

CHAPTER 5

QUANTITATIVE DATA ANALYSIS AND INTERPRETATION

5.1 INTRODUCTION

The single-system design used in this study was a mixed methodology of qualitative and quantitative measures and analysis. In the previous chapter, I described the qualitative analysis of the data into generative themes. In this chapter I present a detailed graphic analysis of the data. To do this, I examined the narrative of each participant at each session at which the Roberts-2 test was administered, and scored it according to the rules of scoring of this test. In this way I was able to see how the participants' perceptions of their lives were changing as the therapeutic sessions progressed.

My assumption in this study was that traumatized children generally respond positively to projective, narrative and play therapy of any type, but traumatized children *of Zulu origin and culture* might benefit from an *indigenous* form of therapy with which they feel familiar. Hence, I was particularly interested as to whether the Roberts-2 scoring of participants showed a marked change between and during the fourth and sixth sessions of therapy, that is, when the intervention treatment of Masekitlana was introduced. In order to build on and expand upon the qualitative analysis, I used a form of quantitative measurement.

5.2 QUANTITATIVE MEASUREMENT

The measure used in this study was the Roberts-2 test, which requires participants to tell stories around typical family situations and activities of individual persons, which are displayed in picture form on picture cards.

Measurement refers to “the process of describing abstract concepts in terms of specific indicators, by the assignment of numbers or other symbols to these indicators in accordance with specific rules”, and “an indicator is an observation that is assumed to be evidence of the attributes or properties of a phenomenon” (Monette, Sullivan & DeJong, 2002, in Delpont, 2005:160). In this research, the phenomenon studied was mental and adaptive functioning in traumatized children, in particular children living with and affected by HIV. The attributes or properties measured by the Roberts-2 test were developmental adaptive function and the

presence of clinical pathology. The indicators in this study were the scored participant's responses to the picture cards at each administration of the Roberts-2 test when he expressed certain situations, such as feeling supported by others or experiencing internal conflict. Hence indicators, scored according to the scoring procedure of the test, were assigned to the statements of the participants.

5.2.1 SINGLE-SYSTEM DESIGN AND REPETITIVE QUANTITATIVE MEASUREMENT

The single-system design (as described by Strydom, 2005d) used in this study appeared useful in that it was comprised of a mixed methodology of qualitative and quantitative measures and analyses. This enabled me to make qualitative observations on how the content of the themes, such as expressions of anger or longing for family, changed as therapy progressed. Furthermore, I was able to show, using the measure of Roberts-2, concrete quantitative proof of positive *changes* in mental functioning in the participants. This was the assumed outcome when embarking on this research. One of the important characteristics of single-system methodology is that it “provides a setting for specific, measurable, client-desired outcomes” (Williams, Tutty & Grinnell, 1995, in de Vos, 2005:146), which was suitable for this study as it benefited from the measurement of a treatment intervention. Of further relevance for this study is the following statement about quantitative measurement as utilized in the single-system design:

“The essence of the single-system design is the repetitive measurement of the target problems or objectives” (Bloom et al., 1999:7). The problem must be measured at regular time intervals in order to ascertain whether changes in the problem have occurred prior to, during or after the treatment was administered. According to Polster and Lynch (1981:374), “the single-system design utilises repeated measures to establish trends and analyze change” (Strydom, 2005d:146).

In the present study, through repeatedly measuring the adaptive functioning of participants before, during and after the intervention, I was able to obtain a more precise and valid idea of the effects of the intervention than the qualitative data analysis alone would have provided me.

5.2.2 RELIABILITY AND VALIDITY OF ROBERTS-2 MEASUREMENT

In order to obtain valid and reliable data, researchers must ensure that measurement instruments have acceptable levels of reliability and validity (Delport 2005, in de Vos et al., 2005). The Roberts-2 test was standardized on 1060 participating individuals in the United States of America, who were broadly and diversely representative of all sectors of society, including ethnic, educational and economic sectors (Roberts, 2005). Although interscorer reliability is quite low on certain of the Roberts-2 scales, test-retest reliability is considerably higher than all ‘projective’ tests used prior to Roberts-2, that is, .70 to .75 for Roberts-2 as opposed to .30 for the Thematic Apperception Test (Lilienfeld et al., 2000, in Roberts, 2005). Validity in the Roberts-2 test rested on two primary functions: its power to document developmental differences and its power to document different performance between non-referred and referred groups. Using facets of the statistical analysis model, MANOVA, it was proven that the Roberts-2 scales “mark significant and thus valid distinctions between children and adolescents whose social understanding is at different developmental levels, and between those whose social understanding is at different levels for reasons that relate to the presence of social and emotional adjustment difficulties” (Roberts, 2005:135). The latter fact is important for this study, which utilized narrative play therapy for children with social and emotional adjustment challenges and was interested in recording changes in *each* participant’s perceptions of his challenges as the intervention progressed rather than developmental differences *between* participants.

5.2.3 CODING, SCORING AND INTERPRETATION OF PARTICIPANTS’ RESPONSES USING THE SCORING PROCEDURE OF ROBERTS-2

As the picture cards of the Roberts-2 test were of ethnic adults and children relating to each other, I felt that they would be suitable for the cohort of children of this study. Masekitlana is a narrative form of therapy, so describing picture cards fitted in well with Masekitlana therapy. The scenes in the picture cards were also reminiscent of the lives of the participants of this study. The Roberts-2 test had been piloted by students of the University of Pretoria psychology clinic on a group of children at the Kgolo Mmogo project in Kalafong Hospital¹⁶ in 2008 to assess anxiety, depression, aggression and stigma (rejection) levels as well as their social adaptation.

¹⁶ Kalafong Hospital is a public hospital in Pretoria, Gauteng. The hospital is situated on the western outskirts of Pretoria in the suburb of Atteridgeville.

The Roberts-2 assessment tool was administered on four occasions during the research process:

- Before standard of care therapy;
- after standard of care therapy and before Masekitlana therapy;
- at completion of Masekitlana therapy; and
- after a time period of two months after completion of therapy (in order to gauge long-term effects of therapy).

The Robert-2 test provides a series of 16 pictures (illustrations of these to be found in Appendix M) depicting social situations that are thought to be part of children's and adolescent's everyday experience. The child/participant is asked to complete a story around each picture. The child's expressive language around each picture is meant to be a reflection of his social, cognitive and problem-solving skills. Analysis of his stories reveals his weaknesses and strengths in recognizing, organizing and assimilating the situations into competent managing of everyday situations. This assessment tool "gauges developmental adaptive functioning as well as clinical functioning, and makes use of free oral narrative" (Roberts, 2005:4). Roberts (2005:4) does not refer to it as a *projective* tool as such, as he maintains that "projection is an unverifiable construct that makes use of undemonstrated direct correspondence between specific statements or expressions and internal states or specific life events". However, inferences are made as to how the child/participant's statements in response to the pictures are a reflection of how he views his experiencing of his present life.

In order to code, score and interpret the participants' responses, I studied the Roberts-2 Manual (Roberts & Gruber, 2005). I studied the themes and emotional expressions that were commonly encountered in the stories told by children/participants in relation to each picture card used during the standardization process of this test (Roberts, 2005). This included a wide range of stories told in response to each card by children of different ages, gender and emotional adjustment. I also examined the meanings behind the scales that had been compiled according to the range of children's/participants' statements, in the standardization process. I then matched the stories of the participants of the current study, in response to being shown the picture cards, with similar statements of other children/participants from the standardization process. I was then able to identify where the participants' statements, from the current study, fitted into the different categories of the different scales (details of which

are described in Appendix N). I noted this down on the ‘Coding Protocol’ sheets (Roberts & McArthur, 2005) using one protocol sheet for each participant for each session (an example of a ‘Coding Protocol’ sheet is in Appendix O). The process described in this paragraph was termed, according to Roberts (2005), “the coding process”.

From the coding protocol sheets, I scored the responses. It was here that I adapted my own form of scoring, the reason for which will be explained. At each successive administration of Roberts-2 (which was four times in total for each participant), the number of times in response to all the picture cards that a participant responded according to a particular category on a particular scale, was scored as a percentage of the total number of picture cards. For instance, if he responded with a ‘Popular Pull’ theme (on the Theme Overview Scale) to three out of ten picture cards, then he scored 30%. These percentages were then represented in the form of graphs. In single-system design, no more complicated statistics than these are called for (Strydom, 2005d).

I did not utilize the scoring procedure to the point of calculating t-scores for the participants. This was because participants did not describe all 14 cards at each session (hence my percentage method). Additionally, I did not want to compare each participant’s results with the general standardized population. I wanted to compare a participant’s scores on each scale with his own scores on successive administrations of the Roberts-2 test. This was to gauge whether there had been improvements after standard of care therapy and after Masekitlana therapy, and whether Masekitlana was more beneficial than standard of care therapy. Hence, I was able to indicate the differential effects on the participants of the two modes of therapy.

I was not able to present quantitative graphic results of Mandla’s responses to the picture cards of the Roberts-2 test as his responses were too simplistic to be able to score. Mandla was not able to go to a mainstream school and hence found it difficult to verbalize many descriptions or stories around the picture cards. We tried hard to encourage him to talk about them. However, he only wanted to play with the stones and talk about his life while doing so. Hence, I was only able to quote him in the qualitative analysis.

5.3 GRAPHIC ANALYSIS OF PARTICIPANTS’ RESPONSES AND INTERPRETATION OF THE GRAPHS

As explained above, each participant’s responses to:

- each of the picture cards,
 - according to the different scales,
 - at each administration of the Roberts-2 test
- were coded, scored and put in graphic form and presented below.

The colours of the columns in the graphs represent the following:

- **The blue** column represents Roberts-2 scores at baseline before therapy commenced.
- **The red** column indicates scores after standard of care therapy.
- **The green** column represents scores after the intervention of Masekitlana therapy.
- **The purple** column represents scores at the follow-up phase, that is, two months after the completion of Masekitlana therapy.

I explained the content of each graph immediately below it. This comprised the analysis and interpretation of the changes in adaptive functioning that resulted from scoring the participants' descriptions to the picture cards.

5.3.1 GRAPHIC ANALYSIS OF HLONIPHO'S RESPONSES TO THE ROBERTS-2 TEST USING THE SCALES OF ROBERTS-2 MANUAL (2005)

Hlonipho was a shy boy who did not communicate readily, but when he did talk, his content revealed serious and deep matters. He had been abandoned as a young boy by his mother and father, who both died without their son being given clear explanations for their disappearance out of his life. He recuperated from his own illness for one year in a government hospital and then was cared for by a priest and his wife. He was then moved to the children's home where he lived at the time of this research, without any contact or knowledge of the whereabouts of any family members. Although a more detailed background to this participant is found in Chapter 3, I believe that this background, given at this stage of the study, is important for the reader to make sense of the graphic analysis and interpretation below.

5.3.1.1 Hlonipho: Popular Pull

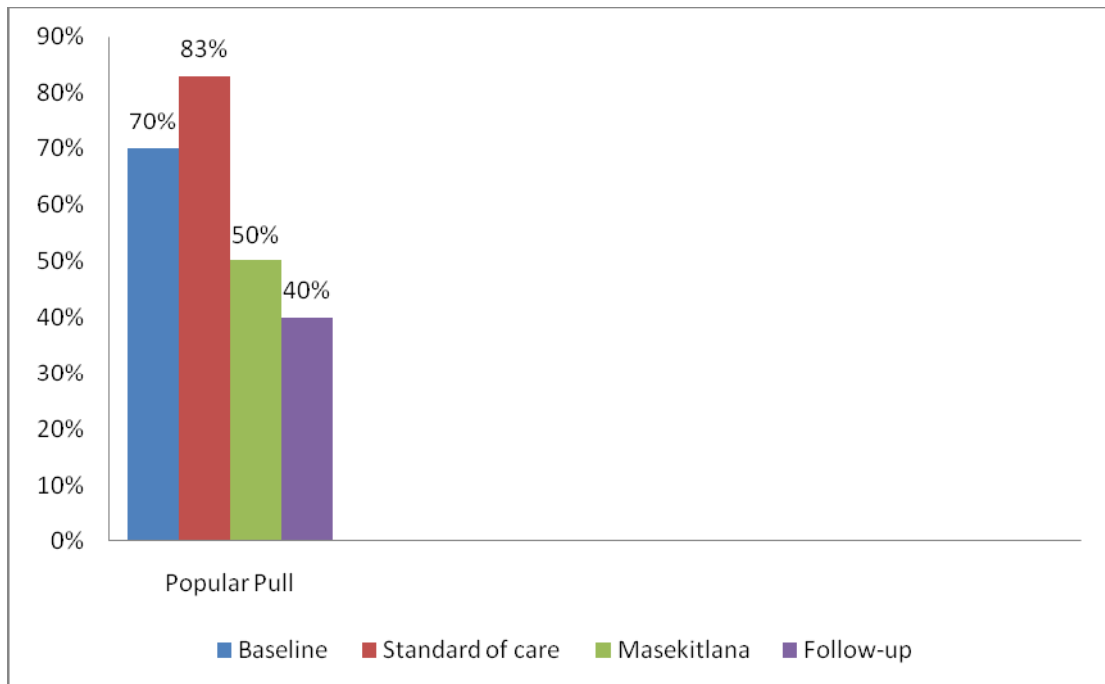


Figure 12: Hlonipho: Popular Pull¹⁷

Hlonipho’s Popular Pull score decreased after Masekitlana, which might have indicated that he was recognizing difficulties within his past family relationships more honestly and openly, and more personally than he had been prepared to admit in previous therapy sessions. His lower scores on Popular Pull after Masekitlana (50%) might also have indicated that he became less inclined to conform to the norms of society after Masekitlana therapy, as his answers at this stage deviated from those of the majority of children in the standardized sample. Comparing Hlonipho’s Popular Pull score with his expressed conformity during standard of care therapy (83%) reveals a significant difference. This result accorded with indications of greater emotional openness and expressiveness recorded after completion of Masekitlana therapy. His score diminished even further at follow-up measurement (40%).

¹⁷ “Popular Pull” is how the majority of non-referred children and adolescents perceive a specific emotion, behaviour, or problem situation designed to be depicted in each of the picture cards (refer Appendix P for description of Roberts-2 objective scales).

5.3.1.2 Hlonipho: Complete Meaning

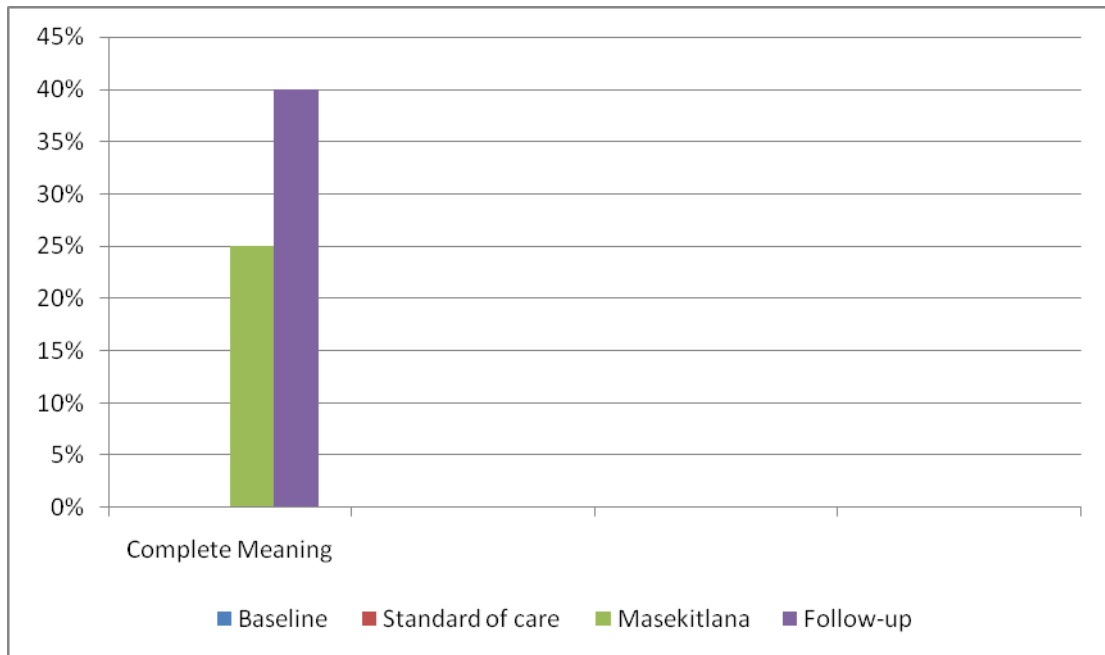


Figure 13: Hlonipho: Complete Meaning¹⁸

Although Hlonipho’s scores for describing a coherent story with a successful outcome were still not very high after Masekitlana (25%) and at follow-up after two months (40%), these scores were an improvement on his baseline score (nil) and his standard of care therapy score (nil) where he did not construct one complete story. The scored results indicate that Hlonipho, after Masekitlana therapy and at the follow-up assessment two months later, was able to develop some outcomes that were positive and successful in resolving problem situations and problem emotions. Hlonipho’s Complete Meaning scores also indicated his increased ability after Masekitlana to express himself verbally and to utilize creativity and past experience to develop ideas.

¹⁸ “Complete Meaning” differentiates the cognitive capacity of different children to follow instructions and devise a complete story around what happened before, during and after the event depicted in the picture card.

5.3.1.3 Hlonipho: Available Resources Scales

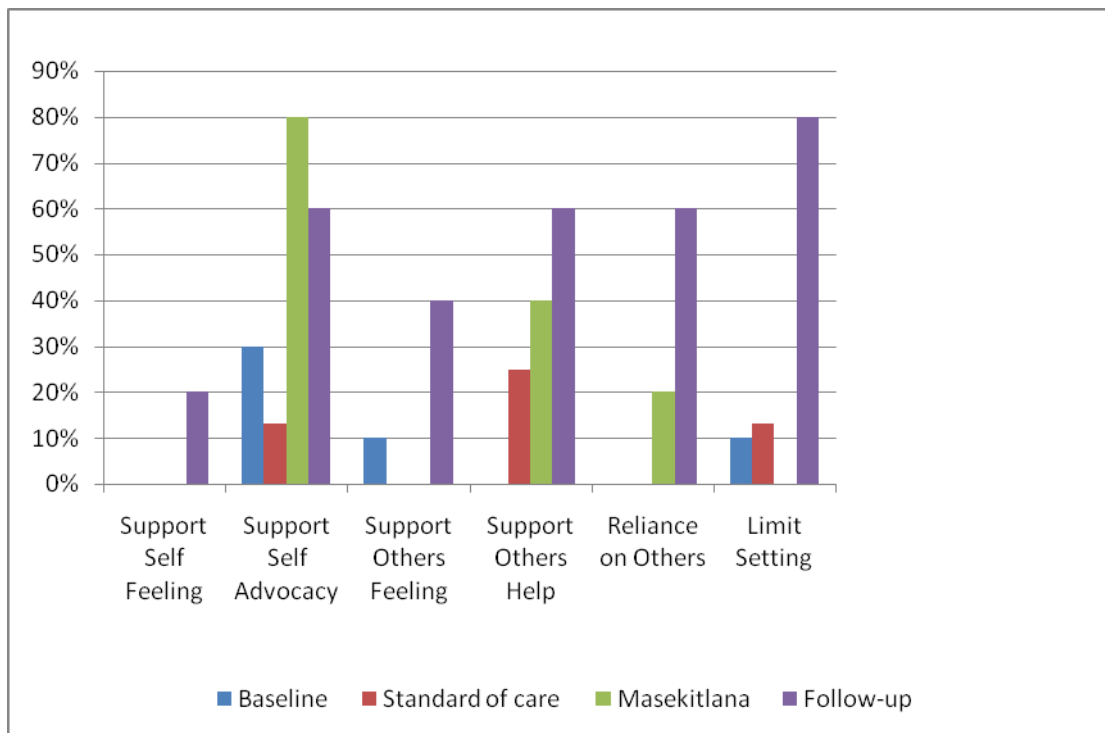


Figure 14: Hlonipho: Available Resources Scales¹⁹

Hlonipho's results, after the follow-up phase, in all categories within this scale, indicated an increased perception of resources in his life.

- **Support Self – Feelings:** Lack of responses to this category (nil scores except for at the follow-up measurement) could have been a reflection of Hlonipho's general anhedonia (flat affect) and melancholic state of mind, which he presented with throughout therapy. There was, however, a slight increase (20% of his responses) of expressed positive feelings and ability to deal with problem situations two months after therapy was complete, that is, at the follow-up phase.
- **Support Self – Advocacy:** Hlonipho's scores on this scale were high after Masekitlana (80%) and at follow-up (60%), which might have indicated a growing awareness of his resources and a greater insight into his life experiences. Scores indicate that Masekitlana might have helped to encourage this awareness.
- **Support Others – Feelings:** I felt that the low score in the first three administrations of Roberts-2 (10%, nil score, nil score) was an indication of the lack of demonstrative love shown between Hlonipho and others around him in the form of

¹⁹ "Available Resources Scales" indicate how a participant uses other people or resources in his environment to support him.

hugging, discussing plans together, and others feeling proud of him. The score increased to 40% at the final administration of Roberts-2, indicating that he viewed his environment as being more helpful and responsive at this stage and period of the research than at the beginning of therapy. This indication occurred at two months after completion of therapy and not immediately after the three sessions of Masekitlana (nil score), which could have meant that therapy had a delayed effect on Hlonipho's perceptions of his life.

- **Support Others – Help:** There was a healthy increase in responses to this category after Masekitlana (60%) which could have been an indication that Masekitlana encouraged Hlonipho to talk about and recognize the support of others, and could have encouraged Hlonipho's awareness that others in his environment were responsive to his problem feelings.
- **Reliance on others:** Hlonipho's overall low response rate in this category might have indicated a lack of ability to ask others for help or to express his needs. This confirmed Hlonipho's inability to express his emotions and utilize external resources, possibly because his historical external resources had been unreliable. He had been deprived of the security and support of a loving family. After Masekitlana, however, his scores on this scale (60%) indicated an improvement in reaching out to others.
- **Limit Setting:** Low scores on the first three administrations of Roberts-2 (10%, 12%, nil score) could have indicated that Hlonipho had not been exposed to consistent and firm structures of discipline. This reflected one of the identified themes (in the qualitative analysis) in Hlonipho's narrative, which was the need for more guidance from adults as to general rules of behaviour. He had expressed experiencing inconsistent and inappropriate limits. Hlonipho's limit-setting scores were low before standard of care therapy (10% of responses), increased slightly after standard of care therapy (12%), and were non-existent (nil score) after Masekitlana. However, by the last scoring of the picture cards at follow-up phase, he was expressing an 80% response for limit setting. This might have indicated that he had begun to use his supportive resources and therefore was feeling more secure at this stage of the research in his environment's structures around behaviour guidance, discipline and punishment.

5.3.1.4 Hlonipho: Problem Identification Scale

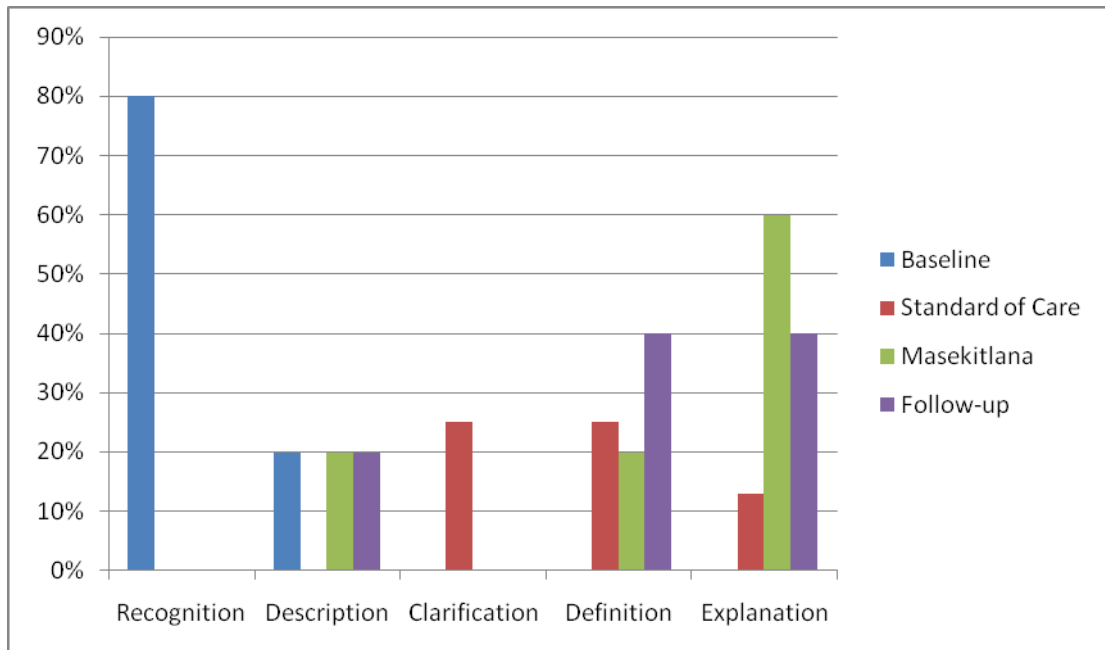


Figure 15: Hlonipho: Problem Identification Scale²⁰

There is a hierarchy between Recognition and Explanation, with Recognition being simple and vague problem solving, and Explanation relating to the most elaborated and differentiated breakdown of a problem.

- Problem Identification 1 (PID 1) – Recognition:** “Referred children (as opposed to non-referred children in the standardization process of this test) showed a markedly higher use of PID1 – Recognition and a markedly lower use of PID3 – Clarification. Thus a high PID1 and low PID3 was commonly seen with clinically referred cases” (Roberts, 2009:118). Hlonipho showed a high PID1 –Recognition score (80%), that is simple and vague problem solving, before therapy commenced, which was synonymous with clinically referred children.
- Problem Identification 3 and 4 – Clarification and Definition:** After standard of care therapy, Hlonipho’s expressed problem solving skills indicated an improvement in clarification and definition of his problems.
- Problem Identification 5 – Explanation:** It can be seen that Hlonipho’s explanations improved from a starting point on PID1 of 80% of his responses being simple explanations and 20% being simple definitions of problems (PID2), to a score

²⁰ The Problem Identification Scale indicates a participant’s problem-solving skills and indicates a hierarchy of problem-solving skills in identifying problems, from relatively vague and global explanations to the most elaborate and differentiated breakdown of the problem.

of 60% of his responses after Masekitlana (PID5) being well articulated explanations of problem situations and internal conflicts, including an elaboration of their causes.

5.3.1.5 Hlonipho: Resolution Scales

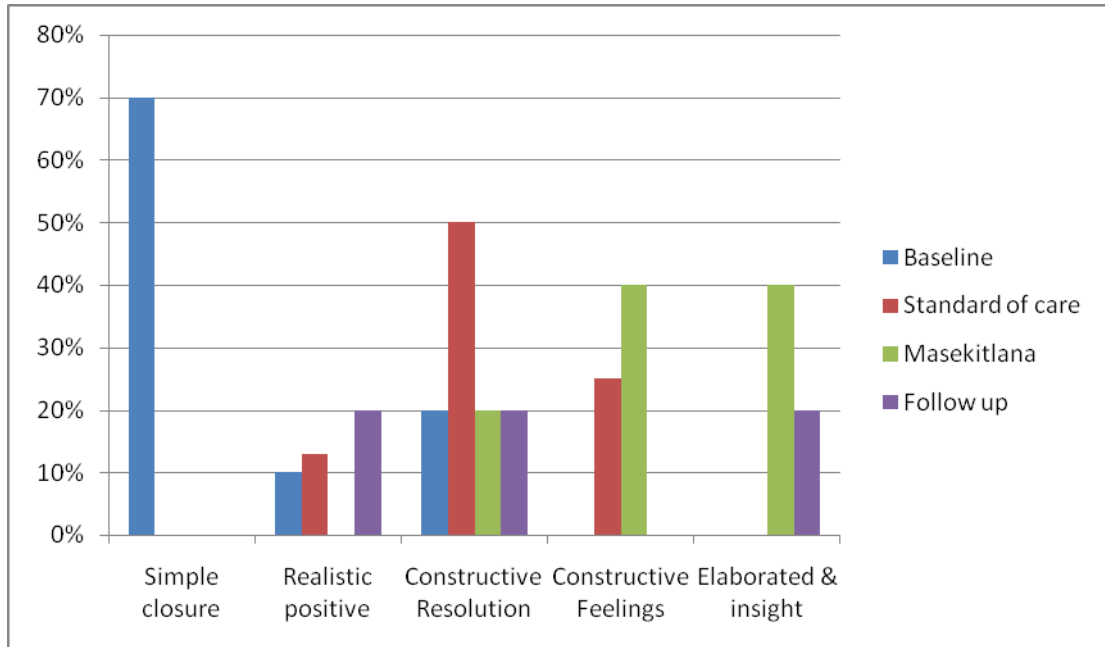


Figure 16: Hlonipho: Resolution Scales²¹

An improvement can be noted from 70% of the described situations being resolved through simple or abrupt closure (Simple Closure category), at baseline, to 40% of situations being constructively resolved (Constructive Feelings category) with insight after Masekitlana. There was a large increase (nil score to 50%) in percentage (indicating improvement) between baseline and after standard of care therapy in relation to constructive resolution skills (Constructive Resolution category), but with little elaboration of feelings (nil score on Elaborated and Insight category) after standard of care therapy. However, Hlonipho's ability to develop a positive outcome for a story (Elaborated and Insight category) appeared to diminish by follow-up (20%). This might have indicated that the impact of Masekitlana on viewing his ability to solve problem situations positively was not long lasting. This result is contradictory to his score on his insight into problem areas of his life, as indicated on the Problem Identification scales in the section above. Hence, it can be extrapolated from this that Hlonipho developed an insight into problems in his life but did not always feel positive about his ability to resolve them.

²¹ "Resolution Scales" indicate a participant's ability to develop a positive outcome for a story.

5.3.1.6 Hlonipho: Emotion Scales

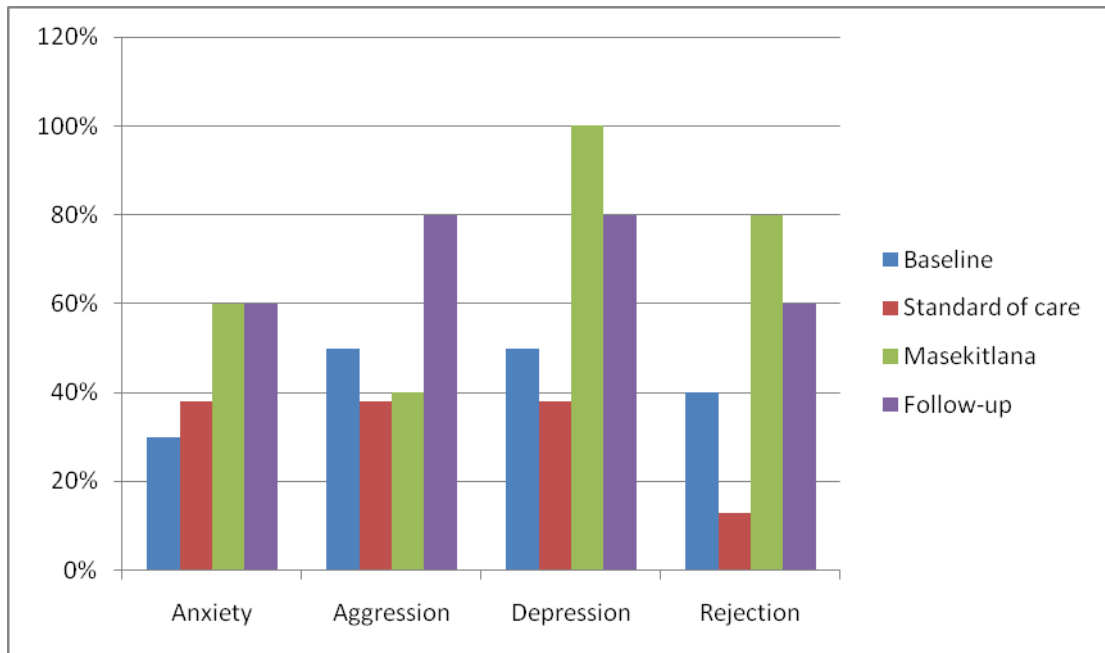


Figure 17: Hlonipho: Emotion Scales²²

- Anxiety:** It might be expected that therapy would diminish displays of emotion in children; however, when examining the effects of Masekitlana in this study, Hlonipho’s score (60%) at the third assessment of Roberts-2 (green column), that is, after Masekitlana therapy indicated a considerable amount of expressed anxiety. I attribute this to the fact that it was only during therapy involving Masekitlana that Hlonipho revealed the details of his mother’s death. This could have resulted in a certain amount of expression of formerly suppressed feelings, hence his anxiety. This anxiety score (60%) remained at this level at the follow-up phase.
- Aggression, depression and rejection** responses from Hlonipho all increased after Masekitlana, again indicating an increase in emotions and expression of internal states as therapy progressed. Graphic results indicated that this was the case in particular after Masekitlana (depression reaching 100% of responses immediately after Masekitlana, and lessening slightly at follow-up, that is, reaching 80% of responses). Hlonipho’s scores on the emotion scales had already begun to increase with standard of care therapy. My interpretation of this was that therapy enabled Hlonipho to express his feelings. This was confirmed by the theme analysis of

²² “Emotion Scales” indicate basic human emotions. They organize the many types of feelings and reactions that are credited to characters in the stories.

Hlonipho’s narratives, which demonstrated how he blocked off or denied emotionality at the beginning of therapy but was more expressive in the Masekitlana sessions. However, therapy might also have ‘retraumatized’ him, which Denis (2003:212) explains happens to people when they are confronted with their painful memories, especially if there is no hope of reparation. This was one of the reasons (amongst the others mentioned previously) why Hlonipho continued therapy after the current study was completed.

5.3.1.7 Hlonipho: Outcome Scales

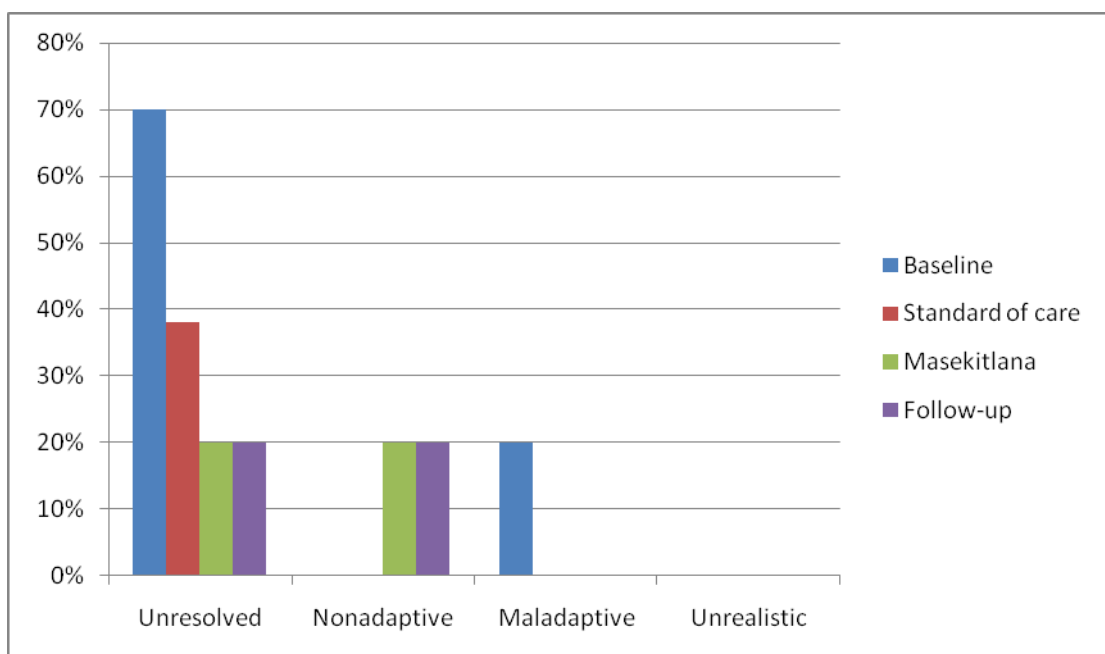


Figure 18: Hlonipho: Outcome Scales²³

- Unresolved outcome:** It is significant that before therapy commenced, Hlonipho’s scores indicated that outcomes in his life were largely unresolved (Unresolved scale indicates a 70% response rate). After Masekitlana, 20% of outcomes were unresolved outcomes. Also after Masekitlana therapy and at follow-up, Hlonipho indicated that 20% of his described resolutions to problem feelings and situations were nonadaptive (‘nonadaptive’ meaning action reported subsequent to the pictured situation that does not resolve the problem or contribute further to make it worse, but some action is taken) after Masekitlana and at follow-up phase. At baseline, he indicated a 20%

²³ “Outcome Scales” indicate the participant’s ability to solve problem feelings and situations where there is a negative outcome to stories.

response rate in the maladaptive category but no score thereafter (‘maladaptive’ meaning action subsequent to the situation that adds to the problem and makes the problem more unsatisfactory). The scales of this graph indicate ‘negative’ forms of outcome resolution. Hlonipho’s scores diminished as therapy proceeded, indicating less negativity to outcomes of life situations. This was a confirmation of his *moderate* results on the Resolution scale (indicating his ability to develop a positive outcome for the story) in the previous Figure 16 in section 5.3.1.5, where 40% of Hlonipho’s story situations were resolved constructively with possible insight.

5.3.1.8 Hlonipho: Unusual or Atypical Responses

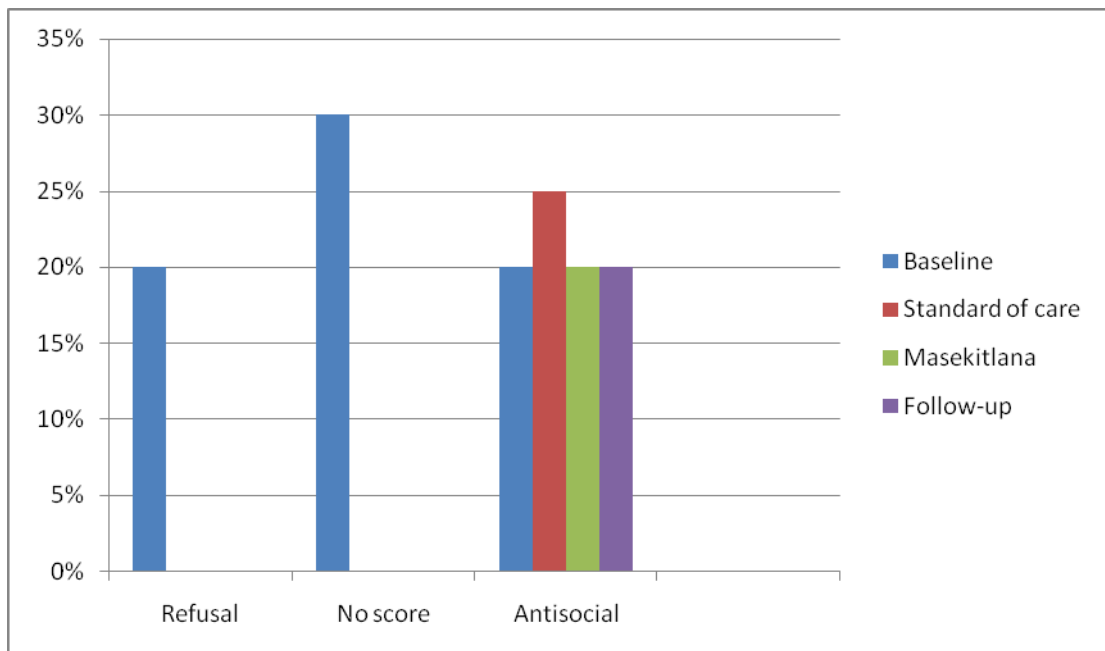


Figure 19: Hlonipho: Unusual or Atypical Responses²⁴

- Refusal:** Talking about the picture cards was the hardest part of the research process for Hlonipho, as he was very shy to begin with and did not want to express feelings around the cards and, for some cards, he appeared to be giving the impression that they were not part of his life’s experiences. Roberts (2005:124) explains that a refusal score means that the participant is “avoiding a pull that is emotionally threatening”. Hlonipho demonstrated a 20% refusal before therapy commenced but thereafter his stories in response to the cards became more adaptively acceptable.

²⁴ Unusual or atypical responses are responses that tend to denote a disturbance in functioning or serious pathology.

- **No score:** Hlonipho’s ‘no score’ response rate of 30% before therapy commenced, that is, at baseline, indicated that he merely provided a physical description of the cards. This, according to Roberts (2005:53), indicates concrete thinking without the ability to achieve a more abstract level of thinking that would permit the inclusion of emotions or the interpretation of the interactions in the cards. This form of response did not occur after Hlonipho had undergone the two types of therapy.
- **Antisocial:** It is significant that Hlonipho scored higher at all phases of the therapy process on the ‘antisocial’ measure, than on the other atypical/unusual response measures, although response rates were consistently under 25%. Hlonipho’s ‘antisocial’ score is probably because a lot of his narrative described fighting in the Home and people in his life, such as his mother and father, behaving irresponsibly. There was a slight improvement on his expressions of anti-social behaviour after Masekitlana (20%) compared with standard of care therapy (25%). The qualitative analysis results of the previous chapter also indicated that he became more positive about his ability to avoid fights with peers as therapy progressed.

5.3.1.9 Hlonipho: Atypical Categories

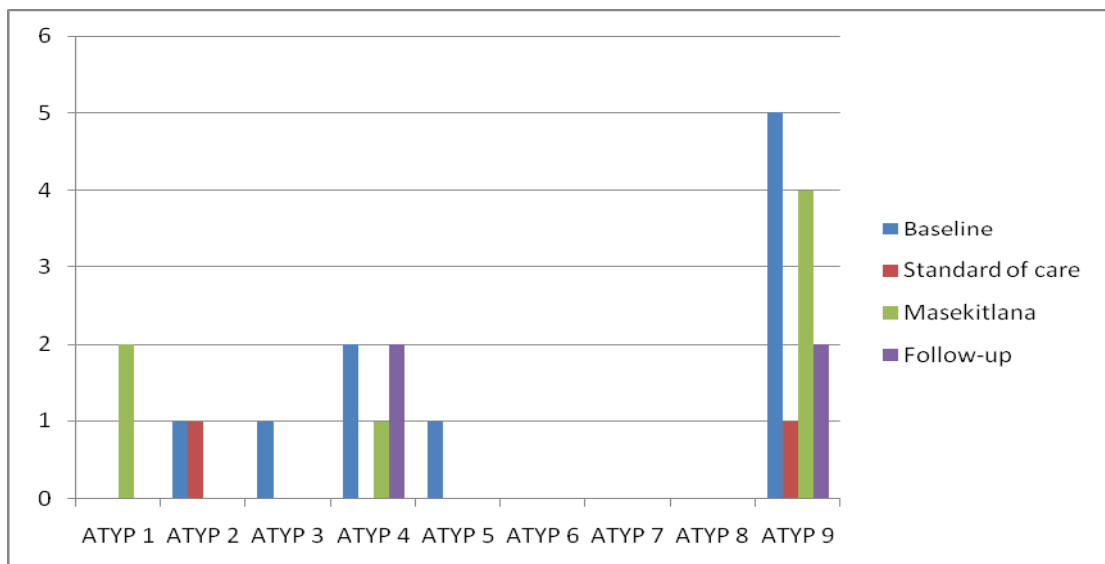


Figure 20: Hlonipho: Atypical Categories²⁵

- **Atypical 1 (illogical, including cognitive distortion and looseness of thought):**
Hlonipho was acting a bit ‘otherwise’ in the third assessment session after

²⁵ Atypical categories indicate content or structure that deviates significantly from the usual perceptions of non-referred children and adolescents.

Masekitlana, as the Home authorities had not warned him that the therapist and I had would not be able to visit him for three weeks. This could have contributed towards the looseness of expression to two out of five of the story cards.

- **Atypical 2 (misidentification of theme, including obvious denial of pictured theme) and Atypical 3 (misidentification of person):** At baseline and after standard of care therapy (for Atypical 2) and at baseline (for Atypical 3), Hlonipho's stories indicated these atypical responses to one of the picture cards. I felt that this could have indicated a certain amount of denial at this stage of therapy.
- **Atypical 4 (violence or aggression of any nature):** Not unexpectedly, Hlonipho described unusual forms of violence to two out of ten of the picture cards at baseline and to two out of five of the cards at follow-up administration of Roberts-2.
- **Atypical 8 (sexual content of any nature):** I would have expected Hlonipho to describe some form of sexual content as he was sexually molested as a child. However, this was not the case, as his nil on this category indicates. Perhaps this is an indication of emotional blocking or denial of such a traumatic occurrence in his life. He never did describe what happened to him in connection with this abuse. He did, however, express an Atypical-4 (violence or aggression of any nature) response on three different administrations of the Roberts-2 Scales, which might have been an indication that he had been exposed to some form of sexual abuse as a child.
- **Atypical 9 (other unusual content or clinically significant material):** Hlonipho mentioned his mother or made references to a mother in the pictures what I considered to be an unusual amount of times, indicating a need for his mother. At baseline, he mentioned his mother in his responses to 5 of the picture cards. His scores for this category of expression decreased (1 card) as a result of or after standard of care therapy and were prevalent again after Masekitlana (4 cards), which might have indicated that he felt freer to express this need as a result of the more familiar type of therapy.

The fact that Hlonipho scored more than one Atypical score on certain cards and many Atypical scores overall “identifies a significant level of psychotic disturbance” (Roberts, 2009:125) and groups him more closely with referred or clinical children (in the standardization process) than non-referred children.

5.3.2 GRAPHIC ANALYSIS OF SENZO’S RESPONSES TO ROBERTS-2 USING THE SCALES OF ROBERTS-2 MANUAL (2005)

Senzo was a lively, endearing and sometimes mischievous participant, who tolerated well the conditions of the children’s home, although he looked forward to returning to his family home at the holidays. At the latter home, his family consisted of the sister of his grandmother, whom he called “grandmother/*gogo*” and her granddaughter, whom he considered to be his sister, although she was only a half-sister. Senzo’s father had questioned Senzo’s paternity, accusing his deceased girlfriend (Senzo’s mother) of being unfaithful. However, at the end of the therapy process of this research, there was talk that his father recognized himself in the looks of Senzo , and therefore the family was considering taking Senzo back into the family home on a permanent basis (although nearly two years later, this still had not occurred; Senzo continued to live in the children’s home).

5.3.2.1 Senzo: Popular Pull and Complete Meaning

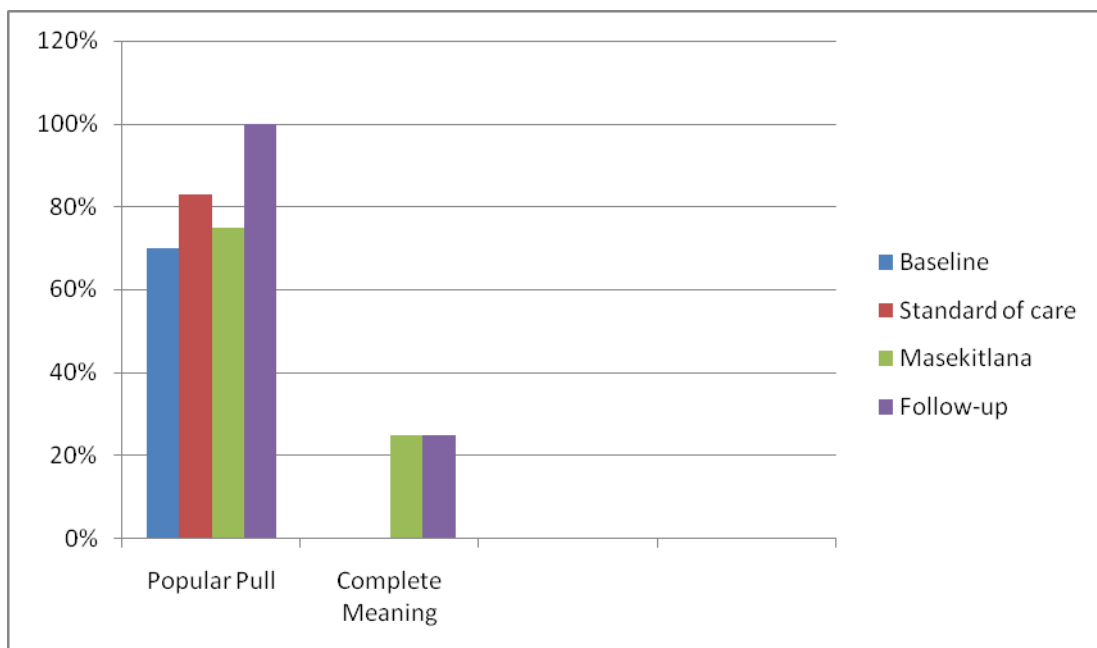


Figure 21: Senzo: Popular Pull and Complete Meaning

Senzo’s Popular Pull results indicated an ability to present a picture similar to the majority of non-referred children and adolescents who perceived the picture. Senzo therefore did not give any uniquely personal responses but appeared to represent the typical child (60%, 82%, 77% and 100%). Senzo’s scores on the Complete Meaning scale indicated that for 23% of his

responses, he was able to narrate a complete story with a complete meaning around the pictures after Masekitlana, as opposed to being unable to do so at baseline and after standard of care therapy. He maintained this ability at follow-up. His results on this scale also indicated a certain degree of understanding of instructions, as well as the ability to express himself verbally at these stages of therapy.

5.3.2.2 Senzo: Available Resources Scales

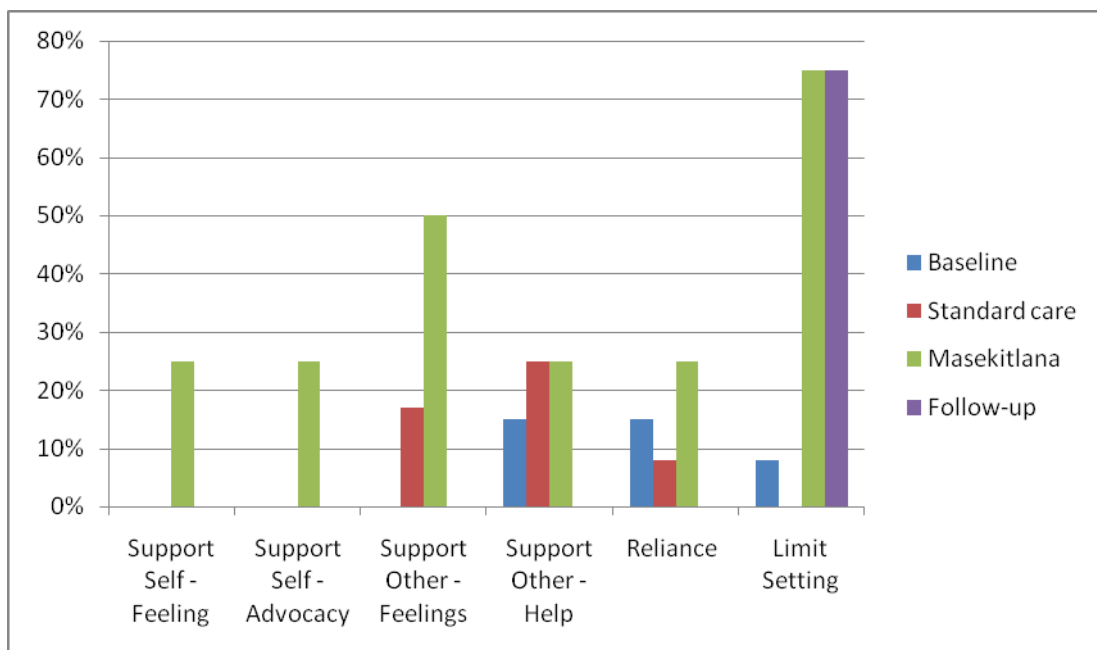


Figure 22: Senzo: Available Resources Scales

Although Senzo at baseline showed a nil score towards feeling positive (Support Self – Feeling category) and able to support himself in problem situations (Support Self – Advocacy category), he showed increases to scores of 25% in these categories after Masekitlana; but these were not maintained over the following two months. Positive interactions with others and feelings towards others (Support Other – Feeling category) improved after Masekitlana (50% from 17% after standard of care therapy) but were also not maintained over the next two months. He showed a 25% response rate to perceiving a helpful interaction between two or more people (Support Other – Help category) after standard of care therapy and Masekitlana. This is not a very high score and was not maintained at follow-up. Senzo’s stories indicated between 12% and 20% confidence score in tapping internal and external resources perceived to be available to the characters in his picture card stories (Reliance category), and therefore

available to him by inference. Again, this was not maintained at follow-up. Therefore, overall, Senzo did not indicate a great reliance on the support of others.

His ideas on limit setting, that is the enforcing of rules or the setting of boundaries, increased greatly after Masekitlana (75% from 8% at baseline, and a nil score after standard of care therapy) and were maintained two months later. This could indicate that, after Masekitlana therapy, he perceived more forms of discipline and guidance in his environment than before and could learn from these limit-setting experiences to “avoid the same mistakes and substitute socially acceptable behaviour” (Roberts, 2005:118).

5.3.2.3 Senzo: Problem Identification Scales

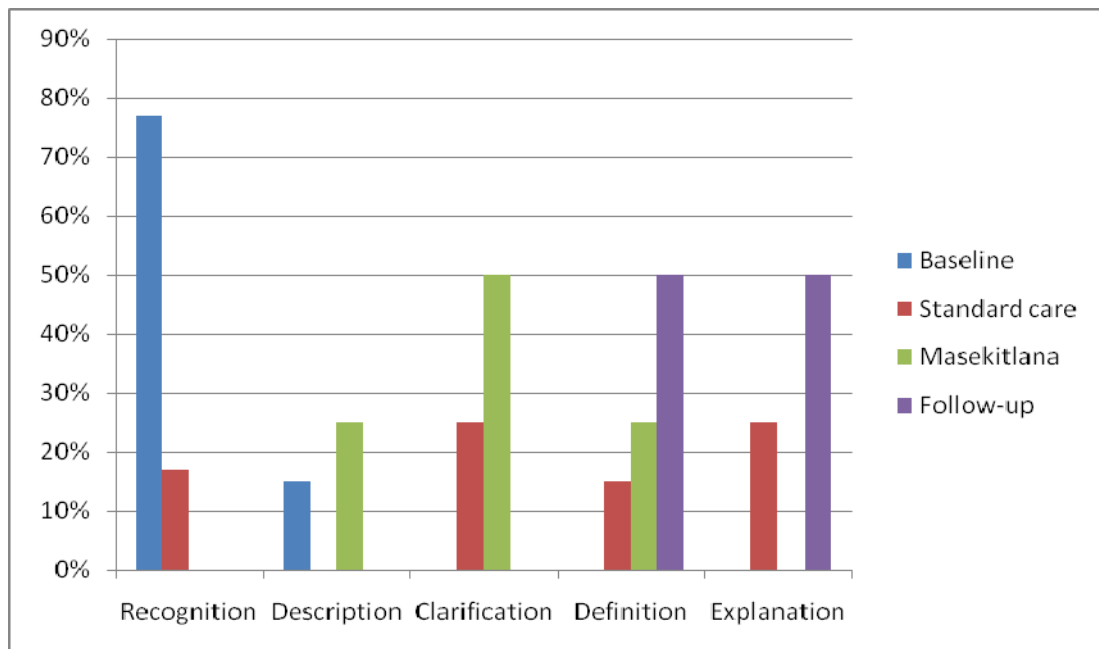


Figure 23: Senzo: Problem Identification Scales

From a simple recognition of a problem situation in the present (78% at baseline), Senzo’s problem-solving skills became more elaborate (50% in the Clarification category) after Masekitlana. At follow-up, Senzo scored 50% in both the Definition category (when a participant gives an explanation for and defines the feelings and behaviour of the character in the picture as well as some description of prior circumstances) and Explanation category (when his feelings around problem situations are fully elaborated as to cause and cognitive states, and when his internal conflicts are well articulated). This might have been an indication of Senzo’s improved problem-solving skills after the course of therapy, although

there was little indication to differentiate the two modes of therapy (25% score for Masekitlana in Definition category, and 25% score for standard of care therapy in Elaboration category).

5.3.2.4 Senzo: Resolution Scales

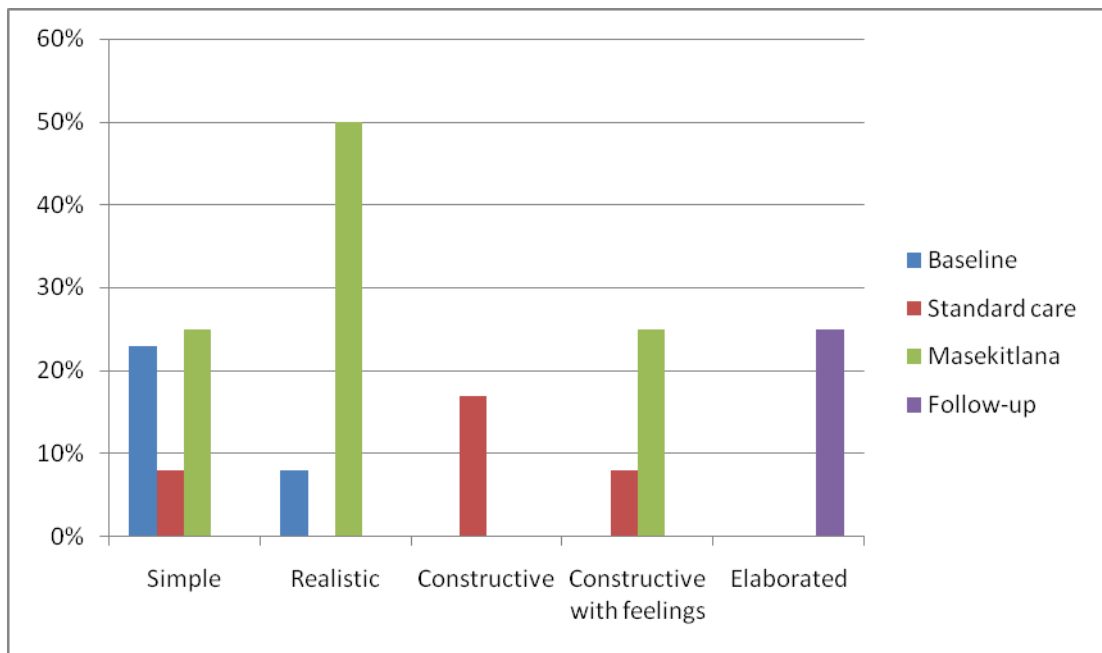


Figure 24: Senzo: Resolution Scales

At baseline, Senzo expressed elementary outcomes (23% response rate) that involved simple closure (Simple category). After standard of care therapy, he showed a 15% response rate for outcomes that showed more processing but where feelings were not addressed (Constructive category). After Masekitlana therapy his 50% response rate in the second level of resolution (Realistic) demonstrated a positive outcome to the stories but still no description of process or how the solution was achieved. However, this was partly compensated for by a 25% response rate of a more constructive resolution to the stories, where the process of solving problems is described and feelings are addressed (Constructive Resolution with feelings category). The most adequate resolution score was indicated under scale level 5 (Elaborated category) at follow-up, although this level of response was only for 25% of the total responses. Overall for this form of adaptive functioning, that is, successful resolutions to problems, Senzo's scores were low (mostly under 30%) but did show significant improvement with the intervention of Masekitlana.

5.3.2.5 Senzo: Emotion Scales

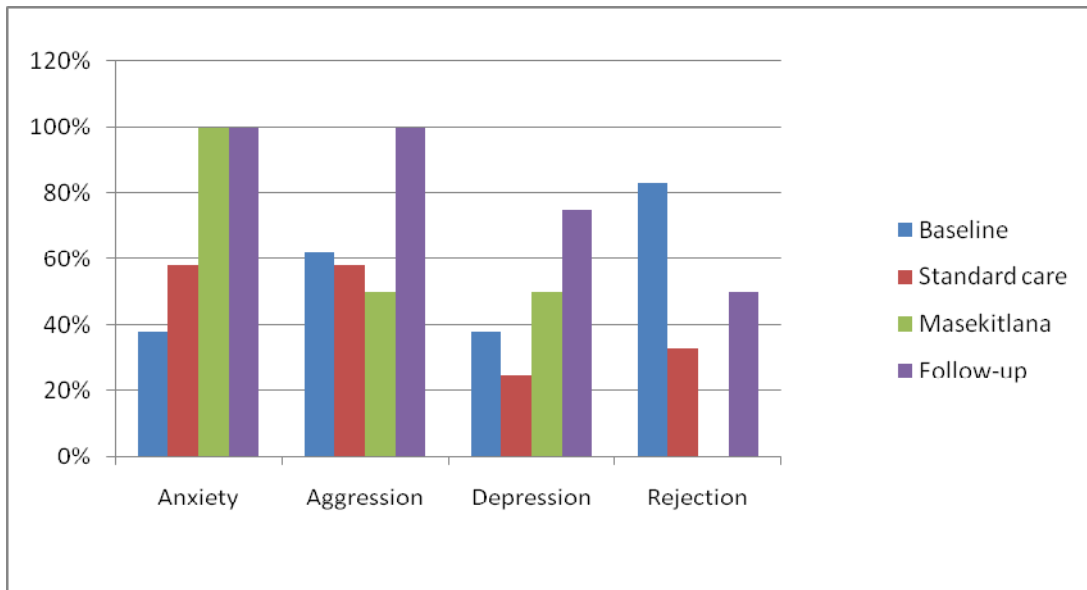


Figure 25: Senzo: Emotion Scales

Senzo’s Anxiety scores increased from 58% after standard of care therapy to 100% after Masekitlana and at follow-up. His Aggression scores were also at 100% at follow-up. Depression decreased after standard of care therapy (25%) but increased after Masekitlana (50%), and rose to 100% at the two-month follow-up assessment after therapy. Senzo’s scores might be synonymous with children who have clinical problems, who “tend to perceive more threatening and fearful stimuli in the environment than non-clinical/non-referred children” (Roberts, 2009:121). Although it is alarming in therapy to see an increase in this type of emotional content, I interpreted it as being the result of the participant feeling freer to express his formerly suppressed feelings. Senzo’s Rejection scores were highest at baseline (83%), decreased after standard of care therapy (33%) and disappeared totally after Masekitlana. This might have indicated that therapy enabled Senzo to see where he was obtaining forms of support in his environment. However, the effect did not last entirely, as his stories reflected 50% Rejection scores at follow-up, although this score was still significantly lower than a Rejection score of 83% at baseline.

5.3.2.6 Senzo: Outcome Scales

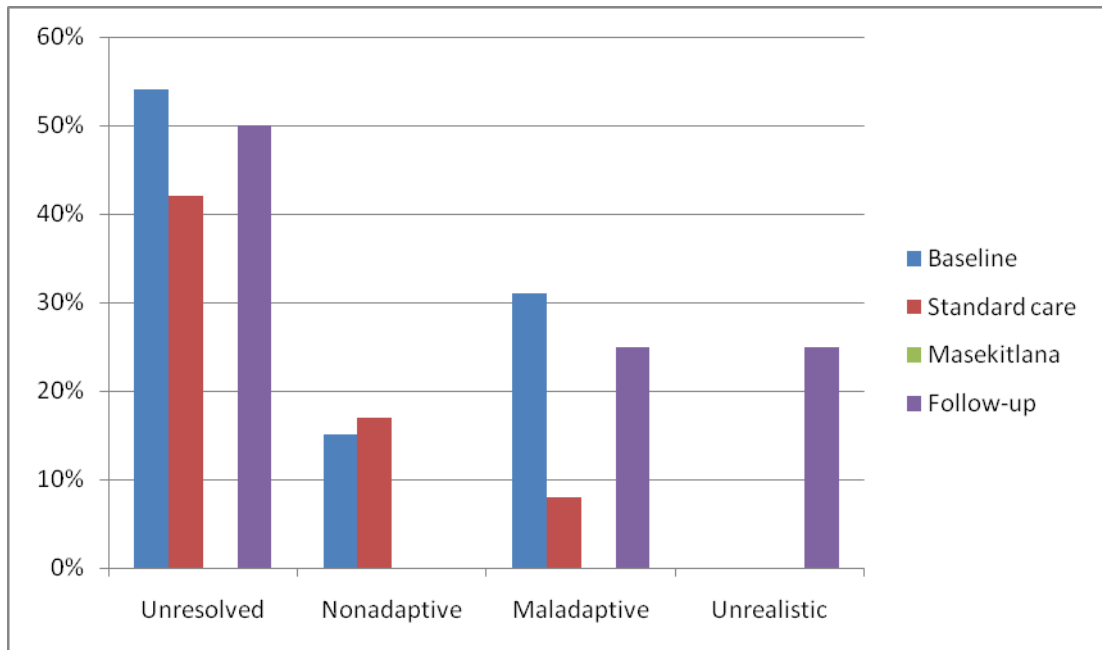


Figure 26: Senzo: Outcome Scales

Senzo's scores on the above scales indicated clinical or problem content in his expressions in response to the picture cards. Senzo's Unresolved content was high at baseline (54%), after standard of care therapy (42%) and after follow-up (50%). This indicated that the storyline was left in the present situation with no ending. Significantly, Senzo showed no problem content on any of the scales after Masekitlana. I interpreted this as indicating that he was feeling better equipped at this stage of therapy to confront and resolve his problem feelings and situations. However, this reflection was not maintained in certain of his stories at the follow-up assessment where he scored 25% for both Maladaptive content (where the situation becomes worse) and Unrealistic content (where the situation is beyond reasonable possibility). These Maladaptive and Unrealistic scores confirm Senzo's statements in the qualitative analysis, which demonstrated at times unrealistic or fantastical expectations for his life.

5.3.2.7 Senzo: Unusual or Atypical Responses

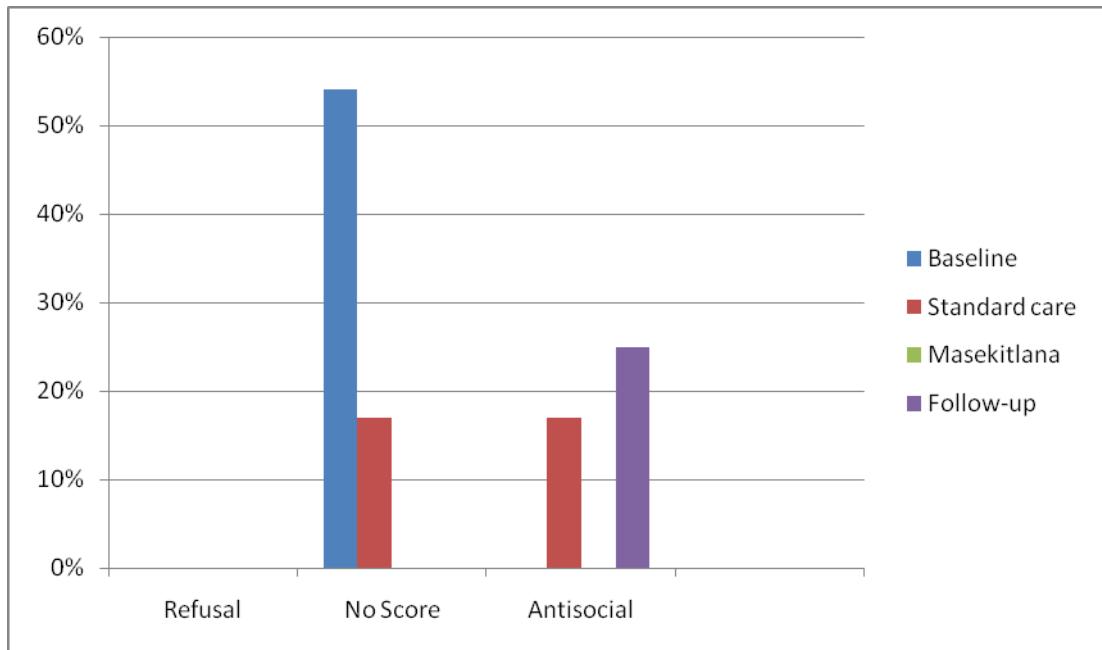


Figure 27: Senzo: Unusual or Atypical Responses

It can be seen that Senzo did not refuse to talk about any of the cards (he had a nil score on the Refusal category). However, his No Score results showed a 50% response at baseline, which indicated that, before therapy commenced, he did not produce any scoreable content to a card and his stories provided only physical descriptions of the pictures on the cards. This indicated, at baseline, that he tended to be thinking concretely, without the ability to achieve a more abstract level of thinking. This form of thinking occurred to a lesser extent after standard of care therapy (16%). (His ability to include the emotions of and interpretations of interactions between characters on the cards improved with Masekitlana therapy, as demonstrated by his Elaborated category score on the Resolutions Scales (section 5.3.2.4), and his Explanation category score on the Problem Identification Scales (section 5.3.2.3). Senzo narrated a small but noticeable percentage of antisocial descriptions (Antisocial category) after standard of care therapy and again after follow-up (17% and 25% respectively). This category indicates content that is thought to reflect behaviour that is against or that breaks rules, or represents a failure to conform to social norms with respect to lawful behaviour. Before Masekitlana, Senzo reflected such thought content in the form of anxiety over complying with school rules and wanting to imprison peers in the Home who were ‘naughty’. However, after Masekitlana, this form of antisocial expression was non-existent (nil score).

5.3.2.8 Senzo: Atypical Categories

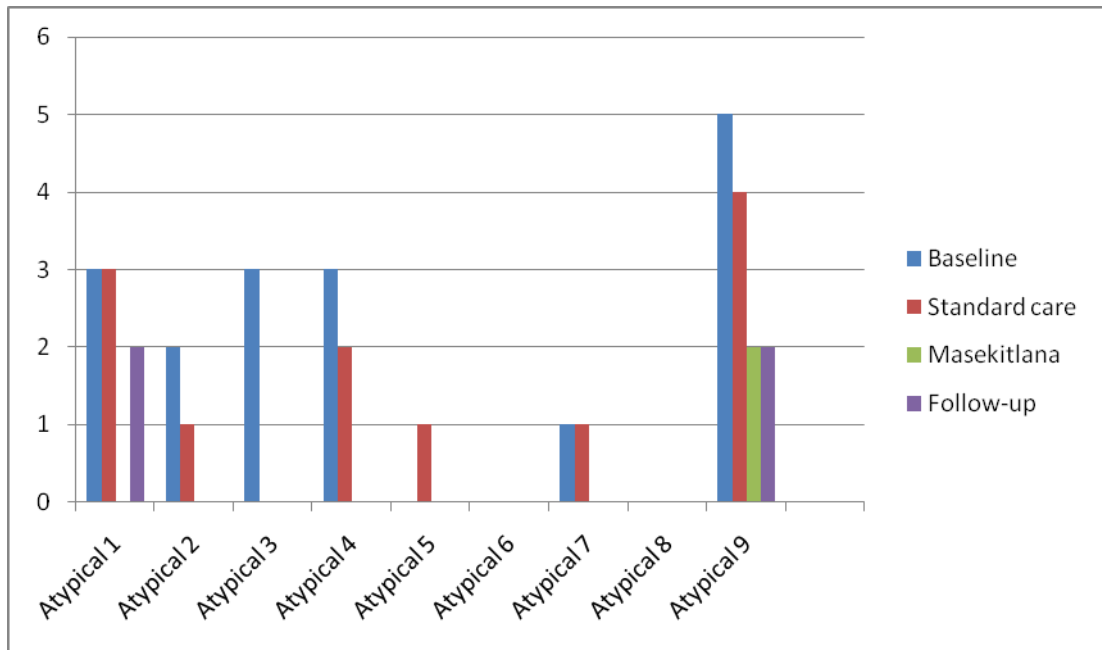


Figure 28: Senzo: Atypical Categories

Senzo’s stories reflected 6 different types of Atypical scores at baseline. “More than one atypical score usually identifies a significant level of psychotic disturbance” (Roberts, 2009:125). Atypical 1 score indicated how Senzo tended to describe stories in an illogical way at baseline (for 3 out of 13 cards) and after standard of care therapy (for 3 out of the 12 cards). Senzo demonstrated a high amount of Atypical 9 (other unusual content or clinically significant material), which reflected his repeated descriptions around not coping with school and other school-related problems. This was one of the themes of the qualitative analysis where his statements to this effect can be read. Fortunately, descriptions reflecting his concern with school difficulties decreased from 5 and 4 cards for baseline and standard of care therapy respectively, to 2 cards after Masekitlana and 2 cards at follow-up. This might have been an indication that the intervention of Masekitlana had helped him to come to some form of resolution to these problems.

5.3.3 GRAPHIC ANALYSIS OF NANA’S RESPONSES TO THE ROBERTS-2 TEST USING THE SCALES OF ROBERTS-2 MANUAL

Nana was a young girl who bemoaned being brought into the children’s home. It appeared that she had been living a stable life before that in the home of her grandmother but had been

sexually molested by men in the vicinity of the home. Her mother, however, lived a life on the streets, only appearing sporadically in her daughter’s life when the grandmother was able to organize to pick her up at an appointed spot. Even then, Nana’s mother would disappear from the home without informing anyone of her departure. At the time of the current study, Nana was adjusting to peer-conflict and group pressures in the children’s home and was looking forward to two years ahead, at which time, she had been informed, the court case regarding her molestation would be complete and she could return home to her grandmother.

5.3.3.1 Nana: Theme Overview Scales

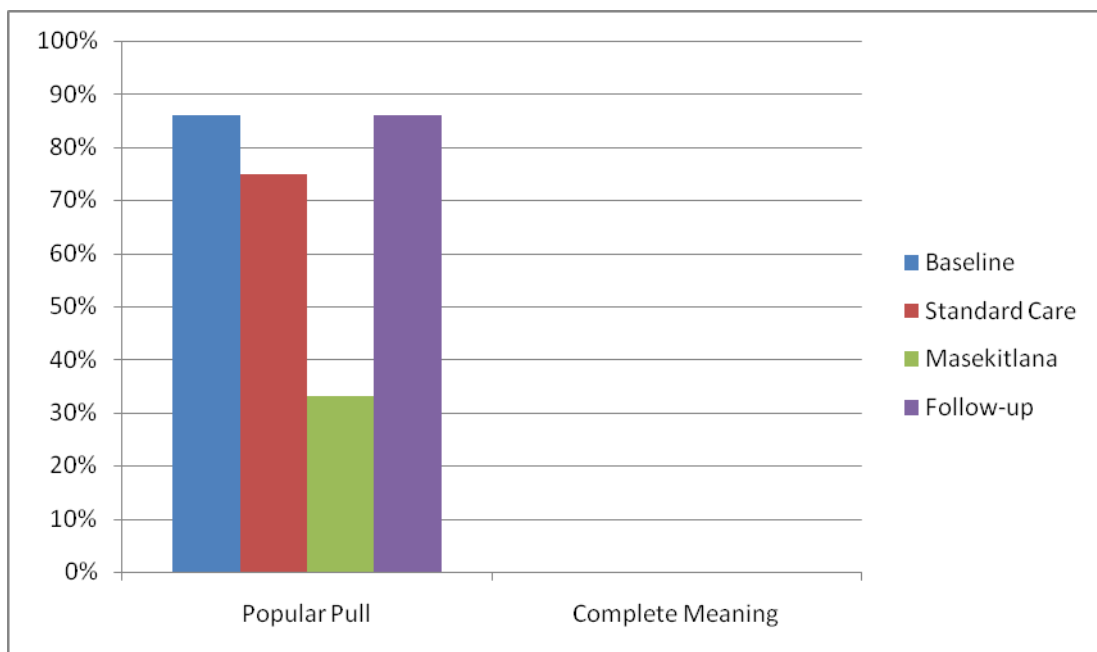


Figure 29: Nana: Theme Overview Scales

Nana’s low Popular Pullscore after Masekitlana (32%) compared with scores at other stages of therapy (85% for baseline, 75% for standard of care and 85% for follow-up) might have been an indication, at this particular stage, of “intrusion of problem feelings” (Roberts, 2009:115). She might have been suppressing her feelings about her sexual molestation, which Masekitlana might have caused to surface in her thinking. Before this Roberts-2 administration and during the Masekitlana intervention, her response was not usual to typical Western children’s responses in that she banged the stones together in an almost farcical, rap way, while narrating the story of a ghost/spirit around her. Furthermore, her response to the picture of a girl sitting up in bed was that a snake was wrapping itself around her neck. This is not a Popular Pull response according to the standardized findings of the test but, in African

thinking, beliefs around snakes are common. Another reason for the low Popular Pull at the third assessment after Masekitlana could have been that Nana had the day before this session, returned from her grandmother’s home with wounds on her arm from oil burns sustained when she had been cooking. Just before the session, the nurse and social worker of the Home treated the wounds and questioned her carefully as to their cause. This could have unsettled Nana for the session, as she was reluctant to talk about the picture cards thereafter. Her responses returned to being more realistic and appropriate, according to Western standards, at follow-up (85%).

At no stage did Nana describe a picture card with Complete Meaning (nil score at all four administrations of Roberts-2 on the Complete Meaning category). She did not respond well to the picture cards in general. Roberts (2005:116) claims that the inability to achieve a complete story “indicates possible clinical significance” and “difficulty with coping skills”. The picture cards of the Roberts-2 test did not seem to be the right medium in the current study to encourage Nana to talk about her life. She was much freer in communication with the unstructured activity or intervention of Masekitlana. She was able to freely narrate imaginative stories about ghosts and snakes in her life whilst knocking the stones together, but she was reluctant to narrate stories around the picture cards. She also frequently requested to play with clay and to draw rather than to talk about the cards.

5.3.3.2 Nana: Available Resources Scales

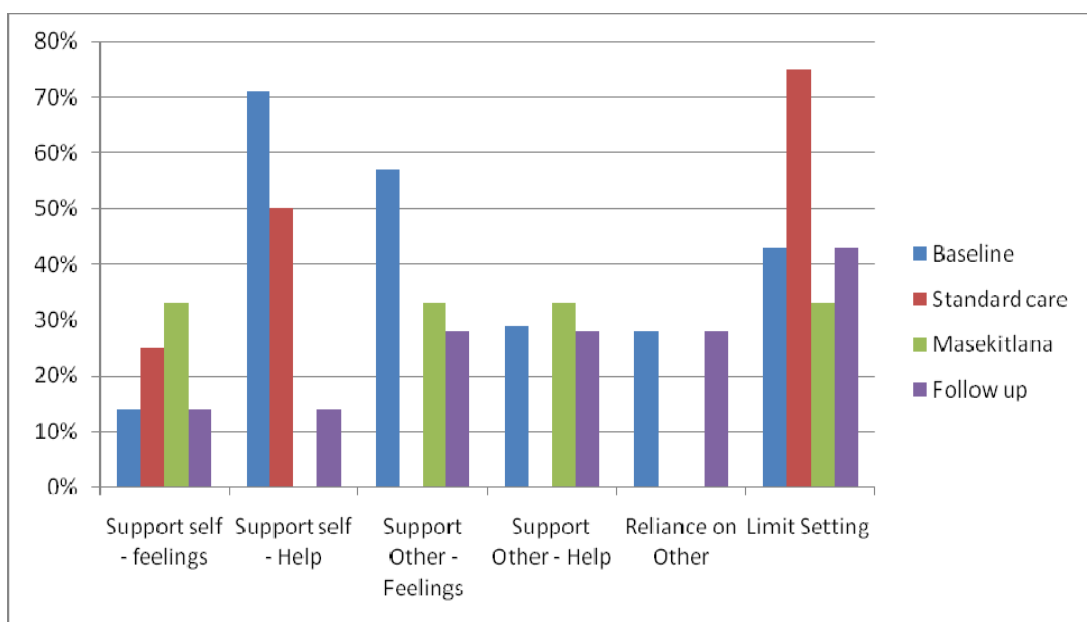


Figure 30: Nana: Available Resources Scales

Nana's score in the Support Self –Feelings category increased, initially, after standard of care therapy (25%) and then improved further after Masekitlana (to 33%). This might have indicated that, after the clay and drawing during standard of care therapy, and after playing Masekitlana (as well as the stone game *umbalabala*, which was spontaneously taught to her at the end of the session by the therapist), she felt more positive feelings and experienced a more appropriate form of self-esteem than at the beginning of the therapeutic process. She also might have felt more able to deal with problem feelings and situations through her own resources. Her responses to the picture cards at this stage of therapy, after Masekitlana, certainly indicated this. An example is her response to Card 16, where she stated, “The girl asked a question of her father, ‘Who was the creator of Jesus Christ?’”. Another instance is her response to Card 12, where the father/man appears to be hitting the mother/woman. She stated, “Then, the child ran away”. These responses indicated a certain amount of self-initiative in thought and action in that she did not only relate what she saw but she also offered some form of personal resourcefulness in managing the situation.

Although the above results indicated that Nana was feeling more competent in how she managed situations in her life, her Support Self – Help category score, after the Masekitlana intervention, indicated a lessening (from 70% for baseline and 50% for standard of care therapy to a nil score after Masekitlana) of confidence in her own abilities to actually help herself, to be persistent, and to gain insight and learn from an experience. These results might have been confounded by the situation that arose just after the Masekitlana intervention of therapy, where she was hit by the other girls and the next week was questioned by management as to the cause of her burn wounds. She was also quite likely to be feeling generally disempowered, as she had been uprooted from her home environment and subjected to court proceedings in connection with sexual abuse. The process of removing the participants from their family homes was a depersonalizing and disempowering experience for all of the participants, resulting in generally low scores on the Available Resources Scales.

In the Support Other – Feelings category, Nana's baseline stories achieved a satisfactory score of 56%, but a nil score was recorded after standard of care therapy. Her score increased moderately after Masekitlana (33%), and was maintained at follow-up (28%). However, these scores are not very high. Therefore, the indication is that therapy did not remarkably improve her sense that her support system was positive, comforting, helpful and responsive.

Similarly, in the Support Other – Help category, although Nana’s score after Masekitlana therapy indicated an increase of 30% from a nil score after standard of care therapy, her relatively low scores reflected her feelings that interactions with others did not yield any significant help in her life.

Nana’s relatively low scores (28% at baseline and at follow-up, but nil scores after standard of care therapy and Masekitlana) in the category, Reliance on Other, also demonstrated little tendency on her part to seek help from or reach out to the support system to help with problems. Nana articulated a lack of support from her schoolteachers and this could have been reflected in this category. Her score at follow-up, however, did indicate an increase from the scores recorded after standard of care and Masekitlana therapy. Therefore, the most that could be deduced from this was that therapy might have allowed her to express her general lack of confidence in others around her, although her 28% score at follow-up indicated a small but nevertheless existing expectation of others around her to be responsive to her needs.

Nana gave responses that reflected an awareness of punishments for bad behaviour and consequences of actions, as demonstrated by her high scores in the Limit Setting category (42%, 74%, 33% and 42%). High scores can also reveal inappropriate consequences. On analysis of her stories, I saw that she had experienced inappropriate limit setting, such as a mother who shouted abusively at her when she wanted Nana to help with the baby. After Masekitlana therapy, the level of limit setting decreased to 33% and this was maintained at follow-up. This might have indicated that she was expressing a fairer and more appropriate perception of limit setting at this stage of therapy.

5.3.3.3 Nana: Outcome Scales

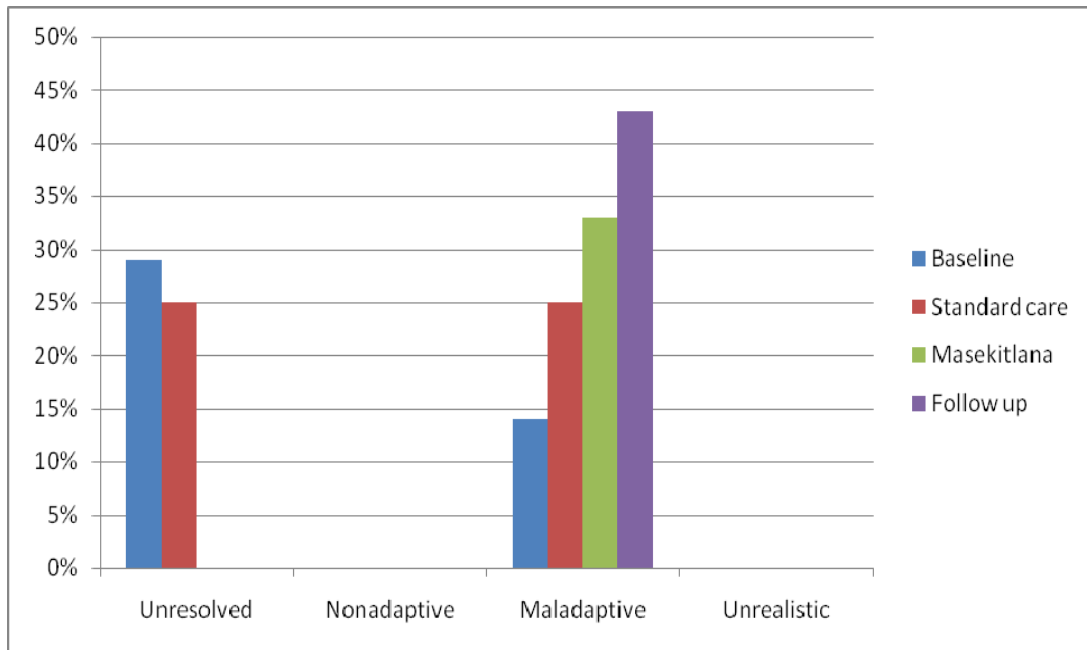


Figure 31: Nana: Outcome Scales

Of significance in the scoring for the above graph was that Nana's score in the Unresolved outcome category was nil after Masekitlana, indicating that, as opposed to before Masekitlana therapy, she was not leaving problem solving unsuccessfully in the present but was perhaps feeling that her problems might reach some form of solution. Her scores in the Maladaptive category were of some concern in that they steadily increased until follow-up. These scores indicated inappropriate responses to the picture cards and might have indicated acting-out behaviour that was liable to have made the situation worse. I did notice that Nana's narration became more and more out of touch with reality as the sessions proceeded. Either she felt, as a result of the traditional form of therapy, at liberty to include a certain element of fantasy into her narration of traditional beliefs, including ghost and snake stories, or she felt more freedom, as a result of therapy, to demonstrate rebellion, and oppositional thinking and behaviour to authority figures around her. Nana was not happy with her Home environment and longed to return to the home of her grandmother, although she understood that she had been placed in a safe refuge for a reason. Her Maladaptive responses might almost have been a foil to obviate her speaking about the sexual abuse she had experienced and that had led to her being placed in the Home. Roberts (2005:123) states that avoiding the demands of the situation by manipulation or deceit is also scored in this category. Nana had been accused of

stealing on two occasions at the Home. This could also have been reflected here in her increasingly higher Maladaptive scores.

5.3.3.4 Nana: Problem Identification Scales

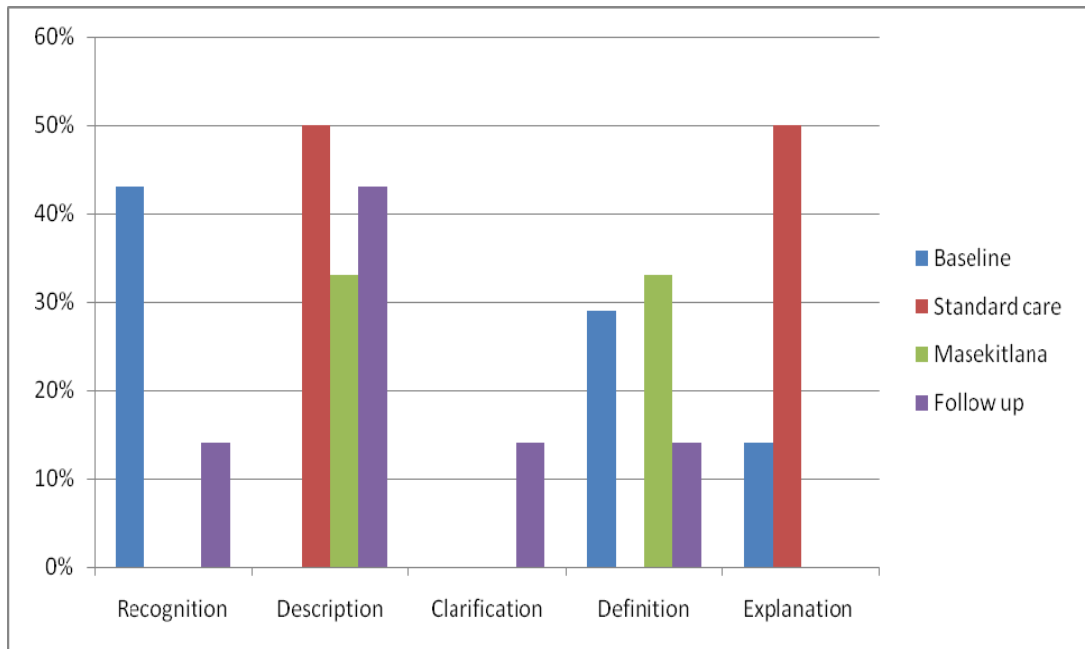


Figure 32: Nana: Problem Identification Scales

It can be seen from Nana's score (43%) on the Recognition category that she demonstrated simple recognition of her present situation without explanation of the preceding factors at baseline, that is, before therapy commenced, although there was a certain definition of the problem as indicated by her Definition score at baseline (28%). Her description (Description) of feelings, the reasons for her situation and her internal conflicts were better articulated after standard of care therapy. There was a diminishing of this score after Masekitlana therapy although only slightly (from 50% to 32%). Her score after Masekitlana in the Definition category reflecting explanations in her stories of feelings and behaviour as well as articulation of her internal conflicts, indicated a 100% increase compared with after standard of care therapy. Masekitlana might have enabled her to see her problems more clearly. Her elaborated Explanation score was high after standard of care therapy (50%). As this is the highest form of explanation, it appeared that standard of care therapy enabled this. However, assessment after Masekitlana therapy did not result in stories of this level of elaboration. It was difficult from these graphic results to pick up any clear trends.

5.3.3.5 Nana: Resolution Scales

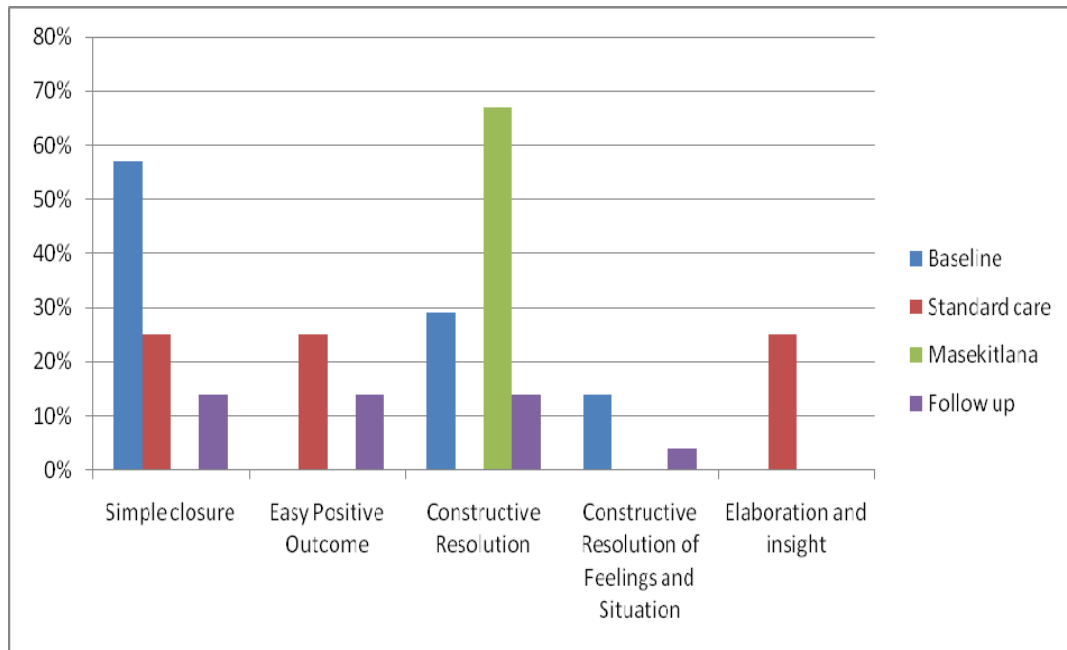


Figure 33: Nana: Resolution Scales

Nana started out with 56% of her descriptions representing simple or elementary closures (in the Simple Closure category), where the endings did not have realistic continuity to content and few process or mediating steps were mentioned. After standard of care therapy, her responses to the Roberts-2 indicated a diminishing in percentage (from 58% at baseline to 25%) in her responses involving Simple Closure to stories. Also after standard of care therapy, her responses demonstrated movement up (a percentage of 25%) the hierarchy of the Resolution Scales to expressing Easy Positive Outcomes, that is, outcomes where the ending is related to the content of the present situation and a positive outcome is envisaged, although there was no description of how the solution was obtained. Of particular interest in this graph is that, after Masekitlana therapy, Nana's stories demonstrated that 68% of her responses satisfied the Constructive Resolution category scale. This indicated that, after Masekitlana, Nana expressed a more positive outcome to stories, although feelings around the pictures still may not have been addressed. Also after standard of care therapy, Nana scored 25% in the Elaboration and Insight category, indicating a constructive resolution of both feelings and the problem situation. Unfortunately, on follow-up, Nana demonstrated few positive outcomes to her story descriptions.

5.3.3.6 Nana: Emotion Scales

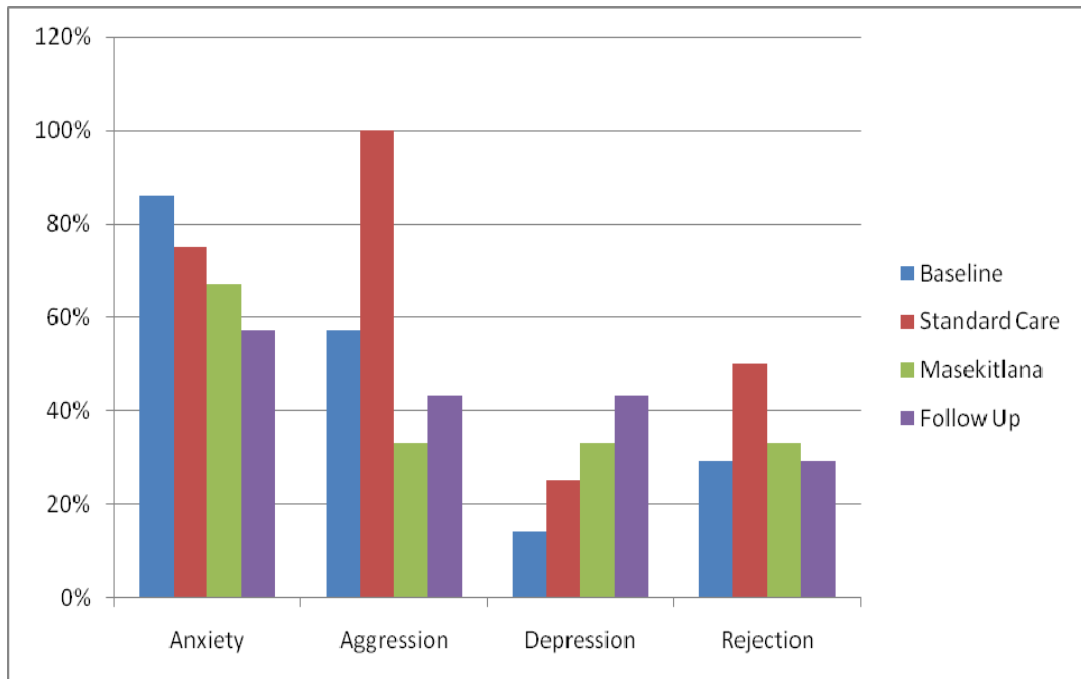


Figure 34: Nana: Emotion Scales

Nana's Anxiety level began at a significant high (82%) and decreased in a regular step-wise pattern as therapy progressed. Both standard of care therapy (68%) and the intervention of Masekitlana (58%) appeared to have had an equal effect in slightly reducing her Anxiety levels. Nana's score for Aggression reached a significantly high level (100% of the stories indicated Aggressive content) after standard of care therapy. The cause of this could have been that she had been hit by her peers on the day that the Roberts-2 was meant of be administered after standard of care therapy. A day later, the test was re-administered and it reflected her angry feelings. After Masekitlana and to a certain extent at follow-up, her Aggression appeared to have diminished (scores of 26% and 41% respectively). I felt that Masekitlana, and the fact that there had been a mediation process with her peers, had helped reduce her levels of expressed aggression. Nana always expressed the hope that she was to leave the Home at the end of 2011, although she had been informed that her departure would only be at the end of 2012. Hence, her expressed levels of Depression were not very high, although, from a very low base (14%) at baseline, they increased to 41% at follow-up. As with the other participants, I felt that therapy enabled Nana to express her feelings and hence, for certain emotions, the scores increased with therapy, in particular for Aggression, to a minor extent for Rejection after standard of care therapy (50%) and for Depression in general

(28% at baseline, to 50% after standard of care therapy, to 30% after Masekitlana, to 28% at follow-up). The Rejection score increased after standard of care therapy, probably also due to her peers hitting her, but by follow-up her score had decreased again to baseline levels.

5.3.3.7 Nana: Unusual or Atypical Responses

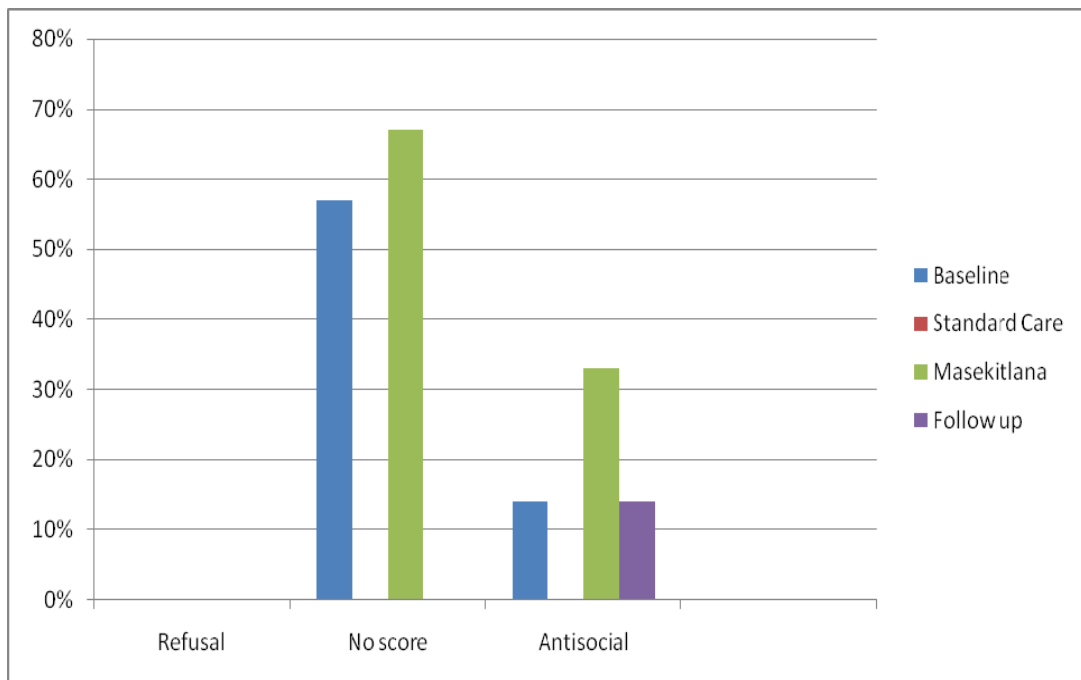


Figure 35: Unusual or Atypical Responses

Nana did not score in the Refusal category although there were certain cards that she consistently refused to talk about, such as the boy looking around the door as the girl bathes. I presumed that this signified “blocking of anxiety-provoking content” (Roberts, 2005:124) as her privacy had in reality been violated by the sexual abuse perpetrated on her. Nana scored significantly in the No Score category. At all times, she responded with low motivation to the cards, requesting frequently to rather play with the stones or clay, or to draw. Hence, her high No Score responses probably indicated a certain amount of oppositional behaviour, which is in accordance with the report of her behaviour by the social worker of the Home. Her high score in this category could also have indicated emotional blocking but, in her case, was not likely to have indicated limited cognitive functioning. She expressed a certain amount of antisocial content as shown in the Antisocial category. Her score increased to 32% after Masekitlana. This could have demonstrated a form of acting-out behaviour or thinking, which Nana might have been released to express after she had played with the stones. Her Antisocial

score is also confirmation of her disregard for rules and principles, which had led her to run away and steal from others on more than one occasion.

5.3.3.8 Nana: Atypical Categories

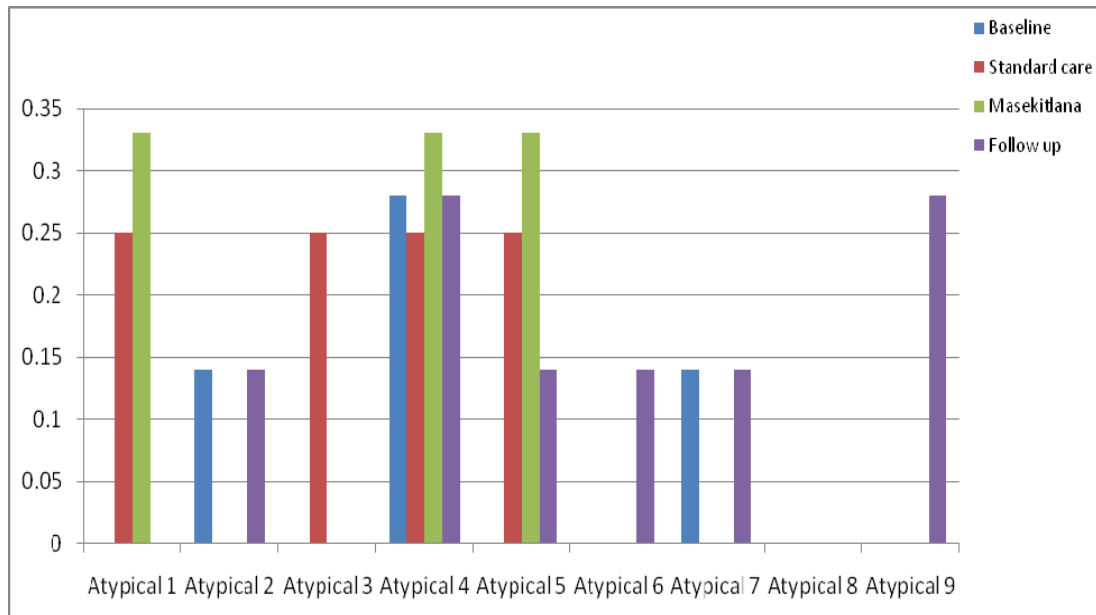


Figure 36: Atypical Categories

Nana’s atypical scores were at their highest after Masekitlana and were most frequent at follow-up. She was very oppositional regarding the picture cards at follow-up. She expressed atypical remarks or stories expressing violence or excessive aggression (33%). This might have been reflective of the Home environment, where she described a considerable amount of physical fighting. Her stories related the death of the main figure (Atypical 7), and demonstrated a misidentification or denial of theme (Atypical 2), a misidentification of person (Atypical 3), abuse including physical abuse, sexual abuse or deprivation (Atypical 5), illogical description, including cognitive distortion and looseness of thought (Atypical 1), and imaginary content (Atypical 6). At follow-up, I scored Nana twice for neglect by mother. It was at this point of the therapy process that she openly expressed forms of neglect and rejection by the mother figure in the picture cards. “Multiple scoring such as this identifies serious pathology and material that should be investigated further in interviews with the caretakers” and more than one Atypical score “usually identifies a significant level of psychotic disturbance, depending on the nature of the content” (Roberts, 2005:125). If I did not understand the tendency to believe in and talk about spirits and snakes in the Zulu culture,

I might have been mistaken Nana's traditional African narrative content for some form of psychotic disturbance.

5.4 INTERPRETING GRAPHIC RESULTS: COMBINING AND COMPARING PARTICIPANT RESULTS

Most of the scales indicated significant improvements or effects after standard of care therapy and even more so after the intervention of Masekitlana. In particular, the quantitative results indicated that Masekitlana helped participants to conceptualize stories with insight and clarity. Results indicated that, after Masekitlana, participants were more ready to use the support of others and their own resources to overcome their challenges. Graphs indicated that Masekitlana resulted in resolutions to problems, although all participants still indicated a certain amount of negativity in outcomes to challenging situations. Emotions were heightened after Masekitlana according to the graphs, and this was confirmed in their multiple responses on the Atypical Responses scale. Multiple scoring such as this identifies serious pathology and material that should be investigated further (Roberts, 2005), therefore I concluded that all three participants would need further support in forms of counselling and other resources in their lives. Results on the different scales were not consistently similar for all participants.

Particular effects of Masekitlana as indicated in the graphs were as follows:

- **Popular Pull**

For all participants, Masekitlana resulted in a decrease in Popular Pull scores, which might have indicated the intrusion of problem feelings into their narration as a result of feeling free to express themselves more openly during this intervention therapy. Alternatively, these scores might have indicated that Masekitlana gave participants courage to express individual creativity in story-telling.

- **Complete Meaning**

Hlonipho and Senzo showed a moderate increase after Masekitlana in being able to narrate stories where endings and outcomes were positive and successful in resolving problem situations and problem emotions.

- **Available Resources**

Masekitlana made a difference to Hlonipho's and Senzo's scores relating to how they used their own resources and the support of others, in particular the former. Nana appeared to be using various forms of resources as a result of standard of care therapy *and* Masekitlana.

- **Limit Setting**

Participants' Limit Setting scores all increased after Masekitlana, which could have demonstrated that they were feeling more adequately rule-bound after Masekitlana than before, and that discipline was being meted out appropriately, or it could have demonstrated that they felt that it was too harsh, depending on the content of their descriptions.

- **Problem Identification**

Masekitlana had a marked effect on Hlonipho's problem explanations, bringing him up to the level of elaborated explanations. Senzo was also affected by Masekitlana, although he only reached clarification. Nana was more affected by standard of care therapy than Masekitlana.

- **Problem Resolution**

All three participants' scores indicated more socially acceptable and complex resolution to problems after Masekitlana, with Hlonipho reaching a majority of successful solutions at the highest level of resolution after Masekitlana.

- **Emotions**

In Hlonipho and Nana, emotional scores were elevated as a result of Masekitlana, but for Nana, emotional scores were less affected by Masekitlana than standard of care therapy.

- **Outcome**

Masekitlana only had slight effects on participants' scores on scales indicating reduction of negative solutions to problems or feeling they were able to confront their problems.

- **Unusual or Atypical Responses**

Only Senzo appeared to benefit from Masekitlana in the reduction of scores indicating inappropriate responses to the picture cards.

- **Atypical Categories 1 to 9**

Masekitlana appeared to aid Hlonipho and Senzo in reducing the atypical responses (for instance excessively violent interpretations of picture cards) and helped them to express what they were particularly worried about. However, after or as a result of Masekitlana, Nana continued to interpret the picture cards in atypical ways.

Of the three participants, Hlonipho showed the most amount of improvement after both forms of therapy but in particular, Masekitlana. Nana showed the least amount of improvement. She was a recalcitrant participant in that she did not want to describe the picture cards, but did so with great reluctance. In many of the graphs in the preceding sections, it can be seen that participants' scores improved to a greater degree after Masekitlana than after standard of care therapy.

However, because of the *cumulative* effect of Masekitlana following on from standard of care therapy, it would not be accurate to compare the numerical results of the two different therapies and draw firm statistical conclusions from this. For instance, if a participant scored 20% between baseline and the completion of standard of care therapy, and 40% between the completion of standard of care therapy and the completion of Masekitlana, I could not say categorically that Masekitlana had a 100% better effect than standard of care therapy. This is because standard of care therapy might have been laying the foundations for the greater effect of Masekitlana. However, I was able to deduce from the difference in scores that Masekitlana *appeared* to have had a greater effect than standard of care therapy.

The following two graphs show the difference in scores between the two forms of therapy.

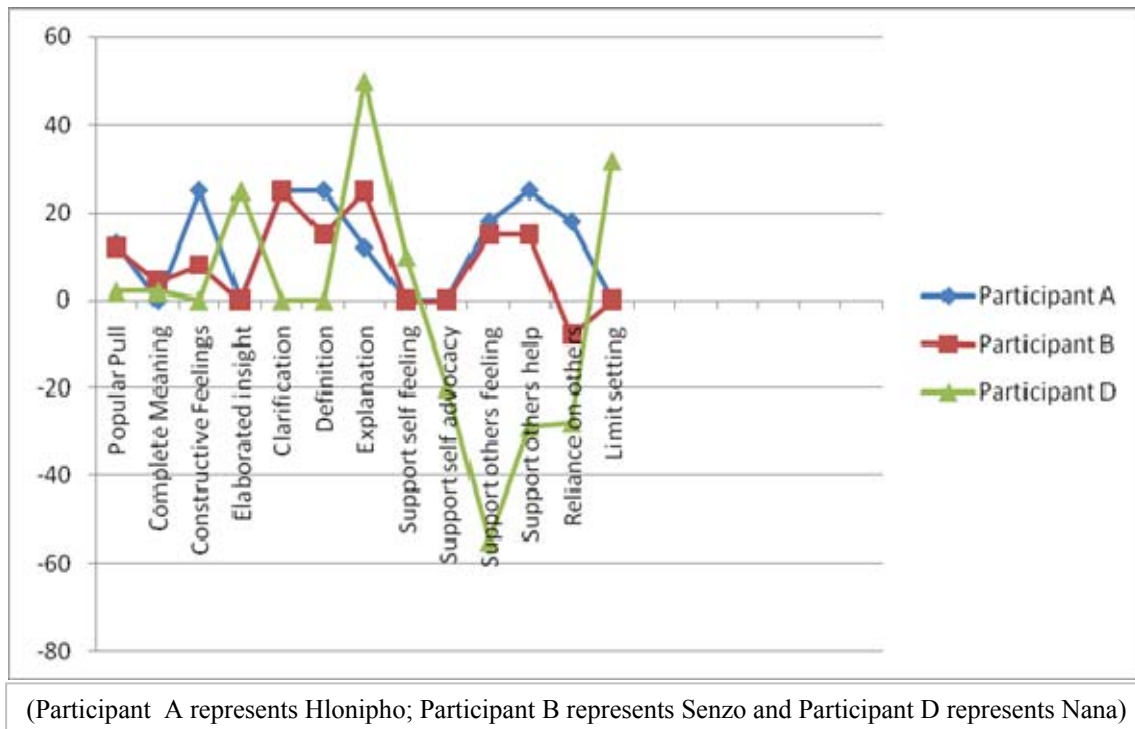


Figure 37: Progress scores from baseline to end of *standard of care* therapy

5.4.1 COMPARING PROGRESS AS A RESULT OF STANDARD OF CARE THERAPY WITH THAT OF MASEKITLANA THERAPY

As an explanation, take the score of Senzo for Popular Pull: his marker is at 12, which indicates that he improved by 12% between baseline and after standard of care therapy.

It can be seen from the above graph that progress scores, as a result of standard of care therapy, were predominantly in the range of between 0 and 23. Nana's scores were erratic, which was indicative of her attitude to therapy and the assessments, as reflective of her attitude to living in the Home.

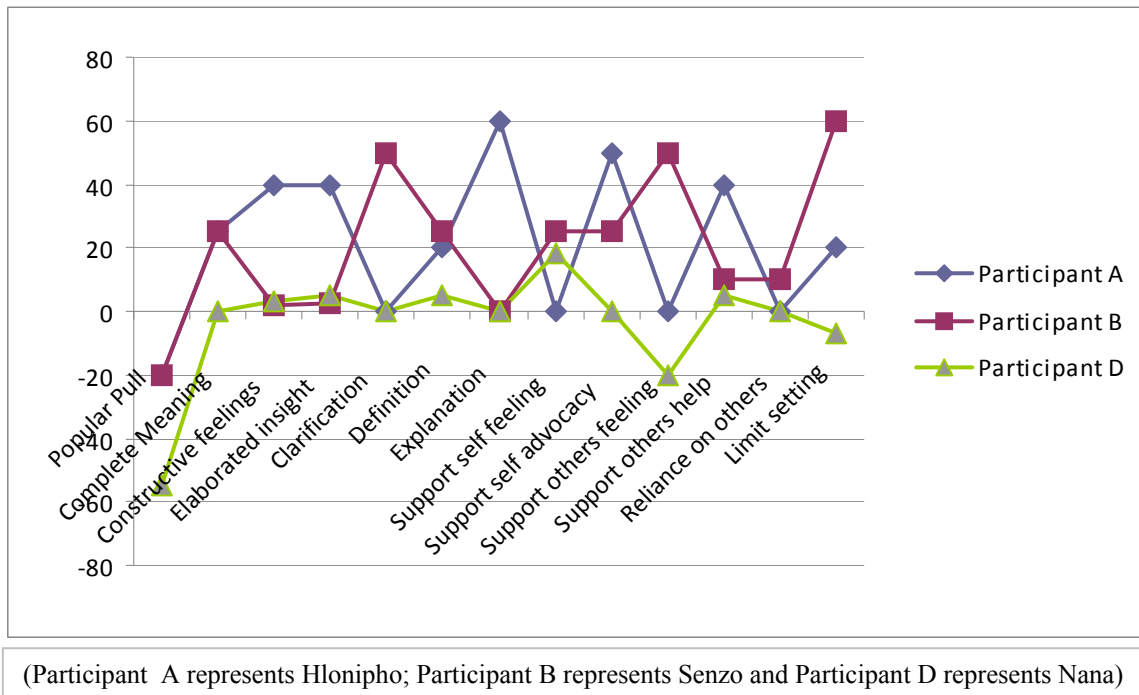
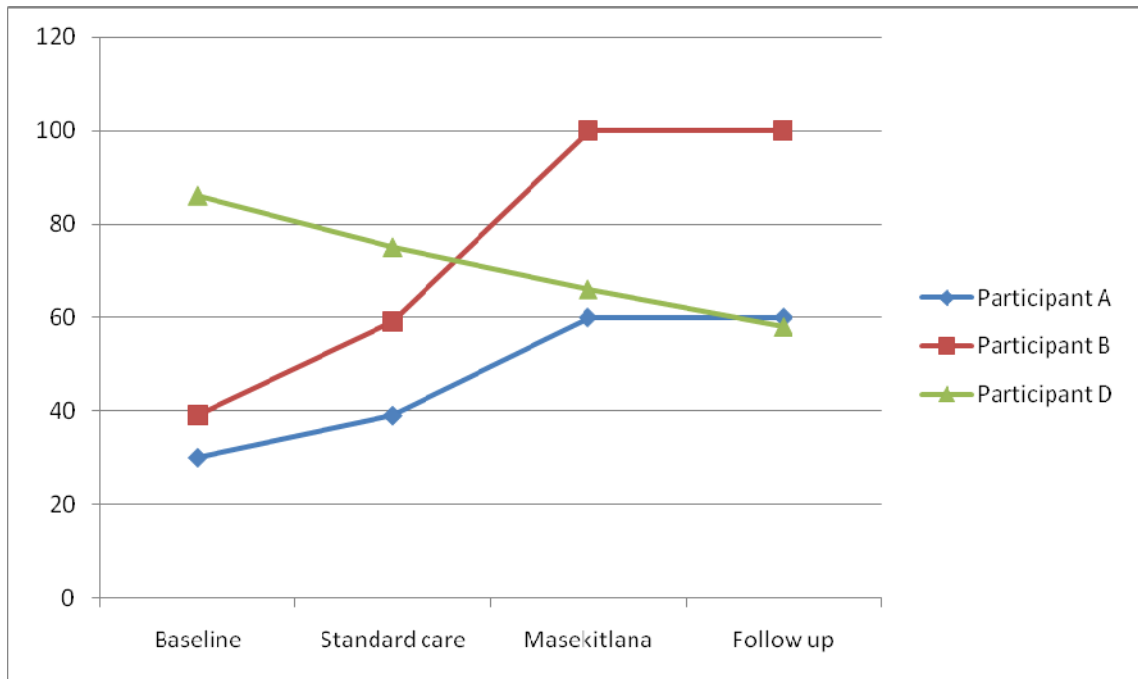


Figure 38: Progress scores from baseline to end of *Masekitlana* therapy

As an explanation, take the score of Senzo for Complete Meaning: his marker is at 23, which indicates that he improved by 23% between baseline and after *Masekitlana* therapy. It can be seen that progress scores for *Masekitlana*, indicated in the graph above, ranged predominantly between 0 and 45, hence into higher ranges than standard of care therapy. For Nana, playing with clay and drawing in the standard of care therapy sessions produced greater scores than *Masekitlana*, as is shown by examining her results in these graphs. Her talking whilst playing with the stones and in describing the picture cards after *Masekitlana*, appeared very negative, hence her low adaptive scores on the Robert-2. However, *Masekitlana* might have produced an accurate representation of her feelings and attitudes, although they were not socially very adaptive.

5.4.2 CHANGES IN EMOTION LEVELS OF PARTICIPANTS



(Participant A represents Hlonipho; Participant B represents Senzo and Participant D represents Nana)

Figure 39: Anxiety levels of participants as therapy progressed

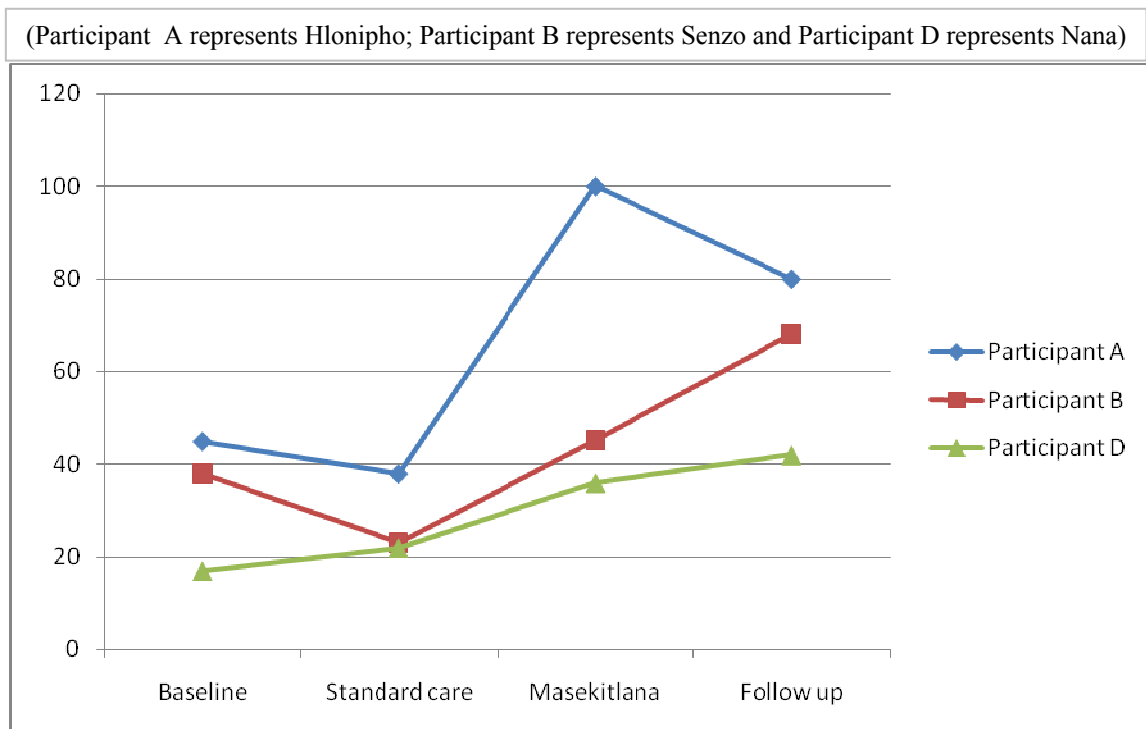


Figure 40: Depression scores of participants as therapy progressed

The graphs above indicate how the participants' scores on the emotional scales consistently (with the exception of Nana's anxiety scores) increased as therapy progressed. Of particular note is that the emotion scores rose fairly sharply as a result of Masekitlana (from 60 to 100 for Hlonipho, and 40 to 60 for Senzo on the Anxiety scale; from 40 to 100 for Hlonipho, from 20 to 43 for Senzo, and from 20 to 38 for Nana, on the Depression scale), as opposed to standard of care therapy (from 40 to 60 for Hlonipho and from 25 to 40 for Senzo, on the

Anxiety scale; there was a decrease for all three participants from 43 to 30 for Hlonipho, from 40 to 20 for Senzo, and a slight rise from 18 to 20 for Nana, on the Depression scale). I therefore deduced that the intervention of Masekitlana encouraged more honest, open and free expression from the participants of their feelings, hence the increased emotion scores. Expressed emotions moderated somewhat at follow-up, but did not return to baseline. If the participants had been given the opportunity of further therapeutic sessions, they might have been able to resolve their heightened emotions.

5.4.3 LIMIT SETTING SCORES OF PARTICIPANTS AS THERAPY PROGRESSED

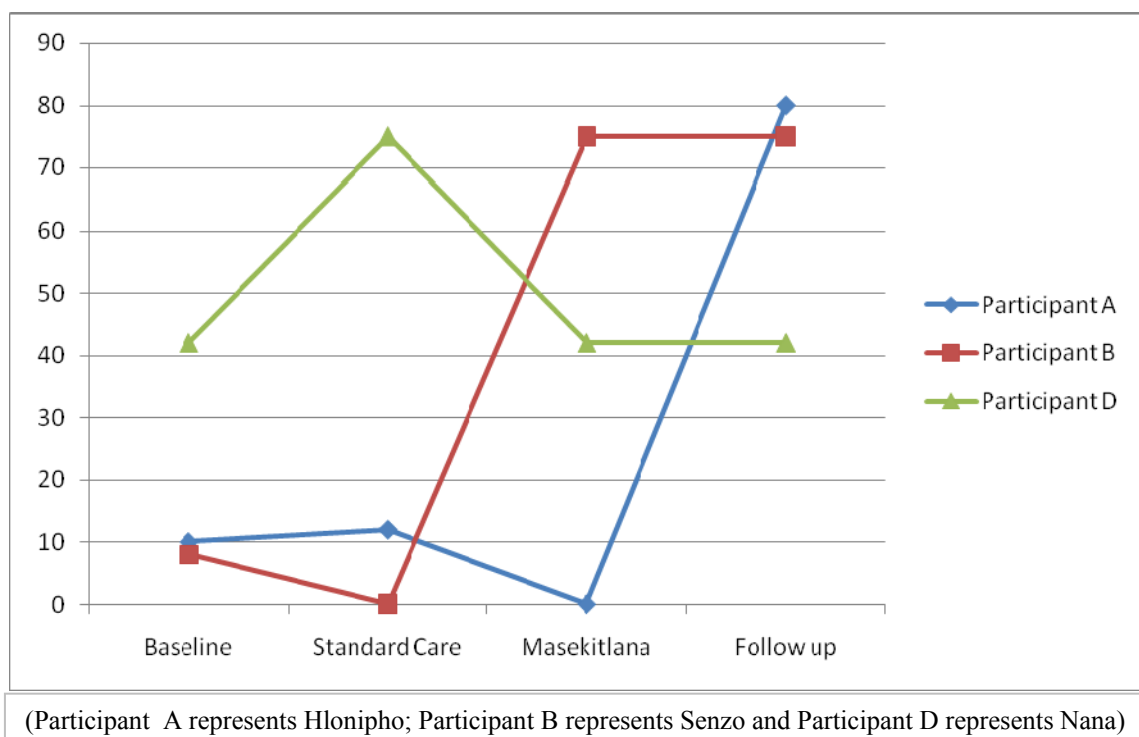


Figure 41: Limit-setting scores of participants as therapy progressed

Hlonipho's and Senzo's scores increased on the Limit Setting scale after the intervention of Masekitlana, and Nana's scores increased as a result of standard of care therapy. For Hlonipho, this reflected his expressed need and increasing awareness of appropriate boundaries around him and his wish to be guided by adults around him. Senzo appeared afraid of harsh consequences, in particular in his school environment; hence, his scores on the Limit Setting scale reflected subjectively harsh and inappropriate forms of punishment. In Nana's case, her increased score reflected her descriptions around inappropriate boundaries and physically and sexually abusive situations in her life. It reflected inappropriate consequences

for bad behaviour from teachers, and a mother figure who was angry but administered no consequences. As Roberts (2005:118) states, “Clinically referred children and adolescents usually have experienced inconsistent and inappropriate limits, and such experience promotes confusion in understanding and responding to the rules and expectations of the environment”.

5.5 CONCLUSION

In this chapter, the participants’ responses to the picture cards of the Roberts-2 test (2005) were coded, scored and presented in the form of graphs. The graphic results were then analyzed and interpreted. I decided to present a graphic presentation of the results in order to more clearly indicate *progress* in therapy which would have been difficult to prove with the qualitative analysis alone. Graphic analysis also enabled differences of effects between standard of care therapy and Masekitlana. Graphic representation is also an acceptable part of the single-system design as described by Strydom (2005d).

The graphic evidence indicated progress in therapy and improvement in the adaptive and problem-solving skills of the participants as a result of both forms of therapy. There was, however, a greater increase/improvement in participant scores on the Roberts-2 scales after Masekitlana, and this was generally maintained during the two-month follow-up (Baseline B) phase. I question, however, whether an *accumulation* of therapy beginning at standard of care therapy as well as exposure to helping, supportive persons in the form of therapist and researcher might have contributed to the clear increase in scores during Masekitlana intervention, as opposed to the positive changes being solely credited to Masekitlana.

An interesting finding was that participants’ anxiety and depression scores increased *after* Masekitlana, although their levels of expressed aggression generally decreased slightly. The reason for the increase in anxiety and depression could have been that the participants appeared to be suppressing their emotions at the outset of therapy, and after Masekitlana, they were more able to express how they felt. I noticed that therapy enabled all four participants to reflect on and consider the experiences in their lives. The realities of their lives that they openly expressed during therapy might have disturbed them, hence, the increased emotional content after therapy. I recommended that all four participants should continue therapy after the study was complete. Hlonipho was reportedly ‘acting out’ after therapy and he therefore continued to receive therapy in the McCord Hospital psychology clinic after the completion of the research.

Another interesting finding was that participants appreciated playing with and manipulating the stones to the point where they were better able to describe the picture cards if they were playing with the stones at the same time. It had not been my intention to allow the participants to play with stones during the assessment sessions of the Roberts-2, after completion of Masekitlana. However, from the first session of Masekitlana, they asked for the stones at each subsequent session, whether it was during the intervention of Masekitlana or during the Roberts-2 sessions. They and the therapist also enjoyed playing other types of stone games at the end of the therapy sessions. These were all traditional African stone games. Two of these games were taught by the therapist to the participants and one of them was taught by Hlonipho to the therapist.

In the next chapter, I will clarify, through the use of literature, the findings from the thematic content analysis and themes that emerged from participants' narratives. I will also link up findings with the literature discussion in Chapter 2.

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