Participant D presented as fairly well groomed in casual attire and made fair eye contact. He was very defensive and closed off to the process and was experienced as very challenging to work with therapeutically. In addition, he made a poor connection with the therapeutic team and was incongruent for most of the process. He also struggled to verbally express himself. He was often observed to be looking around the arena.

He displayed limited insight with poor judgement. His ego-strength was also regarded as very limited/poor.

## **8.5. Results of the MMPI-A (Pre-Test)**

### *Validity Indicators*

The MMPI-A was considered valid and therefore could be interpreted. However, it should be interpreted with caution, due to the high scores obtained on the *Infrequency (F)* and *Lie (L)* scale. The combination of F-L-K was insignificant as the F was not markedly elevated.

The *infrequency (F)* scale indicates that Participant D may have been attempting to portray himself in a bad light or “faking bad”. This is in high contrast to the high *Lie (L)* score, faking good, and this could possibly be severe maladjustment, a tendency to be overly candid, careless responses, or an inconsistency due to possible poor reading skills. In addition, a high L scales indicates that he may have denied minor flaws or weaknesses, possibly unconsciously. Butcher *et al.*, (1992), stated that high *L* scale scores correlated with longer hospitalisations for adolescents and thus they may require longer-term treatment and may be more resistant to treatment. Furthermore, it is also important to note that *L* scale is negatively correlated with education and the more education that the subject has, the more likely the *L* score is to be low (Duckworth & Anderson, 1986).

### *Clinical Scales*

Participant D scored high on the following scales, which indicates that they are clinically significant and the likelihood of their presence is high.

Participant D scored high on the *Hypochondriasis (Hs)* scale. This indicates that he may have a preoccupation with health and illness and may present with many physical complaints. In addition, behavioural descriptors are also related to high elevations on this scale and Participant D may experience difficulties at school especially academic. A high score on the *Depression (D)* scale indicates that Participant D may experience a general sense of dissatisfaction with his life and may experience feelings of discouragement, hopelessness, and low morale. He may experience feelings of

despondency and apathy. The high score that he obtained on the *Hysteria (Hy)* scale, indicates that he may deny problems and experience somatic complaints, and may have a need for social acceptance and approval. Individuals that score high on this scale may express stress through somatization and may be very anxious. Participant D also scored high on the *Paranoia (Pa)* scale, indicating that he may feel suspicious, persecuted, and he may be rigid in his thinking. He may feel distrustful and suspicious and he may also be oversensitive to remarks made by others. Individuals that score high on this scale may act out aggressively and may be experienced as argumentative. Furthermore, Butcher *et al* (1992), stated that a study found that adolescents that scored high on this scale, corresponded with several negative behavioural correlates such as school problems (failing and being suspended), as well as being experienced as hostile.

He also obtained a slightly elevated score on the *Schizophrenia (Sc)* scale indicating that there may be some presence of thought disorder. However, of more relevance, is the likelihood that he experiences disturbances in his mood and behaviour, be socially isolated, and experience difficulties in concentration and impulse control. A high score on this scale is also associated with various behavioural difficulties such as school problems, disagreements with parents as well as a lack of achievement. There is also a possibility of a history of sexual abuse.

## **8.6. Description of the EAP sessions and therapeutic process**

The following is a description of the EAP activities that Participant D underwent:

### ***8.6.1. Meet and greet***

This was undertaken in Session 1. The purpose of this activity is to establish a relationship with the horse (relationship building and building or starting to build a relationship). This activity usually takes place in either the stable, depending on the individual's exposure to horses, and level of anxiety or the small arena. The activity involves merely going up to the horse and spending time with the horse, getting to know each other, stroking, and petting the horse. Participant D seemed very anxious to meet the horse and wanted either the horse specialist or the therapist to go with him. He was also very impulsive, just walking straight up to the horse and then walking straight out of the arena. Once he had met with the horse, he could establish a relationship with Horse A and spent a good twenty minutes patting and stroking her.

### ***8.6.2. Catch and halter***

The goal of this activity is to catch and place the halter on the horse. This took place in session 2 in the small arena. The purpose of this activity is once again on building relationships, but also

boundaries, social skills, assertiveness, and communication. This activity is not goal driven and it is not important whether the participant manages to place the halter on the horse or not, but rather on the process involved, and how the participant goes about the activity. In this session, Participant D's impulsivity was also noted in that he just walked off into the arena and quickly came back, seemingly anxious. He also really struggled with boundaries as he would disregard the horse's safety by putting the halter over her eyes. This had to be pointed out to him. He did seem to struggle with the activity and seemed to give up easily (putting the halter on the horse). He also seemed to struggle to ask for help.

### **8.6.3. *Catch, halter and groom***

This activity, which took place in Session 3, was once again focused on building relationships as well as communication and boundaries. It was felt necessary to repeat some of the previous week's activity (catch and halter) to allow the participant an opportunity to spend more time building a relationship with the horse. The grooming kit contains a variety of brushes to brush and groom all aspects of the horse. Once again, although this activity is not task-orientated, but rather more focused on the content, it is interesting to note whether the participant is thorough in their grooming of the horse or not. Participant D once again struggled to get the halter on, although managed easier this time, and it seemed very important to him to finish the activity but also by spending a lot of time with Horse A. Participant D's anxiety was also very evident in this session as mirrored by the horse through how unsettled and alert she was.

### **8.6.4. *Build your feelings***

This activity involved the participant building how they feel. This activity took place in the big arena and the participant was given a variety of objects, such as poles, blocks, coke bottles, tyres, upright poles, balls, etc., to build how they feel. The horse was also in the arena and it was up to them to decide if they wanted to involve the horse in their structure or not. In this session, Participant D's struggle with relationships was evident through the way Horse A would walk away from him, but remain focused on him and alert on him (ears upright and turned towards him, and head turned towards him). Participant D also did not make much effort to spend time with her and instead focused on his object, making sure that that was well built. He also really struggled to connect with his feelings in this session and when asked to describe what feeling his object represented, he stated that he had built a car that is stopped by a traffic "cop".

### 8.6.5. *Open-ended activity*

The last activity was left open-ended. The participant was given all the equipment from the previous activities (halter, grooming kit, objects to build with) and told to do whatever he wanted. As this was the last session, it was decided that something more non-directive would be helpful and more useful.

Participant D decided to spend time with the horse and engaged with her through grooming her. This session gave a sense of Participant D's loss and difficulty with relationships. He seemed to have created a relationship with the horse as he spent the session just patting and grooming her. Horse A did not move away from him and gave a few licks and chews (indicative of acceptance/submission). He also expressed interest spending time with her another time and wished that his parents could see her. Towards the end of the session when it was time to say goodbye, he seemed to become sad and his eyes swelled up with tears, seemingly indicative of a bond.

## 8.7. **Intra-Individual analysis of the transcripts of the EAP sessions**

Participant D took part in 5 sessions of EAP at an EAPISA certified farm with Pauline Mawson and the Horse Specialist. Unfortunately, one session had to be cancelled and due to the school exams and holidays could not be made up and thus, he did not have the full six sessions, as previously planned. The same horse, Horse A, was used throughout the sessions.

The following four themes were identified and will be discussed in more detail below; Relationships (with the subthemes of trust, control, empathy and affection, rejection and abandonment and boundaries), feelings, missed opportunities and erratic behaviour.

### 8.7.1. *Relationships*

Participant D really struggled to start and maintain a relationship with Horse A. He was initially very scared of the horse and even potentially with making friends with her. He was very hesitant even though the researcher and horse specialist reassured him. This was evident right from the beginning of the sessions;

- **Pauline:** "Okay, so welcome to the farm. You remember I told you we going to be doing some work with the horses." (*Participant D nods.*) "Okay. So what I'm going to do is I'm going to hand you over to Horse Specialist and Horse Specialist is going to give you an instruction."  
**Horse Specialist:** Okay, so this horse's name is Horse A. I would like you to please spend some time with her. Get to know her, bond with her a little bit. I want you to think what you like about her, what you don't like, if there is anything you don't like. If she reminds you of someone. Uhm, you can either stay on the outside, so we, Pauline and I, we going to stay on the outside. If you feel comfortable I would actually like you to go into the ring and spend time with her. You feel comfortable going in?" (*Participant D nods.*) "Okay when you ready."  
**Participant D:** "And do what?" (*Silence 11 seconds*)  
**Horse Specialist:** "Pardon? What did you say I didn't hear you? So you need to do whatever you think you need to do to make friends with her."

**Pauline:** “It’s your decision.” (*Silence 6 seconds*)  
**Participant D:** *Walked into the arena.* “I’m scared of her.” (*Appeared anxious and came back to the fence.*)  
**Pauline:** “You scared of her. Why you scared of her?”  
**Participant D:** “She’s big.”  
**Pauline:** (*Horse Specialist gives soft chuckle*) “She’s big, Ja. What are you scared she might do?”  
**Participant D:** “She can run me over.”  
**Pauline:** “Can run you over?”  
**Participant D:** “Yes.”  
**Pauline:** “Okay.”  
**Participant D:** “Or she can kick me.”  
**Pauline:** “Or she can?”  
**Participant D:** “Kick me.”  
**Pauline:** “Kick you. Okay.”  
**Horse Specialist:** “If I look at her standing there like that, she doesn’t look like she’s going to run you over. She looks actually pretty much very relaxed and very calm. You see how she keeps on looking at you?” (*Silence 7 seconds*).

- **Participant D:** “I’m scared.”  
**Pauline:** “What are you scared of?”  
**Participant D:** “Of her.”  
**Pauline:** “Of her...okay. So you still feeling scared of her?”  
**Horse Specialist:** “Can you see what she does there with her head? Every now and then she puts her head right down to the floor and she keeps her head quite low. You noticed that? Even now her head is down. That’s also her way of telling you, she is, do you know what the word submitting means? She is accepting you as her leader. And there’s a lick and chew so, the lick and chew she does with her mouth and the way she puts her head down is inviting you to her to be her leader. Does that make sense? And the fact that she hasn’t moved away, not even a single step again.”

Even when Horse A indicated that she wanted to be friends with Participant D, he was still very unsure and the establishment of a relationship would appear to be hard for Participant D;

- **Horse Specialist:** “See what she’s doing there with her mouth? Did you see that? There she’s still doing it. It looks like she’s chewing on something. Can you see? That is called a lick and a chew and that is a horses way of telling you they want to be your friend. It’s okay they, they will accept you. (*Silence 9 seconds*) Again she looks very calm standing there.”  
**Pauline:** “I can see you, you don’t look so calm. You’re holding on to the fence. Maybe a part of you doesn’t really trust that she’s calm and she wants to be your friend.”  
**Participant D:** “Can someone come with me to her?”  
**Pauline:** “Sorry, just say that again.”  
**Participant D:** “Can someone come with me to her?”  
**Pauline:** “O, you want someone to go with you, okay.”  
**Horse Specialist:** “If that will make you comfort, more comfortable, I’ll go with you to her.”  
**Pauline:** “Horse Specialist can go with you. (*Silence 71 seconds*) (*Walking noise*) *Participant D walks with Horse Specialist to Horse A. Stood and looked at the horse.* (*Writing noise*) (*Birds chirping softly*).
**Pauline:** “Ja. Cause what other things that Horse specialist and I noticed when you were trying to put the halter on was, when she didn’t want you to, you’d spend time with her and you’d pat her and then you’d try again. And I remember we spoke about that the last time. (*Silence 5 seconds*). So maybe also today was about spending time with each other and building a relationship. But that doesn’t always seem easy hey?”  
**Participant D:** “Yes.” (*Silence 8 seconds*)

Participant D would also seem to not be used to establishing friendships and relationships;

- **Pauline:** “Maybe it’s hard that she wants to be your friend, maybe you not used to that (*Silence 15 seconds*) You look a bit unsure. (*Silence 24 seconds*) I wonder what you thinking?”

However, it was evident that Participant D had managed to establish a relationship with Horse A;

- **Pauline:** “Was that a big lick and chew?”



**Horse specialist:** “Ja. Big lick and chew...”

**Pauline:** “Ja. Sho...”

**Horse specialist:** “...And like he doesn’t even have the halter on or anything. And she’s standing there by him...”

**Pauline:** (*Sound of agreement*)

**Horse specialist:** “...licking and chewing.” (*Silence 5 seconds*)

**Pauline:** “He really seems to ja...I mean like have a really good relationship with her.” (*Silence 4 seconds*) And he’s gentle and he seems, okay he’s not that thorough but he’s trying”

**Horse specialist:** “But compassionate. Ja.”

**Pauline:** “Ja. (*Silence 9 seconds*) Which is also interesting cause remember last week we spoke about how she walks away when he fibs tells lie and he was not happy about that. “

**Horse specialist:** “And that’s how we almost ended last week.”

**Pauline:** (*Sound of agreement*) (*Silence 4 seconds*) “So maybe there’s a part of him now that we seeing that’s a bit more congruent”.

**Horse specialist:** (*Sound of agreement*) (*Silence 21 seconds*) “Look how she follows him.”

- **Horse specialist:** “The whole time while you were grooming her she stood by you. You used the brushes and then she moved away once but, but she didn’t move far away. And you carried on using the brushes. You came back here you fetched another brush you went back to her. As you approached her she stopped eating she stood by you and I said to Pauline she looks extremely comfortable with you. Relaxed comfortable like she was enjoying it. And then when you walked away to come and get, put the brush back and get the cloth she followed you. And in her eye she looked very, very soft. Like she was really enjoying being with you. (*Silence 4 seconds*) And even now she’s eating but she’s right here she hasn’t moved. She can go and eat anywhere in this arena. But she’s right here by you.” (*Silence 3 seconds*)

and was very sad to say goodbye;

- **Pauline:** “You fine today? Okay. Remember today is our last session. Okay it’s the last time you gonna be working with your horse. Okay. I wonder what that’s like for you.”  
**Participant D:** “Sad.”  
**Pauline:** “Sad. Ja. Why is it sad?”  
**Participant D:** “Cause I’m seeing her for the last time.”  
**Pauline:** “Ja. Is it hard to say goodbye? Ja. And tell me a little bit when you’re sad what do you do? (*Silence 4 seconds*) What happens when you’re sad?”
- **Horse specialist:** “Look how she’s engaging with him as well hey. So he approached her and she didn’t even move away there’s no halter or anything. And she’s engaging with him.” (*Silence 3 seconds*)  
**Pauline:** “But it’s almost like uhm...he doesn’t want us to see. Cause I mean I can’t really...”  
**Horse specialist:** “Ja.”  
**Pauline:** “...see from here what he’s doing. (*Silence 10 seconds*) Interesting cause I didn’t feel he made that much of a bond with her. It’s interesting to see.”  
**Horse specialist:** “I think what shows the bond is last week when he said he wishes his mother and father could meet her and that broke me I promise you I was like...”  
**Pauline:** “Aww. (*Silence 5 seconds*) So also again like with these kids you don’t really see what’s going on with them.”  
**Horse specialist:** “It’s all hidden.”
- **Pauline:** “I can see as Horse specialist is talking you look very sad. (*Silence 4 seconds*) It’s very hard to say goodbye to her today. Ja. (*Silence 5 seconds*) It is very hard to say goodbye. (*Silence 15 seconds*) And it seems like when you honest and open you get a really good relationship with her. Do you remember we spoke about it at the end of last week?”  
**Participant D:** “Yes.”  
**Pauline:** “So maybe today you just being really honest and open with her and letting her come into your space and now you’ve got that really close connection with her. (*Silence 6 seconds*) And that’s really hard as well. Cause now you’ve got to say goodbye to her. (*Silence 18 seconds*) You’ve still got like 10 more minutes left. I don’t know if you want to spend those 10 minutes with her. Saying goodbye to her. Just you and her. You don’t have to worry about us. If you want to.” (*Silence 5 seconds*)  
**Horse specialist:** (*To Pauline*) “It’s gonna be interesting to hear what he says what she taught him.”  
**Pauline:** “Oh yes, please remind me. (*Silence 4 seconds*) (*Wind picked up*) Cause I think for him talking is so hard right now.”  
**Horse specialist:** “Did you see the tears building up in his eyes here?”

**Pauline:** “And I don’t think he can be vulnerable enough to cry in front of us. So I thought just let him spend time with her. Do whatever he needs to do.” (*Silence 11 seconds*)

The theme of relationships was further broken down into subthemes: trust, control, empathy, rejection and abandonment vs approval and acceptance as well as boundaries. These will now be discussed in further detail.

#### 8.7.1.1. Trust

Trust was very hard for Participant D. He found it very hard to trust that the horse was safe and wouldn’t hurt him;

- **Horse Specialist:** “See what she’s doing there with her mouth? Did you see that? There she’s still doing it. It looks like she’s chewing on something. Can you see? That is called a lick and a chew and that is a horse’s way of telling you they want to be your friend. It’s okay they, they will accept you. (*Silence 9 seconds*) Again she looks very calm standing there.”  
**Pauline:** “I can see you, you don’t look so calm. You’re holding on to the fence. Maybe a part of you doesn’t really trust that she’s calm and she wants to be your friend.”  
**Participant D:** “Can someone come with me to her?”  
**Pauline:** “Sorry, just say that again.”  
**Participant D:** “Can someone come with me to her?”  
**Pauline:** “Oh, you want someone to go with you, okay.”  
**Horse Specialist:** “If that will make you comfort... more comfortable, I’ll go with you to her.”  
**Pauline:** “Horse Specialist can go with you. (*Silence 71 seconds*) (*Walking noise*) Participant D walks with Horse Specialist to Horse A. Stood and looked at the horse. (*Writing noise*) (*Birds chirping softly*)”
- **Pauline:** “You run away. And it’s interesting that you think that. (*Recorder noise*) Well it’s interesting that you feel like she’s scaring you and you also scared of her and Horse Specialist said the complete opposite. Like she’s the complete opposite. So, what I’m also hearing you say, things are scary and that you don’t feel safe, Ja. (*Silence 12 seconds*) It’s hard to trust Horse A and it’s hard to trust me and it’s hard to trust Horse Specialist.” (*Silence 4 seconds*) (*Softly to Horse Specialist*) “She just moved straight into his space.”

Participant D also appeared to find it very difficult to trust the process and the relationship;

- **Pauline:** “I’m just going to call him over and then ask him about that. (*To participant*) Participant D, she dropped her head a few times and you didn’t put it (*the halter*) on. (*Soft to Horse specialist*) Okay he doesn’t want to come over here though.” (*Soft giggle between Pauline and Horse specialist*) (*Silence 46 seconds*) I almost get a sense that she, like she wants to try and help him, but he’s not, like you said, missed opportunities.”  
**Horse specialist:** (*Said simultaneously*) “Missed opportunities.”  
**Pauline:** “Ja (*Silence 5 seconds*) ...So I think again also trusting, that process is hard for him.”  
**Horse specialist:** (*Sound of agreement*) “And see again how patient she is, she’s standing there.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “She could be moving around, walking away.” (*Aeroplane flew past*)  
**Pauline:** “Ja, true she could’ve walked off by now.” (*Silence 5 seconds*) (*Aeroplane still flying*)  
**Horse specialist:** “There again, head right down. *Horse A puts her head down*. She’s very supportive of him, hey?”  
**Pauline:** (*Sound of agreement*) “Yeah that’s the right word, Ja. (*Silence 30 seconds*) Now he’s come up with a different plan.”

### 8.7.1.2. Control

It appeared very important to Participant D that he was in control of the relationship, even to the extent that he wanted to “own” Horse A and wasn’t very aware of the fact that she might be an individual in her own right;

- **Pauline:** “Perhaps that need to, to walk around is almost like a leadership, I’ve got control...”  
**Horse specialist:** “Cause they all trying to do that hey?”  
**Pauline:** “Ja. I’ve got control over you. Where as to spend time with her like this and get to know her is an equal...”
- **Pauline:** “What’s it like to be her leader?”  
**Participant D:** “That I can own her.”  
**Pauline:** “You can own her. (*Silence 5 seconds*) (*Pauline and Horse specialist start talking together*) May...”  
**Horse specialist:** “It. Sorry”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “It also shows that you, she respects you.” (*Silence 5 seconds*)  
**Pauline:** “Maybe it makes you feel like you powerful? You in control. (*Silence 15 seconds*) Do you get to be the leader in other places as well? Like at school and at home. No. What happens at school if you want to try and be the leader or be the boss?”  
**Participant D:** (*Too noisy to hear participant*)  
**Pauline:** “Sorry?”  
**Participant:** “Nothing”  
**Pauline:** “Nothing happens. Do people just ignore you? Okay. (*Silence 3 seconds*) And at home?”  
**Participant D:** “At home? It’s only me and my sisters.”  
**Pauline:** “Do you get to be the leader at home? What happens when you the leader at home?”  
**Participant D:** “I let my sisters follow me. And then we see.”
- **Pauline:** “I could own her...”  
**Horse specialist:** (*Sound of agreement*) “Ja.”  
**Pauline:** “...that worries me.”  
**Horse specialist:** “I could own her.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “Not I’m gonna lead her, I’ve got leadership qualities. Feels like I can own her.” (*Silence 5 seconds*)

### 8.7.1.3. Empathy and affection

Horse A mirrored that Participant D could show some level of empathy, which is unusual for children diagnosed with Conduct Disorder;

- **Horse specialist:** “So you were 99 percent right, just remember the strap needs to be able to stay on her head and not slip down. So you had it in front of the ears. Where could it go so that it doesn’t slip down? (*Silence 28 seconds*) (*Writing noise*) See she starts throwing her head, he comforts her.”  
**Pauline:** “That’s interesting though because I’m wondering if, and I think it’s very subconscious, he...he does know how something else feels. And I’m not sure if he’s consciously aware of it.”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** “So there is some level of empathy.”  
**Horse specialist:** “And she responds to it so nicely.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “Like there. Now she’s dropped her head again. And there’s a nice lick and chew from her.” (*Silence 31 seconds*)

Participant D was also able to show some level of affection towards Horse A, which was mirrored in the horse’s behaviour;

- Horse specialist:** “See how she’s very aware but also calmer now.”

**Pauline:** (*Sound of agreement*) (*Silence 7 seconds*) “But again it seems like, he’s not just doing what he needs to do. When he spends time with her then she’s calmer.”

**Horse specialist:** (*Sound of agreement*) (*Silence 5 seconds*) “And I think him leaving the halter and just starting to brush was his way of spending time with her.”

**Pauline:** “Ja.”

**Horse specialist:** “Cause she is calmer then...”

**Pauline:** (*Sound of agreement*)
- Horse specialist:** “He’s not very task orientated. He spends time with her. And she’s a lot more settled.”

**Pauline:** “I think that happened with him the last time.”

**Horse specialist:** “Ja.”

**Pauline:** “You said to him when you spend time with her she...”

**Horse specialist:** “...calms down a little bit”

**Pauline:** “...calms down a bit.”

**Horse specialist:** “He’s learnt from that at least.”

Although it is possible that the affection that he shows was experienced as manipulative;

- Pauline:** “He seems to give up though when she like lifts her head. (*Silence 80 seconds*) (*Birds chirping*) I’m not sure, look I’m not sure if him spending time with her is, is genuine or if it’s almost a bit manipulative. Like I know if I do this I can calm her down.”

**Horse specialist:** “I was just thinking the exact same thing”

**Pauline:** “You also thinking it?”

**Horse specialist:** “Ja. Because yes, he’s spending time with her, but she’s, and yes she’s more settled than what she was when he walked in but she’s still not 100% settled.”

**Pauline:** (*Sound of agreement*) “Like it feels a bit...”

**Horse specialist:** “Incongruent, Ja, just there.” (*Silence 12 seconds*)

**Pauline:** “But having said that there is a certain vulnerability to him though.”

**Horse specialist:** “Ja” (*Silence 5 seconds*)

**Pauline:** “But he probably knows it.” (*Silence 40 seconds*) (*Writing noise*)

**Horse specialist:** “And she is standing by him she could walk away at any point...”

#### 8.7.1.4. Rejection and abandonment vs Approval and acceptance

Participant D is very sensitive to rejection and even though initially he had hardly made a relationship with Horse A, he already perceived that she might reject him;

- Pauline:** “Does it feel like, like sometimes people don’t like you? Yes? So maybe it also feels like the horse now also doesn’t like you? So it’s the same thing? (*Silence 5 seconds*) (*Softly to Horse Specialist*) “See she turned her head.”

**Horse Specialist:** “See how she still looks at you?”

**Pauline:** “So I’m wondering maybe that’s not true, maybe it’s not true that she doesn’t like you?” (*Silence 14 seconds*) (*Writing sound*)

Horse A did appear to approve of and accept Participant D even to the extent that she felt he needed to almost be shielded from us;

- Pauline:** “You run away. And it’s interesting that you think that. (*Recorder noise*) Well it’s interesting that you feel like she’s scaring you and you also scared of her and Horse Specialist said the complete opposite. Like she’s the complete opposite. So what I’m also hearing you say, things are scary and that you don’t feel safe, Ja. (*Silence 12 seconds*) It’s hard to trust Horse A and it’s hard to trust me and it’s hard to trust Horse Specialist.” (*Silence 4 seconds*) (*Softly to Horse Specialist*) “She just moved straight into his space...”

**Horse Specialist:** “...his space...” (*Horse A moved directly between Participant D and Pauline and the Horse Specialist.*)

**Pauline:** “Ja and cut us off...”

**Horse Specialist:** “And blocked us off.”

**Pauline:** “Ja.”

**Horse Specialist:** *(To participant)* “I noticed how she moved right into your space now and she’s almost made a wall between...and the two of us. She’s blocking you, it’s almost like she’s protecting you *(Silence 8 seconds)* and again her whole-body language looks soft and gentle. Look how she’s dropping her head again, her eyes are half closed, her ears are hanging to the side, she’s standing still *(Silence 28 seconds)* Her eyes are even closed and she’s giving you a lick and chew.”

#### 8.7.1.5. Boundaries

Participant D seemed to really struggle with boundaries and personal space;

- **Horse specialist:** “But can you see he’s got no regard for her safety?”  
**Pauline:** “Very true Ja. Ja, cause I mean that could be hurting her eyes”  
**Horse specialist:** *(to participant)* “I wonder if that strap in her eye is hurting her?” *(Silence 13 seconds)*  
**Pauline:** “Maybe it goes somewhere else, maybe not on her eyes, maybe somewhere else... .”

The horse seemed to not only put down boundaries for Participant D, but also mirrored his difficulties with regards to personal space;

- **Pauline:** “Okay. Cause it sounds to me like sometimes things and people are scary. Even animals... *(Silence 5 seconds)* *(Writing noise)* and I wonder, I wonder what you do about that?”  
**Participant D:** “Run away.”  
**Pauline:** “You run away. And it’s interesting that you think that. *(Recorder noise)* Well it’s interesting that you feel like she’s scaring you and you also scared of her and Horse Specialist said the complete opposite. Like she’s the complete opposite. So what I’m also hearing you say, things are scary and that you don’t feel safe, Ja. *(Silence 12 seconds)* It’s hard to trust Horse A and it’s hard to trust me and it’s hard to trust Horse Specialist.” *(Silence 4 seconds)* *(Softly to Horse Specialist)* “She just moved straight into his space.”  
**Horse Specialist:** “his space...” *(Horse A moved directly between Participant D and Pauline and the Horse Specialist.)*  
**Pauline:** “Ja and cut us o...”  
**Horse Specialist:** “And blocked us off.”  
**Pauline:** “Ja.”  
**Horse Specialist:** *(To participant)* “I noticed how she moved right into your space now and she’s almost made a wall between...and the two of us. She’s blocking you, it’s almost like she’s protecting you *(Silence 8 seconds)* and again her whole-body language looks soft and gentle. Look how she’s dropping her head again, her eyes are half closed, her ears are hanging to the side, she’s standing still *(Silence 28 seconds)* Her eyes are even closed and she’s giving you a lick and chew.”
- **Horse Specialist:** *(To participant)* “Look how closed her eyes are now. She looks like she wants to fall asleep there, that’s how relaxed she is.” *(Silence 20 seconds)*  
**Pauline:** *(Softly to Horse Specialist)* “Now I can’t even see him now.”  
**Horse Specialist:** *(Sound of agreement)* “It’s like how she shut him off, but if you look at his shadow he’s touching her with both hands.” *(Participant D stood rubbing the side of Horse A.)*

#### 8.7.2. Feelings

Participant D presented as very anxious and nervous. He was also very scared and at times, and seemed a bit suspicious;

- **Horse Specialist:** “See what she did there, she went *(Deep breath in and out)* like a big sigh.” *(Softly to Pauline)* “Looks very emotional...”  
**Pauline:** *(Sound of agreement)* *(Silence 7 seconds)* *(To participant)* “We’ve been doing a bit of talking of what you think and what you thinking. I wonder if you can maybe tell us how you feel.”  
**Participant D:** “Nervous.”  
**Pauline:** “Nervous, and what else?”  
**Participant D:** “A little excited.”

**Pauline:** “A little excited...okay. So, you feeling both nervous, maybe a bit worried, excited, maybe a bit sad?”

**Participant D:** “No.”

**Pauline:** “No. Okay. So, lots of different feelings. Tell us about feeling nervous?”

**Participant D:** “I’m scared.”

**Pauline:** “What are you scared of?”

**Participant D:** “Of her.”

At times, he even presented as helpless and voiced feeling like a failure. This was evident in session 2 when he tried to put the halter on the Horse A and really struggled;

- **Pauline:** “Too long. Do you struggle to get up to her? So, she’s tall hey. What’s that like for you?”  
**Participant D:** “Can’t put it on.”  
**Pauline:** “Can’t put it on. So, you feel like, you, you can’t do it. That’s it, you can’t do it. Do you think maybe you giving up?”  
**Participant D:** “Yes.”  
**Pauline:** “You giving up. Okay. Does that happen sometimes? Do you just give up? Sometimes it’s too hard. *(Silence 6 seconds) (Truck drove past)* What happens when you feel like you can’t do something?”  
**Participant D:** “Feels like I’ll never get it right.”  
**Pauline:** “That you’ll never get it right. Okay. That sounds to me quite sad. *(Silence 5 seconds)* So maybe it’s made you feel a bit sad that you couldn’t put it on.” *(Silence 7 seconds)*.

Participant D would also appear to feel easily distracted and have difficulty paying attention and concentrating at times. This is possibly indicative of ADHD;

- **Pauline:** “What sort of noises are you hearing?”  
**Participant D:** “Like trucks.”  
**Pauline:** “Trucks, okay. Is it maybe from over there?”  
**Participant D:** “Yes.”  
**Pauline:** “Does that sound like the noise you hearing?”  
**Participant D:** “Ja.”  
**Horse specialist:** “Cause I noticed how she’s also looking around the whole time. She’s very aware of everything aro..., going on around her. And it seems like she’s like that all the time with you whenever you work with her.” *(Silence 15 seconds)*  
**Pauline:** “Do you always kind of feel a bit distracted and like you’ve got to look and see were all these noises come from. And then maybe people think you not paying attention?” *(Silence 22 seconds)*.

Even though feelings were identified during the sessions, it would appear to be very difficult for Participant D to express and identify with them. It was huge progress for Participant D to be able to express some emotion;

- **Participant D:** “I feel stressed.”  
**Pauline:** “You feel stressed. Okay. *(Pauline and Horse specialist simultaneously speaks)* So...”  
**Horse specialist:** “Why?”  
**Pauline:** *(Sound of agreement)*  
**Horse specialist:** “We can see it in her when you feeling stressed.”  
**Pauline:** *(Sound of agreement)*  
**Horse specialist:** “Because she, her head stays still and then you putting it on nicely and then you don’t quite manage and then you get stressed and then she starts moving her head around. Then you pat her, maybe you calm yourself down because it looks like she calms down and her head stays still again. So you almost...almost had it.”  
**Participant D:** “But why doesn’t she come here?”  
**Pauline:** “What do you think?”  
**Participant D:** “I want her to come here.”  
**Pauline:** “You want her to come here.”  
**Participant D:** “Yes.”

**Horse specialist:** “Again it looks like she, look how she’s focused on you. So she’s quite patient, patiently waiting for you again”

**Pauline:** Are you may, are you may be stressed because you not getting it right, you not able to, to do it. Cause it looks like, looked like you were doing quite well. And that maybe sometimes it just takes some time. (*Sniffs*) You get a bit anxious when you get stressed?”

**Participant D:** (*Sound of agreement*)

**Pauline:** “And then perhaps you give up quite easily you don’t do it. Instead of trying to just follow through. (*Silence 8 seconds*) And maybe it’s not up to her to come over here, maybe it’s up to you whether she comes over here. It’s like Horse specialist said she’s waiting for you. (*Silence 13 seconds*) Looked like you wanted to go back to her. (*Silence 10 seconds*)

**Horse specialist:** “You almost...almost had it on.” (*Silence 5 seconds*)

**Pauline:** “We still have more time, so I think maybe go try again, okay?”

**Horse specialist:** (*Softly to Pauline*) “It’s a gorgeous little child hey, so cute.”

**Pauline:** “He looks cross”

**Horse specialist:** “But just for him to express that he’s feeling stressed is already...”

**Pauline:** (*Sound of agreement*) “Huge...”

**Horse specialist:** “...huge for us.”

Although it was very evident, especially in session 4 when he was asked to build a structure representative of his feelings, that expressing emotions is challenging for him and that he is not always necessarily in touch with his emotions;

- **Horse specialist:** “They can’t, they battle to describe their feeling hey?”  
**Pauline:** “Ja, they don’t have feeling vocabulary.”  
**Horse specialist:** “To build what you feeling...”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “One builds a soccer field the other builds a house and the other one builds a cop car. (*Giggles*) Hey? Look how she’s following him now. It goes from one extreme to the other hey?”
- **Horse specialist:** “And I noticed how much she really likes you. The whole time since you’ve been in this big space, and she can go anywhere in here but she’s been around your, your building, she’s been around here with you. And as you walked here she follows you right here. So she wants to be around you.” (*Silence 4 seconds*)  
**Participant D:** “I also want to be around her.”  
**Pauline:** “Aww.” (*Silence 5 seconds*)  
**Horse specialist:** (*Whispers to Pauline*) “Ask him how she makes him feel.”  
**Pauline:** “How does she make you feel?”  
**Participant D:** “She makes me feel fun. I know when I look at her then I smile.”  
**Pauline:** “Okay. And try describe that feeling. What does fun feel like if you had to describe it?”  
**Participant D:** “It feels like Uhm, playing with her...”  
**Pauline:** “Okay does it maybe feel warm and fuzzy?”  
**Participant D:** “Yes.” (*Silence 5 seconds*).
- **Pauline:** “O, I see okay. And if you were to give that a feeling word, what word would you give it?”  
**Participant D:** “For what is that?”  
**Pauline:** “Your, Ja your structure.”  
**Participant D:** “The plane.”  
**Pauline:** “Hum?”  
**Participant D:** “The plane.”  
**Pauline:** “A plane, and a feeling word?”  
**Participant D:** “A feeling word?”  
**Pauline:** “Ja.”  
**Participant D:** “Happy.”

It was far easier for him to state that he was “happy” then to really express how he might be feeling. In the last session, it was evident that Participant D was sad;

- **Pauline:** “Sitting but now when you sad to you maybe get angry do you cry do you talk to someone do you keep it to yourself. What happens when you sad? (*Very windy*)

**Participant D:** *(Too windy to hear)*

**Pauline:** “You keep it to yourself, so it’s hard to talk about. Ja. But I think a lot of things are hard to talk about. So, we know it’s very hard to say goodbye and at the end of the session I’ll give you your photo. Okay. So, Horse specialist is gonna give you an instruction. And we’ll take it from there.”

### 8.7.3. Missed opportunities

Participant D tended to give up very easily, possibly due to feeling like a failure as previously mentioned, but also because he seemed to lack effort and thus he would often miss opportunities;

- **Horse specialist:** “I think she’s waiting for you to come and try again.”  
**Pauline:** *(Sound of agreement)* *(Silence 11 seconds)* “He gets frustrated....”  
**Horse specialist:** *(Sound of agreement)*  
**Pauline:** “...and then he doesn’t want to do it. *(Silence 28 seconds)* Okay.”  
**Horse specialist:** “See with a little bit of effort....”  
**Pauline:** *(Sound of agreement)* “She’s too high he said I think, I think that’s what I heard”  
**Horse specialist:** “It wasn’t him that asked us to come in with him, was it? It was him.”  
**Pauline:** *(Sound of agreement)*  
**Horse specialist:** “So he’s not afraid to ask for help...”  
**Pauline:** *(Sound of agreement)* *(Silence 11 seconds)* “But like she also dropped her head....” *Horse A dropped her head down.*  
**Horse specialist:** “Missed opportunities.”  
**Pauline:** “...and he hasn’t tried again. Ja.”  
**Horse specialist:** “And it’s happened a few times where her head has been right down.” *(silence 36 seconds)*  
**Pauline:** “I’m just going to call him over and then ask him about that. *(To participant)* Participant D, she dropped her head a few times and you didn’t put it *(the halter)* on. *(Soft to Horse specialist)* Okay he doesn’t want to come over here though.” *(Soft giggle between Pauline and Horse specialist)* *(Silence 46 seconds)* I almost get a sense that she, like she wants to try and help him, but he’s not, like you said, missed opportunities.”  
**Horse specialist:** *(Said simultaneously)* “Missed opportunities.”
- **Pauline:** “Are you may, are you maybe stressed because you not getting it right, you not able to, to do it. Cause it looks like, looked like you were doing quite well. And that maybe sometimes it just takes some time. *(Sniffs)* You get a bit anxious when you get stressed?”  
**Participant D:** *(Sound of agreement)*  
**Pauline:** “And then perhaps you give up quite easily you don’t do it. Instead of trying to just follow through. *(Silence 8 seconds)* And maybe it’s not up to her to come over here, maybe it’s up to you whether she comes over here. It’s like Horse specialist said she’s waiting for you. *(Silence 13 seconds)* Looked like you wanted to go back to her. *(Silence 10 seconds)*  
**Horse specialist:** “You almost...almost had it on.” *(Silence 5 seconds)*  
**Pauline:** “We still have more time, so I think maybe go try again, okay.”

However, with some encouragement and motivation, he was able to follow through and realised that he may sometimes give up too quickly;

- **Pauline:** *(To participant)* “So now you’ve achieved your goal. What’s that like?”  
**Participant D:** “It’s like, should never give up so easily”  
**Pauline:** “Okay. And we saw a big smile on your face when you walked over.”  
**Horse specialist:** “So you wanted her here, cause that’s what you said to us when you came here, you want her to come here. And you went out there, you never gave up and you brought her here. And the whole time while you were working with her, like I explained to you when you were getting stressed she started moving her head around then you would rub her calm her down calm yourself down. And then she worked patiently with you. Then as soon as you started getting stressed again she’d lift her head and you’d...you’d repeat the pattern of rubbing her and she would calm down. And the whole time I got the feeling of she was supporting you, because she stood there and she, she could have gone anywhere in this ring, but she stood there and was patiently working with you. And even when you put this on and walked here she walked with you.”  
**Pauline:** “So horse specialist and I think that you must feel proud of yourself, cause you achieved your goal, you didn’t give up and also we noticed you asked for help. So do you think that sometimes it’s okay to ask for help? Ja. What else do you sometimes give up with too quickly?”



#### 8.7.4. Erratic behaviour

Participant D also didn't seem like he had any regard for the consequences of his actions or concern/empathy for others. This was evident when he tried to place the halter on Horse A and put it across her eyes;

- **Horse specialist:** "But can you see he's got no regard for her safety?"  
**Pauline:** "Very true Ja. Ja, cause I mean that could be hurting her eyes"  
**Horse specialist:** *(To participant)* "I wonder if that strap in her eye is hurting her?" *(Silence 13 seconds)*  
**Pauline:** "Maybe it goes somewhere else, maybe not on her eyes, maybe somewhere else...."

And seemed to need to show who was 'the boss', who was in control and had power, as previously mentioned, needing to hide his vulnerabilities, although not able to from the horse;

- **Participant D:** "Must I help again?"  
**Pauline:** "If you'd like to. *(Silence 9 seconds)* *(To Horse specialist)* See that answer with kids like this worries me."  
**Horse specialist:** *(Sound of agreement)*  
**Pauline:** "I could own her..."  
**Horse specialist:** *(Sound of agreement)* "Ja."  
**Pauline:** "...that worries me."  
**Horse specialist:** "I could own her."  
**Pauline:** *(Sound of agreement)*  
**Horse specialist:** "Not I'm gona lead her, I've got leadership qualities. Feels like I can own her." *(Silence 5 seconds)*  
**Pauline:** "But then I'm also a bit confused because like you said she does go with him."  
**Horse specialist:** *(Sound of agreement)*  
**Pauline:** "It's not like she feels uncomfortable and refuses"  
**Horse specialist:** "Very comfortable."  
**Pauline:** "...she goes with him."  
**Horse specialist:** "So maybe he's using the wrong word? Because..."  
**Pauline:** "Maybe."  
**Horse specialist:** "His English is a little bit broken. But maybe he's just using the wrong words"  
**Pauline:** "Ja. But his nonverbal comes across very I'm her owner."  
**Horse specialist:** *(Sound of agreement)* "And I think you said it before as well. On our own little side. I remember those words before."  
**Pauline:** "Unless, cause the only other thing I was maybe thinking of is he does have bits of vulnerability so maybe that's why..."  
**Horse specialist:** *(Sound of agreement)*  
**Pauline:** "...she also goes with. She connects with that vulnerability, I don't know. *(Silence 4 seconds)* I don't know if I'd follow him so easily. *(Both start laughing)*

He also presented with some symptoms indicative of ADHD, as previously mentioned;

- **Horse specialist:** "Cause I noticed how she's also looking around the whole time. She's very aware of everything aro..., going on around her. And it seems like she's like that all the time with you whenever you work with her." *(Silence 15 seconds)*  
**Pauline:** "Do you always kind of feel a bit distracted and like you've got to look and see were all these noises come from. And then maybe people think you not paying attention?" *(Silence 22 seconds)*

At times, the psychologists and Horse specialist's counter-transference was very negative towards Participant D. Horse A also mirrored this:

- **Horse specialist:** *(To Pauline)* "This child is very different than the other two hey?"  
**Pauline:** *(Sound of agreement)* *(Silence 5 seconds)* "I think IQ wise he's a bit higher"  
**Horse specialist:** *(Sound of agreement)*  
**Pauline:** "But there is also something..."

**Horse specialist:** "...not right. Something like dangerous. Like you get a lurky feeling."

**Pauline:** "But she also when you were talking she also she went over there, she got a bit of a fright and then she came here."

**Horse specialist:** "And did you see the difference how..." (*Silence 3 seconds*)

**Pauline:** "I'll tell them to move away. (*Silence 3 seconds*) (*Sighs*) (*To participant*) Participant F, I think if you guys can go sit up at the top there. Okay."

**Participant F:** (*Asks something too far to hear*)

**Pauline:** "Go sit at the top there. At the top. (*Silence 13 seconds*) (*To Horse specialist*) Now she's focused on them." (*Very windy*)

**Horse specialist:** "Did you see how different she was once I put the halter on she stood by me she calmed down a bit. And then she followed me and us instead of moving away like she did with him." (*Silence 7 seconds*)

**Pauline:** "Again it's like that mirroring hey?"

**Horse specialist:** (*Sound of agreement*)

**Pauline:** "My concern is I don't think they've got the ability, well he doesn't, to process that insight she's very scared and she's a bit did to me, and she's not happy to be around me. What he's gonna do with that. And that's, that's that conduct stuff coming out." (*Silence 9 seconds*)

It was very hard for participant D to tell the truth and he was found to be lying to the researcher and horse specialist during the second last session. This in congruency in his behaviour was nicely mirrored by Horse A;

- Participant D:** "Sometimes they can to naughty stuff then they blame me"

**Pauline:** "Okay. So do you get into trouble a lot?"

**Participant D:** "No"

**Pauline:** "No. Cause you stay away from them. What naughty stuff do they do?"

**Participant D:** (*Says something, can't hear*)

**Pauline:** "Tell us?"

**Participant D:** "Hu uh. (*Silence 7 seconds*) Sometimes they can steal stuff then I'm involved in it."

**Pauline:** "They steal stuff. What stuff..."

**Participant D:** "Then I'm involved."

**Pauline:** "Are you involved? How do you get involved?"

**Participant D:** "They blame me."

**Pauline:** "Ja?"

**Participant D:** "And then they say other things..."

**Pauline:** "What stuff do they steal?"

**Participant D:** "Like the kid stuff, the children's stuff at the mall."

**Pauline:** "Okay. I noticed as you were saying they blame me she walked away."

**Horse specialist:** "It's like she gets a little uncomfortable." (*Silence 6 seconds*)

**Pauline:** "I wonder if maybe sometimes you are involved. Ja. (*Very windy*) So maybe sometimes it's right that they blame you. (*Silence 4 seconds*) Cause she seems to want to be around you when you being honest, she wants to be around you." (*Silence 5 seconds*)

**Horse specialist:** "Are you involved sometimes?"

**Participant D:** "After I've done playing with them then after I can't, then they run around. Then I'm somewhere then doesn't see them anymore. Then they do something then they blame me."

**Pauline:** (*Sound of agreement*) "Cause what I noticing when you honest and you open and you telling the truth she wants to be with you. When she's not so sure if you telling the truth, she walks away."

**Horse specialist:** (*Sound of agreement*) (*Silence 5 seconds*)

**Pauline:** "So maybe to make friends and to have people be with us we need to be honest. (*Silence 7 seconds*) But it's not always easy to be honest hey? (*Silence 15 seconds*) She's still here she hasn't completely left. Like Horse specialist said she could've gone to the other end already"

**Horse specialist:** "It's almost like she's haunting you"

**Pauline:** (*Sound of agreement*) (*Silence 10 seconds*)

**Horse specialist:** "If I look in her eyes she looks very...very soft." (*Silence 18 seconds*)

**Pauline:** "What's it like for you when she's like this?"

**Participant D:** (*Talking too soft to hear*) (*Very windy*)

**Pauline:** "Okay. And when she walks away?"

**Participant D:** "Looks like she doesn't want to be with me"

**Pauline:** "Than she doesn't want to be around you. But what does that feel like for you? How does that feel inside when she walks away?"

**Participant D:** "Sad."

- **Pauline:** “Ja. And it’s been pulled over by the traffic. (*Both laugh*)  
**Horse specialist:** “Was it speeding?”  
**Pauline:** “Ja. So it was breaking the rules? So maybe she also wants to be part of your space when you don’t break the rules. Cause she moved the traffic out the way. The traffic cop out the way. So that goes back to what we were saying. She wants to be in you space so she wants to be with you when you honest and you open and you tell the truth. (*Silence 5 seconds*) I see you watching her. (*Silence 12 seconds*) What you thinking?”

## 8.8. Results of the MMPI-A (Post-test)

### *Validity Indicators*

Participant D’s profile was considered *valid* although due to the high scores obtained on the validity indicators it should be interpreted with caution. Participant D scored high on all three validity scales: The *Infrequency* (F1) scale which indicates a tendency towards trying to portray himself in as bad a light as possible, also known as “faking bad”, the *Lie* (L) scale, which indicates a tendency to try and portray himself in as favourable light as possible and the *K* (defensiveness) scale which indicates a tendency to respond defensively and without candour.

Once again, the combination of F-L-K is insignificant as the F was not markedly elevated.

### *Clinical Scales*

Participant D scored relatively high on a few scales as discussed below.

He scored high on the *Hypochondriasis* (Hs) scale which indicates that he may have a preoccupation with regards to his health and illnesses and may present with a variety of physical complaints. Behavioural and personality descriptors are related to elevations on this scale and academically it is unlikely that he is doing well.

He also scored high on the *Depression* (D) and *Hysteria scales* (Hy) indicative of possible feelings of discouragement, hopelessness, helplessness as well as physical problems and complaints as previously mentioned. Participant D may be more likely to respond to stressful situations with hysterical reactions that may include sensory or motor disorders without an organic basis (Butcher et al., 1992). He may present with somatic concerns as discussed above and have a need for social acceptance and approval. He may also present with problems at school and have a history of suicidal ideation and gestures.

Participant D scored high on the *Psychopathic Deviate* (Pd) scale. This indicates that he may have a predisposition towards lying, stealing and alcohol abuse. Furthermore, he may also experience problems related to school conduct as well as school adjustment. Adolescents that score high on this scale are usually experienced as hostile, rebellious, and unmotivated and are more likely to abuse drugs. Butcher et al. (1992) stated that nearly half of the adolescents that scored high on this scale received conduct disorder diagnosis. Elevations on this scale are related to lying, cheating, stealing, temper outbursts as well as school, family, and legal problems. It is also likely that Participant D may

have been physically abused. The child and adolescent interview corroborated this, when he stated that he was sometimes beaten with a “sjambok” (*An African name for a long stiff whip*).

Participant D also scored high on the *Paranoia (Pa)* scale indicating that he may feel suspicious, persecuted and he may be rigid in his thinking. He may feel distrustful and suspicious and he may also be oversensitive to remarks made by others. Individuals that score high on this scale may act out aggressively and may be experienced as argumentative.

Lastly, he scored moderately high on the *Schizophrenia (Sc)* scale. This indicates that he experiences disturbances in his mood and behaviour, he may be socially isolated and experience difficulties in concentration and impulse control. A high score on this scale is also associated with various behavioural difficulties such as school problems, disagreements with parents as well as a lack of achievement. There is also a possibility of a history of sexual abuse.

## **8.9. Quantitative Analysis of the Results of the CBCL**

This section focuses on the analysis of the syndrome scales for the CBCL’s as filled out by the youth and parent. Unfortunately, this section does not include the forms as filled out by the teachers as the teacher did not complete the post-test CBCL. For this section, the higher that the score is, the worse that the child is doing and the worse their syndromes are. Behaviour either falls in the normal range or clinical range. The clinical range is worked out per the 98<sup>th</sup> percentile. (This means children need to score higher than average before behaviour is considered clinical. Think this will be beneficial to the study as it is in the South African context).

This section also focuses on the quantitative analysis of the MMPI-A as filled out by the youth.

### **8.9.1. Analysis of Participant D’s Youth Syndrome Scales**

As illustrated by Table 23, Participant D’s Youth CBCL Syndrome scales and Table 24, Scores of the Syndrome Scales, Participant D showed an increase in two of the scales as most of them showed a decrease. He illustrated an increase on the other problems section from 3 to 5. He also showed a small increase on the rule-breaking behaviour syndrome from 3 to 5 (both in the normal range).

He showed a decrease in the following scales;

- Anxious/depressed behaviour from 11 (normal range) to 4 (normal range),
- Withdrawn/depressed from 7 (clinical range) to 1 (normal range),
- Social problems from 7 to 3 (normal range for both),
- Thought problems from 3 to 1 (normal range for both).

Somatic complaints (2 – normal range) stayed the same as well as aggressive behaviour (5 – normal range).

His internal A T-score decreased from 70 to 55 (from clinical to normal range). His external B T-score increased slightly from 54 to 56 (both normal range) and his total T score (overall syndrome score) decreased from 61 to 56 (both in the normal range).

*Table 23*  
*Participant D's Youth CBCL Syndrome Scales*

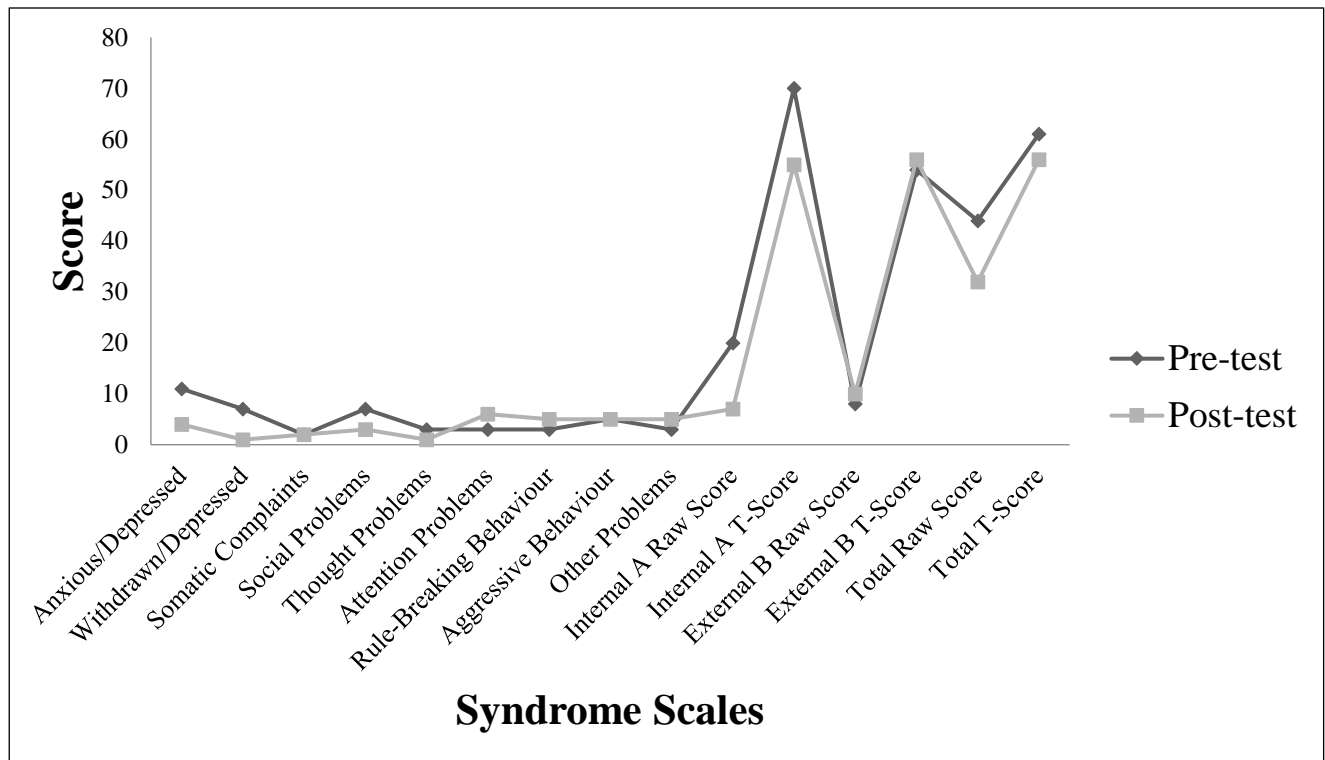


Table 24  
Total Scores of the Syndrome Scales

	Pre-test	Post-test
Anxious/Depressed	11	4
Withdrawn/Depressed	7	1
Somatic Complaints	2	2
Social Problems	7	3
Thought Problems	3	1
Attention Problems	3	6
Rule-Breaking Behaviour	3	5
Aggressive Behaviour	5	5
Other Problems	3	5
Internal A Raw Score	20	7
Internal A T-Score	70	55
External B Raw Score	8	10
External B T-Score	54	56
Total Raw Score	44	32
Total T-Score	61	56

### 8.9.2. Analysis of Participant D's Parent Syndrome Scales

Participant D showed an increase on most of the scales.

Participant D's parent CBCL's showed an increase on the following scales;

- Somatic complaints from 0 to 1 (normal range),
- Social problems from 6 to 9 (from normal to clinical range),
- Thought problems from 0 to 2 (normal range),
- Attention problems from 12 to 13 (normal range),
- Increase in rule breaking behaviour from 5 to 7 (both within normal range),
- Aggressive behaviour increased from 7 to 12 (both with normal range) and
- Other problems increased from 1 to 3 (both within normal range).

He showed a decrease on the anxious/depressed scale from 2 to 1 (both in the normal range) as well as on the withdrawn/depressed scale from 4 to 2 (both in the normal range).

His internal T-score decreased from 54 to 50 (both in normal range). His external T-score increased from 12 to 19 (from normal range to clinical range) and his total T score (overall syndrome score) increased from 58 to 63 (both in normal range).

Table 25  
Participant D's Teacher Syndrome Scales

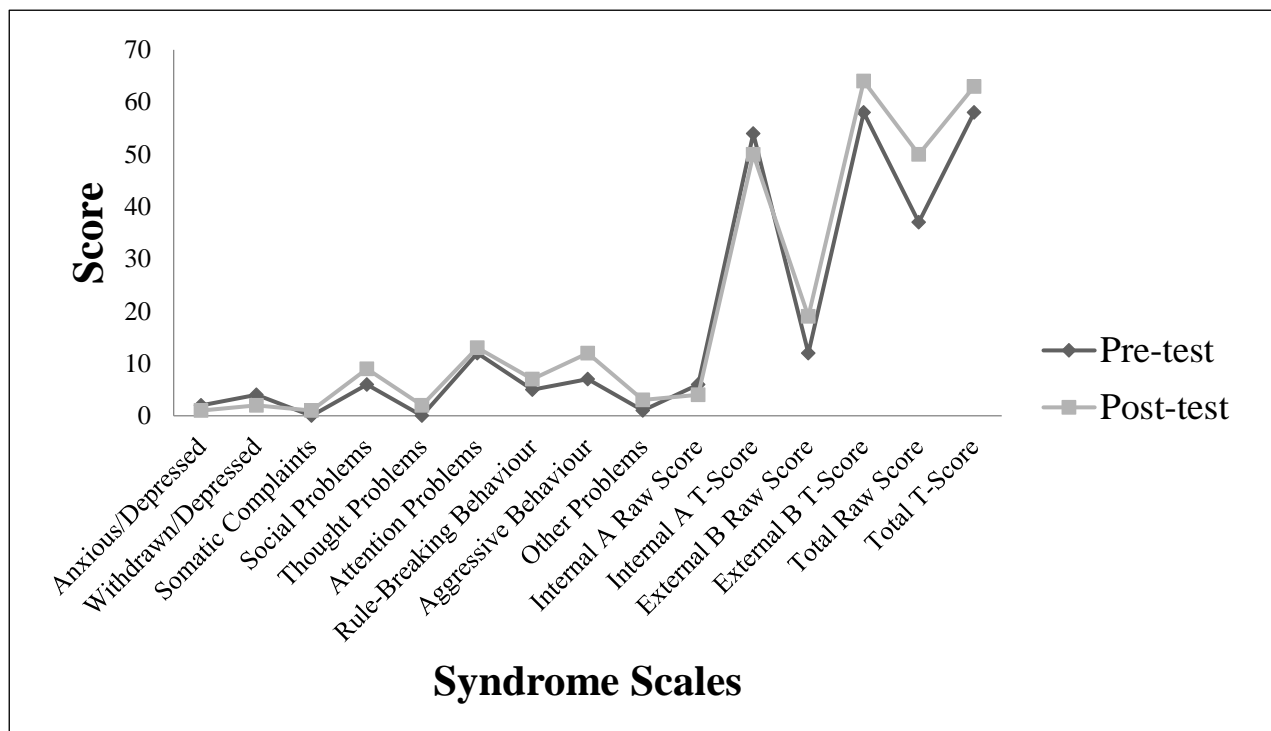


Table 26  
Scores of Syndrome Scales

	Pre-test	Post-test
<b>Anxious/Depressed</b>	2	1
<b>Withdrawn/Depressed</b>	4	2
<b>Somatic Complaints</b>	0	1
<b>Social Problems</b>	6	9
<b>Thought Problems</b>	0	2
<b>Attention Problems</b>	12	13
<b>Rule-Breaking Behaviour</b>	5	7
<b>Aggressive Behaviour</b>	7	12
<b>Other Problems</b>	1	3
<b>Internal A Raw Score</b>	6	4
<b>Internal A T-Score</b>	54	50
<b>External B Raw Score</b>	12	19
<b>External B T-Score</b>	58	64
<b>Total Raw Score</b>	37	50
<b>Total T-Score</b>	58	63

### 8.9.3. Analysis of Participant D's Parent and Youth CBCL Syndrome Scales

The following scores obtained were the same for both the youth and the parent CBCL's. Both the parent and youth CBCL indicated an increase in rule-breaking as well as other problems.

Furthermore, both the parent and the youth CBCL indicated a decrease in anxious/depressed behaviour as well as withdrawn/depressed behaviour. For both the parent and youth the internal A T-score decreased.

Table 27  
Participant D's Parent and Teacher CBCL Scores

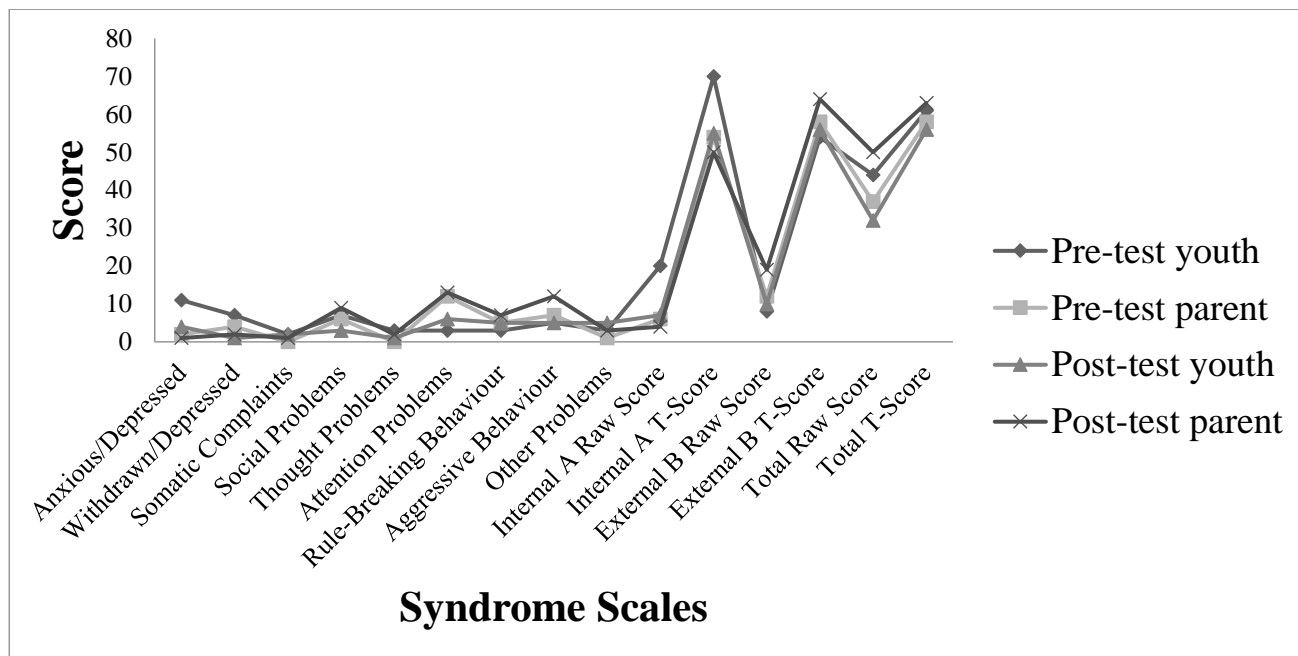


Table 28  
Total Scores of Syndrome Scales

	Pre-test youth	Pre-test parent	Post-test youth	Post-test parent
<b>Anxious/Depressed</b>	11	2	4	1
<b>Withdrawn/Depressed</b>	7	4	1	2
<b>Somatic Complaints</b>	2	0	2	1
<b>Social Problems</b>	7	6	3	9
<b>Thought Problems</b>	3	0	1	2
<b>Attention Problems</b>	3	12	6	13
<b>Rule-Breaking Behaviour</b>	3	5	5	7
<b>Aggressive Behaviour</b>	5	7	5	12
<b>Other Problems</b>	3	1	5	3
<b>Internal A Raw Score</b>	20	6	7	4
<b>Internal A T-Score</b>	70	54	55	50
<b>External B Raw Score</b>	8	12	10	19
<b>External B T-Score</b>	54	58	56	64
<b>Total Raw Score</b>	44	37	32	50
<b>Total T-Score</b>	61	58	56	63



## 8.10. Quantitative analysis of the results of the MMPI-A

The results of this section were obtained by using the T scores. For this section the higher the scores the ‘worse’ that the child is doing. An increase in scores indicates an increase in pathology.

### 8.10.1. Validity scales

With regards to the validity scales, the *Infrequency* (F1) scale stayed the same at 73 for both the pre- and post-test which is considered insignificant. His scores on the *Lie* (L) scales increased from 84 (pre-test) to 89 (post-test) and are considered to indicate a defensive test-taking attitude. Similarly, the scores on the *Defensiveness* (K) scale increased from 61 (pre-test) to 72 (post-test) possibly also indicating a defensive test-taking attitude.

### 8.10.2. Clinical scales

The following results were obtained on the clinical scales:

The following scales showed an increase:

- The Hypochondriasis (Hs) increased from 63, moderately elevated, to clinically significant in the post-test,
- Depression increased from 65 on the pre-test to 73 on the post-test, clinically significant,
- The Hysteria (Hy) scales increased significantly from 69 on the pre-test to 84 on the post-test, clinically significant,
- Psychopathic deviate (Pd) increased from 55 on the pre-test (insignificant) to 67 on the post-test (considered clinical range),
- The masculinity-femininity scale was considered insignificant, but also increased from 54 on the pre-test to 57 on the post-test,
- The schizophrenia scale also increased from 61 on the pre-test (moderately elevated) to 64 on the post-test (also moderately elevated).

The following scales showed a decrease:

- The Paranoia (Pa) scale decreased from 69 (clinically significant) on the pre-test to 66 (also clinically significant) on the post-test,
- The Hypomania (Ma) scale decreased slightly from 46 (insignificant) to 45 on the post-test (also insignificant),
- Social introversion (Si) scores decreased slightly from 56 (insignificant) on the pre-test to 53 (also insignificant) on the post-test.

Table 29  
Participant D's MMPI-A Scores

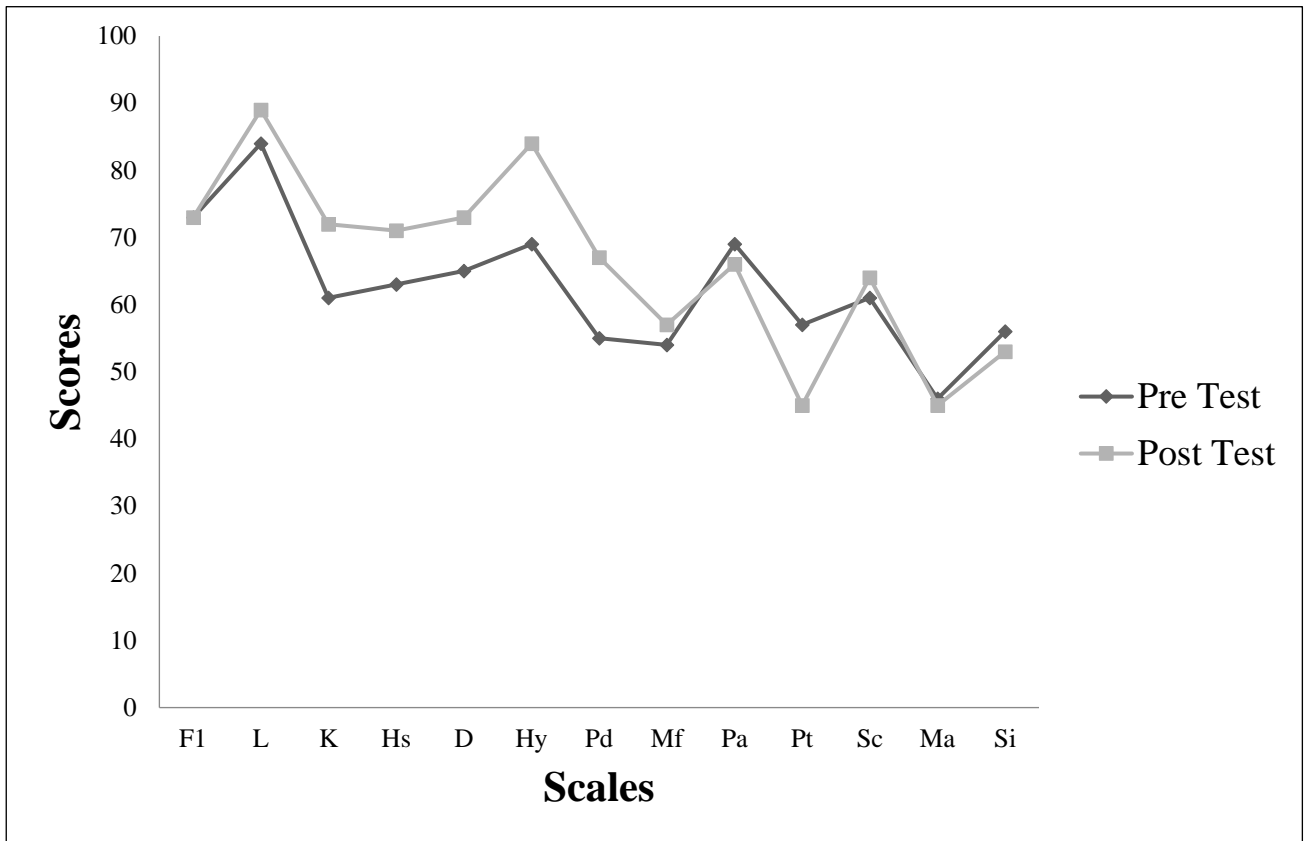


Table 30  
Total of MMPI-A Scores

	Pre-Test	Post-Test
<b>Infrequency (F1)</b>	73	73
<b>Lie (L)</b>	84	89
<b>Defensiveness (K)</b>	61	72
<b>Hypochondriasis (Hs)</b>	63	71
<b>Depression (D)</b>	65	73
<b>Hysteria (Hy)</b>	69	84
<b>Psychopathic Deviate (Pd)</b>	55	67
<b>Masculinity-Femininity (Mf)</b>	54	57
<b>Paranoia (Pa)</b>	69	66
<b>Psychasthenia (Pt)</b>	57	45
<b>Schizophrenia (Sc)</b>	61	64
<b>Hypomania (Ma)</b>	46	45
<b>Social Introversion (Si)</b>	56	53

### 8.11. Discussion

Participant D is a 15-year-old adolescent male who attended five sessions of EAP at the farm. Once again, very little background history could be obtained on him, although he did display several behavioural difficulties.

The thematic analysis of the EAP sessions highlighted difficulties with regards to relationships, which Klein would attribute to his early childhood object relations, as well as difficulties with regards to anxiety and impulsivity. Klein attributes anxiety to a fear of violent objects, which is introjected in an attempt to destroy these objects. Participant D's early object relations may have been perceived as threatening and hostile and thus his attempts to continuously destroy them. This need to continuously destroy them also results in behavioural difficulties as Participant B does not appear to have developed more appropriate social means for mastering his anxiety (talking, leisure activities, relaxation exercises etc.) and he is constantly on the defensive resulting in aggressive behaviour, lying, stealing and generally disrespecting authority figures. Thus difficulties with regards to boundaries as well as the development of empathy ensue. His high score obtained on the *Paranoia (P)* and *Schizophrenia (Sc)* scale are indicative of these difficulties and his perception of the world as

hostile and persecutory. Klein postulates that he may internalize this perception and relate not only to himself in an aggressive manner, but others as well, as indicated by collateral.

Furthermore, Participant D really struggles to acknowledge and express feelings and this is also due his experience of his early object-relation. It is more than likely that his feelings were never acknowledged and contained by his early object and given back to him a meaningful and manageable manner.

Increases on Participant D's parent CBCL protocol scores is possibly indicative that participant D may have started working on his behaviour through the process of EAP. It is often the case in a psychotherapeutic process that the behaviour/emotions/symptoms may get worse before they get better. This is because the difficult behaviours/emotions/symptoms are no longer being avoided.

The analysis of the youth CBCL protocols indicated mostly a decrease in scores, although there was an increase in rule-breaking behaviour. It is possible that the EAP sessions led to improved insight into his behaviour, thus accounting for the results obtained. There were no teacher CBCL protocols.

Both his *Depressed (D)* scales increased on the quantitative analysis of the MMPI-A, and he reported a high score on the qualitative analysis of the MMPI-A, possibly indicating that he is no longer internalising some of his feelings. Symptoms of depression emerged in the qualitative analysis of the EAP sessions through his lack of effort and decreased motivation to accept and acknowledge opportunities. Likierman (2001) states that in Kleinian work depression emerges in the transference and the acting out behaviour diminishes. Thus, an increase in the depressive symptomatology may indicate a decrease in the acting out/conduct disorder behaviour.

Participant D's scores on the MMPI-A seemed to have increased on the post-test. This is indicative of possibly a more awareness of his own behaviour and insight that he may have gained through the EAP sessions. It is also possible, as previously mentioned that he was more self-aware and authentic with himself in answering the post-test questions. This provides a good basis from which to continue EAP as it is often the case that these children are so avoidant of their behaviour and difficulties, thus making therapy very difficult.

Similarly, so, his score on the *Schizophrenia* scale, which is indicative of behavioural disorders, also showed an increase. It is possible that through the process of EAP his behaviour may have gotten worse before it gets better. It would be interesting to monitor his progress over a longer period of time. His anxiety may increase as he starts to process the perceived and possible real threat of his internalised objects and thus his attempts to destroy them may also increase.

## 8.12. Conclusion

Participant D would appear to fit the criteria for conduct disorder, but also fits the criteria for a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), comorbid disorders.

Qualitative analysis of the transcripts revealed that he really struggles with regards to relationships, including trust, control, empathy and affection, rejection, and abandonment as well as boundaries. Further themes included feelings, missed opportunities and erratic behaviour.

Quantitative analysis revealed contradictory results in that the Youth CBCL protocols revealed decreases in behaviour and the parent CBCL protocols revealed increases in behaviour.

Participation in the EAP sessions not only allowed Participant B to create a relationship, which is extremely difficult for adolescents with this diagnosis, but it is also apparent that the EAP sessions assisted in the creation of a meaningful relationship as well as creating a shift in his behaviour as well as his symptoms.

The next chapter, **Chapter 9**, focuses on Participant F. Participant E withdrew from the study.

## **CHAPTER 9**

### **RESEARCH RESULTS: PARTICIPANT F**

#### **9.1. Introduction**

The following chapter explores the findings of Participant F. This includes a background history, the adolescent psychiatric interview, the findings of the initial and post-treatment MMPI-A as well as an intra-individual analysis of the transcripts from the EAP sessions. This chapter also includes the findings of the individual quantitative analysis of the CBCL Youth checklist and the MMPI-A.

#### **9.2. Relevant Background Information**

Very little background history was unfortunately unable to be obtained on Participant F. He was born on the 8<sup>th</sup> January 2002 and is 14 years old. His biological mother is currently unemployed and he has no relationship with his biological father who reportedly resides in a different province to him. Participant F was born prematurely and as a result struggles with a heart condition. His mother also reported that he complains a lot about being bullied at school.

Participant F was described by his teacher as a slow learner, rude and argumentative. He allegedly also doesn't listen in class.

#### **9.3. Child and Adolescent Psychiatric Interview**

Participant F reported that he is a 14 year old, coloured adolescent male currently in Grade 6 at a local primary school. He stated that his date of birth is the 28<sup>th</sup> May 2001. His home language is Afrikaans, he is left handed and goes to church, although his religion is unknown.

He stated that he lives with his mother, his maternal grandmother and his two half-brothers (18 years old and four years old). His father lives in another province, as previously stated, and he reported that he has no relationship with him, which he was saddened by. He reported that he has a good relationship with his mother as well as the other family members. His mother is currently unemployed and they receive grant money to survive on. The house that they reside in only has two bedrooms and he shares a bedroom with his mother. He complained about his younger brother saying that he is very "stout" and swears at other children.

He helps his mother at home to clean his clothes and school uniform as well as cleaning the house. Things were reportedly very hard at home.

His favourite programmes are the “News”, “7de Laan”, “Generations”, “Isidingo” and “Muvhango”, all locally produced television programmes, as well as movies which he enjoys watching every evening. His favourite sports are cricket, soccer and running. Participant F wants to be a policeman when he grows up so that he can catch criminals and his three wishes were to do athletics at school, learn how to swim and he would like to be a coach.

Participant F reported that he struggles at school, although he said that school was “lekker” (*nice*), and has failed Grade 4 and Grade 5. He allegedly failed the following subjects: Afrikaans, English, ‘Lewensvaardigheid’ (*Life Skills*) and ‘Sosiale Wetenskappe’ (*Social Sciences*). He further stated that he enjoys all of his subjects and does not have a favourite. His mother helps him with his homework, which he gets every day. He also reported that he walks to and from school. He stated that he does not have any friends at school as he gets bullied and doesn’t want to play with them. The other children allegedly slap him, but he denied hitting them back. At home, he apparently has five friends.

When asked how he feels every day, Participant F stated that he allegedly felt physically ill yesterday, but was feeling better today. He reported having a sore head. Upon further questioning he stated that he feels happy every day and only occasionally feels hungry. He eats ‘pap’ (*Maize porridge*) for breakfast, fruit for lunch and ‘pap en groentes’ (*Pap, a South African meal also known as maize porridge and vegetables*) for dinner. He goes to sleep at 20h00 and wakes at 06h00. Occasionally he has dreams, about his Uncle who is in prison for “baklei” (*fighting*) and fighting with people. He worries about the fighting and his headaches.

Participant F denied any smoking, drinking or drugs or getting into trouble at school. He denied any conduct disorder symptoms and stated that he likes animals and has his own cat. No head injuries, epilepsy or seizures were reported.

No psychotic symptoms were reported or elicited.

Participant F has previously been around horses, has fed them and has also ridden them in the townships. All safety procedures as well as the correct clothing to wear was explained to him.

#### **9.4. Researchers Impressions of Participant F**

Participant F presented as a poorly groomed, Coloured adolescent male. The clothes that he wore had holes in them and appeared dirty. He had a restricted affect and a euthymic mood throughout the EAP sessions. He was noticeably anxious at times and would become fidgety. He presented as very concrete and appeared low-functioning with possible intellectual deficits. He also presented with some dysmorphic body features; very long arms and ‘floppy’ hands. His thought form and content was normal, although his speech was considered a bit slow. He seemed to really struggle to understand

instructions and instructions needed to be clearly and simply given to him. He also appeared to have a language barrier and during some of the EAP sessions, the language was switched to Afrikaans which he appeared to understand better, although he still struggled. Participant F made fair contact, although he would, at times, avoid eye contact and smile inappropriately. He seemed to become anxious when he perhaps felt that he could not do something or maybe did not understand. He was considered psychotic and suicidal.

He participated and cooperated well with the assessment procedure as well as the EAP sessions. His validity and reliability is questionable.

He was not considered a very good traditional, psychotherapeutic candidate and often appeared very concrete in nature.

### **9.5. Results of the MMPI-A (Pre-Test)**

The following section discusses the results of the pre-test MMPI-A regarding the validity and content scales:

#### *Validity*

The results were deemed *valid* and could therefore be interpreted. However, they should be interpreted with caution as he scored high on the *Infrequency* (F1) scale. This was, however, the only validity scale that he scored high on. This indicates that he may have been “faking bad” and tried to portray himself in as bad a light as possible. It is important to note however, that several factors may impact high F scores such as severe maladjustment, responding carelessly or inconsistently due to possible poor reading skills or exaggeration of symptoms (Butcher *et al.*, 1992). It is highly possible that Participant F responded poorly due to possible reading skills as he did not appear to easily understand the questions and was clinically observed to possibly have an intellectual impairment.

The configuration (F-L-K) did not appear significant.

#### *Content Scales*

Participant F scored high on the following scales;

A high score on the *Depression* (D) scale indicates that Participant F may experience a general sense of dissatisfaction with his life and may experience feelings of discouragement, hopelessness and low morale. He may also experience feelings of despondency and apathy.

Participant F also scored high on the *Paranoia* (Pa) scale, indicating that he may feel suspicious, persecuted and he may be rigid in his thinking. He may feel distrustful and suspicious and he may also be oversensitive to remarks made by others. Individuals that score high on this scale may act out aggressively and may be experienced by others as argumentative. Furthermore, Butcher *et al*



(1992), stated that a study found that adolescents that scored high on this scale corresponded with several negative behavioural correlates such as school problems (failing and being suspended) as well as being experienced as hostile.

Furthermore, participant F scored high on the *Psychasthenia* scale (Pt). Individuals that score high on this scale may report problems with regards to physical complaints, which was corroborated by the clinical observations, generally feeling unhappy, problems with regards to concentration, which was also corroborated by the clinical observations as well as obsessive thoughts, anxiety, and possible feelings of inferiority. He may also be restless and have poor self-confidence.

He also obtained a slightly elevated score on the *Schizophrenia* (Sc) scale indicating that there may be some presence of thought disorder. However, of more relevance is the likelihood that he experiences disturbances in his mood and behaviour, might be socially isolated and experience difficulties in concentration and impulse control. A high score on this scale is also associated with various behavioural difficulties such as school problems, disagreements with parents as well as a lack of achievement. There is also a possibility of a history of sexual abuse.

He obtained a moderately high score on the *Hysteria* (Hy) scale. This indicates that may deny problems and experience somatic complaints and may have a need for social acceptance and approval. Individuals that score high on this scale may express stress through somatization and may be very anxious. This is also corroborated by the high score that he obtained on the Psychasthenia scale.

## **9.6. Description of the EAP activities**

The following is a description of the EAP activities that were performed with Participant F:

### ***9.6.1. Meet and greet***

The meet and greet activity was performed in session 1. The purpose of this activity is on relationship building and the initiation of a relationship with the horse. Both the horse and participant are new to each other and this activity allows them to get to know one another. This activity usually takes place in either the stable, depending on the individual's exposure to horses and level of anxiety or the small arena. The arena was used with participant F. The activity involves going up to the horse and spending time with the horse, getting to know each other. Participant F seemed to really want the relationship which was offered by Horse A that was mirrored by her (she appeared calm and relaxed, her ears were flat, her neck low).

Participant F was also noted to be very concrete in his interactions with Horse A and wanted to feed her, groom her, and walk her around rather than just spending time with her, 'being' with her.

At times his anxiety was evident and Horse A would mirror this through becoming very unsettled and restless.

### ***9.6.2. Catch, halter and groom***

This activity, which took place in session 2, was once again focused on building relationships as well as communication and boundaries. The participant is required to catch the horse, place a halter on him/her and groom them. The participant is given the grooming kit, which contains a variety of brushes in order to brush and groom all aspects of the horse. Once again, although this activity is not task-orientated, but rather more focused on the content, it is interesting to note whether the participant is through in their grooming of the horse or not.

Participant F was notably impulsive in this session and would just rush into the arena before the instructions had been given. He also really struggled with boundaries as he would put the halter over Horse A's eyes and didn't seem aware or even concerned that it might hurt her. He would also walk straight behind her whilst grooming without warning. The developing relationship between himself and Horse A appeared to have a positive impact on him as he seemed to become more confident.

### ***9.6.3. Build a space that is representative of you***

During this activity, which takes place in the big arena, the participant is given a variety of objects (jumping poles, uprights, tyres, cones, blocks, coke bottles etc.), to build an object, that is representative of himself. This activity is also focused on relationships as it is interesting to see whether the participant uses the horse, that is in the arena or not, as well as communication and boundaries. This activity also allows the participant to project their thoughts and feelings onto the object which can allow for interpretation. Participant F built a very small space that did not allow for Horse A to enter. Furthermore, she also appeared to ignore him, although she was still aware of him. This is indicative of how guarded and closed off Participant F can be and illustrates how difficult it may be for him to build relationships.

### ***9.6.4. Build your feelings***

This activity took place in session 4 and involved the participant building how they feel in the "here and now". This activity was performed in the big arena and the participant was given a variety of objects, such as poles, blocks, coke bottles, tyres, upright poles, balls, etc., to build how they feel. The horse was also in the arena and it was up to them to decide if they wanted to involve the horse in their structure or not. During this session it became very clear that Participant F really seemed to

struggle to understand instructions. Initially there was a lot of distance between him and Horse A, with the horse staying at the opposite end of the arena, however still very focused on him (head and ears turned towards him and constantly watching him). This behaviour is very indicative of a push and pull type of a relationship, a need to be close, but perhaps feeling guarded and struggling to trust Horse A, fearing rejection by Horse A. Participant F built a house and stated that he felt happy and it was nice to work together as a team, possibly with the horse.

### **9.6.5. Open-ended activity**

The last session and activity was left open-ended. The participant was given all the equipment from the previous activities (halter, grooming kit, objects to build with) and told to do whatever he liked. As this was the last session, it was decided that something more non-directive would be helpful and more useful, allowing him the chance to process the previous sessions and say goodbye to Horse A. Participant F chose to halter Horse A and walk her around the arena, perhaps illustrating again his need for a relationship and a bond. Participant F seemed to still struggle with boundaries in this session as he walked right behind the horse potentially placing himself in danger, but Horse A showed a lot of patience and understanding especially whilst he tried to put the halter on often bending down to assist him. It was also evident from this session that he struggled with concepts and instructions and didn't really seem to remember from session 2 how to put the halter on. He confirmed that he struggles at school as well.

## **9.7. Intra-Individual analysis of the transcript of the EAP sessions**

Participant F took part in 5 sessions of EAP at the stables with Pauline Mawson and the Horse specialist. Unfortunately one of the sessions had to be cancelled and could not be rescheduled due to examinations and school holidays. The same horse, Horse A, was used throughout all the sessions.

The following four themes were identified across all 5 of his EAP sessions and will be discussed in more depth: Relationships (with the subthemes of boundaries, rejection and abandonment and social skills), feelings, erratic behaviour and intellectual disability.

### **9.7.1. Relationships**

Relationships are very hard for Participant F. He would appear to really struggle to form relationships and even seemed initially very fearful of forming one with the horse;

- **Participant F:** "I'm gonna stand on the outside."  
**Pauline:** "You wanna stand on the outside?"  
**Participant F:** "Ja."  
**Pauline:** "How... can you tell me a little bit about how it felt? You said it was nice what else?"  
**Participant F:** Uh, Uh. I'd like to give him some food."

**Pauline:** “You wanna give her some food?”  
**Participant F:** “Ja.”  
**Pauline:** “So you’d like to feed her?”  
**Participant F:** “Ja.”  
**Pauline:** “Okay, well we’re not going to feed her today. Today it’s for you to get to know her. (*Silence 6 seconds*). Did it feel nice, was it scary, was it hard, was it comfortable?”  
**Participant F:** “It feels nice.”  
**Pauline:** “Feels nice. Okay. Cause you seemed a bit...like worried to me?”  
**Participant F:** “Ja.”  
**Pauline:** “Tell me about that?”  
**Participant F:** “What must I, what must I tell?”  
**Pauline:** “Why you worried...”  
**Participant F:** “Jo, cause uh, she might, gonna runaway.”  
**Pauline:** “Okay you’re scared she’s gonna run away. No? You think she might.”  
**Participant F:** “Ja.”  
**Pauline:** “Where would she run to?”  
**Participant F:** (*Confused noises*) “To were, to ther..., to uh, to there.” (*Participant pointing to the opposite side of the arena*).  
**Pauline:** “The other side?”  
**Participant F:** “Ja.”

- Horse Specialist:** “So it looks like she’s settled down a little bit now and she’s, she’s there by the gate waiting for you.”  
(*Silence 31 seconds*)  
**Pauline:** “Maybe it was hard for you to go and say hallo, again? Okay.”  
**Horse Specialist:** (*Talking softly*) “I think he wants to go in, he can go in.”  
**Pauline:** “Okay. Participant F if you want to go inside, you can go inside.”  
**Participant F:** “We go in or nothing hey?”  
**Pauline:** “This isn’t a very good choice for him.” (*Participant’s choice to go inside*)  
**Horse Specialist:** “I know”  
**Pauline:** “Well he’s a lot more brave.”  
**Horse Specialist:** “But doesn’t connect, hey, at all.”  
**Pauline:** “There’s like...no sense of a relationship.”

It was so hard for Participant F to trust the horse and the relationship, even when Horse A showed him that he can feel comfortable, that he always seemed to need to have a way out;

- Horse Specialist:** “Look how her eyes are closing. Look how he’s enjoying it. (*Silence 9 seconds*) Nice lick and chew. See what she’s doing with her mouth my sweetheart? Did you see? It looks like she’s eating something, she’s chewing? That’s her way of telling you she trusts you. She likes you, she’s comfortable, with you.” (*Silence 7 seconds*) See how she just moves closer and closer to him.”  
**Pauline:** (*Sound of agreement*) But he also moves away.”  
**Horse Specialist:** “He moves away and she moves closer.”  
**Pauline:** “Ja.”  
**Horse Specialist:** “Look how she’s leaning into him.”  
**Pauline:** “Aaaaa.” (*Participant F and horse standing very close together, sharing a moment*).  
**Horse Specialist:** “If he had to just walk around this ring I’m sure she’ll be follow him.”  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “Look there. (*Silence 8 seconds*) See how he’s always only touching her with one hand, the other hand always holds on to something. Holding onto a pole. See?  
**Pauline:** (*Sound of agreement*)  
**Horse Specialist:** “Even when he swaps hands?”  
**Pauline:** “Ja.”  
**Horse Specialist:** “She really looks like she’s enjoying that.”  
**Participant F:** (*Sound of agreement*)  
**Horse Specialist:** “See how she’s standing still now, she’s looking at you, she’s moving into you?” (*Silence 16 seconds*)  
**Pauline:** “I’m gonna ask him just now what it’s like. Cause he seems to have relaxed a bit. Ja.” (*Silence 27 seconds*)  
**Horse Specialist:** “Still very aware of her though.”  
**Pauline:** (*Agrees*) “Almost like he doesn’t quite trust her though.”

**Horse Specialist:** (*Sound of agreement*) “See she’s (*Pauline clears her throat*) doing that thing with her mouth again...”

**Participant F:** (*Sound of agreement*)

**Horse Specialist:** “The lick and chew” (*Silence 8 seconds*) (*Walking*)

**Pauline:** “Participant F what’s it like for you?”

**Participant F:** (*Incoherent speech*)

**Pauline:** “Can you say it a bit louder for us?”

**Participant F:** “She’s, she’s feeling good”

**Pauline:** “She’s feeling good?”

**Participant F:** “Ja”

**Pauline:** “And you?”

**Participant F:** “Me also maam.”

**Pauline:** “You also feeling good.”

**Participant F:** “Yebo.”

**Pauline:** “One thing that we noticed was that it’s hard for you to touch her with both hands. You always keep one hand on the gate, it’s like you’re not a 100% sure?”

**Participant F:** “O, o this?” (*Silence 6 seconds*)

**Pauline:** “Still one hand.” (*Conversation between Pauline and the horse specialist*)

**Horse Specialist:** (*Sound of agreement*)

He did seem to manage to create some sort of connection, relationship with Horse A, which was evident towards the end of session 1;

- Pauline:** (*Sound of agreement*) “I think he’s quite concrete, so therapy is gonna be a bit of a...”

**Horse Specialist:** “...very difficult.”

**Pauline:** “...challenge.”

**Horse Specialist:** “But this alone.” *Participant F standing in the arena just stroking and talking to Horse A.*

**Pauline:** (*Sound of agreement*)
- Horse Specialist:** “It really looks like she’s enjoying this. She’s enjoying you rubbing her. Did you see every time you move away from her, she moves closer to you?”

**Participant F:** (*Sound of agreement*)

**Horse Specialist:** “She doesn’t want you to move away.” (*Silence 14 seconds*)

**Pauline:** “And I see you smiling as well.”

**Participant F:** “Ja.” (*Silence 22 seconds*)

**Pauline:** “Perhaps it feels nice to be close to her?”

**Participant F:** “Say again?”

**Pauline:** “Is it nice to be close to her and stroking her?”

**Participant F:** “Ja.”

**Pauline:** “Ja (*Silence 25 seconds*) (*Car hoots*) Okay Participant F when you’re finished you can come join us over here. (*Softly to the horse specialist*) He can stand the whole day and do this.”

#### 9.7.1.1. Boundaries

Participant F really struggled to understand boundaries and personal space, which was very evident from the EAP sessions;

- Pauline:** “It’s almost like she doesn’t like that.” (*Horse A flipping her head around, whilst Participant F tries to put the halter on.*)

**Horse specialist:** ‘He’s too much in her face.’”

**Pauline:** (*Sound of agreement*) (*To participant*) “Participant F do you think that maybe she doesn’t like it, maybe it’s too fast?”

**Participant F:** “No.”

**Horse specialist:** “Maybe if you work a bit slower, she won’t lift her head so much. (*Silence 17 seconds*) (*Soft to Pauline*) Let go head and get you. (*Silence 5 seconds*) There we go.”

**Pauline:** “She’s helping him now. At least she was...” (*Silence 25 seconds*) (*Car hooted*) (*Dog still barking*)

**Horse specialist:** (*To participant*) “So remember to watch out for her eyes, there we go.” (*Silence 4 seconds*)

**Participant F:** “Like this?”

**Pauline:** “You happy?”

**Participant F:** “Ja.”

**Pauline:** “Okay. Did you noticed when you were a bit slower...”

**Participant F:** “Ja”

**Pauline:** “...it was easier.”

**Horse specialist:** “Cause when you walk..., worked slowly she dropped her head and she helped you a bit. But when you were fast and, and...and a bit too much in her space she was lifting her head cause she didn't like that.” (*Silence 9 seconds*)

**Pauline:** “I don't think I'm right but she seems very like...agitated and uncomfortable...”

**Horse specialist:** “Very tense with him. Ja”

And at times, he would place himself in positions where he could easily get hurt;

- **Horse Specialist:** “See how he keeps going behind her?”  
**Pauline:** “Ja.”  
**Horse Specialist:** “So he asks ‘is horse gonna harm’ him but then he puts himself in dangerous situations without even realizing.” (*Silence 5 seconds*)
- **Pauline:** “But I've also noticed he seems to move himself into corners,”  
**Horse Specialist:** (*Sound of agreement*)  
**Pauline:** “...like where he could get stuck.”  
**Horse Specialist:** (*Said simultaneously*) “Restrict himself.”  
**Pauline:** “Ja.”  
**Horse Specialist:** “And that goes hand in hand with the moving right behind her...”  
**Pauline:** “Ja.”  
**Horse Specialist:** “Safety you know...”  
**Pauline:** “Yes.”  
**Horse Specialist:** “Like not once did he...once did he like hesitate to go behind her, he just walks.” (*Silence 7 seconds*)

#### 9.7.1.2. Rejection and abandonment

Participant F would appear to really struggle with feelings of abandonment and was very concerned, especially in Session 2, about losing “his” horse;

- **Pauline:** “Interesting how he picks the other side of the ring away from us. I think he knows that he struggles but he doesn't know what to do about it. And he's embarrassed about it.” (*Silence 11 seconds*)  
**Horse specialist:** “See how he holds the grooming kit bag and her in the other hand”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “So he, he won't let go...lighten his load a little bit.”  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “See he's, he's carrying it. He's holding on to it.”  
**Pauline:** “But it's almost like he's scared to lose her.”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** “Like he's got her now, they've built a relationship, Ja.” (*Silence 16 seconds*) (*Birds chirping*) (*Construction vehicle noise*)
- **Pauline:** “Sy was ñ bietjie beter ne? Ons sien jy hou vas om haar. Baie vas. Hoekom?”  
“*She was a bit better, hey? We can see that you holding firmly to her, very firmly. Why?*”  
**Participant F:** “Wat jy gesê?”  
“*What did you say?*”  
**Pauline:** “Hoekom hou jy so vas?”  
“*Why are you holding so firmly?*”  
**Participant F:** “Uh dat die perd nie kan los is en weg loop nie.”  
“*Umm so that the horse doesn't get loose and walk away.*”  
**Pauline:** “So jy's bekommered sy sal weg gaan. Ja?”  
“*So you're worried that she will go away. Yes?*”  
**Horse specialist:** “Maar dit lyk nie my dat, dat sy weg van jou wil wees nie. Sy lyk as of sy by jou wil wees. Die hele tyd as jy borsel dan kyk sy vir jou, as jy loop dan loop sy. As ons hier so staan...staan sy by jou. En ek het gesien terwyl jy loop hoeveel keer sy gelick en chew het. Het jy dit ook gesien?”  
“*But it doesn't look to me like, like she wants to be away from you. She looks as if she wants to be with you. The whole time that you were brushing, she looked at you, if you walk, then she walks. Whilst*”

*we standing here, she stands by you. And I saw as you were busy walking, how many times she gave a lick and chew. Did you also see it?"*

**Pauline:** "So miskien sal sy nie weggaan nie?"

*"So maybe she won't go away?"*

**Participant F:** "Ja."

*"Yes."*

**Pauline:** "Ja."

*"Yes."*

**Horse specialist:** "Kyk hoe lick en chew sy weer, sien jy?"

*"Look how she's licking and chewing again, do you see?"*

**Pauline:** "Dis amper soos sy wou by jou wees."

*"It's like she wants to be by you."*

**Participant F:** "Ja." (*Silence 5 seconds*)

*"Yes."*

He seemed to also really struggle with feeling accepted;

- **Horse specialist:** "He's quite rough with her, hey? I think that's the word, rough. But he is unintentionally rough, like he pulls her and he yanks her and he's not aware that he's doing it but it shows that he's rough by her reaction. (*Silence 21 seconds*) Is he an only child?"  
**Pauline:** "I'll have to double check the file. Often they, not they have a lot of ... half..."  
**Horse specialist:** "Oh."  
**Pauline:** "...half-sister half-brother. Why? What were you thinking?"  
**Horse specialist:** "I'm just wondering, how he gets on with other, with his other..."  
**Pauline:** "Ja."  
**Horse specialist:** "...family and how they accept him. Cause these kids seem to have accepted him. Like even the..."  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** "...first little boy says to me, oh you have a horse named Horse C here, my friend is also called Participant F."  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** "So you know they accept him here."  
**Pauline:** "And they went together around the farm. (*Silence 5 seconds*) I do remember he's got quite problematic relationships. But I..."  
**Horse specialist:** "I imagine from his boundary issues."

### 9.7.1.3. Social skills

Participant F really appears to struggle with social skills and empathy. He did not appear to fully understand that Horse A may not like his behaviour or be impacted by it and how to engage with her differently;

- **Pauline:** "We noticed that you walk around all of her and you go behind her at the back, and that's a difficult place for her to be, for you to be. Tell me about that, cause she could kick you."  
**Participant F:** "Ja."  
**Pauline:** "Ja. Do you think maybe it's dangerous?"  
**Participant F:** "No."  
**Pauline:** "No. Okay."  
**Horse specialist:** "It's very uncomfortable for horses when you're behind them, they don't really like it..."  
**Pauline:** (*Sighs*)  
**Horse specialist:** "...And I noticed both times you went behind her, she, she showed she wasn't comfortable with you behind her."  
**Participant F:** "Ja."  
**Horse specialist:** "Okay, so she doesn't really like you going behind her back legs like that. (*Soft to Pauline*) Let's see what he does with that. (*Silence 10 seconds*) She's had enough now."
- **Pauline:** "It's almost like she doesn't like that." (*Horse A flipping her head around, whilst Participant F tries to put the halter on.*)  
**Horse specialist:** "He's too much in her face."

**Pauline:** (*Sound of agreement*) (*To participant*) Participant F do you think that maybe she doesn't like it, maybe it's too fast."

**Participant F:** "No."

**Horse specialist:** "Maybe if you work a bit slower she won't lift her head so much. (*Silence 17 seconds*) (*Soft to Pauline*) Let go head and get you. (*Silence 5 seconds*) There we go..."

- **Pauline:** "Okay. Did you noticed when you were a bit slower..."  
**Participant F:** "Ja." (*Impulsively interrupts*)  
**Pauline:** "...it was easier."  
**Horse specialist:** "Cause when you walk, worked slowly she dropped her head and she helped you a bit. But when you were fast and, and...and a bit too much in her space she was lifting her head cause she didn't like that." (*Silence 9 seconds*)  
**Pauline:** "I don't think I'm right but she seems very like agitated and uncomfortable..."  
**Horse specialist:** "Very tense with him. Ja."  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** "Tense but very compliant. So she's still..."  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** "... her body showing tension and a little bit uncomfortableness but she's working with him." (*Lots of wind noise*)  
**Pauline:** "I'm sure she was like that last week as well?"  
**Horse specialist:** "Ja."  
**Pauline:** "...With him"  
**Horse specialist:** "But last week as well he was so in her space and..."  
**Pauline:** "Also..."  
**Horse specialist:** "...like disregarded and mindless a bit."  
**Pauline:** 'Ja I written here she was unsettled she moved around a lot. So I think that happens a lot. (*Very windy*) He gets in peoples space too much."

### 9.7.2. Feelings

Participant F really struggled to express his emotions and doesn't really seem to have a feeling vocabulary, at times coming across as very concrete and not really able to reflect on the deeper meaning of his emotions;

- **Pauline:** "Okay, well we're not going to feed her today. Today it's for you to get to know her. (*Silence 6 seconds*). Did it feel nice, was it scary, was it hard, was it comfortable?"  
**Participant F:** "It feels nice."  
**Pauline:** "Feels nice. Okay. Cause you seemed a bit like worried to me?"  
**Participant F:** "Ja."  
**Pauline:** "Tell me about that?"  
**Participant F:** "What must I, what must I tell?"  
**Pauline:** "Why you worried."  
**Participant F:** "Jo, cause uh, she might gona runaway."  
**Pauline:** "Okay, you scared she's gona run away. No? You think she might."
- **Pauline:** "I wonder if sometimes you, you feel quite scared and worried so that's why you end up looking around a lot, and looking out for yourself and maybe you look over your shoulder? Maybe you a bit scared that someone's gona hurt you or they out to get you?"  
**Participant F:** "No, it, it's not gona."  
**Pauline:** "No. Okay. So what do you worry about at school then? Help us understand why maybe you look over your shoulder and you look around a lot"  
**Participant F:** "Uh the school work."  
**Pauline:** "The school work?"  
**Participant F:** "Ja."  
**Pauline:** "And at home?"  
**Participant F:** "Ja. I do my, I, I do, I do my, my work at home." (*Aeroplane flew by*)
- **Pauline:** "Okay. Tell us what you've built?" (*Silence 3 seconds*)  
**Participant F:** "I build a fence and these a house."  
**Pauline:** "Okay. So it's inside the house?"  
**Participant F:** "Ja."  
**Pauline:** "I see it's at the front of the fence though, towards the front."



**Participant F:** “Ja”  
**Pauline:** “Tell us about your house cause... built it a few times.” (*Silence 2 seconds*)  
**Participant F:** “Uh there’s the door, uh there’s the, uh, gowns and there’s uh window and there’s the dak (roof).”  
**Pauline:** “Okay. Wil jy in Afrikaans praat? Gaan dit bietjie beter wees?”  
*“Do you want to speak in Afrikaans? Will it be better?”*  
**Participant F:** “Ja.”  
*“Yes.”*  
**Pauline:** “Okay. Ons sal probeer in Afrikaans praat. Sê weer?”  
*“Okay, we will try speak in Afrikaans. Say it again?”*  
**Participant F:** “Daai is die deur daar onner.”  
*“There is the door, there under.”*  
**Pauline:** “Ja.”  
*“Yes.”*  
**Participant F:** “Daai is die vensters en die dak.”  
*“There are the windows and the roof.”*  
**Pauline:** “Okay. Okay”  
**Horse specialist:** (*Whispers to Pauline*) “Ask him how does the house make him feel.”  
**Pauline:** (*To participant*) “Sê vir my bietjie hoe maak hiedie huis, hoe maak dit vir jou voel?”  
*“Tell me a bit, how does this house, how does it make you feel?”*  
**Participant F:** “Voel?”  
*“Feel?”*  
**Pauline:** “Ja. Voel. Hierso voel (*Tapping on chest*).”  
*“Yes feel, feel here (*Tapping on chest*).”*  
**Participant F:** “Uh...bly.”  
*“Um...stay.”*  
**Pauline:** “Bly. Gelukkig?”  
*“Stay. Happy?”*  
**Participant F:** “Ja.”  
*“Yes.”*  
**Pauline:** “Ja. Hoekom? Hoekom maak die huis vir jou om bly te wees?”  
*“Yes. Why? Why does the house make you feel happy?”*  
**Participant F:** “Want dis, want dis lekker om saam te werk.”  
*“Because its, because it’s nice to work together.”*

Even though he had managed to create a relationship with Horse A and was fearful of losing her, he really struggled to show that he was sad in the last session;

- Pauline:** “Okay so today is the last day. Okay it’s the last time you’re gonna be working with Horse A the last Monday. After today there is no more sessions with her.”  
**Participant F:** “Ja.”  
**Pauline:** “Okay. I did get your photo printed I’ll give you your photo at the end of your session. And then you can keep that.”  
**Participant F:** “Ja.”  
**Pauline:** “Okay. How you feeling about it being the last day?”  
**Participant F:** “Nice.”  
**Pauline:** “Nice. So it’s nice to be here again?”  
**Participant F:** “Ja”  
**Pauline:** “But maybe it’s also a bit sad that it’s the last day. Ja. It is sad hey, Ja. Okay. Horse specialist is gonna give you an instruction again like normal.” (*Very windy*)

### 9.7.3. Erratic behaviour

It is possible that Participant F also struggles with other symptoms which are possibly indicative of ADHD;

- Pauline:** “He is, I noticed when we were waiting for you to fetch the horse he’s very fidgety...”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** “...very restless, very fidgety. And I’m wondering if...uhm there’s maybe some like ADHD with him...”  
**Horse specialist:** “And that show’s out in her, where she’s also very restless, very...”

And at times, his attention was all over the place, which was mirrored by the horse;

- **Horse Specialist:** “I noticed how this horse is also looking everywhere. Did you see? Then she’s looking there and she’s looking there, now she’s looking here. So her attention is all over. She’s very aware of everything.” (*Silence 11 seconds*) (*Construction vehicle*)  
**Pauline:** “Are you sometimes like that as well? You’re very aware of everything? Do you sometimes also feel a bit unsettled?”  
**Participant F:** “Ja.”
- **Pauline:** “Okay. I wonder, you see what’s happening with her?”  
**Participant F:** “Uh ha.”  
**Pauline:** “Maybe Horse Specialist can tell us what’s going on.”  
**Horse Specialist:** “So I noticed how she’s walking around a lot. So then she’s here, then she’s there, then, now she walked that side. Now she’s put her head down and she’s walking again. So she’s a little bit, she looks a bit unsettled, she’s not....”  
**Pauline:** (*Agreement sigh*)  
**Horse Specialist:** “.....very calm. She, she’s moving a lot. But when you were standing here and you were rubbing her, she looked a bit more calm then what she looks like now.” (*Silence 6 seconds*)

#### 9.7.4. Intellectual disability

Participant F presented as very low functioning and could possibly have an intellectual disability. This was evident during the EAP sessions as he seemed to really struggle to process any reflections made and was experienced as very concrete, not always understanding instructions;

- **Pauline:** “Ja.”  
**Horse specialist:** “I don’t think he, I don’t think he processes properly.”  
**Pauline:** “No.”  
**Horse specialist:** “He doesn’t understand us...”  
**Pauline:** “No I don’t think he understands us.”  
**Horse specialist:** “Not at all.”  
**Pauline:** “Ja.”  
**Horse specialist:** “She seems a lot...” (*Referring to the horse*).  
**Pauline:** (*Sound of agreement*)  
**Horse specialist:** “...calmer.”  
**Pauline:** “I think for him this is just gonna be about building a relationship with the horse and that’s it...”  
**Horse specialist:** “And confidence.”  
**Pauline:** “Yes.”
- **Pauline:** (*Softly to Horse specialist*) “They must definitely look into his schooling.”  
**Horse specialist:** “Again don’t you see characteristics of a bit of retardation hey. The way his hand flopped and... (*Dog barking*) (*Lots of wind noise*) (*Silence 23 seconds*) I noticed she’s moving her head a lot.”
- **Horse specialist:** “...around his hand as well. So walks behind her, doesn’t look after her eyes when he puts the halter on, wraps the lead around his hand.” (*Silence 7 seconds*)  
**Pauline:** I, I think it’s a combination, I’m not sure he knows any better like cognitively”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** “But then also I think he’s so scared to lose her, he’s got to keep her right in his space. But I don’t think he’s got the cognitive ability to, to...”  
**Horse specialist:** “...see that’s not so clear.” (*Silence 15 seconds*) (*Car hoots*)
- **Pauline:** (*Sound of agreement*) (*sigh*) (*silence 11 seconds*) “But he definitely needs like an IQ test and different schooling.”  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** “He’s gonna struggle in that school. (*Silence 53 seconds*) He seems to struggle to initiate stuff as well hey. Like you have to tell him what to do.”  
**Horse specialist:** “Ja.”  
**Pauline:** “Go this way, go that way.”
- **Pauline:** “Ja. (*Silence 38 seconds*) I don’t know he almost looks a bit unsure.”

**Horse specialist:** (*Sound of agreement*) "I don't know if he understood the instructions properly."

**Pauline:** "Ja, well let's see what he does with it."

**Horse specialist:** "And if he asks for help, if he doesn't see how he handles it." (*Silence 8 seconds*)

**Pauline:** "it's almost like he doesn't know what to do. Cause she's busy eating."

He would appear to perhaps be aware of the fact that he struggles;

- **Pauline:** "Interesting how he picks the other side of the ring away from us. (*Participant F walks to the other side of the ring*). I think he knows that he struggles but he doesn't know what to do about it. And he's embarrassed about it." (*Silence 11 seconds*)

And may have a need to prove himself;

- **Horse specialist:** (*Sound of agreement*) "I was just thinking with him, he's the only one out of the three that didn't ask us how to put the halter on."  
**Pauline:** "True, Ja."  
**Horse specialist:** "He just went jumped in and did it. He didn't hesitate, he didn't once say he can't"  
**Pauline:** "I think he's got a need to show people he can do things"  
**Horse specialist:** (*Sound of agreement*) "To prove himself."  
**Pauline:** "Ja. And he tries and I mean sometimes he does get it right, I mean he got the halter on. But I think sometimes he gets it wrong and he doesn't know why he gets it wrong. Doesn't matter how hard he tries he can't get it right. Especially like school. (*Silence 5 seconds*) And then he probably ends up getting teased or moaned at or yelled at."  
**Horse specialist:** "Get into trouble."

He also displayed some dysmorphic body features;

- **Pauline:** (*Sound of agreement*) "He's got this big grin on his face. But even the way, I mean the way he walks is very stiff hey."  
**Horse specialist:** (*Sound of agreement*)  
**Pauline:** "His arms are..."  
**Horse specialist:** "Stiff."  
**Pauline:** "Ja."  
**Horse specialist:** "But the hands are like ..."  
**Pauline:** "Quite floppy."  
**Horse specialist:** "...loose. Ja"  
**Pauline:** "Ja" (*Silence 7 seconds*)

## 9.8. Results of the MMPI-A (Post-test)

### *Validity*

Participant F's profile was considered valid and can therefore be interpreted, although it should be interpreted with caution as he again scored high on the *Infrequency* (F1) scale. Once again the configuration of F-L-K did not seem significant.

### *Clinical Scales*

Participant F scored high on the following scales; *Depression* (D), *Psychopathic deviance* (Pd), *Paranoia* (Pa) and *Schizophrenia* (Sc).

A high score on the *Depression* scale, as previously mentioned, indicates that Participant F may experience a general sense of dissatisfaction with his life and may also experience feelings of discouragement, hopelessness, and low morale. He may experience feelings of despondency and apathy.

Participant F scored high on the *Psychopathic Deviate* (Pd) scale. This indicates that he may have a predisposition towards lying, stealing and alcohol abuse. Furthermore, he may also experience problems related to school conduct as well as school adjustment. Adolescents that score high on this scale are usually experienced as hostile, rebellious and unmotivated and are more likely to abuse drugs. Butcher, *et al.* (1992), stated that nearly half of the adolescents that scored high on this scale received conduct disorder diagnosis. Elevations on this scale are related to lying, cheating, stealing, temper outbursts as well as school, family and legal problems. It is also likely that Participant D may have been physically abused.

Participant F also scored high on the *Paranoia* (Pa) scale, indicating that he may feel suspicious, persecuted and he may be rigid in his thinking. He may feel distrustful and suspicious and he may also be oversensitive to remarks made by others. Individuals that score high on this scale may act out aggressively and may be experienced as argumentative.

He also obtained a slightly elevated score on the *Schizophrenia* scale. As previously mentioned, of relevance is the likelihood that he experiences disturbances in his mood and behaviour. A high score on this scale is also associated with various behavioural difficulties such as school problems.

He scored moderately high on the *Hypochondriasis* (Hs), *Hysteria* (Hy) and *Psychasthenia* (Pt) scales.

He scored high on the *Hypochondriasis* (Hs) scale which indicates that he may have a preoccupation with regards to his health and illnesses and may present with a variety of physical complaints. Behavioural and personality descriptors are related to elevations on this scale and academically it is unlikely that he is doing well.

His high score on the *Hysteria* and *Psychasthenia* scale is as previously discussed.

## **9.9. Quantitative analysis of the results of the CBCL**

The following section focuses on the quantitative analysis of the pre- and post-test CBCL protocols that were filled out by Participant F, his teacher, and his parents.

### **9.9.1. Analysis of the teachers CBCL**

#### *Syndrome Scales*

On the Syndrome Scales of the CBCL, a high score indicates an area of difficulty and the higher the score is, the worse the child is doing. The participant's scores either fall in the normal range or the clinical range. The clinical range was scored according to the 98<sup>th</sup> percentile (participants needed to score higher than average before their behaviour was considered clinical).

There are 9 syndrome scales: anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviour, aggressive behaviour and other problems.

As shown in Table 31, Participant F's Teacher CBCL Syndrome Scales and Table 32, Scores of the Syndrome Scales, Participant F showed an increase in anxious/depressed behaviour (2 to 24/normal to clinical range), withdrawn/depressed behaviour (6 to 11/normal to clinical range), somatic complaints (0 to 6 – normal range), social problems (9 to 19 – clinical range), thought problems (1 to 14/normal range to clinical range), aggressive behaviour (20 to 24 – clinical range) as well as attention problems (17 to 20 – clinical range).

There was a decrease in his rule-breaking behaviour (13 to 7/decreased from the clinical range to the normal range) as well as other problems section from (5 to 3 – normal range).

His internal T-score increased from 57 to 77 (from normal range to clinical range). His external T-score slightly decreased from 73-72 (both in the clinical range). His total T score (overall syndrome score) increased from 70 to 89 (both in the clinical range).

This section indicated mostly increases in his behaviour which were rather significant in that they rose to the clinical range.

*Table 31  
Participant F's Teacher CBCL Syndrome Scales*

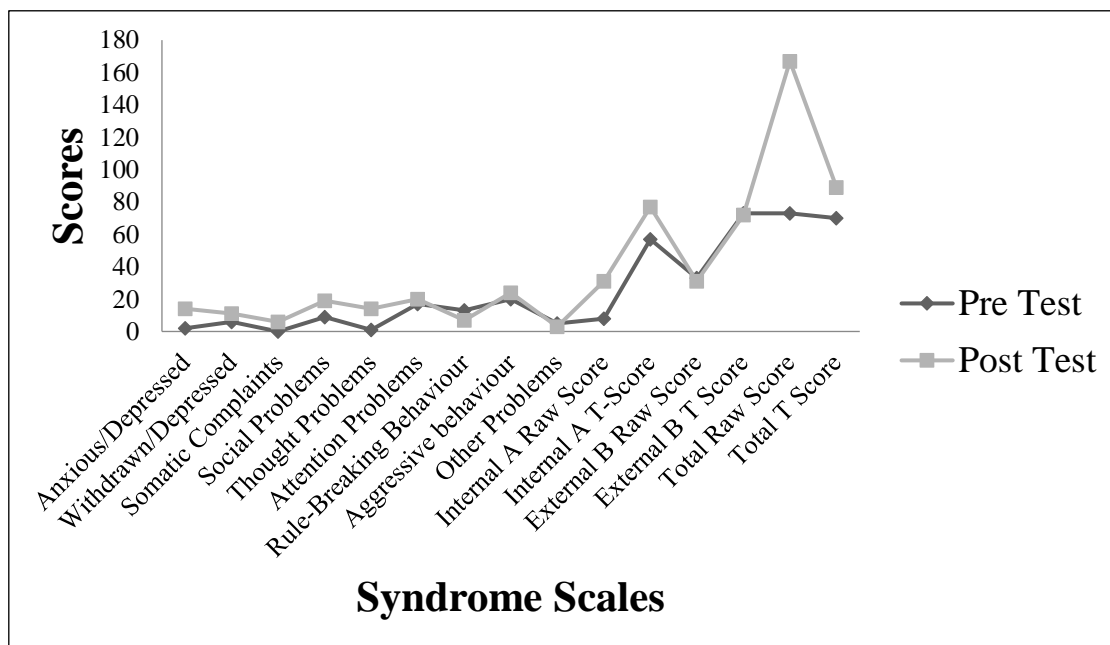


Table 32  
Total Scores of the Syndrome Scales

Syndrome Scales	Pre-Test	Post - Test
Anxious/Depressed	2	14
Withdrawn/Depressed	6	11
Somatic Complaints	0	6
Social Problems	9	19
Thought Problems	1	14
Attention Problems	17	20
Rule-Breaking Behaviour	13	7
Aggressive behaviour	20	24
Other Problems	5	3
Internal A Raw Score	8	31
Internal A T-Score	57	77
External B Raw Score	33	31
External B T Score	73	72
Total Raw Score	73	167
Total T Score	70	89

### 9.9.2. Analysis of the youths CBCL

#### Syndrome Scales

As previously discussed, on these scales, the higher the score, the worse the child is doing. Behaviour either falls in the normal or the clinical range (according to the 98<sup>th</sup> percentile).

According to Table 32, Participant F CBCL Syndrome Scales and Table 34 , Total Scores of the Syndrome Scales, Participant F showed an increased in anxious/depressed behaviour (5 to 15 – normal to clinical range); somatic complaints (4 to 8 – normal to clinical range), social problems (10 to 12 – clinical), thought problems (5 to 9 – normal to clinical range), attention problems (7 to 12 – normal range), rule-breaking behaviour (14 to 21 – clinical range), aggressive behaviour (12 to 15 – normal range). His external T score (69 to 75) and total T score also increased (71 to 76 – clinical range). This indicates that Participant F showed symptoms indicative of doing worse after the EAP sessions. This may also be due to his tendency to exaggerate symptoms as well as the fact that the EAP sessions may have brought to the forefront his difficulties.

He showed a decrease in withdrawn/depressed behaviour (10 to 8 – clinical) indicating that he does not feel as withdrawn and depressed anymore. There was also a decrease in other problems (14 to 10).

His internal T-score stayed the same at 71 which is in the clinical range.

Table 33  
Participant F's CBCL Syndrome Scales

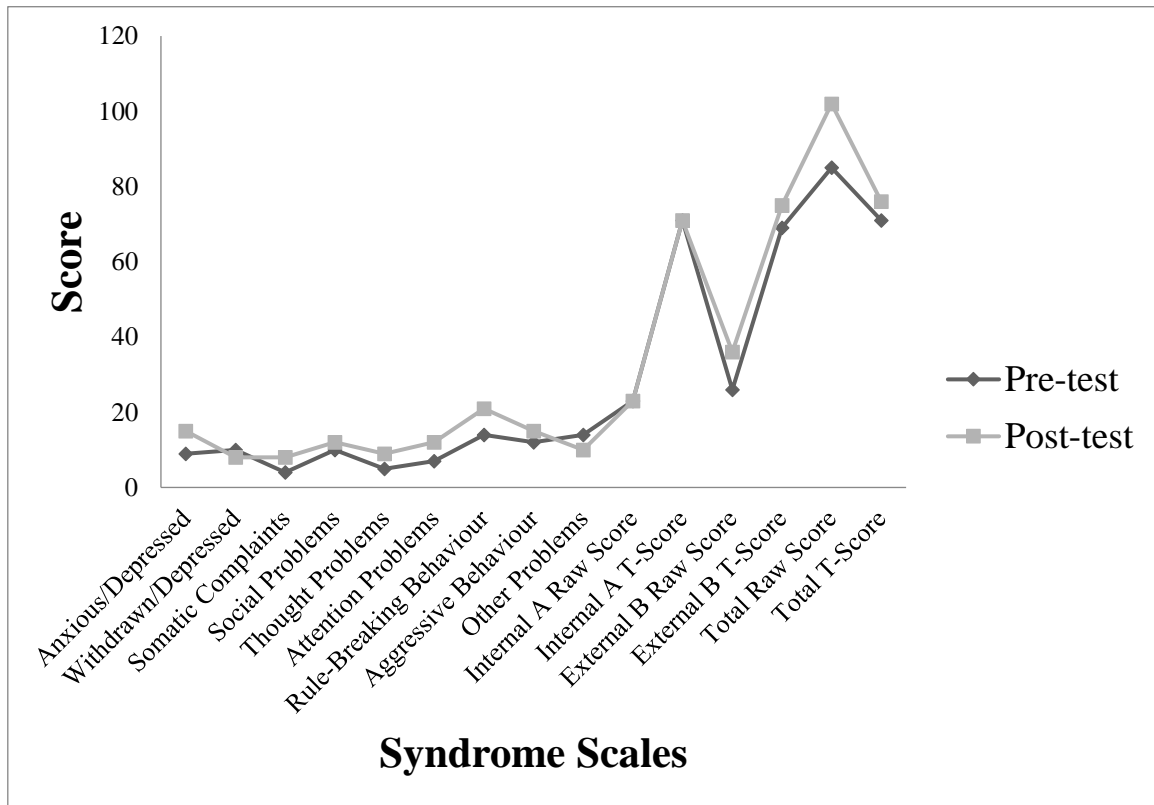


Table 34  
Total Scores of the Syndrome Scales

	Pre-test	Post-test
<b>Anxious/Depressed</b>	9	15
<b>Withdrawn/Depressed</b>	10	8
<b>Somatic Complaints</b>	4	8
<b>Social Problems</b>	10	12
<b>Thought Problems</b>	5	9
<b>Attention Problems</b>	7	12
<b>Rule-Breaking Behaviour</b>	14	21
<b>Aggressive Behaviour</b>	12	15
<b>Other Problems</b>	14	10
<b>Internal A Raw Score</b>	23	23
<b>Internal A T-Score</b>	71	71
<b>External B Raw Score</b>	26	36
<b>External B T-Score</b>	69	75
<b>Total Raw Score</b>	85	102
<b>Total T-Score</b>	71	76

### 9.9.3 Analysis of both the teacher and youth CBCL

According to Table 35, Teacher and Youth CBCL Syndrome scales and Table 36, Total Scores of the Teacher and Youth Syndrome Scales, both the youth and teacher indicated that social problems and the external T-score were high for the pre-and post-test. This indicates that they are both aware of the behaviour and it is clinically significant for both of them.

Both the teacher and the youth scored high, within the clinical range, for rule-breaking behaviour in the pre-test. However, in the post-test, the youth indicated an increase in this behaviour whilst the teacher reported a decrease in this behaviour (from clinical range to normal range).

In the post-test, both the youth and teacher indicated that anxious/depressed, withdrawn/depressed and thought problems were a difficulty in the clinical range.

Furthermore, both the youth and teacher, indicated that the internal T score was in the clinical range on the pre-test. This is in contrast to the teachers post-test score where it fell in the normal range. The youth's score stayed the same.

The teacher indicated high scores on aggression in both the pre- and post-test.

Table 35  
Teacher and Youth CBCL Syndrome Scales

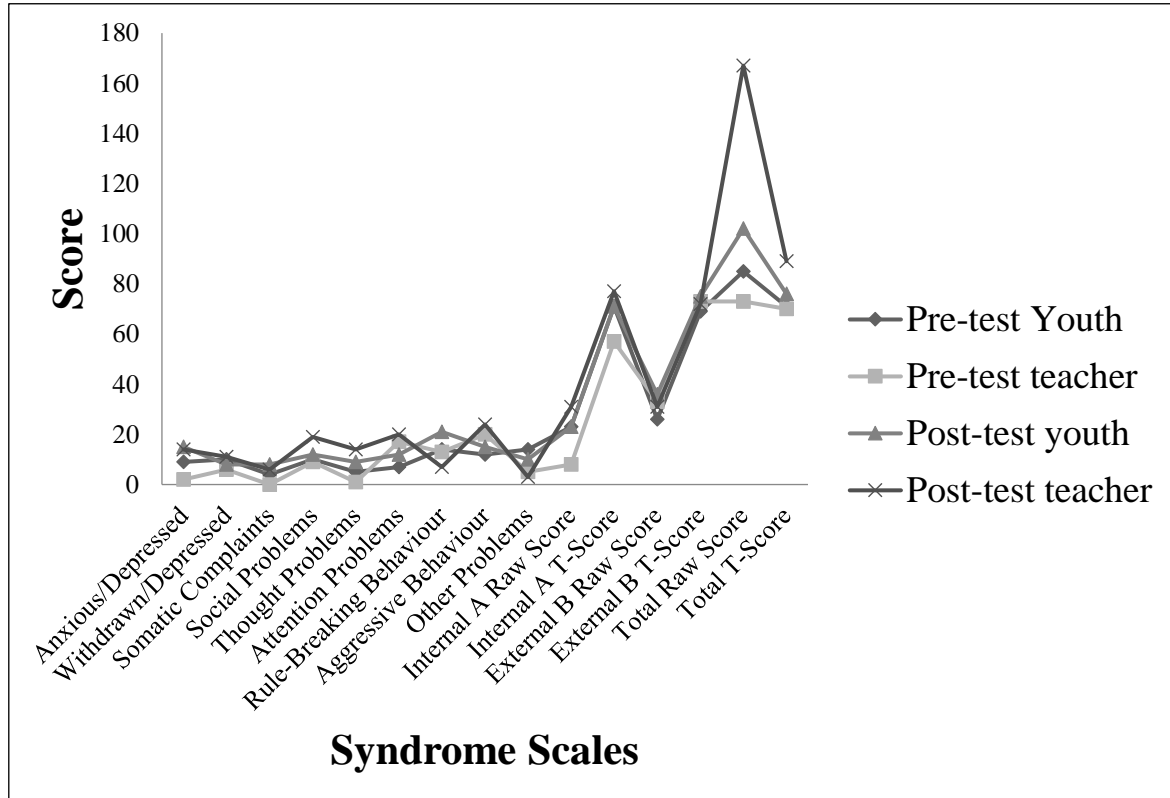




Table 36  
Total Scores of the Teacher and Youth Syndrome Scales

	Pre-test Youth	Pre-test teacher	Post-test youth	Post-test teacher
<b>Anxious/Depressed</b>	9	2	15	14
<b>Withdrawn/Depressed</b>	10	6	8	11
<b>Somatic Complaints</b>	4	0	8	6
<b>Social Problems</b>	10	9	12	19
<b>Thought Problems</b>	5	1	9	14
<b>Attention Problems</b>	7	17	12	20
<b>Rule-Breaking Behaviour</b>	14	13	21	7
<b>Aggressive Behaviour</b>	12	20	15	24
<b>Other Problems</b>	14	5	10	3
<b>Internal A Raw Score</b>	23	8	23	31
<b>Internal A T-Score</b>	71	57	71	77
<b>External B Raw Score</b>	26	33	36	31
<b>External B T-Score</b>	69	73	75	72
<b>Total Raw Score</b>	85	73	102	167
<b>Total T-Score</b>	71	70	76	89

### 9.10. Quantitative analysis of the results of the MMPI-A

Below in Table 37, Participant F's Pre- and Post-test MMPI-A scores, follows the quantitative analysis of the pre- and post-test data from Participant F's MMPI-A.

The scores on this section were worked out according to the T scores obtained. The higher the score, the worse that the child is doing. Thus an increase in the score represents an increase in pathology.

#### 9.10.1. Validity Scales

With regards to the validity scales, the *Infrequency (FI)*, which measures a problematic/invalidating response pattern) scores decreased from 95 (serious concerns) in the pre-test to 83 (problematic) in the post-test.

The scores (59 for both) obtained on the *Lie (L)* scales could be interpreted as insignificant on both the pre- and post-test.

Participant F scored 51 for the *Defensiveness (K)* scale on both the pre- and post-test, which indicates that he didn't display a defensive test taking attitude.

### **9.10.2. Clinical Scales**

The following results were obtained on the clinical scales:

Participant F showed an increase on the following scales:

- Hypochondriasis (Hs) from 52 (insignificant) to 60 (moderately elevated) in the post-test,
- Depression (D) from 73 (clinically significant) to 75 (clinically significant),
- Psychopathic deviate (Pd) from 55 (insignificant) to within the clinical range (70) on the post-test,
- Masculinity-Femininity (Mf) from 37 (insignificant) to 47 (insignificant) on the post-test,
- Schizophrenia (Sc) from 66 (clinically significant) to 71 (also clinically significant),
- Hypomania (Ma) from 56 to 59 on the post-test, both considered insignificant,
- Social introversion (Si) from 54 to 56 (both clinically insignificant).

Participant F showed a decrease in the following scales:

- Hysteria (Hy) decreased slightly from 63 to 61 (both moderately elevated),
- Paranoia (Pa) decreased slightly from 76 to 73 (although both still clinically significant),
- Psychasthenia (Pt) decreased from 67 (clinically significant) to 62 on the post-test (moderate elevation),

Table 37  
Participant F's Pre-and Post-Test MMPI-A scores

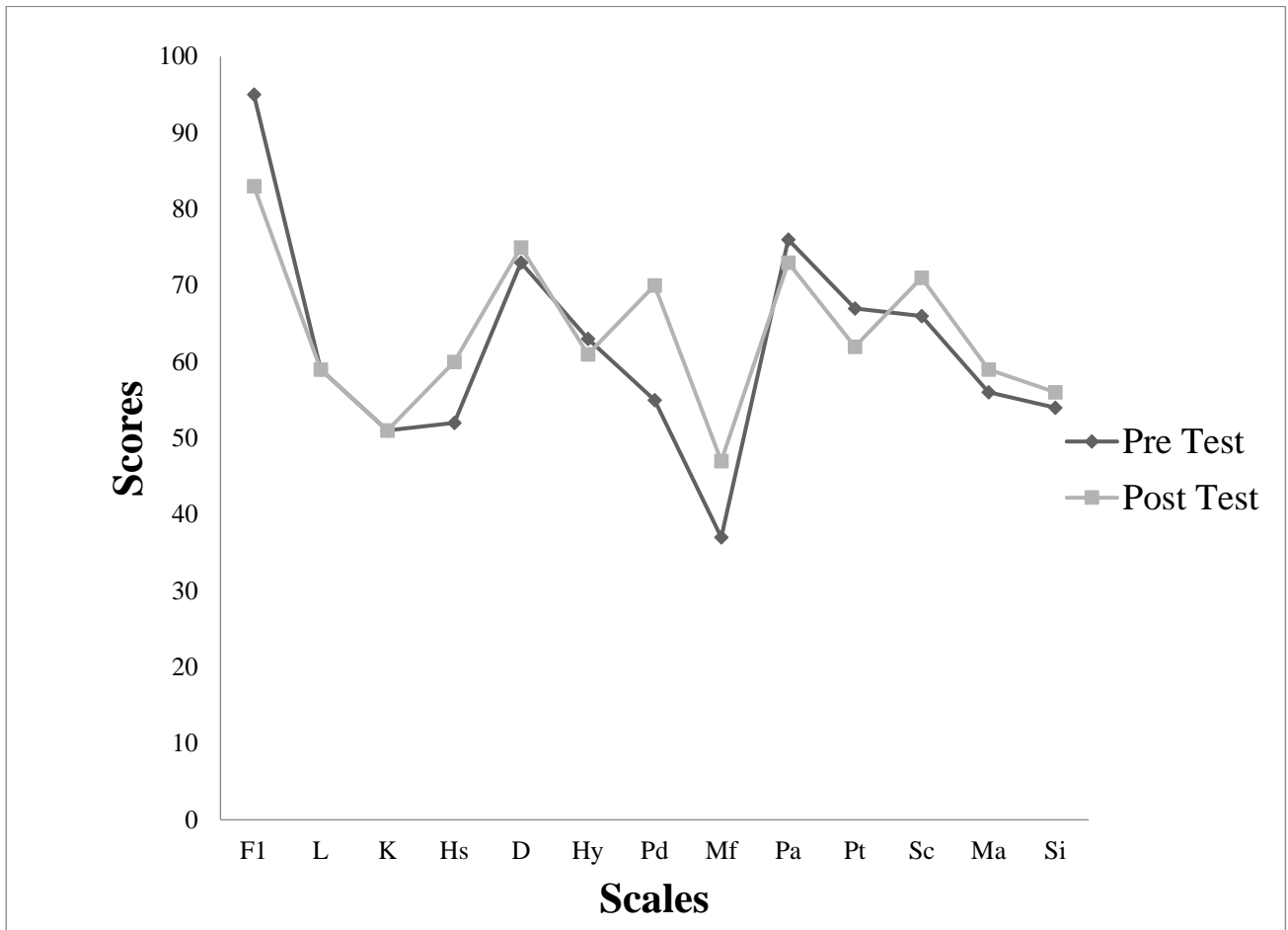


Table 38  
Total Scores for the MMPI-A results

	Pre-Test	Post-Test
<b>Infrequency (F1)</b>	95	83
<b>Lie (L)</b>	59	59
<b>Defensiveness (K)</b>	51	51
<b>Hypochondriasis (Hs)</b>	52	60
<b>Depression (D)</b>	73	75
<b>Hysteria (Hy)</b>	63	61
<b>Psychopathic Deviate (Pd)</b>	55	70
<b>Masculinity-Femininity (Mf)</b>	37	47
<b>Paranoia (Pa)</b>	76	73
<b>Psychasthenia (Pt)</b>	67	62
<b>Schizophrenia (Sc)</b>	66	71
<b>Hypomania (Ma)</b>	56	59
<b>Social Introversion (Si)</b>	54	56

### 9.11. Discussion

Participant F is a 14-year-old coloured adolescent male in Grade 6 at a Primary School in the area. Very little is known about his background history, but he would appear to have suffered a lot of deprivation and loss. He has never had a relationship with his father and would appear to have a lot of anger and self-blame surrounding this. Per Kleinian theory, Participant F may view his father as competition to his mother and may have a lot of mixed feelings towards his father's absence, blaming himself for his father's absence due to viewing his father as competition. Thus resulting in feelings of depression (due to the internalised blame) as well as feelings of anger and hostility resulting in acting-out behaviour.

Participant F presented with dirty clothes that had holes in them. He had a restricted affect and euthymic mood. Upon clinical observation he appeared to have cognitive deficits and his speech was slow. He also seemed to struggle to follow instructions even when the sessions were conducted in Afrikaans. He did, at times, become anxious, although he struggled to acknowledge and reflect on this.

Relationships was a significant theme for Participant F during the EAP sessions and he seemed to really want to connect with Horse A, but also appeared guarded and unsure of himself. Klein would attribute these difficulties to his early object relations and he may perceive them as threatening and thus the difficulty in forming and establishing relationships. This would be reinforced by the absence of a father figure. Due to his possible intellectual disability these feelings may be very difficult to process and understand and change may not necessarily be possible. Furthermore, his

relationships would appear to be characterised with deprivation, not just physically but emotionally as well. This can result in Participant F experiencing envy and his belief that goodness is withheld. He may struggle to hold onto the goodness of the EAP sessions believing that everything is always taken away from him and may result in aggressive acting out behaviours as postulated by Klein.

He presented with symptoms of an intellectual disability which may account for the results obtained on the MMPI-A and CBCL as well as the complaints of poor performance and behavioural difficulties by his teacher. This was also evident in the EAP sessions whereby he seemed to struggle to understand instructions and presented as very concrete in nature. He also reported failing at school and struggling with certain subjects. Unfortunately, due to his cognitive ability, Participant F is not an ideal therapeutic candidate. The high scores that he obtained on the *Schizophrenia* subscale of the MMPI-A also support poor performance at school and behavioural difficulties.

The results of the pre- and post-test teachers CBCL indicated that he experienced difficulty with regards to aggression. From the EAP sessions, as discussed, Participant F would appear to have cognitive impairment and may become aggressive when feeling frustrated because he doesn't understand and doesn't know how to express himself. Horse A seemed to understand this and was patient with him. However, possibly not everyone is as understanding.

However, it is important to note that even though his high scores may be accounted for by his intellectual disability, he did also score high on the *Psychopathic deviate* scale which is indicative of behavioural difficulties and he also presented in the EAP sessions with possible symptoms of ADHD.

The results on the MMPI-A illustrated that his scores increased on 7 out of the 10 syndrome scales. Similarly the Teachers CBCL and Youth CBCL protocols also indicated increases. It is possible that he had developed more insight and self-awareness after the EAP sessions, into his behaviour and was able to answer more honestly about his behaviour. The Infrequency scale decreased. However, his potential cognitive impairment should also be taken into consideration and he may have struggled to answer the questions.

Significant increases may show that he is actually starting to work on his difficulties and that they are coming to the forefront. Shifts are clearly evident.

## **9.12. Conclusion**

Due to Participant's low functioning/intellectual disability he would benefit from IQ testing and the correct school placement as well as a possible placement in a job where he can use his hands such as a carpenter or a groomsman. Furthermore, he is possibly acting out his intellectual deficits and may know that he struggles but doesn't know how to cope with it. Participant F is not a candidate for main stream schooling.

Prevalent themes that emerged from the thematic analysis of Participant F's EAP sessions included; relationships (boundaries, rejection and abandonment and social skills), feelings, erratic behaviour as well as intellectual disability.

Quantitative analysis revealed that there was mostly an increase in behavioural difficulties noted on both the teacher and youth CBCL protocols, however there was a decrease in rule breaking behaviour as well as depressive symptoms, which is indicative of an appropriate expression of anger.

However, even with these difficulties, Participant F seemed to benefit from the EAP sessions and although he is not necessarily a candidate for psychotherapy, may actually benefit from EAP, even in the simplest of forms.

The next chapter, **Chapter 10**, focuses on the analysis and results of the quantitative section of this research.

## **CHAPTER 10**

### **QUANTITATIVE RESEARCH FINDINGS: THE CHILD BEHAVIOUR CHECKLIST (CBCL) AND THE MINNESOTA MULTIPHASIC PERSONALITY INVENTORY – ADOLESCENT (MMPI-A)**

#### **10.1. Introduction**

This chapter explores the findings of the quantitative research data for both the experimental as well as the control group. The experimental group received intervention in the form of the EAP sessions, whilst the control group received no intervention at all. Pre- and post-tests were conducted for both the control and experimental group with approximately 6 months in-between.

The findings from both the CBCL, as well as the Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A) will be discussed. The first part of this chapter will focus on the CBCL analysis, followed by the analysis of the MMPI-A.

As much data, as possible, has been provided in this chapter to provide the reader with a holistic understanding of the quantitative research results.

#### **10.2. Analysis of the 6-18 Child Behaviour Checklist (CBCL) – Youth Checklist**

The following section is an analysis of the CBCL protocols for the experimental and control groups. For all the analyses below a Wilcoxon Signed Rank Test was used to investigate whether the findings were statistically significant or not.

##### ***10.2.1. Sample description***

The final sample used for this study consisted of only 11 participants (N=11). The experimental group consisted of 5 participants, and the control group consisted of 6 participants. The overall sample consisted of 5 males and 6 females, 7 were Black African and 4 were classified as Coloured (a South African population group of mixed ethnic ancestry and unique culture). The minimum age for this sample was 12, while the maximum age was 19. The mean age of this sample was 14.545.

The youth filled out their own CBCL for the pre- and post-test (N=11), while 4 parents and 6 teachers completed the pre-and post CBCL about the youth. Please refer below to the frequency distributions (the following 3 tables) for more information on the sample.

Table 39  
Overall Scores

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.0	11	9.2	52.4	52.4
	2.0	4	3.4	19.0	71.4
	4.0	6	5.0	28.6	100.0
	Total	21	17.6	100.0	
Missing	System	98	82.4		
Total		119	100.0		

Table 40  
Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	5	45.5	45.5	45.5
	Female	6	54.5	54.5	100.0
	Total	11	100.0	100.0	

Table 41  
Race

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Black African	7	63.6	63.6	63.6
	Coloured	4	36.4	36.4	100.0
	Total	11	100.0	100.0	

The next section explains the overall analysis of both the control and experimental groups for all the CBCL protocols filled out by the parents, teachers as well as the youth.



### *10.2.2. Overall comparison and interpretation*

The findings in this section are based on the CBCL protocols completed by the youth, parents and teachers combined. For this section, the T-Scores (as indicated on the CBCL) for each of these variables were used and not the raw scores.

A Wilcoxon Signed Rank Test of the overall findings in this section indicated that none of the scores were statistically significant between the pre- and post-test for both the control and experimental groups. For the scores to have been statistically significant, the p value, symbolised by a “p” needs to be 0.05 or smaller. An effect size, symbolised by a “r” is an extra explanation of the p value and conveys to the reader how large the impact of the p value is. A r value between 0.1 and 0.3 is a small effect size, a r value of between 0.3 and 0.5 is a medium effect size and any r value 0.5 upwards is a large effect size.

Effect sizes were used in the research due to the overall findings being insignificant. Thus, effect sizes may have allowed for us to pick up any slight change of significance. It is important to remember that even though a large effect size may illustrate a change, it is still statistically insignificant. For each of the categories below, the effect size, the r value is explored in more detail.

#### *10.2.2.1. Total scores*

##### *Internal A Scores*

As per the CBCL this refers to internalising behaviours such as withdrawn/depressed as well as anxious/depressed.

No statistically significant differences were found between the pre- and post-tests for both the control ( $p = 0.875$ ) and the experimental ( $p = 0.400$ ) groups.

Upon further analysis of the p value, the effect size for both the control group ( $r = 0.198$ ) and experimental groups ( $r = 0.280$ ) was found to be small.

This indicates that not only were the results statistically insignificant, but neither the presence nor absence of the EAP intervention had a notable effect on the scores for both the control and experimental groups.

##### *External B Scores*

As per the CBCL, this refers to externalising behaviours such as anger and aggressive behaviour.

Once again, no statistically significant difference was found between the pre- and post-test for both the control group ( $p = 0.833$ ), and the experimental group ( $p = 0.833$ ).

The effect size for the control group ( $r = 0.217$ ) and for the experimental group ( $r = 0.050$ ) was small.

This indicates that neither the presence nor absence of the EAP intervention had a notable impact on the scores for both the control and experimental groups.

#### *Total scores*

This refers to the total scores obtained (Internal A + External B = Total Scores).

A Wilcoxon Signed Rank Test revealed no statistically significant differences were found with regards to the overall syndrome scores for both the control ( $p = 0.255$ ) and the experimental group ( $p = 1$ ) after participation in EAP therapy.

Upon further analysis of the  $p$  scores, the effect size of the control group was small ( $r = 0.232$ ) and for the experimental group it was zero ( $r = 0.$ ).

As already mentioned, for findings to be considered statistically significant, the  $p$  value (Asymp. Sig. 2-tailed) should be less than or equal to 0.05. This was not the case for the 'Internal A Score', 'External B Score', or the 'Total Score'.

#### *10.2.2.2. Syndrome Scales*

For this section, the raw scores for each scale was used as there are no other scores to use for the analysis. This section was divided into nine different syndromes: Anxious/depressed, withdrawn/depressed, somatic complaints, social problems, thought problems, attention problems, rule-breaking behaviour, aggressive behaviour and other problems. The quantitative results are explained below per syndrome with regards to the overall analysis.

#### *Anxious/Depressed*

For this syndrome, there were no significant statistical differences found between the pre- and post-tests for both the control ( $p = 0.592$ ) and experimental group ( $p = 0.440$ ).

Further analysis of the  $p$  value illustrated that the control group had a small effect size ( $r = 0.109$ ) and the experimental group also had a small effect size ( $r = 0.182$ ).

This indicates that, neither the presence nor absence of EAP has an impact on the scores obtained, and the results are statistically insignificant.

#### *Withdrawn/Depressed*

Once again there were no statistical differences found between the pre- and post-test for both the control group ( $p = 0.964$ ) and the experimental group ( $p = 0.231$ ).

Both the control group ( $r = 0.009$ ) and the experimental group ( $r = 0.294$ ) had a small effect size.

This indicates that not only are the results statistically insignificant, but that neither the presence nor absence of the EAP intervention had an impact on the scores.

#### *Somatic complaints*

For this syndrome, no significant statistical differences were found between the pre- and post-tests for both the control group ( $p = 1$ ) and the experimental group ( $p = 0.866$ ).

The effect size for the control group was zero ( $r = 0$ ) whilst the effect size for the experimental group was small ( $r = 0.040$ ).

This indicates that the presence of the EAP intervention had a larger impact, although statistically insignificant, than no intervention on both the control and experiential groups.

#### *Social Problems*

With regards to social problems, there was also no statistically significant difference found between the pre- and post-test scores for the control group ( $p = 0.119$ ) and the experimental group ( $p = 0.341$ ).

The effect size was medium on the control group ( $r = 0.318$ ) and small on the experimental group ( $r = 0.225$ ).

This indicates that no EAP intervention had a slightly larger impact on the scores compared to an EAP intervention. However, this is still statistically insignificant.

#### *Thought problems*

With regards to thought problems, no statistical differences were found between the pre- and post-tests for both the control group ( $p = 0.838$ ) and the experimental group ( $p = 0.284$ ).

Further analysis reveals that the effect size was small for both the control group ( $r = 0.041$ ) and the experimental group ( $r = 0.252$ ).

This indicates that neither the presence nor absence of the EAP intervention had a notable effect on the scores for the control and experimental groups.

#### *Attention Problems*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.95$ ) and the experimental groups ( $p = 0.26$ ).

The control group had a small effect size ( $r = 0.024$ ) whilst the experimental group had a medium effect size ( $r = 0.376$ ).

This indicates that the presence of EAP had a larger impact on the scores on the attention problems syndrome scale than the individuals receiving no EAP. However, this is still statistically insignificant.

### *Rule breaking behaviour*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.082$ ) and the experimental group ( $p = 0.905$ ), however it is approaching statistical significance as it is close to 0.05

Furthermore, the effect size for the control group was medium ( $r = 0.355$ ), whilst the effect size of the experimental group was small ( $r = 0.028$ ).

This indicates that these scores are approaching statistical significance and may indicate that the use of no intervention almost had a statistically significant difference with regards to rule breaking behaviour. Although the results are not a statistical significance, the sample is very small and thus worthwhile noting.

### *Aggressive behaviour*

With regards to aggressive behaviour, no statistical significant differences were found between the pre- and post-tests for both the control group ( $p = 0.580$ ) and the experimental group ( $p = 0.866$ ).

In addition, further analysis revealed that the effect size was small for both the control group ( $r = 0.113$ ) and the experimental group ( $r = 0.040$ ).

This indicates that the results were statistically insignificant and that neither the presence nor the absence of the EAP intervention had a notable effect on the scores for the aggressive behaviour syndrome scale scores for both the control and the experimental group.

### *Other problems*

With regards to the other problems syndrome scale, once again, no statistically significant differences were found between the pre-and post-tests for both the control group ( $p = 0.514$ ) and the experimental group ( $p = 0.233$ ).

The effect size of the control group was small ( $r = 0.133$ ), whilst the effect size for the experimental group was medium ( $r = 0.281$ ).

Although this is not statistically significant it indicates the EAP intervention had a slightly larger impact on the scores than no intervention, on both the control and experimental groups.

The overall findings for this section indicate that none of the scores in this section were statistically significant between the pre- and post-tests for both the control and experimental groups. Therefore, this study found that EAP as an intervention did not improve CBCL scores when analyzed overall. This includes the youth, teacher, and parent CBCL protocols. However, it is important to note that the scores obtained on the rule – breaking behaviour syndrome were close to being statistically significant and important to note especially with such a small sample size.

10.2.2.3. Graphs for the overall analysis: Control group

The next section highlights the relevant graphs for the overall analysis (the parent, teacher, and youth CBCL protocols) for the control group.

10.2.2.3.1. Internal A, external B, and total scores

Below follows the graphs for the overall analysis of the control group with regards to the total scores.

Table 42

Descriptive Statistics for the Control Group: Overall Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Internal A T Score Pre	12	55.750	67.500	80.000
External B T Score Pre	12	53.000	64.000	66.000
Total T Score Syndrome Pre	12	56.750	65.500	76.000
Internal A T Score Post	12	59.500	64.500	76.250
External B T Score Post	12	57.250	65.000	68.000
Total T Score Syndrome Post	12	58.500	66.500	75.000

Table 43  
Ranks for the Control Group: Overall Analysis

		N	Mean Rank	Sum of Ranks
Internal A T Score Post Internal A T Score Pre	Negative Ranks	6	6.17	37.00
	Positive Ranks	6	6.83	41.00
	Ties	0		
	Total	12		
External B T Score Post External B T Score Pre	Negative Ranks	3	8.50	25.50
	Positive Ranks	9	5.83	52.50
	Ties	0		
	Total	12		
Total T Score Syndrome Post Total T Score Syndrome Pre	Negative Ranks	4	6.13	24.50
	Positive Ranks	8	6.69	53.50
	Ties	0		
	Total	12		

Table 44  
Test Statistics for the Control Group: Overall Analysis

	Internal A T Score Post Internal A T Score Pre	External B T Score Post External B T Score Pre	Total T Score Syndrome Post Total T Score Syndrome Pre
Z	-.157 <sup>b</sup>	-1.061 <sup>b</sup>	-1.139 <sup>b</sup>
Asymp. Sig. (2-tailed)	.875	.289	.255

a. Wilcoxon Signed Ranks Test.

10.2.2.3.2. Syndrome Scales (Anxious/depressed; withdrawn/depressed; somatic complaints; social problems)

Below follows the graphs for the overall analysis with regards to the syndrome scales.

Table 45

Descriptive Statistics for the Control Group: Overall Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Anxious/Depressed Pre	12	3.000	5.000	14.000
Withdrawn/Depressed Pre	12	3.250	7.500	11.750
Somatic Complaints Pre	12	1.000	5.500	11.250
Social Problems Pre	12	.500	3.000	11.000
Anxious/Depressed Post	12	3.000	6.000	15.750
Withdrawn/Depressed Post	12	5.000	6.000	10.250
Somatic Complaints Post	12	1.250	5.000	13.250
Social Problems Post	12	1.500	7.000	12.500

Table 46  
Ranks for the Control Group: Overall Analysis

		N	Mean Rank	Sum of Ranks
Anxious/Depressed Post Anxious/Depressed Pre	Negative Ranks	4	4.50	18.00
	Positive Ranks	5	5.40	27.00
	Ties	3		
	Total	12		
Withdrawn/Depressed Pre Withdrawn/Depressed Pre	Negative Ranks	5	6.50	32.50
	Positive Ranks	6	5.58	33.50
	Ties	1		
	Total	12		
Somatic Complaints Post Somatic Complaints Pre	Negative Ranks	5	6.60	33.00
	Positive Ranks	6	5.50	33.00
	Ties	1		
	Total	12		
Social Problems Post Social Problems Pre	Negative Ranks	4	3.88	15.50
	Positive Ranks	7	7.21	50.50
	Ties	1		
	Total	12		



Table 47  
 Test Statistics for the Control Group: Overall Analysis

	Anxious/Depressed Post Anxious/Depressed Pre	Withdrawn/ Depressed Pre Withdrawn/ Depressed Pre	Somatic Complaints Post Somatic Complaints Pre	Social Problems Post Social Problems Pre
Z	-.535 <sup>b</sup>	-.045 <sup>b</sup>	.000 <sup>c</sup>	-1.559 <sup>b</sup>
Asymp. Sig. (2-tailed)	.592	.964	1.000	.119

a. Wilcoxon Signed Ranks Test.

b. Based on negative ranks

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

10.2.2.3.3. Syndrome Scales (Thought problems, attention problems, rule breaking behaviour, aggressive behaviour, other problems)

Below follows the second set of tables for the overall analysis, syndrome scales.

Table 48

Descriptive Statistics for the Control Group: Overall Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Thought Problems Pre	12	1.000	5.000	13.000
Attention Problems Pre	12	3.000	6.000	9.000
Rule-Breaking Behaviour Pre	12	2.250	4.000	9.500
Aggressive Behaviour Pre	12	4.000	11.000	13.500
Other Problems Pre	12	3.500	7.000	11.750
Thought Problems Post	12	2.000	5.000	10.250
Attention Problems Post	12	4.250	6.500	8.000
Rule-Breaking Behaviour Post	12	4.250	7.500	12.750
Aggressive Behaviour Post	12	6.000	9.000	14.750
Other Problems Post	12	4.250	6.500	13.750

Table 49  
Ranks for the Control Group: Overall Analysis

		N	Mean Rank	Sum of Ranks
Thought Problems Post Thought Problems Pre	Negative Ranks	4	6.38	25.50
	Positive Ranks	6	4.92	29.50
	Ties	2		
	Total	12		
Attention Problems Post Attention Problems Pre	Negative Ranks	5	4.30	21.50
	Positive Ranks	4	5.88	23.50
	Ties	3		
	Total	12		
Rule-Breaking Behaviour Pre	Negative Ranks	3	5.67	17.00
	Positive Ranks	9	6.78	61.00
	Ties	0		
	Total	12		
Rule-Breaking Behaviour Post	Positive Ranks	6	7.67	46.00
	Ties	0		
	Total	12		
	Positive Ranks	5	5.60	28.00
Ties	3			
Total	12			

Table 50  
 Test Statistics for the Control Group: Overall Analysis

	Thought Problems Post Thought Problems Pre	Attention Problems Post Attention Problems Pre	Rule-Breaking Behaviour Pre Rule-Breaking Behaviour Post	Aggressive Behaviour Post Aggressive Behaviour Pre	Other Problems Post Other Problems Pre
Z	-.205 <sup>b</sup>	-.119 <sup>b</sup>	-1.739 <sup>b</sup>	-.553 <sup>b</sup>	-.653 <sup>b</sup>
Asymp. Sig. (2-tailed)	.838	.905	.082	.580	.514

a. Wilcoxon Signed Ranks Test.

b. Based on negative ranks.

10.2.2.3.4. Graphs for the overall analysis: Experimental group

Below follow all the graphs for the overall analysis (parent, teacher, and youth CBCL protocols) for the experimental group.

10.2.2.3.5. Internal A, External B, and overall Scores

Table 51  
 Descriptive Statistics for the Experimental Group: Overall Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Internal A T Score Pre	9	55.500	70.000	76.500
External B T Score Pre	9	58.000	67.000	72.500
Total T Score Syndrome Pre	9	63.000	70.000	73.500
Internal A T Score Post	9	56.000	62.000	72.000
External B T Score Post	9	57.000	64.000	73.500
Total T Score Syndrome Post	9	59.500	67.000	77.000

Table 52

Ranks for the Experimental Group: Overall Analysis

		N	Mean Rank	Sum of Ranks
Internal A T Score Post Internal A T Score Pre	Negative Ranks	6	4.00	24.00
	Positive Ranks	2	6.00	12.00
	Ties	1		
	Total	9		
External B T Score Post External B T Score Pre	Negative Ranks	3	5.50	16.50
	Positive Ranks	5	3.90	19.50
	Ties	1		
	Total	9		
Total T Score Syndrome Post Total T Score Syndrome Pre	Negative Ranks	5	4.50	22.50
	Positive Ranks	4	5.63	22.50
	Ties	0		
	Total	9		

Table 53

Test Statistics for the Experimental Group: Overall Analysis

	Internal A T Score Post Internal A T Score Pre	External B T Score Post External B T Score Pre	Total T Score Syndrome Post Total T Score Syndrome Pre
Z	-.841 <sup>b</sup>	-.211 <sup>c</sup>	.000 <sup>d</sup>
Asymp. Sig. (2-tailed)	.400	.833	1.000

a. Wilcoxon Signed Ranks Test.

b. Based on positive ranks.

c. Based on negative ranks.

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

10.2.2.3.6. Syndrome Scales (Anxious/depressed; withdrawn/depressed; somatic complaints; social problems)

Below follows the tables for the syndrome scales of the overall analysis for the experimental group.

Table 54

Descriptive Statistics for the Experimental Group: Overall Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Anxious/Depressed Pre	9	2.000	9.000	11.500
Withdrawn/Depressed Pre	9	4.500	6.000	10.500
Somatic Complaints Pre	9	.000	2.000	15.500
Social Problems Pre	9	5.500	7.000	9.500
Anxious/Depressed Post	9	3.500	5.000	10.000
Withdrawn/Depressed Post	9	2.000	4.000	8.000
Somatic Complaints Post	9	1.500	3.000	8.000
Social Problems Post	9	4.000	9.000	14.000

Table 55  
Ranks for the Experimental Group: Overall Analysis

		N	Mean Rank	Sum of Ranks
Anxious/Depressed Post - Anxious/Depressed Pre	Negative Ranks	6	4.83	29.00
	Positive Ranks	3	5.33	16.00
	Ties	0		
	Total	9		
Withdrawn/Depressed Pre - Withdrawn/Depressed Post	Negative Ranks	7	4.71	33.00
	Positive Ranks	2	6.00	12.00
	Ties	0		
	Total	9		
Somatic Complaints Post - Somatic Complaints Pre	Negative Ranks	3	5.00	15.00
	Positive Ranks	4	3.25	13.00
	Ties	2		
	Total	9		
Social Problems Post - Social Problems Pre	Negative Ranks	3	4.83	14.50
	Positive Ranks	6	5.08	30.50
	Ties	0		
	Total	9		

Table 56  
Test Statistics for the Experimental Group: Overall Analysis

	Anxious/Depressed Post - Anxious/Depressed Pre	Withdrawn/Depressed Pre - Withdrawn/Depressed Pre	Somatic Complaints Post - Somatic Complaints Pre	Social Problems Post - Social Problems Pre
Z	-.771 <sup>b</sup>	-1.246 <sup>b</sup>	-.169 <sup>b</sup>	-.953 <sup>c</sup>
Asymp. Sig. (2-tailed)	.440	.213	.866	.341

a. Wilcoxon Signed Ranks Test.

b. Based on positive ranks.

c. Based on negative ranks.

10.2.2.3.7. Syndrome Scales (Thought problems, attention problems, rule breaking behaviour, aggressive behaviour, other problems)

Below follow more tables for the analysis of the syndrome scales.

Table 57

Descriptive Statistics for the Experimental Group: Overall Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Thought Problems Pre	9	1.000	4.000	7.000
Attention Problems Pre	9	4.500	7.000	13.500
Rule-Breaking Behaviour Pre	9	4.000	8.000	13.500
Aggressive Behaviour Pre	9	8.500	12.000	20.000
Other Problems Pre	9	4.000	6.000	13.500
Thought Problems Post	9	1.500	5.000	10.500
Attention Problems Post	9	4.500	6.000	16.000
Rule-Breaking Behaviour Post	9	5.000	7.000	11.000
Aggressive Behaviour Post	9	4.500	11.000	19.500
Other Problems Post	9	3.000	5.000	7.000



Table 58

Ranks for the Experimental Group: Overall Analysis

		N	Mean Rank	Sum of Ranks
Thought Problems Post	Negative Ranks	3	4.50	13.50
Thought Problems Pre	Positive Ranks	6	5.25	31.50
	Ties	0		
	Total	9		
Attention Problems Post	Negative Ranks	2	5.00	10.00
Attention Problems Pre	Positive Ranks	6	4.33	26.00
	Ties	1		
	Total	9		
Rule-Breaking Behaviour Pre	Negative Ranks	4	5.88	23.50
Rule-Breaking Behaviour Post	Positive Ranks	5	4.30	21.50
	Ties	0		
	Total	9		
Aggressive Behaviour Post	Negative Ranks	2	6.50	13.00
Aggressive Behaviour Pre	Positive Ranks	5	3.00	15.00
	Ties	2		
	Total	9		
Other Problems Post	Negative Ranks	4	5.25	21.00
Other Problems Pre	Positive Ranks	3	2.33	7.00
	Ties	2		
	Total	9		

Table 59

Test Statistics for the Experimental Group: Overall Analysis

	Thought Problems Post Thought Problems Pre	Attention Problems Post Attention Problems Pre	Rule-Breaking Behaviour Pre Rule-Breaking Behaviour Post	Aggressive Behaviour Post Aggressive Behaviour Pre	Other Problems Post Other Problems Pre
Z	-1.071 <sup>b</sup>	-1.127 <sup>b</sup>	-.119 <sup>c</sup>	-.169 <sup>b</sup>	-1.192 <sup>c</sup>
Asymp. Sig. (2-tailed)	.284	.260	.905	.866	.233

a. Wilcoxon Signed Ranks Test.

b. Based on negative ranks.

c. Based on positive ranks.

The next section focuses on the analysis of the CBCL per the parent and teacher protocols.

### 10.2.3. Parent and teacher analysis

The findings for this section are based on a combination of both the CBCL protocols filled out by the parents as well as the teachers. Both groups were too small to analyse separately and thus to obtain better results were analysed together.

This section aims to provide an understanding of whether the parents and teachers noticed/reported any differences in the youth's behaviour for both the control and experiential groups during the pre- and post-tests.

#### 10.2.3.1. Total scores

For this section, the T-Scores (as indicated on the CBCL) for each of these variables were used and not the raw scores.

#### Internal A Scores

No statistical significant differences were found between the pre- and post-tests for both the control group ( $p = 0.463$ ) and the experimental group ( $p = 0.465$ ).

The effect size for the control group was small ( $r = 0.212$ ) as well as for the experimental group ( $r = 0.258$ ).

This indicates that not only were the results statistically insignificant, neither the presence nor absence of the EAP intervention had a noticeable effect on the scores for the control or experimental group.

#### *External B Scores*

No statistically significant differences were found between the pre-and post-tests for both the control group ( $p = 0.833$ ) and the experimental group ( $p = 0.593$ ).

Further analysis revealed that the effect size of the control group ( $r = 0.061$ ) and the experimental group ( $r = 0.189$ ) were both small.

This means that not only were the results statistically insignificant, neither the presence nor absence of the EAP intervention had a noticeable effect on the scores for the control or experimental group.

#### *Total Scores*

Once again, no statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.600$ ), and the experimental group ( $p = 0.273$ ).

The control group had a small effect size ( $r = 0.151$ ) while the experimental group had a medium effect size ( $r = 0.387$ ).

This indicates that the presence of EAP had a notable impact on scores compared to no EAP. Yet this is still statistically insignificant.

#### *10.2.3.2. Syndrome Scales*

For this section the raw scores for each group was used and not the T-scores as used in the previous section. This is because only the “Internal A”, “External A” and “Total score” sections of the CBCL have T scores.

#### *Anxious/Depressed*

With regards to the anxious/depressed scales no statistically significant differences were found between the pre-and post-tests for both the control group ( $p = 0.680$ ) and the experimental group ( $p = 0.581$ ).

The effect size was small for both the control group ( $r = 0.119$ ) and the experimental group ( $r = 0.195$ ).

This means that not only were the results statistically insignificant, neither the presence nor absence of the EAP intervention had a notable effect on the scores for the control or experimental group.

#### *Withdrawn/Depressed*

On this scale, no statistical significant differences were found between the pre- and post-tests for the control group ( $p = 0.916$ ) and the experimental group ( $p = 0.715$ ).

The control group had a small effect size ( $r = 0.030$ ) as well as the experimental group ( $r = 0.129$ ).

This means that not only were the results statistically insignificant, neither the presence nor absence of the EAP intervention had a notable effect on the scores for the control or experimental group.

#### *Somatic Complaints*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.416$ ) and the experimental group ( $p = 0.273$ ).

Further analysis of the  $p$  value indicates that the effect size was small for the control group ( $r = 0.235$ ) and medium for experimental group ( $r = 0.387$ ).

This indicates that the presence of the EAP intervention had a notable impact on the scores compared to no EAP. However, it is important to note, that this is not a statistically significant difference.

#### *Social Problems*

Close to statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.279$ ) and the experimental group ( $p = 0.063$ ).

Further analysis showed that the control group had a medium effect size ( $r = 0.313$ ) while the experimental group had a large effect size ( $r = 0.657$ ).

This indicates that the presence of EAP had a notable impact on scores compared to no EAP. Yet this is still not quite statistically significant, although due to the small sample size, might be important to note.

#### *Thought Problems*

No statistically significant differences were found between the pre-and post-tests for both the control group ( $p = 0.686$ ) and the experimental group ( $p = 0.144$ ).

The control group had a small effect size ( $r = 0.117$ ) while the experimental group had a large effect size ( $r = 0.517$ ).

This indicates that the presence of EAP had a prominent impact on scores compared to no EAP. Yet this is still statistically insignificant.

#### *Attention Problems*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.786$ ) and the experimental group ( $p = 0.109$ ).

Furthermore, the control group had a small effect size ( $r = 0.078$ ) while the experimental group had a large effect size ( $r = 0.567$ ).

This indicates that the presence of EAP had a prominent impact on scores compared to no EAP. Yet this is still statistically insignificant.

#### *Rule Breaking Behaviour*

No statistical significant differences were found between the pre-and post-tests for both the control group ( $p = 0.485$ ) and the experimental group ( $p = 0.144$ ).

Further analysis revealed that the control group had a small effect size ( $r = 0.214$ ), while the experimental group had a large effect size ( $r = 0.517$ ).

This indicates that the presence of EAP had a larger impact on scores compared to no EAP. Yet this is still statistically insignificant.

#### *Aggressive Behaviour*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.600$ ) and the experimental group ( $p = 0.713$ ).

The control group had a small effect size ( $r = 0.151$ ) as well as the experimental group ( $r = 0.130$ ).

This indicates that not only were the results statistically insignificant, neither the presence nor absence of the EAP intervention had a noteworthy effect on the scores for the control or experimental group with regards to aggressive behaviour.

#### *Other Problems*

No statistical significant differences were found between the pre-and post-tests for both the control group ( $p = 1$ ) and the experimental group ( $p = 1$ ).

The control group had no effect size ( $r = 0$ ) as well as the experimental group ( $r = 0$ ).

This means that not only were the results statistically insignificant, neither the presence nor absence of the EAP intervention influenced the scores for the control or experimental group.

The overall findings for this section, per the Wilcoxon Rank Test, indicate that NONE of the scores in this section were statistically significant between the pre- and post- tests for both the control and experimental groups. However, it is important to note that the scores obtained on the Social Problems scale was borderline/approaching statistical significance.

Therefore, this study found that EAP as an intervention did not improve the CBCL scores for the parents and teachers.

### 10.2.3.3. Graphs for the parent and teacher analysis: Control group

Below follow the graphs for the parent and teacher analysis for the control group.

#### 10.2.3.3.1. Overall Scores (Internal A, External B and Total)

Table 60

Descriptive Statistics for the Control Group: Parent and Teacher Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Internal A T Score Pre	6	52.500	60.000	79.000
External B T Score Pre	6	48.250	64.000	71.250
Total T Score Syndrome Pre	6	49.250	63.500	72.000
Internal A T Score Post	6	55.500	61.500	66.250
External B T Score Post	6	56.250	62.000	67.250
Total T Score Syndrome Post	6	58.000	64.500	67.250

Table 61  
Ranks for the Control Group: Parent and Teacher Analysis

		N	Mean Rank	Sum of Ranks
Internal A T Score Post Internal A T Score Pre	Negative Ranks	4	3.50	14.00
	Positive Ranks	2	3.50	7.00
	Ties	0		
	Total	6		
External B T Score Post External B T Score Pre	Negative Ranks	2	4.75	9.50
	Positive Ranks	4	2.88	11.50
	Ties	0		
	Total	6		
Total T Score Syndrome Post Total T Score Syndrome Pre	Negative Ranks	2	4.00	8.00
	Positive Ranks	4	3.25	13.00
	Ties	0		
	Total	6		

Table 62  
Test Statistics for the Control Group: Parent and Teacher Analysis

	Internal A T Score Post Internal A T Score Pre	External B T Score Post External B T Score Pre	Total T Score Syndrome Post Total T Score Syndrome Pre
Z	-.734 <sup>b</sup>	-.211 <sup>c</sup>	-.524 <sup>c</sup>
Asymp. Sig. (2-tailed)	.463	.833	.600

- a. Wilcoxon Signed Ranks Test.  
b. Based on positive ranks.  
c. Based on negative ranks.

10.2.3.3.2. Syndrome Scales - Anxious/depressed; withdrawn/depressed; somatic complaints; social problems

Below follow the tables for the results obtained on the syndrome scales for the control group.

Table 63

Descriptive Statistics for the Control Group: Parent and Teacher Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Anxious/Depressed Pre	6	1.500	3.000	8.750
Withdrawn/Depressed Pre	6	2.500	5.500	10.000
Somatic Complaints Pre	6	.000	4.000	8.000
Social Problems Pre	6	.000	1.500	6.750
Anxious/Depressed Post	6	2.000	3.000	5.500
Withdrawn/Depressed Post	6	3.750	5.500	7.250
Somatic Complaints Post	6	.000	2.500	6.000
Social Problems Post	6	2.500	5.500	8.000



Table 64  
Ranks for the Control Group: Parent and Teacher Analysis

		N	Mean Rank	Sum of Ranks
Anxious/Depressed Post	Negative Ranks	3	3.00	9.00
Anxious/Depressed Pre	Positive Ranks	2	3.00	6.00
	Ties	1		
	Total	6		
Withdrawn/Depressed Pre	Negative Ranks	3	3.67	11.00
Withdrawn/Depressed Post	Positive Ranks	3	3.33	10.00
	Ties	0		
	Total	6		
Somatic Complaints Post	Negative Ranks	3	3.50	10.50
Somatic Complaints Pre	Positive Ranks	2	2.25	4.50
	Ties	1		
	Total	6		
Social Problems Post	Negative Ranks	1	3.50	3.50
Social Problems Pre	Positive Ranks	4	2.88	11.50
	Ties	1		
	Total	6		

Table 65  
Test Statistics for the Control Group: Parent and Teacher Analysis

	Anxious/Depressed Post Anxious/Depressed Pre	Withdrawn/Depressed Pre Withdrawn/Depressed Pre	Somatic Complaints Post Somatic Complaints Pre	Social Problems Post Social Problems Pre
Z	-.412 <sup>b</sup>	-.105 <sup>b</sup>	-.813 <sup>b</sup>	-1.084 <sup>c</sup>
Asymp. Sig. (2-tailed)	.680	.916	.416	.279

- a. Wilcoxon Signed Ranks Test.  
b. Based on positive ranks.  
c. Based on negative ranks.

10.2.3.3.3. Syndrome Scales (Thought problems, attention problems, rule-breaking behaviour, aggressive behaviour, other problems)

Below follow the graphs for the second set of syndrome scales.

Table 66

Descriptive Statistics for the Control Group: Parent and Teacher Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Thought Problems Pre	6	.750	3.000	11.250
Attention Problems Pre	6	2.750	7.000	10.250
Rule-Breaking Behaviour Post	6	2.500	6.000	14.000
Aggressive Behaviour Pre	6	2.250	11.000	16.250
Other Problems Pre	6	2.750	5.500	11.250
Thought Problems Post	6	1.750	3.500	5.250
Attention Problems Post	6	3.750	6.000	8.250
Rule-Breaking Behaviour Pre	6	3.750	5.500	10.000
Aggressive Behaviour Post	6	5.000	7.500	12.250
Other Problems Post	6	3.250	6.000	7.750

Table 67

Ranks for the Control Group: Parent and Teacher Analysis

		N	Mean Rank	Sum of Ranks
Thought Problems Post Thought Problems Pre	Negative Ranks	2	4.50	9.00
	Positive Ranks	3	2.00	6.00
	Ties	1		
	Total	6		
Attention Problems Post Attention Problems Pre	Negative Ranks	3	2.83	8.50
	Positive Ranks	2	3.25	6.50
	Ties	1		
	Total	6		
Rule-Breaking Behaviour Pre Rule-Breaking Behaviour Post	Negative Ranks	2	3.50	7.00
	Positive Ranks	4	3.50	14.00
	Ties	0		
	Total	6		
Aggressive Behaviour Post Aggressive Behaviour Pre	Negative Ranks	4	3.25	13.00
	Positive Ranks	2	4.00	8.00
	Ties	0		
	Total	6		
Other Problems Post Other Problems Pre	Negative Ranks	2	2.50	5.00
	Positive Ranks	2	2.50	5.00
	Ties	2		
	Total	6		

Table 68

Test Statistics for the Control Group: Parent and Teacher Analysis

	Thought Problems Post - Thought Problems Pre	Attention Problems Post - Attention Problems Pre	Rule-Breaking Behaviour Pre - Rule-Breaking Behaviour Post	Aggressive Behaviour Post - Aggressive Behaviour Pre	Other Problems Post - Other Problems Pre
Z	-.405 <sup>b</sup>	-.271 <sup>b</sup>	-.742 <sup>c</sup>	-.524 <sup>b</sup>	.000 <sup>d</sup>
Asymp. Sig. (2-tailed)	.686	.786	.458	.600	1.000

a. Wilcoxon Signed Ranks Test.

b. Based on positive ranks.

c. Based on negative ranks.

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

10.2.3.4. Graphs for the parent and teacher analysis: Experimental group

Below follow the graphs for the CBCL protocols completed by the parents and teachers for the experimental group.

10.2.3.4.1. Overall Scores (Internal A, External B and Total)

Table 69

Descriptive Statistics for the Experimental Group: Parent and Teacher Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Internal A T Score Pre	4	49.500	55.500	66.750
External B T Score Pre	4	61.500	72.500	79.750
Total T Score Syndrome Pre	4	59.750	67.500	74.500
Internal A T Score Post	4	52.500	61.000	73.250
External B T Score Post	4	59.500	68.000	79.500
Total T Score Syndrome Post	4	61.500	70.500	86.250

Table 70

Ranks for the Experimental Group: Parent and Teacher Analysis

		N	Mean Rank	Sum of Ranks
Internal A T Score Post Internal A T Score Pre	Negative Ranks	2	1.50	3.00
	Positive Ranks	2	3.50	7.00
	Ties	0		
	Total	4		
External B T Score Post External B T Score Pre	Negative Ranks	2	2.00	4.00
	Positive Ranks	1	2.00	2.00
	Ties	1		
	Total	4		
Total T Score Syndrome Post Total T Score Syndrome Pre	Negative Ranks	1	2.00	2.00
	Positive Ranks	3	2.67	8.00
	Ties	0		
	Total	4		

Table 71

Test Statistics for the Experimental Group: Parent and Teacher Analysis

	Internal A T Score Post Internal A T Score Pre	External B T Score Post External B T Score Pre	Total T Score Syndrome Post Total T Score Syndrome Pre
Z	-.730 <sup>b</sup>	-.535 <sup>c</sup>	-1.095 <sup>b</sup>
Asymp. Sig. (2-tailed)	.465	.593	.273

a. Wilcoxon Signed Ranks Test.

b. Based on negative ranks.

c. Based on positive ranks.

10.2.3.4.2. Syndrome Scales (Anxious/depressed; withdrawn/depressed; somatic complaints; social problems)

Below follow the tables for the analysis of the syndrome scales for the experimental group.

Table 72

*Descriptive Statistics for the Experimental Group: Parent and Teacher Analysis*

	N	Percentiles		
		25th	50th (Median)	75th
Anxious/Depressed Pre	4	1.250	2.000	6.500
Withdrawn/Depressed Pre	4	1.750	5.000	10.500
Somatic Complaints Pre	4	.000	.000	1.500
Social Problems Pre	4	3.000	6.000	8.250
Anxious/Depressed Post	4	1.750	4.500	11.750
Withdrawn/Depressed Post	4	2.500	6.000	10.250
Somatic Complaints Post	4	.250	2.000	5.250
Social Problems Post	4	6.000	12.500	18.250

Table 73

Ranks for the Experimental Group: Parent and Teacher Analysis

		N	Mean Rank	Sum of Ranks
Anxious/Depressed Post - Anxious/Depressed Pre	Negative Ranks	2	1.75	3.50
	Positive Ranks	2	3.25	6.50
	Ties	0		
	Total	4		
Withdrawn/Depressed Pre - Withdrawn/Depressed Post	Negative Ranks	2	2.00	4.00
	Positive Ranks	2	3.00	6.00
	Ties	0		
	Total	4		
Somatic Complaints Post - Somatic Complaints Pre	Negative Ranks	1	2.00	2.00
	Positive Ranks	3	2.67	8.00
	Ties	0		
	Total	4		
Social Problems Post - Social Problems Pre	Negative Ranks	0	.00	.00
	Positive Ranks	4	2.50	10.00
	Ties	0		
	Total	4		

Table 74

Test Statistics for the Experimental Group: Parent and Teacher Analysis

	Anxious/Depressed Post Anxious/Depressed Pre	Withdrawn/ Depressed Pre - Withdrawn/ Depressed Pre	Somatic Complain ts Post - Somatic Complain ts Pre	Social Problems Post - Social Problems Pre
Z	-.552 <sup>b</sup>	-.365 <sup>b</sup>	-1.095 <sup>b</sup>	-1.857 <sup>b</sup>
Asymp. Sig. (2-tailed)	.581	.715	.273	.063

a. Wilcoxon Signed Ranks Test.

b. Based on negative ranks.



10.2.3.4.3. Syndrome scale (Thought problems, attention problems, rule-breaking behaviour, aggressive behaviour, other problems)

Below follows the second set of tables for the syndrome scales analysis.

Table 75

*Descriptive Statistics for the Experimental Group: Parent and Teacher Analysis*

	N	Percentiles		
		25th	50th (Median)	75th
Thought Problems Pre	4	.250	1.000	4.750
Attention Problems Pre	4	7.500	13.500	16.500
Rule-Breaking Behaviour Post	4	6.750	12.500	16.750
Aggressive Behaviour Pre	4	10.250	20.000	27.500
Other Problems Pre	4	2.000	5.000	6.500
Thought Problems Post	4	.500	6.500	13.250
Attention Problems Post	4	7.750	16.000	19.750
Rule-Breaking Behaviour Pre	4	7.000	7.000	12.250
Aggressive Behaviour Post	4	5.250	18.000	31.500
Other Problems Post	4	3.000	4.000	6.500

Table 76

Ranks for the Experimental Group: Parent and Teacher Analysis

		N	Mean Rank	Sum of Ranks
Thought Problems Post Thought Problems Pre	Negative Ranks	1	1.00	1.00
	Positive Ranks	3	3.00	9.00
	Ties	0		
	Total	4		
Attention Problems Post Attention Problems Pre	Negative Ranks	0	.00	.00
	Positive Ranks	3	2.00	6.00
	Ties	1		
	Total	4		
Rule-Breaking Behaviour Pre Rule-Breaking Behaviour Post	Negative Ranks	3	3.00	9.00
	Positive Ranks	1	1.00	1.00
	Ties	0		
	Total	4		
Aggressive Behaviour Post Aggressive Behaviour Pre	Negative Ranks	1	4.00	4.00
	Positive Ranks	3	2.00	6.00
	Ties	0		
	Total	4		
Other Problems Post Other Problems Pre	Negative Ranks	1	1.50	1.50
	Positive Ranks	1	1.50	1.50
	Ties	2		
	Total	4		

Table 77

Test Statistics of the Experimental Group: Parent and Teacher Analysis

	Thought Problems Post Thought Problems Pre	Attention Problems Post Attention Problems Pre	Rule Breaking Behaviour Pre Rule Breaking Behaviour Post	Aggressive Behaviour Post Aggressive Behaviour Pre
Z	-1.461 <sup>b</sup>	-1.604 <sup>b</sup>	-1.461 <sup>c</sup>	-.368
Asymp. Sig. (2 – Tailed)	.144	.109	.144	.713

a. Wilcoxon Signed Ranks Test.

b. Based on negative ranks.

c. Based on positive ranks.

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

#### 10.2.4. Youth analysis

The results in this section are based on the CBCL protocols filled out by the youth. The aim of this section is to provide an understanding into whether the youth thought that there were any differences in their behaviour during the pre- and post-test for the control group, that received no intervention, and the experimental group that received intervention in the form of the EAP sessions.

##### 10.2.4.1. Total scores

For this section the T-scores for each group was used.

##### Internal A Scores

Close to statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.249$ ) and the experimental group ( $p = 0.068$ ).

Further analysis of the  $p$  value revealed that the effect size for the control group was medium ( $r = 0.333$ ) whilst it was large for the experimental group ( $r = 0.577$ ).

This indicates that the presence of EAP had a larger impact on scores compared to no intervention with EAP. However, it is important to note that this is still statistically insignificant

### *External B Scores*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.249$ ) and the experimental group ( $p = 0.498$ ).

Further analysis revealed that the effect size of the control group was medium ( $r = 0.333$ ) and small for the experimental group ( $r = 0.214$ ).

This indicates that the participant's that received no EAP had a larger impact on scores than the EAP intervention. However, this is statistically insignificant.

### *Total Scores*

No statistical significant differences were found between the pre- and post-tests for both the control group ( $p = 0.207$ ) and the experimental group ( $p = 0.279$ ).

Furthermore, the control group had a large effect size ( $r = 0.364$ ) whilst the experimental group had a medium effect size ( $r = 0.343$ ).

This indicates that no EAP had a larger impact on scores compared to the EAP intervention. Yet this is still statistically insignificant.

#### *10.2.4.2. Syndrome Scales*

For this section the raw scores for each group was used as previously discussed.

### *Anxious/Depressed*

No statistically significant differences were found between the pre- and post- tests for both the control group ( $p = 0.141$ ) and the experimental group ( $p = 0.176$ ).

The effect size was medium for both the control group ( $r = 0.364$ ) and the experimental group ( $r = 0.428$ ).

These results indicate that both the presence or absence of the EAP intervention had a prominent effect on the scores of the control and experimental group with regards to the anxious/ depressed syndromes, however it was still not statistically significant. This could indicate that the difference in scores between pre- and post-test for both control and experimental groups could be related to another unknown variable.

### *Withdrawn/Depressed*

No statistical significant differences were found between the pre- and post-tests for the control group ( $p = 0.272$ ). However, an important finding to note is that a statistically significant difference was found between the pre- and post-test for the experimental group ( $p = 0.042$ ). This indicates that the

presence of EAP intervention has a statistically significant impact on the scores on the withdrawn/depressed syndrome (it was helpful/it initiated a change).

Further analysis of the p value indicated that the control group had a small effect size ( $r = 0.079$ ) whilst the experimental group had a large effect size ( $r = 0.643$ ).

These results indicate that the presence of EAP had a prominent impact on scores compared to no EAP, with statistically significant scores with regards to the withdrawn/depressed syndromes.

### *Somatic Complaints*

With regards to the somatic complaints syndrome scale no statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.293$ ) and the experimental group ( $p = 0.285$ ).

The effect size was medium for both the control group ( $r = 0.303$ ) and the experimental group ( $r = 0.338$ ).

This means that not only were the results statistically insignificant, neither the presence nor absence of the EAP intervention had a noteworthy effect on the scores for the control or experimental group. This could possibly indicate that the difference in scores between pre- and post-test for both control and experimental groups could be related to another unknown variable.

### *Social Problems*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.344$ ) and the experimental group ( $p = 0.588$ ).

The control group ( $r = 0.270$ ) and the experimental group had a small effect size ( $r = 0.171$ ).

This indicates that neither the presence nor absence of EAP influenced the scores for the control and experimental group.

### *Thought Problems*

With regards to the thought problems syndrome scale, no statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.416$ ) and the experimental group ( $p = 1$ ).

Further analysis revealed that the control group had a small effect size ( $r = 0.235$ ) and the experimental group had no effect size ( $r = 0$ ).

This indicates that neither the presence nor absence of the EAP intervention had an impact on the scores.

### *Attention Problems*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.581$ ) and the experimental group ( $p = 0.786$ ).

The control group had a small effect size ( $r = 0.159$ ) as well as the experimental group ( $r = 0.086$ ).

This indicates that not only were the results statistically insignificant, neither the presence nor absence of the EAP intervention had a noteworthy effect on the scores for both the control or experimental group.

### *Rule Breaking Behaviour*

Close to statistically significant differences (borderline) were found between the pre- and post-tests for both the control group ( $p = 0.058$ ) and the experimental group ( $p = 0.225$ ).

Furthermore, the control group had a large effect size ( $r = 0.546$ ) and the experimental group had a medium effect size ( $r = 0.384$ ).

This indicates that no EAP intervention had a larger impact on the scores than the EAP intervention. However, it is important to note, that this is still not statistically significant.

### *Aggressive Behaviour:*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.236$ ), and the experimental group ( $p = 1$ ), with regards to the aggressive behaviour syndrome.

Further analysis of the  $p$  value indicated that the control group had a medium effect size ( $r = 0.343$ ) whilst the experimental group had no effect size ( $r = 0$ ).

This indicated that no EAP intervention had a larger impact on the scores compared to the presence of an EAP intervention. Yet this is still statistically insignificant.

### *Other Problems*

Once again, no statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.279$ ), and the experimental group ( $p = 0.225$ ).

Both the control group ( $r = 0.313$ ) and the experimental group had a medium effect size ( $r = 0.384$ ).

This indicates that neither the presence nor absence of the EAP intervention had a notable impact on the scores obtained for both the control and experimental groups. However, this is still statistically insignificant.

The overall findings for this section indicated that most the scores in this section were statistically insignificant between the pre- and post-tests for the control and experimental groups. Therefore, this study found that EAP as an intervention did not improve CBCL scores except for on the withdrawn/depressed scales for the experimental group. On the control group, no statistically significant differences were found.

As mentioned, a statistically significant difference was found between pre- and post-test for the experimental group ( $p = 0.042$ ) on the withdrawn/depressed scale. Therefore, per the youth group, the EAP intervention significantly improved their withdrawn/depressed scores.

#### 10.2.4.3. Graphs for the youth analysis: Control group

Below follow the graphs for the quantitative analysis of the CBCL protocols filled out by the youth for the control group.

##### 10.2.4.3.1. Overall Scores (Internal A, External B and Total)

Below follow the table for the statistical analysis.

Table 78

*Descriptive Statistics for the control group of the youth analysis*

	N	Percentiles		
		25th	50th (Median)	75th
Internal A T Score Pre	6	62.500	73.500	81.250
External B T Score Pre	6	57.000	63.000	67.250
Total T Score Syndrome Pre	6	58.250	69.500	77.000
Internal A T Score Post	6	61.750	75.500	87.500
External B T Score Post	6	55.500	68.000	85.250
Total T Score Syndrome Post	6	56.750	74.000	87.750

Table 79

Ranks for the control group of the youth analysis

		N	Mean Rank	Sum of Ranks
Internal A T Score Post Internal A T Score Pre	Negative Ranks	2	2.50	5.00
	Positive Ranks	4	4.00	16.00
	Ties	0		
	Total	6		
External B T Score Post External B T Score Pre	Negative Ranks	1	5.00	5.00
	Positive Ranks	5	3.20	16.00
	Ties	0		
	Total	6		
Total T Score Syndrome Post Total T Score Syndrome Pre	Negative Ranks	2	2.25	4.50
	Positive Ranks	4	4.13	16.50
	Ties	0		
	Total	6		

Table 80

Test Statistics for the control group of the youth analysis

	Internal A T Score Post Internal A T Score Pre	External B T Score Post External B T Score Pre	Total T Score Syndrome Post Total T Score Syndrome Pre
Z	-1.153 <sup>b</sup>	-1.153 <sup>b</sup>	-1.261 <sup>b</sup>
Asymp. Sig. (2-tailed)	.249	.249	.207

a. Wilcoxon Signed Ranks Test.

b. Based on negative ranks.



10.2.4.3.2. Syndrome Scales (Anxious/depressed; withdrawn/depressed; somatic complaints; social problems)

Below follow the tables for the syndrome scales of the youth analysis.

Table 81

Descriptive Statistics for the Control Group of the Youth Analysis: Syndrome Scales

	N	Percentiles		
		25th	50th (Median)	75th
Anxious/Depressed Pre	6	5.000	10.500	15.500
Withdrawn/Depressed Pre	6	3.750	9.500	12.250
Somatic Complaints Pre	6	3.750	9.000	13.500
Social Problems Pre	6	2.000	5.500	13.000
Anxious/Depressed Post	6	6.500	14.500	18.250
Withdrawn/Depressed Post	6	4.250	7.500	13.250
Somatic Complaints Post	6	3.250	12.500	15.500
Social Problems Post	6	1.000	10.500	15.500

Table 82

Ranks for the control group of the youth analysis: Syndrome scales

		N	Mean Rank	Sum of Ranks
Anxious/Depressed Post Anxious/Depressed Pre	Negative Ranks	1	1.00	1.00
	Positive Ranks	3	3.00	9.00
	Ties	2		
	Total	6		
Withdrawn/Depressed Pre Withdrawn/Depressed Prost	Negative Ranks	2	3.25	6.50
	Positive Ranks	3	2.83	8.50
	Ties	1		
	Total	6		
Somatic Complaints Post Somatic Complaints Pre	Negative Ranks	2	2.75	5.50
	Positive Ranks	4	3.88	15.50
	Ties	0		
	Total	6		
Social Problems Post Social Problems Pre	Negative Ranks	3	2.00	6.00
	Positive Ranks	3	5.00	15.00
	Ties	0		
	Total	6		

Table 83

Test Statistics for the control group of the youth analysis: Syndrome Scales

	Anxious/Depressed Post Anxious/Depressed Pre	Withdrawn/ Depressed Pre Withdrawn/ Depressed Pre	Somatic Complaints Post Somatic Complaints Pre	Social Problems Post Social Problems Pre
Z	-1.473 <sup>b</sup>	-.272 <sup>b</sup>	-1.051 <sup>b</sup>	-.946 <sup>b</sup>
Asymp. Sig. (2-tailed)	.141	.785	.293	.344

a. Wilcoxon Signed Ranks Test.

b. Based on negative ranks.

10.2.4.3.3. Syndrome scales (Thought problems, attention problems, rule breaking behaviour, aggressive behaviour, other problems)

Below follow the tables of the second set of syndrome scales.

Table 84

Descriptive Statistics of the Youth analysis for the control group: Syndrome Scales

	N	Percentiles		
		25th	50th (Median)	75th
Thought Problems Pre	6	1.750	7.500	14.000
Attention Problems Pre	6	3.000	6.000	9.250
Rule-Breaking Behaviour Pre	6	1.750	3.500	6.750
Aggressive Behaviour Pre	6	6.000	9.500	14.000
Other Problems Pre	6	6.750	9.500	12.250
Thought Problems Post	6	1.500	9.500	18.000
Attention Problems Post	6	4.000	8.000	9.250
Rule-Breaking Behaviour Post	6	3.750	11.000	21.750
Aggressive Behaviour Post	6	5.750	10.500	29.250
Other Problems Post	6	4.500	12.000	16.250

Table 85

Ranks for the Control Group of the Youth Analysis: Syndrome Scales

		N	Mean Rank	Sum of Ranks
Thought Problems Post Thought Problems Pre	Negative Ranks	2	2.25	4.50
	Positive Ranks	3	3.50	10.50
	Ties	1		
	Total	6		
Attention Problems Post Attention Problems Pre	Negative Ranks	2	1.75	3.50
	Positive Ranks	2	3.25	6.50
	Ties	2		
	Total	6		
Rule-Breaking Behaviour Pre Rule-Breaking Behaviour Post	Negative Ranks	1	1.50	1.50
	Positive Ranks	5	3.90	19.50
	Ties	0		
	Total	6		
Aggressive Behaviour Post Aggressive Behaviour Pre	Negative Ranks	2	2.50	5.00
	Positive Ranks	4	4.00	16.00
	Ties	0		
	Total	6		
Other Problems Post Other Problems Pre	Negative Ranks	2	1.75	3.50
	Positive Ranks	3	3.83	11.50
	Ties	1		
	Total	6		

Table 86

Test Statistics for the Control Group of the Youth Analysis: Syndrome Scales

	Thought Problems Post Thought Problems Pre	Attention Problems Post Attention Problems Pre	Rule-Breaking Behaviour Pre Rule-Breaking Behaviour Post	Aggressive Behaviour Post Aggressive Behaviour Pre	Other Problems Post Other Problems Pre
Z	-.813 <sup>b</sup>	-.552 <sup>b</sup>	-1.892 <sup>b</sup>	-1.186 <sup>b</sup>	-1.084 <sup>b</sup>
Asymp. Sig. (2-tailed)	.416	.581	.058	.236	.279

a. Wilcoxon Signed Ranks Test.

b. Based on negative ranks.

10.2.4.4. Graphs for the youth analysis: Experimental group

Below follow the graphs for the quantitative analysis of the CBCL protocols filled out by the youth for the group that participated in the EAP sessions, the experimental group.

10.2.4.4.1. Overall Scores (Internal A, External B and Total)

Table 87

Descriptive Statistics for the Experimental group of the Youth Analysis

	N	Percentiles		
		25th	50th (Median)	75th
Internal A T Score Pre	5	70.500	75.000	83.000
External B T Score Pre	5	56.000	63.000	68.000
Total T Score Syndrome Pre	5	65.000	70.000	76.000
Internal A T Score Post	5	56.000	67.000	72.000
External B T Score Post	5	55.000	64.000	69.500
Total T Score Syndrome Post	5	57.000	67.000	72.500

Table 88

Ranks of the Experimental Group of the Youth Analysis

		N	Mean Rank	Sum of Ranks
Internal A T Score Post Internal A T Score Pre	Negative Ranks	4	2.50	10.00
	Positive Ranks	0	.00	.00
	Ties	1		
	Total	5		
External B T Score Post External B T Score Pre	Negative Ranks	1	5.00	5.00
	Positive Ranks	4	2.50	10.00
	Ties	0		
	Total	5		
Total T Score Syndrome Post Total T Score Syndrome Pre	Negative Ranks	4	2.88	11.50
	Positive Ranks	1	3.50	3.50
	Ties	0		
	Total	5		

Table 89

Test Statistics of the Experimental Group of the Youth Analysis

	Internal A T Score Post Internal A T Score Pre	External B T Score Post External B T Score Pre	Total T Score Syndrome Post - Total T Score Syndrome Pre
Z	-1.826 <sup>b</sup>	-.677 <sup>c</sup>	-1.084 <sup>b</sup>
Asymp. Sig. (2-tailed)	.068	.498	.279

a. Wilcoxon Signed Ranks Test.

b. Based on positive ranks.

c. Based on negative ranks.

10.2.4.4.2. Syndrome Scales (Anxious/depressed; withdrawn/depressed; somatic complaints; social problems)

Below follow the tables for the scores for the experimental group's syndrome scales.

Table 90

Descriptive Statistics of the Experimental Group of the Youth Analysis: Syndrome Scales

	N	Percentiles		
		25th	50th (Median)	75th
Anxious/Depressed Pre	5	10.000	11.000	14.500
Withdrawn/Depressed Pre	5	5.000	7.000	10.500
Somatic Complaints Pre	5	3.000	15.000	17.000
Social Problems Pre	5	6.000	8.000	11.500
Anxious/Depressed Post	5	3.500	6.000	10.500
Withdrawn/Depressed Pre	5	1.500	4.000	6.000
Somatic Complaints Post	5	2.500	8.000	12.000
Social Problems Post	5	3.000	6.000	12.000

Table 91

Ranks of the Experimental Group of the Youth Analysis: Syndrome Scales

		N	Mean Rank	Sum of Ranks
Anxious/Depressed Post Anxious/Depressed Pre	Negative Ranks	4	3.13	12.50
	Positive Ranks	1	2.50	2.50
	Ties	0		
	Total	5		
Withdrawn/Depressed Pre Withdrawn/Depressed Pre	Negative Ranks	5	3.00	15.00
	Positive Ranks	0	.00	.00
	Ties	0		
	Total	5		
Somatic Complaints Post Somatic Complaints Pre	Negative Ranks	2	2.50	5.00
	Positive Ranks	1	1.00	1.00
	Ties	2		
	Total	5		
Social Problems Post Social Problems Pre	Negative Ranks	3	3.17	9.50
	Positive Ranks	2	2.75	5.50
	Ties	0		
	Total	5		



Table 92

Test Statistics of the Experimental Group of the Youth Analysis: Syndrome Scales

	Anxious/Depressed Post Anxious/Depressed Pre	Withdrawn/ Depressed Pre Withdrawn/ Depressed Pre	Somatic Complaints Post Somatic Complaints Pre	Social Problems Post Social Problems Pre
Z	-1.355 <sup>b</sup>	-2.032 <sup>b</sup>	-1.069 <sup>b</sup>	-.542 <sup>b</sup>
Asymp. Sig. (2-tailed)	.176	.042	.285	.588

a. Wilcoxon Signed Ranks Test.

b. Based on positive ranks.

10.2.4.4.3. Syndrome Scales (Thought problems, attention problems, rule breaking behaviour, aggressive behaviour, other problems)

Below follow the tables of the second set of syndrome scales.

Table 93

Descriptive Statistics of the Experimental Group of the Youth Analysis: Syndrome Scales

	N	Percentiles		
		25th	50th (Median)	75th
Thought Problems Pre	5	3.500	5.000	12.500
Attention Problems Pre	5	3.000	6.000	8.500
Rule-Breaking Behaviour Pre	5	1.500	7.000	11.000
Aggressive Behaviour Pre	5	7.500	11.000	13.000
Other Problems Pre	5	4.500	13.000	16.500
Thought Problems Post	5	3.000	5.000	9.500
Attention Problems Post	5	4.000	5.000	9.000
Rule-Breaking Behaviour Post	5	4.500	5.000	14.500
Aggressive Behaviour Post	5	4.500	11.000	13.000
Other Problems Post	5	3.500	7.000	8.500

Table 94

Ranks of the Experimental Group of the Youth Analysis: Syndrome Scales

		N	Mean Rank	Sum of Ranks
Thought Problems Post Thought Problems Pre	Negative Ranks	2	3.75	7.50
	Positive Ranks	3	2.50	7.50
	Ties	0		
	Total	5		
Attention Problems Post Attention Problems Pre	Negative Ranks	2	3.25	6.50
	Positive Ranks	3	2.83	8.50
	Ties	0		
	Total	5		
Rule-Breaking Behaviour Pre Rule-Breaking Behaviour Post	Negative Ranks	1	3.00	3.00
	Positive Ranks	4	3.00	12.00
	Ties	0		
	Total	5		
Aggressive Behaviour Post Aggressive Behaviour Pre	Negative Ranks	1	3.00	3.00
	Positive Ranks	2	1.50	3.00
	Ties	2		
	Total	5		
Other Problems Post Other Problems Pre	Negative Ranks	3	4.00	12.00
	Positive Ranks	2	1.50	3.00
	Ties	0		
	Total	5		

Table 95

Test Statistics of the Experimental Group of the Youth Analysis: Syndrome Scales

	Thought Problems Post Thought Problems Pre	Attention Problems Post Attention Problems Pre	Rule-Breaking Behaviour Pre Rule-Breaking Behaviour Post	Aggressive Behaviour Post Aggressive Behaviour Pre	Other Problems Post Other Problems Pre
Z	.000 <sup>b</sup>	-.271 <sup>c</sup>	-1.214 <sup>c</sup>	.000 <sup>b</sup>	-1.214 <sup>d</sup>
Asymp. Sig. (2-tailed)	1.000	.786	.225	1.000	.225

a. Wilcoxon Signed Ranks Test.

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

c. Based on negative ranks.

d. Based on positive ranks.

The next section focuses on the quantitative analysis of the MMPI-A.

### 10.3. Analysis of the Minnesota Multiphasic Personality Inventory – Adolescent (MMPI-A)

For this section the analysis of the MMPI-A will be discussed. The analysis is based on the MMPI-A's as filled out by the youth. The teachers and parents were not involved in this assessment procedure as the MMPI-A is considered more of a self-report questionnaire. The T-scores were used for the analysis of the data in this section as T-scores can provide more meaningful information when available, as opposed to raw scores. For all the analysis below a Wilcoxon Signed Rank Test was used to investigate whether the findings were statistically significant or not.

#### 10.3.1. Sample Size

The sample for the MMPI-A is different to the sample for the CBCL protocols due to a different attendance rate. The sample for the MMPI-A consisted of 7 participants (N=7). The experimental group consisted of 4 participants, and the control group consisted of 3 participants. The overall sample consisted of 4 males and 3 females and 3 of the participants were Black African while 4 were

classified as Coloured. The minimum age for this sample was 12, the maximum age 19 with a mean age of 14.71.

*Table 96*  
*Statistics for the MMPI-A: Gender and Race*

		Gender	Race
N	Valid	7	7
	Missing	0	0
Mean		1.429	3.143
Median		1.000	4.000
Mode		1.0	4.0
Minimum		1.0	2.0
Maximum		2.0	4.0

*Table 97*  
*Gender*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	4	57.1	57.1	57.1
	Female	3	42.9	42.9	100.0
Total		7	100.0	100.0	

*Table 98*  
*Race*

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Black African	3	42.9	42.9	42.9
	Coloured	4	57.1	57.1	100.0
Total		7	100.0	100.0	

*Table 99*  
*Descriptive Statistics*

	N	Minimum	Maximum	Mean	Std. Deviation
Age	7	12.0	19.0	14.714	2.8115
Valid N	7				

### **10.3.2. Validity Scales**

#### *F1 – Infrequency Scale*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.414$ ) and the experimental group ( $p = 0.109$ ). Upon further analysis of the  $p$  value, the effect size for the control group was medium ( $r = 0.333$ ) and the effect size for the experimental group was large ( $r = 0.567$ ).

This indicates that the EAP intervention had a larger impact on scores compared to no EAP. However, this is still statistically insignificant.

#### *L – Lie Scale*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 1$ ) and the experimental group ( $p = 0.109$ ). Further analysis of the  $p$  value showed that the control group had zero effect size ( $r = 0$ ) whilst the experimental group had a large effect size ( $r = 0.567$ ).

This indicates that the EAP intervention had a greater impact on scores compared to no EAP intervention although this is still statistically insignificant.

#### *K – Defensiveness Scale*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.285$ ) and the experimental group ( $p = 0.285$ ). The effect size of the control group ( $r = 0.447$ ) and the experimental group was medium ( $r = 0.378$ ).

This indicates that both the presence and absence of EAP influenced the scores of the control and experimental group. Yet this is still statistically insignificant.

### **10.3.3. Clinical syndrome scales**

#### *Hs – Hypochondriasis*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.285$ ) and the experimental group ( $p = 0.066$ ). Further analysis revealed that the effect size of the control group was medium ( $r = 0.447$ ). For the experimental group the effect size was large ( $r = 0.651$ ).

This indicates that EAP had a larger impact on scores compared to no EAP intervention, however this is still statistically insignificant.

### *D – Depression*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.285$ ) and the experimental group ( $p = 0.273$ ). The control group has a medium effect size ( $r = 0.329$ ) and the experimental group had a medium effect size ( $r = 0.387$ ).

This indicates that both the presence and absence of the EAP intervention influenced the scores. Yet this is still statistically insignificant. This could indicate that the difference in scores between pre- and post-test for both control and experimental groups could be related to another unknown variable.

### *Hy - Hysteria*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.285$ ) and the experimental group ( $p = 0.144$ ). Further analysis of the  $p$  value revealed that the control group has a medium effect size ( $r = 0.329$ ), and the experimental group had a large effect size ( $r = 0.516$ ).

This indicates that EAP had a greater impact on the scores compared to no EAP intervention, but it was not statistically significant.

### *Pd – Psychopathic deviate*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.785$ ) and the experimental group ( $p = 0.068$ ). Further analysis revealed that the effect size for the control group was small ( $r = 0.111$ ) and large for the experimental group ( $r = 0.646$ ).

This indicates that EAP had a greater impact on scores compared to no EAP intervention, however this is still statistically insignificant.

### *Mf – Masculinity-Femininity*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.414$ ) and the experimental group ( $p = 0.066$ ). Further analysis of the  $p$  value indicated that the effect size was medium for the control group ( $r = 0.333$ ) and large for the experimental group ( $r = 0.651$ ).

This indicates that the presence of EAP had a larger impact on scores compared to no EAP intervention. However, this is still statistically insignificant.

### *Pa - Paranoia*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.414$ ) and the experimental group ( $p = 0.713$ ). Furthermore, the effect size for the control group was medium ( $r = 0.333$ ), while the effect size for the experimental group was small ( $r = 0.130$ ).

This indicates that no EAP had a larger impact on scores compared to the EAP intervention. Yet this is still statistically insignificant.

### *Pt - Psychasthenia*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.109$ ) and the experimental group ( $p = 0.063$ ). The control group had a large effect size ( $r = 0.655$ ) and the experimental group had a large effect size ( $r = 0.657$ ).

Both the presence and absence of the EAP intervention influenced the scores of both the control and experimental group, but it was not statistically significant. This could indicate that the difference in scores between pre- and post-test for both control and experimental groups could be related to another unknown variable.

### *Sc - Schizophrenia*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.414$ ) and the experimental group ( $p = 1$ ). Further analysis of the  $p$  value revealed that the effect size for the control group was medium ( $r = 0.333$ ), and the effect size of the experimental group was zero ( $r = 0$ ).

This indicates that no EAP had a larger impact on the scores compared to the EAP intervention. However, this is still statistically insignificant.

### *Ma - Hypomania*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.285$ ) and the experimental group ( $p = 0.273$ ). The effect size was medium for the control group ( $r = 0.329$ ) and medium for the experimental group ( $r = 0.387$ ).

Both the presence and absence of EAP influenced the scores obtained, however this is still statistically insignificant.

### *Si – Social Introversion*

No statistically significant differences were found between the pre- and post-tests for both the control group ( $p = 0.85$ ) and the experimental group ( $p = 0.144$ ). The effect size of the control group is medium ( $r = 0.517$ ), while the effect size for the experimental group was also medium ( $r = 0.436$ ).



Both the presence and absence of the EAP intervention influenced the scores of the control and experimental group, but it was not statistically significant. This could indicate that the difference in scores between pre- and post-test for both control and experimental groups could be related to another unknown variable.

#### ***10.3.4. Scores for the analysis of the MMPI-A for the Control Group***

Below follow the graphs for the analysis of the MMPI-A for the control group.

##### *10.3.4.1. Validity scales*

*Table 100*

*Descriptive statistics: Control Group*

	N	Percentiles		
		25th	50th (Median)	75th
F1T Pre	3	59.000	70.000	72.000
L_T Pre	3	49.000	75.000	89.000
K_T Pre	3	44.000	67.000	74.000
Hs_T Pre	3	49.000	56.000	76.000
F1T Post	3	60.000	76.000	82.000
L_T Post	3	59.000	70.000	80.000
K_T Post	3	58.000	65.000	78.000
Hs_T Post	3	61.000	70.000	71.000

Table 101  
Ranks: Control Group

		N	Mean Rank	Sum of Ranks
F1T Post - F1T Pre	Negative Ranks	1	1.50	1.50
	Positive Ranks	2	2.25	4.50
	Ties	0		
	Total	3		
L_T Post - L_T Pre	Negative Ranks	2	1.50	3.00
	Positive Ranks	1	3.00	3.00
	Ties	0		
	Total	3		
K_T Post - K_T Pre	Negative Ranks	1	1.00	1.00
	Positive Ranks	2	2.50	5.00
	Ties	0		
	Total	3		
Hs_T Post - Hs_T Pre	Negative Ranks	1	1.00	1.00
	Positive Ranks	2	2.50	5.00
	Ties	0		
	Total	3		

Table 102  
Test Statistics: Control Group

		F1T Post - F1T Pre	L_T Post - L_Pre	K_T Post - K_T Pre	Hs_T Post - Hs_T Pre
Z		-.816b	.000c	-1.069b	-1.069b
Asymp. Sig. (2-tailed)		.414	1.000	.285	.285

a. Wilcoxon Signed Ranks Test.

b. Based on negative ranks.

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

10.3.4.2. Syndrome scales

Table 103

*Descriptive Statistics of the Control Group: Syndrome Scales*

	N	Percentiles		
		25th	50th (Median)	75th
D_T Pre	3	55.000	73.000	73.000
Hy_T Pre	3	39.000	46.000	87.000
Pd_T Pre	3	47.000	60.000	62.000
Mf_T Pre	3	61.000	64.000	72.000
D_T Post	3	67.000	77.000	83.000
Hy_T Post	3	55.000	65.000	84.000
Pd_T Post	3	48.000	55.000	67.000
Mf_T Post	3	52.000	53.000	80.000

Table 104  
Ranks of the Control Group: Syndrome Scales

		N	Mean Rank	Sum of Ranks
D_T Post - D_T Pre	Negative Ranks	1	1.00	1.00
	Positive Ranks	2	2.50	5.00
	Ties	0		
	Total	3		
Hy_T Post - Hy_T Pre	Negative Ranks	1	1.00	1.00
	Positive Ranks	2	2.50	5.00
	Ties	0		
	Total	3		
Pd_T Post - Pd_T Pre	Negative Ranks	1	2.50	2.50
	Positive Ranks	2	1.75	3.50
	Ties	0		
	Total	3		
Mf_T Post - Mf_T Pre	Negative Ranks	2	2.25	4.50
	Positive Ranks	1	1.50	1.50
	Ties	0		
	Total	3		

Table 105  
Test Statistics of the Control Group: Syndrome Scales

	D_T Post - D_T Pre	Hy_T Post - Hy_T Pre	Pd_T Post - Pd_T Pre	Mf_T Post - Mf_T Pre
Z	-1.069b	-1.069b	-.272b	-.816c
Asymp. Sig. (2-tailed)	.285	.285	.785	.414

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

c. Based on positive ranks.

*Table 106*  
*Descriptive Statistics of the Control Group: Syndrome Scales*

	N	Percentiles		
		25th	50th (Median)	75th
Pa_T Pre	3	49.000	62.000	63.000
Pt_T Pre	3	41.000	45.000	63.000
Sc_T Pre	3	46.000	50.000	62.000
Ma_T Pre	3	38.000	39.000	68.000
Si_T Pre	3	54.000	59.000	70.000
Pa_T Post	3	57.000	59.000	68.000
Pt_T Post	3	35.000	38.000	59.000
Sc_T Post	3	47.000	49.000	71.000
Ma_T Post	3	30.000	41.000	48.000
Si_T Post	3	51.000	58.000	60.000

*Table 107*  
*Ranks of the Control Group: Syndrome Scales*

	N	Mean Rank	Sum of Ranks
Pa_T Post - Pa_T Pre	Negative Ranks	1	1.50
	Positive Ranks	2	2.25
	Ties	0	
	Total	3	
Pt_T Post - Pt_T Pre	Negative Ranks	3	2.00
	Positive Ranks	0	.00
	Ties	0	
	Total	3	
Sc_T Post - Sc_T Pre	Negative Ranks	1	1.50
	Positive Ranks	2	2.25
	Ties	0	
	Total	3	
Ma_T Post - Ma_T Pre	Negative Ranks	2	2.50
	Positive Ranks	1	1.00
	Ties	0	
	Total	3	
Si_T Post - Si_T Pre	Negative Ranks	2	2.50
	Positive Ranks	1	1.00
	Ties	0	
	Total	3	

*Table 108*  
*Test Statistics for the Control Group: Syndrome Scales*

	Pa_T Post - Pa_T Pre	Pt_T Post - Pt_T Pre	Sc_T Post - Sc_T Pre	Ma_T Post - Ma_T Pre	Si_T Post - Si_T Pre
Z	-.816b	-1.604c	-.816b	-1.069c	-1.069c
Asymp. Sig. (2-tailed)	.414	.109	.414	.285	.285

*a. Wilcoxon Signed Ranks Test*

*b. Based on negative ranks.*

*c. Based on positive ranks.*

#### **10.4.1. Scores for the analysis of the MMPI-A for the Experiential Group**

Below follow the graphs for the analysis of the MMPI-A for the experiential group.

##### *10.4.1.1. Validity scales*

*Table 109*  
*Descriptive statistics of the Experimental Group*

	N	Percentiles		
		25th	50th (Median)	75th
FIT Pre	4	74.250	86.500	95.000
L_T Pre	4	63.000	75.500	82.000
K_T Pre	4	45.750	55.000	60.500
Hs_T Pre	4	52.500	57.000	62.250
FIT Post	4	69.000	72.500	80.500
L_T Post	4	65.250	84.500	88.000
K_T Post	4	52.500	64.500	73.500
Hs_T Post	4	60.750	64.000	69.500

Table 110  
Ranks of the Experimental Group

		N	Mean Rank	Sum of Ranks
F1T Post - F1T Pre	Negative Ranks	3	2.00	6.00
	Positive Ranks	0	.00	.00
	Ties	1		
	Total	4		
L_T Post - L_T Pre	Negative Ranks	0	.00	.00
	Positive Ranks	3	2.00	6.00
	Ties	1		
	Total	4		
K_T Post - K_T Pre	Negative Ranks	1	1.00	1.00
	Positive Ranks	2	2.50	5.00
	Ties	1		
	Total	4		
Hs_T Post - Hs_T Pre	Negative Ranks	0	.00	.00
	Positive Ranks	4	2.50	10.00
	Ties	0		
	Total	4		

Table 111  
Test Statistics of the Experimental Group

	F1T Post - F1T Pre	L_T Post - L_T Pre	K_T Post - K_T Pre	Hs_T Post - Hs_T Pre
Z	-1.604 <sup>b</sup>	-1.604 <sup>c</sup>	-1.069 <sup>c</sup>	-1.841 <sup>c</sup>
Asymp. Sig. (2-tailed)	.109	.109	.285	.066

- a. Wilcoxon Signed Ranks Test.
- b. Based on positive ranks.
- c. Based on negative ranks.



10.4.1.2. Syndrome scales

Table 112

*Descriptive Statistics for the Experimental Group: Syndrome Scales*

	N	Percentiles		
		25th	50th (Median)	75th
D_T Pre	4	60.500	67.000	72.000
Hy_T Pre	4	55.500	63.500	67.750
Pd_T Pre	4	48.500	54.000	55.000
Mf_T Pre	4	39.750	51.000	54.000
D_T Post	4	64.750	74.000	79.500
Hy_T Post	4	64.750	79.000	83.500
Pd_T Post	4	52.000	61.000	69.250
Mf_T Post	4	48.500	55.000	58.500

Table 113

Ranks for the Experimental group: Syndrome Scales

		N	Mean Rank	Sum of Ranks
D_T Post - D_T Pre	Negative Ranks	1	2.00	2.00
	Positive Ranks	3	2.67	8.00
	Ties	0		
	Total	4		
Hy_T Post - Hy_T Pre	Negative Ranks	1	1.00	1.00
	Positive Ranks	3	3.00	9.00
	Ties	0		
	Total	4		
Pd_T Post - Pd_T Pre	Negative Ranks	0	.00	.00
	Positive Ranks	4	2.50	10.00
	Ties	0		
	Total	4		
Mf_T Post - Mf_T Pre	Negative Ranks	0	.00	.00
	Positive Ranks	4	2.50	10.00
	Ties	0		
	Total	4		

Table 114

Test Statistics for the Experimental Group: Syndrome Scales

	D_T Post - D_T Pre	Hy_T Post - Hy_T Pre	Pd_T Post - Pd_T Pre	Mf_T Post - Mf_T Pre
Z	-1.095 <sup>b</sup>	-1.461 <sup>b</sup>	-1.826 <sup>b</sup>	-1.841 <sup>b</sup>
Asymp. Sig. (2-tailed)	.273	.144	.068	.066

a. Wilcoxon Signed Ranks Test

b. Based on negative ranks.

*Table 115*  
*Descriptive Statistics for the Experimental Group: Syndrome Scales*

	N	Percentiles		
		25th	50th (Median)	75th
Pa_T Pre	4	59.250	69.000	74.250
Pt_T Pre	4	52.500	58.000	65.000
Sc_T Pre	4	59.500	63.500	71.250
Ma_T Pre	4	48.500	59.000	63.500
Si_T Pre	4	54.000	55.000	65.750
Pa_T Post	4	63.750	67.000	71.750
Pt_T Post	4	45.250	46.500	58.250
Sc_T Post	4	56.500	61.000	69.250
Ma_T Post	4	45.000	50.500	58.250
Si_T Post	4	47.750	53.000	55.250

Table 116

Ranks of the Experimental Group: Syndrome Scales

		N	Mean Rank	Sum of Ranks
Pa_T Post - Pa_T Pre	Negative Ranks	3	2.00	6.00
	Positive Ranks	1	4.00	4.00
	Ties	0		
	Total	4		
Pt_T Post - Pt_T Pre	Negative Ranks	4	2.50	10.00
	Positive Ranks	0	.00	.00
	Ties	0		
	Total	4		
Sc_T Post - Sc_T Pre	Negative Ranks	2	2.50	5.00
	Positive Ranks	2	2.50	5.00
	Ties	0		
	Total	4		
Ma_T Post - Ma_T Pre	Negative Ranks	3	2.67	8.00
	Positive Ranks	1	2.00	2.00
	Ties	0		
	Total	4		
Si_T Post - Si_T Pre	Negative Ranks	3	3.00	9.00
	Positive Ranks	1	1.00	1.00
	Ties	0		
	Total	4		

Table 117

Test Statistics of the Experimental Group: Syndrome Scales

	Pa_T Post - Pa_T Pre	Pt_T Post - Pt_T Pre	Sc_T Post - Sc_T Pre	Ma_T Post - Ma_T Pre	Si_T Post - Si_T Pre
Z	-.368 <sup>b</sup>	-1.857 <sup>b</sup>	.000 <sup>c</sup>	-1.095 <sup>b</sup>	-1.461 <sup>b</sup>
Asymp. Sig. (2-tailed)	.713	.063	1.000	.273	.144

a. Wilcoxon Signed Ranks Test.

b. Based on positive ranks.

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

The overall findings for the statistical analysis of the MMPI-A as filled out by the youth indicated that none of the scores were statistically significant between the pre- and post-tests for both the control and the experimental groups.

As a study, the analysis shows that EAP as an intervention did not improve the findings on the MMPI-A protocols.

## **10.5. Conclusion**

Overall the statistical analysis of the CBCL for the control and experimental groups for the teachers and parents, showed no statistically significant differences on the scores. On the youth, experimental scales of the CBCL, a statistically significant change was noted on the withdrawn/depressed scale where the EAP intervention was shown to improve these scores on the CBCL.

It is also important to note that there were several scales where the results were close to statistically significant on the CBCL protocols.

The scores obtained on the MMPI-A were not statistically significant.

There are various possible reasons that could have contributed to the lack of statistically significant findings in this study. The sample may have been too small to achieve any statistical differences in the scores and a larger group may have shown different results. It is also possible that the EAP intervention was too short (only 6 sessions) and that a longer period of EAP sessions, may obtain statistically significant results. In some cases, different individuals filled out the pre-and post-test (CBCL), especially with regards to teachers and parents/guardians. This happened for instance when a learner started a new academic year with another teacher who filled out only the post-test CBCL. With regards to parents, the biological parent of a learner may have filled out the pre-test CBCL, but another adult filled out the post-test. These inconsistencies with respondents who completed the pre-and post-tests could have had an influence on the results of this study.

The next chapter, **Chapter 11**, focuses on a discussion and combination of all of the results from this research.

# CHAPTER 11

## DISCUSSION OF RESEARCH FINDINGS

### 11.1. Introduction

This chapter focuses on a discussion and summary of the overall research findings. The inter-individual analysis of the themes that were discussed in Chapters 5, 6, 7, 8 and 9 will be discussed as well as the quantitative research results that were discussed in Chapter 10.

The research was divided up into two sections; a qualitative and a quantitative section. First the discussion will focus on the qualitative findings and then move onto the quantitative findings. This chapter also focuses on an integration of the results with Melanie Klein's psychodynamic object-relations theory.

### 11.2. Qualitative research findings

For this section there were initially 6 participants. However, one of the participants dropped out as he no longer wanted to participate in the research. Thus, the inter-individual analysis of the EAP sessions are based on the research findings from 5 participants, 1 of which was female and the other 4 males. All of them were demographically Coloured adolescents that fell within the required age range and spoke English fluently enough in order to participate in the EAP sessions. However, it was observed that one of the participants, Participant F, seemed more able to express himself in Afrikaans and therefore, part of his session was conducted in Afrikaans.

#### *11.2.1. Summary of the participants*

The following is a summary of the participants that underwent the EAP sessions (the experimental group). Unfortunately, very little background history and collateral was able to be obtained on them. They were all diagnosed with conduct disorder, however, it would appear that some of them have co-morbid diagnosis and one of them, Participant F, was misdiagnosed, possibly fulfilling the criteria for intellectual disability instead.

Participant A is a 14-year-old, female, Coloured adolescent who is currently in Grade 7 at a primary school in the area. She lives with her maternal grandmother and there is a history of substance abuse in the family. She was referred by the social worker for the purposes of this study due to problematic behaviour mostly at home and was reported to allegedly be stubborn and does not always follow the house rules. Participant A would appear to also fulfil the diagnosis for depression as well as possibly attention deficit hyperactivity disorder (ADHD). Participant A presented as very anxious

with the horses and was very hesitant to create a relationship with them. The horse was also changed from a bigger horse (Horse A), to a smaller horse (Horse B) to try and accommodate her fears. It was felt by the horse specialist that she may find a smaller horse/pony less intimidating. She could create a relationship with Horse B towards the end of the sessions and a constant theme for her was one of unmet needs within a relationship. Horse B clearly illustrated this by constantly going to eat the grass on the side of the arena (fulfilling a need), but still being very aware of her through consistently looking at her, paying attention to her and/or eating right next to her.

Participant B is a 15-year-old, male, coloured adolescent who is also currently in Grade 7 at a primary school in the area. He lives with his mother after his parents were separated and his father has passed away. Participant B was referred by the social worker for the purposes of this study due to problematic behaviour, especially substance abuse, lying, manipulation and truancy, and he fulfilled the criteria for conduct disorder. He also only completed 3 of the 6 sessions of EAP as he was truant. Participant B seemed to really struggle with developing a meaningful relationship with the horse and lacked boundaries, often placing himself in a dangerous position (walking behind the horse), as well as social skills, (he didn't seem to understand or even know how to approach Horse A and engage with her to start developing a relationship). He was also impulsive, not waiting for an instruction to be completed and rush straight in to the horse's personal space.

Participant C is a 13-year-old, male, coloured adolescent who is currently in Grade 5 in a primary school in the area. His biological mother passed away in 2012, and he lives with his father who is currently unemployed, in a shack at the back of his paternal grandmother's place. He was referred for EAP due to problematic behaviour, fulfilling the criteria for conduct disorder, and it was reported that he steals, lies, doesn't obey instructions, and generally doesn't listen. Participant C managed to establish a relationship with the horse, evident especially towards the end of the sessions as he really struggled to say goodbye and looked forward to the sessions every Monday. Relationships was also a central theme for him, and he was initially very hesitant to create a relationship with the horse possibly due to fear of abandonment which was mirrored by the horse's distance. He also struggled with boundaries, having no regard for how the horse may feel (placing the halter over her eyes) and his conduct disorder symptoms were very evident in the sessions, which will be discussed in more detail in the section below.

Participant D is a 13-year-old, male, coloured adolescent that is currently in Grade 7 at a school in the area. He resides with both of his parents and his maternal grandparents have passed away. He was also referred for EAP due to behavioural difficulties and fulfilling the criteria for conduct disorder. He was also reportedly slow in class, according to his teacher. Participant D would also appear to fulfil the diagnosis for depression. Once again, the theme of relationships was central to the therapeutic process and he would appear to have created a bond with the horse becoming tearful

when he had to say goodbye, although he was initially very fearful of the relationship even when the horse illustrated to him through a lick and chew as well as constantly being aware of him, that she wanted a relationship with him and was being both submissive and congruent in her desire to be with him.

Participant E was also a male, coloured adolescent who unfortunately dropped out of the study. He reported no longer wanting to participate.

Participant F is a 14-year-old, male, coloured adolescent who is currently in Grade 6. He resides with his biological mother and his biological father is unknown to him. They live on grant money as his mother is unemployed. He was referred for behavioural difficulties, being rude and argumentative and not listening, however, would appear to fulfil the criteria for an intellectual disability rather than conduct disorder. Participant F would benefit from IQ testing and appropriate school placement. During the EAP sessions he seemed to really struggle to follow instructions (such as to go and halter, lead and groom the horse) and presented as very concrete in nature. Instructions had to consistently be repeated to him in a very concrete nature. He also presented with dysmorphic body features as previously discussed. He did appear to try very hard though and was able to establish a relationship with the horse (this was witnessed by many licks and chews, the horse following him around and a general acceptance from the horse).

The next section focuses on the combined findings of the MMPI-A pre- and post-test results.

### ***11.2.2. Summary of the results of the MMPI-A (Pre-test)***

Not all five participants showed the same elevations in the syndrome scales. However, four out of the five participants scored high on the following two scales (Paranoia and Schizophrenia):

#### *Scale 6 - Paranoia (Pa)*

This indicates that the majority of the participants may feel suspicious, have feelings of persecution, and may be experienced as rigid and have a moral self-righteousness. They may struggle to interact and form relationships with others as they may perceive them as hostile and have the potential to cause them harm. This can develop into a mistrust and suspiciousness of others.

Klein argues that paranoia develops as a result of feeling persecuted by their mother/primary caregiver. Paranoid traits are less easily observable in children/adolescents and are often linked with the tendency to become secretive or deceptive (1975). Paranoia is also linked to the paranoid-schizoid position and persecutory anxiety whereby the adolescent is fearful of annihilation and projects these feelings outward towards significant others and thus results in feeling paranoid.



Furthermore, this scale also indicates that the participants may have a higher likelihood to drop out of school and may be described by others as distrustful and suspicious and may manifest delusions of persecution or paranoia (Butcher *et al.*, 1992). This was especially noted in Participant B and C as they were known for their truancy, even becoming truant from the research.

#### *Scale 8 – Schizophrenia (Sc)*

Elevations on this scale indicate that the majority of the participants may have bizarre thought processes that are more than likely related to behavioural difficulties. They may also experience difficulties with regards to mood and behaviour instability, impulse control as well as difficulty with concentration. Furthermore, these adolescents are more than likely to have poorer academic achievement, be less intelligent and more than likely to drop out of school. High scores on this scale are also associated with several behavioural problems and negative life outcomes (Butcher *et al.*, 1992).

It would appear from the qualitative research findings that the majority of the participants illustrated behavioural difficulties that may be as a result of their paranoid perceptions of their significant caregivers and world as Klein would suggest. All of the participants were referred for behavioural difficulties such as lying, manipulation, not listening to instructions and generally being disrespectful. The participants also seemed to have difficulties with regards to impulse control, as illustrated by not listening to instructions first before rushing into the arena. Several complaints like this were also received from the school teachers.

The following elevation was noted on three out of the five participant's scales:

#### *Scale 2 - Depression (D)*

This indicates that the participants may experience a general dissatisfaction with their life, may feel discouraged, hopeless, and helpless. They may also feel despondent and apathetic and have a lot of physical complaints. High scores on this scale are also associated with suicidal thoughts. Furthermore, these adolescents may also have a low self-esteem, may be socially withdrawn and have few friends (Butcher *et al.*, 1992). These participants did complain of not having many friends.

Klein (1975), links depressive feelings, (feelings of hopelessness and helplessness, worthlessness, negative thoughts, and low self-esteem), as being derived from the fear of losing the mother (both as an internal and external object). Both Participant B and C suffered severe losses, which they possibly express through anger and behavioural difficulties. It is possible that once their anger has been processed, a depression may develop. Klein (1975), further states that these feelings are an important impetus towards the Oedipus conflict and desires. She also discusses the depressive

position which may account for depressive feelings later on in life. These are important factors to consider for Participant A and D as they also appeared to fulfil the criteria for depression.

### ***11.2.3. Summary of the results of the MMPI-A (Post- test)***

Only four participants participated in the post-test MMPI-A. Unfortunately, the fifth participant was truant from the assessment sessions.

The following four syndrome scales were elevated on four out of the four participants after the EAP sessions (post-intervention).

#### *Scale 1 – Hypochondriasis (Hs)*

High scores on this scale indicate a preoccupation with health and illness. Individuals who score high on this scale present with many different physical complaints. Furthermore, and possibly more significant to this research, is that several personality and behavioural descriptors are related to elevations on this scale as well as poor performance in school as well as family problems (Butcher *et al.*, 1992). Thus, after the EAP sessions, the participants reported far more physical symptoms than before. This may possibly have been due to the fact that they were starting to express their difficulties through the EAP sessions and experienced difficulties in expressing their emotions, thus resulting in somatic complaints.

As far as Klein's theory is concerned, physical symptoms may result from the aggressive and sad feelings meant to be directed towards the hostile and unaccepting object that is instead internalised. These feelings become overwhelming and are thus expressed through physical pain and possible illness. Until such a time that the participant is able to express his/her emotions effectively, their physical complaints will continue possibly also resulting in absence from school due to perceived physical illness.

#### *Scale 2 – Depression (D)*

It is possible that the participants scored higher on the depressive scale after the EAP sessions as they are starting to process difficult emotions and events. More specifically, they may be able to express their angry emotions in a different way and thus a depression emerges. Most of the participants struggled with relationships, which will be discussed in more detail below, as well as underlying fears of rejection and abandonment. Furthermore, most of the participants experienced loss in some form (absence of a father figure, loss of a significant caretaker such as a grandmother or mother, loss of financial freedom, loss of support), and these losses and the difficult feelings and thoughts associated with them, may be processed through the EAP sessions. As previously discussed in Chapter 3 and

above, Likierman (2001), states that within the theory of object relations depression shares important elements with mourning. Furthermore, depression is rooted in a metaphorical loss and the introjection of a hostile object. The depressive feelings meant to be directed towards that object become internalised and directed towards themselves thus resulting in a depression.

#### *Scale 3 – Hysteria (Hy)*

High scores on this scale may express a lot of somatic concerns, deny their problems, and have a high need for social acceptance and approval (Butcher *et al.*, 1992). It is possible that the participants scored high on this scale after the EAP sessions as they may have felt a need to belong and be accepted by their primary caregivers, teachers, and broader society. These feelings may have been exacerbated by receiving unconditional acceptance and belonging from the horses.

Similar to the high scores obtained on the Hypochondriasis scale, the participants somatic complaints may be related to an inability to identify and express emotions (which will also be discussed in more depth below), as well as the denial of these emotions and thus result in physical complaints.

#### *Scale 6 – Paranoia (Pa)*

As described above paranoia according to Klein is linked to feeling persecuted by their primary caregiver. Furthermore, it is created by persecutory anxieties and the mere development of a relationship with the horse may have re-evoked these primitive defence mechanisms. Klein argues that it is the primitive experience of the world that exposes the infant to intolerable and persecutory anxiety, thus setting in motion defences that when excessively reinforced, create mental illness (Likierman, 2001).

The mere process of therapy can evoke the primitive defence mechanisms and result in a worsening of symptoms before they improve through the process of processing these defence mechanisms in a safe, non-judgemental therapeutic space.

The next section focuses on the inter-individual analysis of the EAP sessions.

#### ***11.2.4. Inter-Individual analysis and discussion of central themes***

The following section focuses on the most common and central themes that were present in all of the participants. An important aspect of psychodynamic psychotherapy is to identify recurring themes in the participant's thoughts, feelings, and relationships. These themes characterise the analysis of the outcomes of the EAP sessions and include relationships, boundaries and feelings which will be further discussed below.

#### *11.2.4.1. Relationships*

Relationships were the most prominent theme evident from the inter-individual analysis of the EAP sessions. The theory of Melanie Klein's object relations also places a lot of emphasis on the development of the relationship which is formed from the foundation of the baby's first experience of its primary caregiver, the object (Klein spoke of the mother). Klein postulates that relationships, current and future, are formed in the same way that the individual formed a relationship with his/her primary object. This relationship with the significant other, becomes the object which gets internalised and thus the inner world of the child becomes directed at and projected onto significant others. Horses are ideal to use to analyse this projection as they are non-judgemental and do not carry emotional baggage like human psychotherapists might. They are a blank slate.

In all of the participants, there was a hesitancy and sometimes a fearfulness to create relationships. They appeared anxious of the horse and some were fearful that the horse may kick or bite them. This may have been due to the horse's size, the participants unfamiliarity with horses as well as their projection onto the horse that the horse is a hostile and unaccepting object. The participant's difficulties with regards to relationships was also corroborated by the background history in that they all had very poor social relationships at home and at school as well as the high scores that they obtained on the paranoia subscale of the MMPI-A. In some cases, their relationships were coloured by violence which fed into their fears and paranoia.

The participant's hesitancy and anxiety with regards to establishing a relationship is more than likely, per Klein, because they had the same type of relationship with their primary object and the transference carries through to other relationships. Their distrust and lack of meaningful, secure object figures was evident from their object – relations with the horses as they were characterised with distrust and insecurity even though the horses, may have at times, illustrated that they were understanding and wanted the relationships. This was evident through their body language, standing in a relaxed calm position with their heads and ears turned towards the participant despite distractions, walking up to the participant, constantly being aware of the participant).

Some of the participants seemed to try to impulsively and superficially create a relationship with the horse. However, the horse would often mirror that more was needed from them, to create a lasting and meaningful relationship. This was clearly illustrated through the horse almost forcing the participant to do what they wanted by staying 'rooted' to the spot, not doing what the participant wanted until they stroked him/her some more. Sometimes, this would get frustrating for the participant and perhaps, they are not used to spending 'quality' time with others in order to create meaningful relationships and feel like they belong.

Furthermore, the majority of the adolescents scored high on the MMPI-A scale of paranoia, thus indicating that their relationships are characterised by paranoia, and therefore would view others as distrustful and would be hesitant and suspicious of forming relationships with them. Klein's understanding of paranoia is that it results from persecutory anxiety and a sense of an internalised object that is persecutory and hostile, possibly originating from their primary caregiver.

Despite this, it would appear, that these children were able to create meaningful relationships with the horses, as indicated by the results. possibly due to the horse's inherent qualities. This may be due to the fact that the horses represent an object that lacks judgement, has unconditional positive regard, and can come into the relationship with no previous baggage which may influence the transference. They represent a trusting and congruent object for the adolescent to create a relationship with and internalise, thus enabling their perception of the environment and the object to be less hostile and rejecting and more trusting, accepting and loving. This change in the internalised object may allow the adolescent to change their behaviour thus resulting in an alleviation of the conduct disorder symptoms.

#### *11.2.4.2. Boundaries*

All five of the participants really struggled with boundaries to varying degrees. They either did not seem to understand them or had a complete disregard for them, sometimes even placing themselves in a position where they could be injured, at risk for their safety, by walking behind or under a horse without warning placing themselves at risk of being kicked. They would also place the horse's safety and sense of comfort at risk, as illustrated through placing the halter over his/her eyes. Furthermore, when leading the horse in some of the activities they would drop the lead rein on the floor, possibly placing the horse at risk of standing on it and injuring themselves.

They also seemed to really struggle with regards to personal space boundaries. They would often rush impulsively into the horse's personal space. This was also mirrored by the horse in that the horse would often step right up to their personal space, at times, almost stepping on their feet.

This indicates that it is possible that their personal space as infants was never respected. Furthermore, they may never have been able to develop a sense of self that is different from that of their primary caregiver. Their primary caregiver may have been over involved in their lives, possibly in a non-caring and self-centred manner or completely distant. Based on the background histories obtained, it is possible that they were distant, cold, and probably even uninvolved. Boundaries are also established through the setting of consequences and rules. Distant and uninvolved caregivers are unable to provide this for their children, resulting in the children learning that they can do whatever they want as there are no limits. Overbearing caregivers also do not set limits and boundaries as they

tend to allow the infant to behave without boundaries and limit setting, thus in turn making the caregiver content and happy.

#### *11.2.4.3. Feelings*

Feelings would appear to be very difficult for all of these participants. They really seemed to struggle to express their feelings and some of them even lacked a feeling vocabulary. The focus on feelings and putting a name to the feeling is a key feature in psychodynamic psychotherapy. They present as very emotionally guarded and even though their feelings were reflected in the horse's behaviour and objectively noticed and reflected by the therapist, the participants still often denied them. As a possible result of not identifying and expressing these feelings, somatization also occurs as also indicated by the high scores obtained on the hypochondriasis and hysteria scales of the MMPI-A. Furthermore, Klein postulates that in children who display behavioural difficulties, there was no expression and containment of emotion within their families as well as from their early object relation. Thus, there was no development of a feeling's vocabulary and the expression of feelings was not normalised or even enabled.

Feelings observed during the EAP process mostly included anxiety, sadness, and anger. These emotions were mirrored by the horse for example, anxiety would be reflected in the horses through their body language such as the position of their ears (straight up), neck (stiff) as well as the position of their feet and tail (stiff). As previously mentioned, their anxiety according to Klein is as a result of their perception of their object as hostile and their attempts to annihilate their introjection of the object. This may result in feelings of anger that the participant struggles to express and thus overwhelms him/her. With the adolescent diagnosed with conduct disorder these angry feelings emerge through the behavioural difficulties and when intolerable, lead him to attack his own ego, thus resulting in behaviours symptomatic of depression.

During infancy, it is possible that these emotions, amongst others, were not mirrored and reflected to the baby in a meaningful, non-judgemental, and understandable way by the object. Klein believed that children are emotionally dependent on adults for the regulation of their states and emotions (Likierman, 2001). It is possible that this regulation of the participant's emotions as infants was not met by their primary care-givers and thus no meaningful identification and expression of emotion can occur.

### *11.2.5. Inter-individual analysis and discussion of peripheral themes*

The following section focuses on themes that were only present in four and three of the participants. These themes further characterise the analyse of the outcomes of the EAP sessions and include trust, rejection, and erratic behaviour. These will be further discussed in the section below:

#### *11.2.5.1. Trust*

It was very hard for the participants to trust the horses as well as the horse specialist and the clinical psychologist that were facilitating the EAP sessions. Some of them were wary of the horses and fearful that they may either bite or kick them and it was hard to trust the therapeutic team that they wouldn't be given a horse that would kick or bite them. However, this was on a more superficial level. On a deeper level it was really hard to let the horses into their inner personal space and really get to understand and know them on a more meaningful level. It was difficult for the participants to trust that they would be unconditionally accepted and not judged by the horse. An example of this was when Participant D lied about getting into trouble at school as he was possibly fearful that the horse would reject him. Although the horse did walk away when he lied, she walked back to him when he told the truth thus illustrating that she does accept the participant, just not his behaviour, an important distinction.

It would appear that the participants were never able to internalise a sense of a trustful, reliable, and dependable object and thus they view others as untrustworthy and may be wary and anxious about developing a relationship with others as evidenced in the EAP sessions. This is possibly as a result of their caregivers (primary objects) not being dependable, reliable, and trustworthy.

Klein also alludes to this as the development of envy. Excessive envy can result from a sense of complete helplessness and deprivation, as discussed in Chapter 3, perhaps in the form of not being able to trust the primary caregiver to provide the necessary nurturance and care. This results in a sense that goodness is never possible or within reach and can't be held onto thus developing a lack of trust in their already hostile and persecutory environment/object-relations.

#### *11.2.5.2. Rejection*

The participants would appear to be very fearful of rejection, possible even preventing them from developing the relationship in the first place. Participant A seemed to feel that the horse had somehow rejected her through stomping her foot attempting to get rid of a fly. She felt that the horse had tried to kick her, thus feeling like the horse didn't want her around. The participant would appear to have internalised a sense of a very rejecting object, which may have also been exacerbated by the death of a loved one as well as the absence of a loved one such as their father figure. This sense of rejection

is often internalised through an object that is uninvolved and is not able to meet the infant's needs. The object is perceived as harsh, hostile, punishing, and rejecting. Klein would postulate that this sense of an absent object relation gets internalised and the adolescent directs their anger at this hostile, rejecting and possibly even unloving object towards themselves, thus viewing themselves as bad and thus the reason that they are rejected. The infant will often perceive others as rejecting even though they may not be.

Through the horse showing unconditional positive regard, the transference that develops is one of acceptance and that the adolescent is not bad, their behaviour may be, but not the adolescent. This was also illustrated through the horse walking away when Participant D lied about the reason for getting into trouble but walked back to him when he told the truth. Thus, showing that she accepts him for who he is, but not his behaviour. Thus, a meaningful relationship can be fostered and developed based on one of acceptance and trust.

Over time and through the process of EAP, it is hoped that the adolescent will internalise the good experience, the good-object and thus decrease the behavioural difficulties as well as the anxiety and depressive symptoms.

#### *11.2.5.3. Erratic behaviour*

This title was used to describe the symptoms of conduct disorder that the participants displayed during the EAP sessions. Not all symptoms as listed by the DSM 5 were observed in the EAP sessions and it is important to remember that the diagnosis of conduct disorder emerges because of an integration of the collateral information obtained, the clinical observations and behaviour of the participant noted during the EAP sessions as well as the various diagnostic assessments.

Symptoms indicative of conduct disorder that were identified from the participants include;

- An observation made by the clinical psychologist that the participant presented in a 'gangsterish' manner – very street smart, charming and manipulative,
- Possible substance abuse,
- Possible involvement in criminal activities,
- Aggression (directed towards the horse),
- Disrespectful of the horse (e.g. placing the halter over her eyes) as well as other people's property (e.g. throwing objects and consequentially breaking them),
- Disregard for consequences (e.g. the horse would stand on their toes as a result),
- Lying and deceitfulness,



- A very negative countertransference developed between the therapist and horse therapist towards the participant at times,
- Possible comorbid disorders would appear to also exist such as ADHD and depression, which was expanded upon in the individual chapters of the participants.

Klein's view on conduct disorder, as also discussed in Chapter 3, is that in the infant we find in the unconscious the stages that are observed in primitive individuals, that of cannibalism and murderous tendencies (Likierman, 2001). Klein goes on to describe the baby as being born ready to fight others to have access to vital life supplies and his/her needs. Initially, the infant's attacks are turned towards his/her mother as she is initially experienced as the site of nourishment and pleasure, warmth, and love (Likierman, 2001). Any interruption or denial of this access to his mother triggers apprehension and thus the Oedipal aggression. Thus, the infant may bite, scratch, kick etc. and in the phantasy world this pre-genital aggression is expressed through wetting translate into cutting, stabbing, wounding and faeces which is equated with missiles and weapons (Likierman, 2001).

Klein's notion of the infant's pre-genital destructiveness can outlive infancy and infiltrate the morality bound world of the adult and thus the aggression noted in children/adolescents diagnosed with conduct disorder and their potential to become so violent, break rules, steal, be deceitful and manipulative to gain what they perceive as a necessary need.

### **11.3. Quantitative research findings**

This section will focus on a summary of the overall analysis of the CBCL, a summary of the analyses of the parent and teacher CBCL as well as a summary of analyses of the youth CBCL. Lastly a summary of the results of the MMPI-A is also discussed.

The sample differed for the quantitative assessments due to truancy and absenteeism and consisted of 11 participants for the CBCL and 7 for the MMPI-A.

#### **11.3.1 Summary of the results of the CBCL**

The CBCL is made up of the following scales, as mentioned and discussed in Chapter 4; Internal A, External B, Total, Anxious/depressed, Withdrawn/depressed, Somatic complaints, Social problems, Thought problems, Attention problems, Rule-breaking behaviour, and Aggressive behaviour. The results of the analysis of these scales will be discussed in more detail below.

##### *11.3.1.1. Overall results of the analysis of the CBCL*

This section focused on the analysis of the overall results (Parent, teacher, and youth CBCL's) and

no statistical differences were found on any of the scales for both the control and experimental groups (Internal A, External B, Total, Anxious/depressed, Withdrawn/depressed, Somatic complaints, Social problems, Thought problems, Attention problems, rule breaking behaviour, aggressive behaviour, and Other problems).

This indicates that EAP as in intervention did not have a statistically significant difference on any of the overall scores obtained. However, neither did no intervention for the control group.

#### *11.3.1.2. Parent and teacher results of the analysis of the CBCL*

This section focused on the findings of the analysis of the results of the parent and teacher CBCL's combined. They were combined as unfortunately not enough forms were filled out for each section separately in order to conduct an analysis of just the parent protocols and just the teacher protocols.

The results of this section indicated that no statistical differences were found on any of the scales for both the control and experimental group (Internal A, External B, Total, Anxious/Depressed, Withdrawn/Depressed, Somatic complaints, Thought problems, Attention problems, Rule breaking behaviour, Aggressive behaviour, and Other problems).

However, it is important to note that a close to statistical difference (borderline result) was found on the social problems scale for both the control and the experimental group.

These results indicate that EAP as an intervention had no statistically significant impact on the results, however with a larger sample size it may have had a statistically significant difference on the Social Problems scale.

#### *11.3.1.3. Youth results for the analysis of the CBCL*

The results for the youth analysis are far more remarkable and the analysis of these scores did find statistically significant differences for the experimental group.

For most of the scales, no statistical significance was found for both the control and experimental groups. This included the following scales:

- External B
- Total
- Anxious/Depressed
- Withdrawn/Depressed – the control group only
- Somatic Complaints
- Social Problems
- Thought Problems
- Attention Problems

- Aggressive behaviour and
- Other problems

On two of the scales, namely the Internal A and the Rule-breaking behaviour scale, borderline scores were obtained on both the control and experimental groups, which indicated that they were close to statistically significant.

There was a statistically significant difference found on one of the syndrome scales. A statistically significant difference was found between pre- and post-test for the experimental group ( $p=.042$ ) on the withdrawn/depressed scale, while the results for the control group showed no statistically significant findings ( $p=.272$ ). Therefore, according to the youth experimental group, the EAP intervention significantly improved their withdrawn/depressed scores/symptomatology.

Furthermore, the research findings indicate a shift in behaviour and even though in some cases such as Participant C, the symptoms may have increased, this is indicative of the fact that these behaviours and feelings are being processed. Psychodynamic psychotherapy theory argues that symptoms usually get worse before they get better. Furthermore, the theory argues that suppressed anger results in depression. Thus, the decrease in Participant C's depressed symptoms, but increase in aggressive, acting-out behaviour.

With regards to this section it is also important to consider the fact that on the Youth CBCL's, the adolescents may have filled out socially desirable answers or may have underreported. The CBCL does not have a built in scale like the MMPI-A for identifying this. This is a limitation to the study and in future, can be ruled out, by using a larger sample size. However, it is also the nature for this group to not necessarily answer truthfully and thus may always remain a limitation.

### ***11.3.2. Summary of the results of the MMPI-A***

The analysis of the MMPI-A included the analysis of the following 3 validity scales; Infrequency, Lie and Defensiveness scale.

It also includes an analysis of the following content 10 scales: Hypochondriasis (Hs), Hysteria (Hy), Psychopathic deviance (Pd), Masculinity-Femininity (Mf), Paranoia (Pa), Schizophrenia (Sc), Depression (D), Psychasthenia (Pt), Hypomania (Ma) and Social introversion (Si)

The analysis of the MMPI-A's consisted only out of the youth protocols as the MMPI-A is a self-report questionnaire.

For both the control as well as the experimental groups no statistically significant differences were noted on either the validity or the content scales.

Below follows a more detailed description. Although no statistical differences were found, due to the small sample size, it is important to have a more detailed discussion of the results.

#### *11.3.2.1. Validity Scales*

The analysis of the validity scales, mentioned below, indicated that no statistically significant differences were found on the following validity scales:

- Infrequency scale (F1)
- Lie Scale (L)
- Defensiveness scale (K)

#### *11.3.2.2. Content Scales*

Out of the 10 scales, 4 indicated that EAP had a greater impact than no EAP, although this is still statistically insignificant. This included the following scales:

- Hypochondriasis (Hs)
- Hysteria (Hy)
- Psychopathic deviance (Pd)
- Masculinity-Femininity (Mf)

Out of 10 scales, 3 indicated that NO EAP had a greater impact on the scores than the EAP intervention:

- Paranoia (Pa)
- Schizophrenia (Sc)

Out of the 10 scales, 3 indicated that neither the presence nor the absence of EAP had an impact on the scores obtained:

- Depression (D)
- Psychasthenia (Pt)
- Hypomania (Ma)

Out of the 10 scales, on one scale both the presence and absence of EAP had an impact:

- Social introversion (Si)

#### **11.4. Conclusion**

This chapter has provided the reader with an inter-individual discussion and integration of the results obtained in Chapters 6, 7, 8, 9 and 10. These results were contextualised within the literature review of Chapter 2 as well as the psychodynamic object relations perspective as outlined in Chapter 3.

The results of the study indicate that EAP as an intervention, would appear to have had an impact on the scores obtained. This was more evident through the qualitative research analysis as the data was far richer qualitatively and more shifts in the participants behaviour was noticed through the intra and inter-individual analysis. Common themes discussed included relationships, boundaries, feelings and then the peripheral themes of trust, rejection, and their erratic behaviour.

However, the quantitative data also yielded results, although minimal, with a statistically significant difference noted on the youth CBCL's with regards to the withdrawn/depressed scales for the experimental group.

The last and final chapter, **Chapter 12**, discusses the relevance that this research may have for future studies, recommendations for further research as well as the strengths and weaknesses of this study.

## **CHAPTER 12**

### **EVALUATION, RECOMMENDATIONS AND CONCLUSION**

The concluding chapter of this research provides an overview of this study's findings. An evaluation of the study is also provided regarding the study's strengths and limitations. Recommendations for future research in the area of the use of EAP with adolescents diagnosed with conduct disorder are made.

#### **12.1. An overview of the research findings**

This research was conducted through the use of a mixed methods approach; therefore, this section provides an overview of both the qualitative and quantitative research findings.

The research elicited both central and peripheral themes using thematic analysis. These themes were discussed in Chapters 5, 6, 7, 8 and 9 as well as combined and integrated with the relevant literature (Chapter 2) and psycho-dynamic object relations theory (Chapter 3) in Chapter 10. Below follows a summary of these themes;

##### ***12.1.1. Qualitative research data***

The qualitative data consisted of the thematic analysis of the EAP sessions as well as background histories, clinical observations, and a qualitative discussion of the pre- and post-test results from the MMPI-A. The CBCL did not form part of the qualitative data.

Relationships was a very prominent and important theme that emerged during the analysis of the qualitative data. The participant's current relationships would appear to be characterised by paranoia and suspiciousness (as indicated by the MMPI-A) that would appear to result in behavioural difficulties (as indicated by the collateral as well as high scores on the Schizophrenia subscale of the MMPI-A). The nature of these relationships was characterised by different facets such as boundaries (a lack of), trust and rejection.

It would appear that most, if not all of the participants' experience of their primary care giver was one of hostility, persecution, rejection, and unmet dependency needs. From the findings of the research it is evident that the participants experience of a theoretically distant and hostile object relation is at the centre of their pathology. Their behaviour would appear to be as a result of this experience\perception. The experience with the horse as being one of acceptance, unconditional positive regard and belonging, in contrast to their experience of their primary object relation, would hopefully over time change this internalised object, thus resulting in a change in problematic behaviour and the development of trust and healthy, meaningful object relations.

Possibly due to their experience of their primary object as untrustworthy and distant, the participants struggle to express emotion and lacked a feelings vocabulary, as they did not appear to have an object off which to ‘mirror’ their emotions, thus possibly resulting in somatization (headaches and nausea). Klein (1975), argues that the difficult, harsh and aggressive feelings that are directed at the object are directed inwards due to a fear of annihilation and rejection resulting in anxiety and paranoia. The participants’ did not seem confident that their feelings would be understood and contained. However, the horse was able to contain and assist in processing the participant’s feelings and thus allowing for the possibility of a deeper and meaningful relationship to develop.

The symptoms of conduct disorder were clearly evident in the EAP sessions as well as comorbid diagnoses such as ADHD and depression.

The results of this study have shown that EAP certainly provides a shift in behaviour as well as the participants’ feelings, thoughts, and perceptions from a qualitative point of view.

### ***12.1.2. Quantitative research data***

The quantitative data consisted of the analysis of a Wilcoxon sign ranked test for the pre- and post-test CBCL and MMPI-A protocols. The results did reveal a shift and a **statistical significance** on the withdrawn\depressed scale of the CBCL for the experimental group. This indicates that the EAP would appear to have improved the participants withdrawn and depressive symptoms and possible DSM diagnosis of depression. This improvement in their depressive symptoms may also result in an increase in aggressive\acting out behaviour.

However, for the rest of the results, although there were some scales where borderline statistical significance was noted, they were **statistically insignificant**.

The results obtained on the MMPI-A were also **statistically insignificant**.

## **12.2. Evaluation of the study**

The following is an evaluation of the study with regards to the strengths and limitations of the study.

### ***12.2.1. Strengths of the study***

The following strengths of this research have been identified and are discussed below. They are indicative of the value, reliability and validity of the study;

- Chapter 2, the literature review, provided a wealth of information on EAP, mostly from American and European countries. This highlighted the need for more literature and studies pertaining to EAP from a South African perspective and more specifically to the use of EAP

with adolescents diagnosed with conduct disorder. Little to no literature\data was found on this phenomenon.

- Therefore this research addresses an area in psychology that is relatively new and that also lacks research.
- The mixed methods approach allows for information to emerge that may not necessarily have if it was purely a quantitative study. It also allows for information to be statistically compared and evaluated through the use of the quantitative research and thus the possibility for the results of the study to be generalised.
- An objective assessment was used, namely the CBCL which allows for validity and reliability.
- The results of this research has also illustrated that EAP as a form of psychotherapy can be effective with adolescents diagnosed with conduct disorder and that it creates shifts in the participants behaviour, thoughts and emotions, even only after such a short period of intervention.
- Furthermore, the use of EAP is also statistically significant with regards to depressed\withdrawn symptoms present in adolescents diagnosed with conduct disorder.

For reliability and validity purposes it is also important to explore the shortcomings and limitations of this research.

### ***12.2.2. Limitations of the study***

The following limitations have been identified and are discussed in more detail;

- The mere nature of the sample made it difficult to obtain as many participants as was initially anticipated due to their behaviour (truancy, poor motivation, lack of interest and commitment). Thus the sample size was relatively small and the quantitative results obtained are unable to be generalised.
- Furthermore, compliancy to the study and completion of the assessment procedures was poor. This is also considered a difficulty experienced with this particular population (adolescents diagnosed with conduct disorder).



- The community that was sampled for the research was extremely impoverished and even though the researcher went to the participants at a centralised location, not all the children had the necessary resources to attend. In addition, many of the children had not eaten and did not have food for lunch. Thus the results of the assessment procedures may have been impacted upon by hunger, distraction and poor motivation.
- Although only English speaking participants were requested, some of the participants first language was Afrikaans or an African language. Although they spoke English fluently enough in order to participate and complete the questionnaires, it would be interesting to see whether doing the sessions and assessments in their home language yields different results.
- On the Youth CBCL's, the adolescents may have filled out socially desirable answers or may have underreported. The CBCL does not have a built-in scale like the MMPI-A for identifying difficulties such as these as previously discussed in Chapter 11,
- The MMPI-A specifies specific age ranges (from 14 years onwards) and participants outside this age range (13 years) completed the questionnaire. The MMPI-A should be interpreted with caution with the age range of under 14 years old. It is possible to administer this assessment with this age range, and during the collection of data for the development of the MMPI-A did include this age range, more research is needed with regards to the use of the MMPI-A with this age range and the researcher should be aware that this age range was previously shown to have a higher incidence of difficulty when interpreting the test questions (Butcher *et al*, 1992).
- The validity of the MMPI-A is questionable due to the nature of the participants and restrictions on language. However, as the assessment was used for research purposes and not necessarily treatment or court purposes, the findings will still be helpful and can be used.
- The MMPI-A is a more self-report questionnaires, and it is possible that responses were not always truthful as indicated by the validity scales.
- Only the validity and content scales of the MMPI-A were analysed and this may be considered a limitation as more scales on the MMPI-A could have been analysed.

### 12.3. Recommendations for future research

Future research in this area and the general area of the use of EAP with adolescents is recommended.

The following suggestions are made:

- Future research could try to obtain participants that are fluent in English. However, due to the nature of the South African population, the majority of which speaks an African language, this may not be practical. Thus, it may also be beneficial to conduct the research in an African language\the participant's home language. Unfortunately, different assessment procedures may need to be used as there is not a standardised 6 – 18 CBCL and MMPI-A in African languages.
- A sample that has a greater diversity with regards to ethnic and socio-economic status may provide a more in-depth analysis of the outcomes\effectiveness of EAP with conduct disorder. Adolescents from more privileged backgrounds were not utilised in this study and although the diagnosis of conduct disorder involves applying the same diagnostic criteria across ethnic and socioeconomic status's, incorporating all socioeconomic status can provide for a fuller and more in-depth study.
- A larger sample size may produce better results with regards to the statistical analysis of the research,
- The participants may benefit from a more longer term intervention with regards to the EAP than just the 6 sessions. This could possibly even extend to a few months\one years,
- Different assessment techniques, perhaps not self-report questionnaires, can be utilised or an incorporation of multiple-faceted questionnaires not just those focused on symptomology,
- The study did not focus on the long-term effects (10 – 15 years) of the intervention. It would be beneficial and interesting to note the long-term effects of EAP on the diagnosis of conduct disorder and whether EAP has a lasting impact of the adolescents behaviour, emotions, thoughts and ultimately their internalised object-relation.

## 12.4. Conclusion

It is assumed that the current research has managed to explore, explicate, and understand whether EAP as an intervention is effective in the treatment of conduct disorder in adolescents and whether it has an impact on the adolescents internalised object.

The qualitative results for each participant as discussed in Chapters 5, 6, 7, 8 and 9 illustrate very specific and individualised themes. However, as shown in Chapter 10, common themes amongst the participants emerge through the use of thematic analysis. The thematic analysis also allowed for an explication of a shift in the participants emotions, behaviour and object-relations. The difficulty to have a meaningful relationship with significant objects in the adolescents lives was very evident. However, each participant was able to create a meaningful relationship with the horse by the end of the EAP sessions.

The qualitative results indicated shifts with regards to the adolescents internalised object and that it is possible to form a different type of relationship, a more meaningful relationship, with an object that is non-judgemental and gives unconditional positive regard.

The quantitative results indicated shifts in the form of an improvement of symptoms in the reported depression of the participants which was statistically significant. However, most of the quantitative results were statistically insignificant.

The use of EAP as a psychotherapeutic intervention has shown to qualitatively and limited quantitatively not only be effective through the reduction of symptoms, but also in the creation of meaningful relationships in adolescents that may otherwise be unable to create meaningful relationships. EAP can certainly be considered for future use with regards to the treatment of these adolescents.

*“There’s something about the outside of a horse that is good for the inside of man”.*

Winston Churchill

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