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# An evaluation of the Learning Support Group Programme at the UCT Child Guidance Clinic

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## DECLARATION

**This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.**

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# ABSTRACT

The objective of the Learning Support Group (LSG) programme at the UCT Child Guidance Clinic (CGC) is to develop the academic and psychosocial functioning of children with learning difficulties. The programme operates on the rationale that remediation alone cannot address the multiple needs of the learning-disordered child, and that psychotherapeutic intervention for the child and for his or her parents may enhance the child's academic, emotional and behavioural functioning. This study evaluated the programme outcomes for the child participants ($n$=6), and for the participating parents ($n$=9), of the 2006 LSG programme. A single-group pre- and post-measures design was used. Data were triangulated from multiple sources including pre- and post-intervention semi-structured interviews with the children and with their parents, qualitative reports from the children's teachers, parents' and teachers' ratings of the children's cognitive and behaviour problems on the Conners' Rating Scales – Revised, the children's school reports, and scholastic tests conducted by the LSG remedial teacher. A combination of qualitative and quantitative analytic methods were employed. Findings from the evaluation indicated a statistically significant improvement in the children's academic functioning and in their problem behaviours, and qualitative reports of progress in their social relationships. The participating parents' reported that their knowledge and understanding of learning disorders had increased, alongside the acquisition of parenting and homework strategies. Parents also experienced positive shifts in their parenting style and in their relationship with their child. Given a number of methodological limitations, the extent to which the LSG intervention is responsible for these shifts cannot be conclusively established, however, the findings suggest considerable promise for its efficacy. Recommendations for the evaluation of similar programmes are offered, based on the lessons learned from the current study.

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# CHAPTER 1 INTRODUCTION

In South Africa, there exists a dearth of support services available for learners with learning difficulties in the formal education system (Biersteker & Robinson, 2000; Flack, 2005; Holz & Lessing, 2002; van den Berg, 2004). An inequitable specialized education system was inherited from the Apartheid era (Biersteker & Robinson, 2000; Donald, 2007). While specialized services and facilities were developed and accessible to the privileged minority, learners with special needs who lived in socio-economically disadvantaged communities were excluded from expert interventions, commonly resulting in repeated scholastic failure and eventual dropout (ibid.). The low educational attainment of these children was associated with future socio-economic disadvantage, and the cycle of poverty and inequality was thus perpetuated through the education system (ibid.). The post-Apartheid inclusive education system seeks to redress these issues by initiating policies aimed at inclusion and support of learners with 'barriers to learning', be these the product of inherent cognitive difficulties, or of environmental causes, such as inappropriate pedagogy and poverty-related factors (to be discussed further in Chapter Two). However, there are constraints to the implementation of these policies, which include, among others, backlogs in fundamental components of services, for example, the training of mainstream teachers in identifying, facilitating and supporting the inclusion of learners with special needs into classrooms, as well as the inefficient co-ordination and distribution of services (Biersteker & Robinson, 2000; Engelbrecht, 2006; van den Berg, 2004). As a result, children with learning difficulties who reside in schools where inclusive education conditions have not been met, and who do not have access to appropriate intervention, are likely to be at risk for the abovementioned socio-economic risks, as well as being vulnerable to compromised psychological well-being, that is, emotional, behavioural and relational difficulties (Biersteker & Robinson, 2000; Carr, 1999; Donald, 1994; Donald, 2007; Lopes, 2005; Rourke & Fuerst, 1991, Rutter, Taylor & Hersov, 2002). This study aims to evaluate a multi-modal intervention for such children, which has the potential to be implemented in community-based settings.

This introductory chapter describes the background, aims and underlying assumptions of the intervention programme, followed by an outline of the rationale and aims of the study, as well as an outline of the structure of this thesis.

## 1.1 The Learning Support Group Programme[1]

The Learning Support Group (LSG) was first implemented in 2000 on the initiative of the University of Cape Town's (UCT) Child Guidance Clinic[2] (CGC). It developed in response to the growing need for support for children with learning difficulties referred to the CGC for psychometric assessment, after changes in the education system resulted in the gradual phasing out of special education and the subsequent mainstreaming of children with learning difficulties. Limited referral possibilities were available for the large number of children assessed at the CGC who required remedial assistance (Melvill, 2000). In the process of developing the LSG, the CGC undertook a preliminary investigation of the services available for learners with scholastic difficulties by conducting interviews with educational psychologists at three different school clinics as well as a clinical psychologist at the Red Cross Child and Family Unit. It was found that individual remedial interventions with children and families were no longer offered by the school clinics and intervention was instead implemented at classroom or teacher level only - focusing on supporting mainstream teachers to develop knowledge and skills in special education learning strategies. Through informal discussions with teachers and school principals, it emerged that in the new inclusive education system, learners with special needs tended to lag behind their peers because teachers were unable to provide them with the individualized attention they required, due to large class sizes (van den Berg, 2004). Furthermore, teachers did not feel adequately equipped to deal with the scholastic and behavioural challenges presented by these learners (ibid.).

An initial intervention offered by the CGC involved a remedial group run a by a trained remedial instructor. However, the programme co-ordinator found that it was unsuccessful because (a) the emotional and behavioural difficulties that the children presented with were

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[1] Information describing the programme and its underlying assumptions was obtained from programme records, particularly those from the programme initiator, R. van den Berg, and from discussions with programme staff.

[2] The CGC is a training institution for UCT Master's level Clinical Psychology students that, in concurrence with its academic functions, provides psychological services (such as psychometric assessment and individual, group and family psychotherapies) to local communities, particularly disadvantaged children and their families (www.uct.ac.za/depts/cgc).

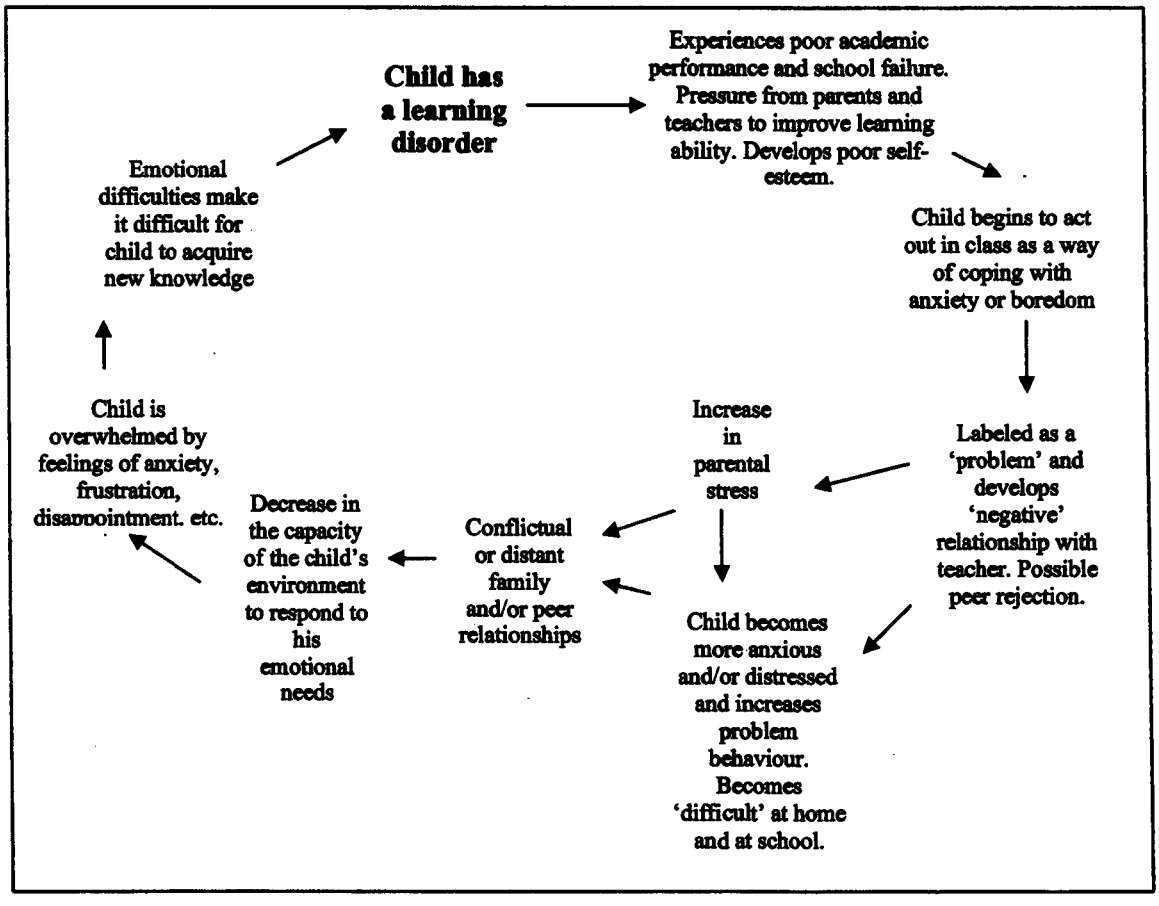
seemingly difficult for the remedial instructor to manage; and (b) no intervention was conducted with the parents, which meant that parents did not reinforce the remedial strategies, and few resources were thus available in the child's system to support possible gains. The need to include parents in the intervention, together with recognition of the emotional and behavioural aspects of learning disorders that cannot be addressed by remediation alone, led to the inception of the LSG intervention. It is structured so as to address both the academic and emotional needs of children with learning problems, as well as to provide information and emotional support to their parents. It thus comprises of three components; remedial and emotional group interventions for the children as well as a support group for their parents/caregivers. Liaison with the children's school teachers is also conducted. The children and their parents are required to enrol in the programme for the duration of the school year. Throughout the course of the intervention, there is a focus on helping parents to access resources to get their children into appropriate school placements, or to best utilize their existing placements, so that at the end of the intervention the participants feel more equipped to manage on their own.

A key objective of the LSG is to develop and evaluate an intervention model that can be implemented in school clinics, schools and other community settings, so as to extend services to an increasing number of families in need. Attempts to utilize resources optimally and to develop an effective intervention have resulted in many permutations of the LSG since it first started. Clinical psychology master's students initially facilitated both the remedial and the emotional support groups for the children, while the parent support group was run by a senior clinical psychologist. From 2001 to 2005, the LSG collaborated with a teacher's training college and the remedial tuition was provided by student remedial teachers, who were supervised by a trained remedial instructor. The clinical psychology master's students, supervised by clinical psychologists, facilitated both the child and parent emotional support groups. Thus, alongside objectives for the participating children and parents (as above), the LSG has training objectives for the psychology and remedial students by providing clinical psychology master's students with an opportunity to develop their theoretical knowledge, skills and techniques of facilitating group work in a supervised setting, and helping student remedial teachers gain experience and develop the skills and techniques of remedial teaching. Since 2001, there have been changes in the age-range (latency and adolescent), gender component (same-sex and mixed) and number of children's groups, the number of trainee

therapists per group and the number of remedial teachers working with children individually or in small groups. The 2006 LSG intervention forms the focus of this evaluation study and a more detailed discussion of its structure and content is therefore provided in the methodology chapter.

Based on their experience of working with children with learning difficulties and on a significant research base for learning disorders (discussed further in Chapter Two), the CGC staff developed a framework for understanding the multiple challenges experienced by the child. Within this framework, it is believed that cognitive and systemic factors influence the learning difficulty in such a way that the child has to contend with both internal and environmental challenges, as diagrammatically shown in Figure 1 below.

Figure 1: **Inter-related challenges of the child with a learning disorder**




The problem can be explained as follows. The child with a learning difficulty develops emotional and behaviour problems in response to difficult and anxiety-provoking learning

experiences. These in turn impact negatively on his relationships with teachers and peers. The academic and behavioural difficulties heighten the parents' stress and impact negatively on their response to the child. This results in the parents being less likely to be responsive to their child's emotional needs, which are then experienced by the child as overwhelming and unmanageable. The child's emotional distress then further affects his ability to learn – an anxious or depressed child cannot engage effectively in the learning process. While poor relationships with peers and teachers play a significant role in the progression of the problem, the focus of the LSG is on intervention with the parent-child subsystem, which can be feasibly addressed at the CGC.

Central to the underlying logic of the LSG intervention is Bion's (1962) notion of 'containment'. 'Containment' refers to a process whereby a 'container' (caregiver) modulates the difficult and overwhelming emotions of the 'contained' (child) through internal reflection and meaningful dialogue about the nature of these feelings. The child's ability to regulate his or her own feelings is understood to be linked to the parent's ability to provide emotional containment (ibid.). Given that learning disorders are closely associated with poor affect regulation, that is, inability to express and manage feelings (Bion, 1988; Elias, 2004; Salzberger-Wittenberg, Henry & Osborne, 1983), it is important that an intervention model should address both the child's ability to express his or her feelings and the capacity of the parent to respond to them. The LSG parent group therefore aims to facilitate the parents' expression of difficult feelings, strengthen their sense of being good enough parents, provide information and understanding about learning difficulties and their attendant emotional and behavioural difficulties, and provide parenting strategies and skills to address the child's learning needs, emotional needs, and difficult behaviours. The children's remedial group aims to address their academic difficulties in a safe, non-judgemental space, where they can work at their own pace and gradually develop more independent strategies for learning. In addition to reports of poor regulation of affect, the literature also suggests that children with learning difficulties demonstrate less competent problem-solving abilities that their peers (Bryan et al, 2004; Elias, 2004; Rourke & Fuerst, 1991). This is in line with the experience of the LSG clinical staff regarding the presenting problems of the children referred to the CGC and the LSG programme over a number of years. The children's emotional group thus aims to help participants to talk about difficult experiences, that is, to verbalize their internal world and make sense of their emotional experiences through play, art, and drama activities, and to

develop social problem-solving strategies in order to reduce aggression, withdrawal or other 'problematic' behaviours. It is hypothesized that by working with both the parents and the children, a shift in parent-child interaction is more likely to occur, which may ideally produce benefits for both parties.

The LSG intervention thus aims to strategically intervene in the system of a child with a learning disorder, by directly addressing the remedial and emotional needs of the child and enabling the capacity of the parent to assist him or her with learning strategies and to respond to his or her emotional needs. In so doing, parental support, which has been identified in the literature as a protective factor in the life of a learning-disordered child, is enhanced (Carr, 1999; Dawes & Donald, 2000; Gardynik & McDonald, 2005; Kaplan & Sadock, 2003; Rourke & Fuerst, 1991; Rutter et al, 2002; Shechtman & Gilat, 2005). Emotional containment of the parent-child subsystem thus forms the basis of the LSG intervention.

## 1.2 Rationale for the present study

Where services do exist in South Africa for children with learning difficulties, they tend to focus on remedial aspects of the problem, which fail to address the emotional and systemic components (van den Berg, 2004). In the absence of co-ordinated specialized resources for children with learning difficulties, and given the scarcity of resources and funding in a developing country like South Africa, it is very important to develop effective and accessible interventions. There is thus a pressing need for research into programmes designed to deal with the multiple facets of learning difficulties. It is possible that the LSG programme, if beneficial, could be used as a model in the broader community, for example at schools or school clinics. However, no systematic evaluation of the LSG has yet been conducted. This study aims to evaluate the outcomes of the 2006 LSG programme from the perspective of its participants. More specifically, it aims to investigate whether the children evidenced any change in their school achievement, their behaviour, their capacity to articulate their emotions, and their ability to engage in competent social problem-solving, and whether their parents reported any change in their parenting experiences. A secondary aim is to enquire into the participants' experiences of the LSG programme.

## 1.3 Structure of the dissertation

Prior to outlining the structure of the thesis, a few preliminary comments may help to contextualize the study. The researcher was offered the opportunity to conduct this evaluation during her clinical psychology master's training at the CGC. During this time, interaction with the LSG staff allowed for an 'inclusive' approach to learning about the programme and its objectives, despite essentially being an 'external' researcher, who was not involved with the programme. In keeping with literature on functional approaches to programme evaluation (discussed further in Chapter Two), the study included participation and input from stakeholders in various aspects of the research design and process.

The format of the thesis is as follows: **Chapter 2** commences with a discussion of the literature on the field of learning disorders, followed by an outline of the theory and techniques in programme evaluation, and concludes with a review of the previous research conducted on the LSG intervention. **Chapter 3** details the methodology of the study, providing information on the research aims, the research design, the sample, the instruments used, the structure and content of the LSG intervention as implemented in 2006, and the ethical considerations that were addressed in the study. The findings are presented in **Chapter 4**, followed by a discussion thereof in **Chapter 5**, which also includes a reflection on the limitations of the study, as well as recommendations and conclusions drawn from the research.

# CHAPTER 2 LITERATURE REVIEW

In this chapter, three key theoretical and empirical areas pertaining to the research are discussed. Firstly, an overview of the concept of 'learning disabilities' and its definition and classification is presented. Following an outline of the multi-factorial aetiologies implicated in such learning difficulties, the psychosocial functioning of the child with a learning difficulty is explored. Thereafter, interventions that address learning difficulties, including education policies adopted in South Africa, remedial tuition, psychotherapies and systemic interventions, are explicated. Secondly, a review of the literature on the theory and practice of programme evaluation, with specific attention to the literature on evaluating services that involve children, is provided. Finally, the chapter concludes with an overview of the previous research conducted on the LSG.

## 2.1 Learning Disabilities

### 2.1.1 Definition, classification and terminology

'Learning disability' appears to be the most commonly used term to describe scholastic problems or learning difficulties and yielded by far the largest number of articles in literature searches for this study. However, attempts to clarify the definition of this term have proven to be a challenging task. Despite its widespread application, there is continued controversy regarding the meaning of the above term (Donald, 2007; Flack, 2005; Gresham et al, 2003; Mather & Gregg, 2006).

In her critique of the phenomenon of learning disability as it is understood in the South African context, Flack (2005) highlights two fundamental issues that underpin the difficulty in defining learning disability: the lack of consensus of what constitutes a learning disability and the lack of consistency in the terminology used. A brief review of the most common terms and their meanings in current usage will be provided here.

Relevant terminology changes across different countries. Donald (2007) states that terms such as 'minimal brain dysfunction', 'dyslexia', 'specific learning disability', 'learning disability' and others have historically been used in a transposable way. In the United

Kingdom, for instance, the terms 'learning disability' and 'learning difficulty' are used to describe scholastic problems resulting from mild and moderate intellectual disability (also known as mental retardation) as well as specific learning disorders, such as dyslexia, which occur in children with at least average intellectual functioning. The United States of America's National Joint Committee on Learning Disabilities (NJCLD) defines 'children with learning disabilities' as children who have a disorder in one or more of the cognitive processes involved in listening, speaking, reading, writing, reasoning or mathematical abilities (NJCLD, 1991 in Gardynik & McDonald, 2005). These deficits are further described as not primarily due to sensory (visual, hearing or motor) impairments, mental retardation, emotional disorder or environmental vulnerabilities. The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000) of the American Psychological Association (APA), largely uses this definition for diagnosis of a 'learning disorder'. Learning disorders are thus classified in the DSM-IV-TR as:

a. *specific deficits, as measured by standardized tests, that manifest in the development of reading, mathematical and writing (including spelling) skills and are substantially lower than expected, given the individual's age, level of schooling or intelligence*
b. *significantly affecting academic achievement or daily functioning*
c. *the difficulty is in excess of a sensory deficit if one is present*

The three sub-divisions of learning disorders, reading (*dyslexia*), mathematics (*dyscalculia*), and written expression (*dysgraphia*), are frequently known to co-occur, although dyslexia is by far the most common (APA, 2000). Little is understood about the prognosis of a learning disorder although some understand it to be a stable condition that the individual has to compensate for and adapt to; one that requires life-long support much like intellectual and physical impairments (APA, 2000; Elkins, 2007; Mather & Gregg, 2006).

Psychologists in South Africa generally use the DSM-IV-TR term 'learning disorder' to represent specific learning difficulties, that is to refer to children with average to above average intellectual functioning who present with specific scholastic problems, although this is not uniform as some use associated terms loosely (Flack, 2005). While 'learning disorders', 'learning difficulties' and 'specific learning disabilities' are synonymously used

in South Africa, all espouse definitions distinct from 'intellectual disability' (Donald, 2007; Donald, Lazarus & Lolwana, 1997; Flack, 2005). Intellectual disability is a diagnostic label applied to individuals who consistently obtain an IQ score below 70 on standardized intelligence scales and who show adaptive and functional impairment as a consequence thereof (APA, 2000). Intellectual disability is divided into four subcategories namely, mild (an IQ of 50-55 to approximately 70), moderate (an IQ of 35-40 to 50-55), severe (an IQ of 20-25 to 35-40) and profound (an IQ below 20 or 25). Borderline level of IQ (an IQ of 70-80) is just above the range for intellectual disability and it is acknowledged that this classification also presents high risk for developing academic problems. Careful clinical distinctions must be made between mild intellectual disability and borderline level of functioning when making a diagnosis as both present uneven scholastic profiles. While distinct from it, children with mild intellectual disability and borderline IQ functioning may present in conjunction with learning disorders, that is, their performance in specific areas is significantly below their achievement on general tests of intelligence (Gresham et al, 2004; Kavale, Holdnack & Mostert, 2005).

Another dilemma regarding what constitutes a learning disability lies within the aetiological debate. Some researchers argue that a learning disability is purely an intrinsic condition, preferring to focus on underlying neuro-cognitive deficits that are not caused by social and environmental factors, while others take the view that internal and external factors are not distinct and separate but rather are connected and interactive variables that make up the conditions of a child's learning disadvantages (Donald, 2007; Mather & Gregg, 2006). The aetiology section, which follows this one, provides further details in this debate as well as a brief overview of the other possible causative factors in learning disabilities.

Several South African authors have called for the extension of the definition of learning disability and its meaning to include the strengths and weaknesses of the individual, using 'difference' rather than 'deficit' terminology (Flack, 2004:326), as well as consideration of the wider learning context within which the individual operates, including the social and environmental factors which impact on learning (Archer & Green, 1996; Burden, 1996; Donald, 2007; Kriegler & Skuy, 1996).

While it is an endeavour of this research to respect the complexities in definition noted by South African researchers, there appears to be no major difference in using either the term 'learning disorders' or 'specific learning difficulties' in South Africa (Flack, 2005). In keeping with terminology in this country, 'learning disorders' and 'learning difficulties' will be used in this study to denote specific difficulties in learning unless another term with equivalent meaning is used by the author(s) cited.

### 2.1.2 The prevalence of learning disorders

The problems with the clinical definition and classification of learning disorders (LDs) pose practical difficulties in South Africa (Donald, 2007). Debates regarding the causes of learning difficulties (as noted in sections 2.1.1 and 2.1.3), together with the paucity of specialized diagnostic and assessment resources, have made it difficult to gather prevalence data, and therefore, there are no clear statistics available (ibid.). The World Health Organisation maintains that 40% of Africa's school-going population may have 'disabilities' and require learner support (Abosi, 2007). However, this refers to all forms of 'disabilities' (including physical and intellectual disabilities) and does not account specifically for the academic 'learning-disabled' population. Following a review of the efforts to obtain statistics in Africa, Abosi (2007) makes a rudimentary estimate that 20% of learners in any given African class experience specific learning problems and thus perform below the average for their age. Learning disorders are reported to affect at least 5% of school-aged children in the United States. These studies found no clear gender differential, although it appears that boys are three to four times more likely to be referred for evaluation than girls (APA, 2000; Kaplan & Sadock, 2003). The reasons for this are unknown (ibid.). No data on gender differences are available for South Africa, nor were statistics for the prevalence of borderline IQ functioning found.

### 2.1.3 The aetiology of learning disorders

No single, definitive aetiology of LDs has been proposed in the literature, since it is likely that LDs are influenced by multiple factors (Carr, 1999; Kaplan & Sadock, 2003). While specific risk factors have not been conclusively established, theoretical possibilities have been postulated (APA, 2000; Carr, 1999; Jansen, 1996; Kaplan & Sadock, 2003; Rutter,

Taylor & Hersov, 2002; Voeller, 2004). These can be grouped into two basic categories: intrinsic and extrinsic factors.

***Intrinsic factors***

These refer to factors inherent in the individual which may manifest in a LD. Research studies have suggested that neurological deficits in encoding and phonological processes, working-memory and language functions, underlie difficulties in learning (Jansen, 1996; Kaplan & Sadock, 2003). It is hypothesized that these deficits may develop before, during and after birth (Carr, 1999). Research supports the hypothesis that genetic predisposition plays a major role in the development of LDs (Carr, 1999). Pre-natal exposure to maternal infectious illnesses, such as influenza, and toxins such as cigarettes, as well as maternal abuse of alcohol, may be contributing factors in the development of later cognitive delays (Carr, 1999; Kaplan & Sadock, 2003). Peri-natal difficulties, such as anoxia, prematurity and extremely low birth weight, are common in the histories of children with LDs (Carr, 1999; Kaplan & Sadock, 2003). Studies have shown that children with the above histories are at higher risk for LDs than children who were born full-term, with normal birth weight (ibid.). Other research suggests that the cognitive functions of children with LDs may be slower to mature than their peers; that is, there is a maturational lag in the child's development (Jansen, 1996). This implies that learning-disordered children will eventually 'match' their peers, but research shows that this does not occur (ibid.).

***Extrinsic factors***

These refer to events or conditions occurring 'outside' the individual that may result in learning problems. Traumatic brain injury, as a result of accidents and disease or illness in infancy and childhood, often causes problems in the ability to take in and understand information presented (Carr, 1999; Jansen, 1996). In addition, the literature on LDs proposes that socio-economic deprivation and associated environmental factors have a considerably negative impact on learning (Carr, 1999; Donald, 2007; Jansen, 1996; Kaplan & Sadock, 2003). Research shows that poverty and lack of resources may lead to poor quality of education (such as poor teaching and lack of learning materials) and lack of intellectual stimulation, which is evidenced to have a negative impact on academic performance (Abosi, 2007; Carr, 1999; Donald, 2000). Impoverished conditions are also closely associated with

malnutrition, and studies have shown that undernourished children demonstrate difficulties in attention and concentration (Richter, Griesal & Rose, 2000). Furthermore, long-term malnourishment can produce structural and biochemical changes in the brain, that interfere with cognitive functioning (Kaplan & Sadock, 2003; Jansen, 1996; Richter et al, 2000). Some researchers argue that exposure to trauma and abuse (which is often more prevalent in conditions of poverty), including family, political and community violence can affect academic performance (Angless & Shefer, 1997; Department of Education, 2002; Duncan & Rock, 1997; Sinason, 2001). The psychological effects of traumatic experiences (particularly repeated traumas), such as anxiety and depression, may result in frequent absenteeism, inability to concentrate, general apathy and the gradual erosion of learning capacity in South African children (ibid.)

It is argued that these intrinsic and extrinsic factors are not linked to the development of learning disabilities in a linear way and cannot be used as predictors, nor are they present in the history of all children with learning problems (APA, 2000; Jansen, 1996). The DSM-IV-TR (APA, 2000) regards the extrinsic factors as exclusion criteria for the diagnosis of a LD. Donald (2007), however, argues that internal and external vulnerabilities interact to produce a cycle of challenges that make up the deficits that a child with learning problems has to compensate for. For instance, a child with a specific cognitive deficit as well as disadvantaged environmental circumstances will inevitably have a different learning experience to a child with a LD living in ameliorated environmental conditions. He further states that it is unproductive and ethically questionable to prioritize this split when it is likely to exclude a child in need of specialized assistance from already scarce resources.

### 2.1.4 Learning disorders and psychosocial functioning

The link between LDs and socio-emotional and behavioural difficulties is well documented (Bryan, Burstein & Ergul, 2004; Carr, 1999; Elias, 2004; Kaplan & Sadock, 2003; Mishna & Muskat, 2004; Rourke & Fuerst, 1991; Rutter et al, 2002; Voeller, 2004). A bidirectional manner of interaction is presumed, where social, emotional, behavioural and learning problems impact on one another (Lopes, 2005; Rourke & Fuerst, 1991).

***Behavioural correlates***

Bryan et al (2004) highlight a number of behavioural correlates of LDs, including aggression and withdrawal. Teachers have rated children with learning problems as more disruptive and attention-seeking and less attentive than their classmates (Pearl, Donahue & Bryan, 1985 in Bryan et al, 2004). Parents report that they are inattentive and have difficulty following instructions and completing tasks, while peers label them as aggressive or disruptive (Gresham & Reschly, 1988 in Bryan et al, 2004; Perlmutter, 1983 in Bryan et al, 2004).

LDs, particularly Reading Disorder, are frequently found to be co-morbid with Attention-Deficit/Hyperactivity Disorder (ADHD), which is characterised by persistent inattention, impulsivity and/or hyperactivity (APA, 2000; Karande eta al, 2007; Rutter et al, 2002; Savitz & Jansen, 2005; Slone, Durrheim & Kaminer, 1996). Studies have suggested an organic basis to this connection, that is, common genetic factors may underlie both syndromes, where dysfunction in one part can lead to, or correlates with, dysfunction in another (Kaplan & Sadock, 2003; Voeller, 2004). It is also possible that an underachieving learner may appear to have attention problems that are instead due to a LD, for instance, the child may lack motivation to learn after repeated failures and consequently be easily distracted by other factors in the environment (APA, 2000; Kaplan & Sadock, 2003). The reverse is possible for learners with intrinsic attention difficulties who, on the surface, appear to have LDs and poor scholastic achievement (ibid.).

There is also a relatively high incidence of co-morbidity with conduct disorders in children with a LD (APA, 2000; Kaplan & Sadock, 2003; Rutter, 2002). Some researchers understand aggressive and disruptive behaviour to be externalized attempts to ward off anxieties about lack of comprehension and feelings of demoralization and frustration due to repeatedly poor academic performance (Kaplan & Sadock, 2003; Salzberger-Wittenberg, Henry & Osborne, 1983). Behavioural problems may also be secondary to difficulties in attention and concentration (Kaplan & Sadock, 2003).

***Emotional correlates***

Research suggests that LDs are associated with high risk for mood disorders and that mood disorders can result in learning problems in children (Bender, Rosenkrantz & Crane, 1999; Lopes, 2005). Studies have consistently found that negative affects such as sadness, anger, anxiety and loneliness are more likely to be experienced by children with LDs than children without LDs (Bryan et al, 2004; Shechtman & Pastor, 2005). This may account for the higher incidence of the clinical diagnosis of mood disorders, such as depression and dysthymia, in children with LDs (APA, 2000; Bender et al, 1999; Kaplan & Sadock, 2003). It has also been demonstrated that depression and anxiety can affect complex cognitive functions and depress memory through processes such as slowing and blocking of thoughts and words, which, if chronic, can significantly undermine a child's learning capacity (Lezak, Howieson & Loring, 2004; Lopes, 2005).

Research suggests that children with a LD have diminished capacity to recognize and interpret emotions in self and others, marked difficulties in tolerating or regulating overwhelming feelings, as well as a poor emotional vocabulary to verbalise their feelings (Elias, 2004). This is understood to have an adverse effect on the psychosocial functioning of the learning-disordered child.

***Social relationships***

In their study of pre-adolescent children with and without LDs, Walker and Nabuzoka (2007) found a positive relationship between poor academic achievement and difficulties in interpersonal relatedness. This finding is supported by other research findings that poor social relationships are highly correlated with learning disorders (Donald, 2007; Elias, 2004; Rourke & Fuerst, 1991). It is understood that learning-disordered children's vulnerability to negative emotions, difficulties in recognizing and regulating emotions, and subsequent acting out or undesirable behaviour, have an adverse effect on their interaction with peers and adults (Rourke & Fuerst, 1991; Kavale & Forness, 1996 in Gardynik & McDonald, 2005). Children with LDs tend to respond less sensitively to social situations or social problems and demonstrate poorer social reasoning ability than children without (Bryan et al, 2004; Elias, 2004; Kaplan & Sadock, 2003; Rourke & Fuerst, 1991). While they are capable of generating potentially competent solutions to social dilemmas, children with a LD tend to prefer

significantly more incompetent or inappropriate problem-solving strategies than their average-achieving peers (Bryan et al, 2004). In his examination of the role of language competence in social adjustment, Rinaldi (2003, cited in Elias, 2004) notes that children with LDs are unable to mobilize language (vocabulary, semantics and syntax) to establish and maintain interpersonal relationships with peers and adults and this often reflects similar difficulties with using language to understand their social world. Some researchers have found that children with LDs tend to have impaired perception in non-verbal social cues, such as facial expressions, gestures and body language, which guide social behaviour (Bryan et al, 2004). Other researchers suggest that children with LDs have a basic sense of mistrust in others, and that insecure attachment patterns, due to repeated negative experiences in relatedness with parents, teachers, siblings and peers, underlie their difficulties in social relationships (Al-Yagon & Mikulincer, 2004; Salzberger-Wittenberg et al, 1983).

***Adaptive functioning***

It has been proposed that a negative cycle occurs in the adaptive functioning of children with LDs, where academic problems and experiences of accumulated failure result in chronic frustration, demotivation, stigma, peer rejection, low self-esteem and lack of self-confidence (Donald, 2007; Kaplan & Sadock, 2003; Rourke & Fuerst, 1991). The high levels of anxiety related to these emotional traumas become associated with the school environment, which in turn impacts on ability to learn (Bender et al, 1999). Children with LDs face heightened vulnerability for repeated failure and eventual school dropout, and are subsequently at greater risk for economic disadvantage (APA, 2000; Donald, 2007; Kaplan & Sadock, 2003; Mishna & Muskat, 2004). Furthermore, studies reveal that in comparison to the general population, a large proportion of youth in the criminal system have a LD (Mishna & Muskat, 2004). Although the above risk factors are substantial, research indicates that the vulnerabilities that a child with a LD faces can be countered by protective factors, which include: early identification; the individual's, parents' and teachers' understanding of the difficulty; remedial support; and intervention to improve social skills, to enhance self-esteem and self-understanding, and to improve affect regulation (Elias, 2004; Gardynik & McDonald, 2005; Kaplan & Sadock, 2003; Mishna & Muskat, 2004). The developmental trajectory of a learning-disordered child is not cast in stone, but is rather subject to the interplay of risk and protective factors, as well as the availability and accessibility of resources and opportunities (ibid.).

### 2.1.5 Interventions for learning disorders

***Current education policy in South Africa***

In 1998, South Africa opted to introduce an inclusive education system for learners ordinarily educated in special schools, on the rationale that it will reduce stigmatization, promote independence and prepare learners for post-school employment by helping them to 'fit in' with 'normal' school and social activity (Department of Education [DoE], 2001; Naicker, 1999). The new system of education aims to identify and minimize 'barriers to learning', which refer to a broad range of problems including *systemic factors* (such as inadequate facilities and learning materials at school and overcrowded classrooms), *societal factors* (including poverty and community-related violence), *inappropriate pedagogy* (problems pertaining to curriculum instruction, lack of teacher support and classroom management), and *medical problems* (including physical, cognitive, sensory, and neurological deficits) (DoE, 2001, 2002). Furthermore, specific reference is made to 'academic learning difficulties', which refers to difficulties in reading, writing and mathematics, matching the DSM-IV-TR diagnosis of learning disorders (DoE, 2002). The policy aims to progressively integrate learners who have mild to moderate 'barriers to learning' into mainstream education facilities, while those with severe and profound physical and intellectual disabilities will remain in special schools (DoE, 2002).

The Education White Paper 6 (DoE, 2001) outlines a model for implementation of inclusive policy, stating that the development of 'full service schools' (selected primary schools implementing full inclusion, such as facilities for the physically disabled, learner support materials and resources, etc.), is a core of the inclusive education system. Full service schools function as pilots for 'best-practice' studies, which may ease the eventual conversion of all 'ordinary' schools when resources increase and the system becomes more operational (DoE, 2003a). It is proposed that the various educational support services (psychologists, counsellors, occupational therapists and other learning support staff employed by the Department of Education, such as remedial teachers, language and communication therapists, and 'special needs' teachers) make up specialist 'district-based support teams' (DoE, 2001). The main purpose of the district-based support teams is to build the capacity of professionals in schools to identify and intervene appropriately in the case of learners with 'barriers to learning' (DoE, 2003b). A secondary function includes linking school professionals with formal and informal local support systems (ibid.). Special schools are to be converted into

'resource centres', admitting only severe or profoundly disabled learners who cannot cope in mainstream schools (DoE, 2001). Resource centres are designed to serve as part of the district-based support teams, providing specific expertise and assistance to local schools, particularly full service schools, acting as consultative services for teachers in curriculum, assessment and instruction (DoE, 2003c). Nationally distributed EMDCs (Education Management and Development Centres) serve as the centre-points for coordinating administrative and logistical issues in the shift from special to inclusive schooling (DoE, 2001, 2002). School referrals are now conducted via EMDCs and not directly with schools or school clinics, as was the previous route. Educational support services and district-based support teams are attached to EMDCs.

Concrete steps in the shift to inclusion have been taken, such as the pilot project involving the identification and selection of 30 full service schools, 30 special schools to be converted to resource centres and 30 districts in which to establish district-based support teams; the provision of funding to develop full service schools, resource centres and district-based support teams; and the development of conceptual and operational guidelines for the implementation of the above initiatives as well as an inclusive curriculum (DoE, 2003a, 2003b, 2003c; Donald, 2007). While these positive shifts have been made, the outcomes for learners with LDs still need to be assessed (Donald, 2007). In order for a learner with a LD to benefit from inclusion, certain professional competencies and processes have to occur on classroom and district-based levels in terms of how effectively teachers can assess, identify and intervene, and how effectively educational support services provide professional support to teachers (Donald, 2007; Holz & Lessing, 2002). Most teachers currently lack adequate training and experience in special education strategies and are unable to cope with the reality of integrating learners with disabilities into their classrooms and access to education support services is very limited, particularly in socio-economically disadvantaged regions (Biersteker & Robinson, 2000; Flack, 2005; Holz & Lessing, 2002). Furthermore, it is widely argued that the lack of collaborative partnerships with parents (while inclusive theory highlights this, it is not evident in practice) and the absence of socio-emotional skills training in the curriculum for learners with LDs are serious limitations in the education system (Collins, 2006; Swart et al, 2004; Yssel, Engelbrecht, Oswald, Eloff & Swart, 2007). In reality, the system is not, as yet, adequately functional to meet the extensive needs of children with LDs, who are consequently at a disadvantage in the formal education system (ibid.). According to the

Education White Paper 6 in 2001, the long-term time-frame for full implementation in South Africa is 20 years, and it is anticipated that because inclusion is an ongoing process with expectable developmental limitations, difficulties will exist for some time (DoE, 2001; Donald, 2007; Engelbrecht, 2006).

***Remediation***

In the past, psychometric assessment and remediation have been the primary approaches to addressing problems with learning (Carr, 1999; Mishna & Muskat, 2004; Rutter et al, 2002). While there are specific remedial strategies, which depend on the presenting difficulty, the basic approach is to teach learning skills by building the child's strengths and abilities while compensating for weaknesses (Kaplan & Sadock, 2003; Rutter et al, 2002). In South Africa, remediation was traditionally offered, where available, in the form of a self-contained remedial support class in mainstream schools, but these separate classrooms have been phased out (Naicker, 1999). Intervention now focuses on developing the general education teachers' capacity to identify and respond to learning difficulties in the inclusive classroom through training and collaboration with special education professionals at district-based support teams (as discussed in the previous section). In the interim period, the policy for learners who require learning support states that these learners are still to be withdrawn from the general classroom at least twice a week (for about 35-40 minutes) to receive group-based remedial lessons from 'learning support teachers' (LSEN teachers) who are assigned by the district-based support teams to various schools (A. Arendse[3], June 2008, personal communication). However, this intervention faces a number of challenges - problems occur at institution or classroom level, where general teachers are unable to identify learning difficulties and refer appropriately to LSEN teachers; there are constraints in service delivery, such as high learner-LSEN teacher ratios, resulting in a large number of learners identified as requiring learning support receiving no support at all; some LSEN teachers themselves face challenges in terms of acquiring the skills needed to address socio-emotional aspects of learning; and due to various reasons, many are unable to obtain collateral information from parents and families, and so cannot conduct comprehensive assessments

[3] Specialist Learner and Educator Support, Metropole South District.

(ibid). As an alternative to formal intervention, the services of a private remedial tutor can be elicited, but this is financially prohibitive for many families in South Africa.

Teacher preparation and support is an integral component of addressing LDs from a remedial perspective (DoE, 2003; Sideridis, 2006). Abosi (2007) recommends the incorporation of special needs training (identification, treatment and/or appropriate referral) into general teacher training programmes as well as promoting the training of more special teachers in Africa to help integrate the inclusive education policy. There is also evidence that parental involvement, such as reading with the child at home, plays a significant role in remediation, although the underlying mechanisms of progress are unclear (Kaplan & Sadock, 2003; Rutter et al, 2002). While there is little evidence that psychotropic medication can directly treat LDs, it has been known to help the child learn by enhancing attention and concentration and it may be used in conjunction with remedial support (Rutter et al, 2002).

In a meta-analysis of the literature on interventions with reading-disabled children in the US, the National Reading Panel (2000, cited in Alexander & Slinger-Constant, 2004) found that in studies of learners ranging from Grade 2 to Grade 6, the children performed better with one-to-one or small group remedial instruction and required more intensive input (daily) for a longer duration (over an hour) than average-achieving peers. Most children managed to maintain the gains at follow-up. Factors that exacerbated difficulties were poor verbal ability, poor attention and poor behaviour control.

Remedial intervention can neither prevent nor cure LDs (Alexander & Slinger-Constant, 2004). It has been evidenced to produce results while it is ongoing but longer-term follow-up studies are needed to assess how far and under which conditions these effects are maintained (Rutter et al, 2002). It is argued that remediation as a solitary intervention is inadequate because it does not address the associated emotional and behavioural problems described earlier (Alexander & Slinger-Constant, 2004; A. Arendse, June 2008, personal communication).

***Psychotherapy***

Given that increased self-esteem, self-understanding, emotional regulation and improved social skills are noted as factors that build resilience in a child with a LD, it would appear that psychotherapy is a good candidate for intervention. Nevertheless, there are queries in the literature pertaining to the relevance of its application to LDs as well as the evaluation of intervention outcomes in this area.

In his critical overview of psychotherapeutic interventions for learning disabilities[4], Willner (2005) reports that the latter have been increasingly advocated. He presents literature demonstrating the efficacy of psychotherapeutic support (psychodynamic, cognitive and cognitive-behavioural) with many people with learning disabilities. Despite the fact that this evidence base comes from methodologically limited studies that lack randomised control trials and fail to identify the specific therapeutic processes underlying successful outcomes, he suggests that in most contexts there is no alternative if these individuals are to be offered the mental health services they are entitled to. Willner prioritizes the evaluation of psychotherapeutic effectiveness and the particulars of its efficacy, such as the components of therapeutic processes and how to optimally offer the service, above questions of the relevance of psychotherapy to the field of learning disabilities.

Two primary psychotherapy models in the general mental health service, namely cognitive-behavioural and psychodynamic approaches, are highlighted in the learning disabilities intervention literature (Whitehouse, Tudway, Look & Kroese, 2006; Willner, 2005). The benefits of cognitive-behavioural therapies (CBT) for LD's are empirically supported (Sams, Collins & Reynolds, 2006; Willner, 2005). For example, didactic self-management techniques such as *self-instructional training* (self-monitoring, self-evaluation and self-reinforcement) and *relaxation training* have been evidenced to increase social competence and decrease anger, anxiety and aggression (Willner, 2005). While CBT has proven to be effective in learning-disabled individuals with higher IQs and better verbal ability, it is

[4] The UK-based author uses the term to represent specific learning disabilities as well as global intellectual disabilities. Further, literature on interventions for learning problems largely employs the above denotation of the term. *Learning disability* is therefore used as such throughout the section on psychotherapeutic interventions, unless studies refer to what is understood to be learning disorders or intellectual disability exclusively.

markedly less so with more severely disabled persons (Sams et al, 2006). While beneficial, this approach fails to take cognizance of the fundamental problem in *self-regulation* of affect and behaviour arising from, and contributing to, learning disabilities (Willner, 2005). The learning-disabled person has become accustomed to external cues that are not unlearned or challenged in the instructive CBT techniques and may thus fail to transfer acquired skills or gains to other aspects of his or her functioning. Attempts to circumvent the expression of feelings in the case of a child with a LD may encumber the opportunity to effect improved and sustainable change (Elias, 2004; Shechtman & Pastor, 2004).

The benefits of individual psychodynamic-oriented therapy with children with learning disabilities have been enumerated by Sinason (1992). She proposes the concept of a secondary handicap, where the pain and emotional distress associated with the inability to think and learn exacerbates the cognitive difficulty. Her descriptive methodology is characteristic of the wider body of research on the effectiveness of psychodynamic approaches, and large-scale objective studies of the effectiveness of psychodynamic interventions are absent in the literature (Rutter et al, 2002). Moreover, the research designs of psychodynamic studies in general fall short when describing clear therapeutic components involved in the intervention and as a result, gains following psychodynamic therapy could be attributed to processes also found in humanistic or person-centered approaches (Willner, 2005). Even so, outcomes of significant decreases in emotional-behavioural problems and increases in self-esteem are substantive in available studies, at three-month and six-month follow-ups (Willner, 2005).

Given that learning-disabled persons have historically been excluded from psychological intervention on the premise of perceived unsuitability for psychotherapies presumed to require a certain level of cognitive functioning, it is argued that a degree of flexibility is needed and that existing approaches can be adapted to meet the needs of this population (Sams et al, 2006; Whitehouse et al, 2006; Willner, 2005). Following a broad review of published case studies in psychotherapies involving clients with learning disabilities, Whitehouse et al (2006) recognized a variety of structured adaptations to psychodynamic and CBT models including: simplifications in technique, presentation, tasks assigned and language used, as well as the involvement of caregivers and the utilization of flexible methods which complimented the client's unique needs.

Group-based psychotherapies for children and adolescents with learning disabilities have gained popularity in international literature, while very little regarding this type of intervention has been published in South Africa (Mishna & Muskat, 2004; Packman & Bratton, 2003; Schiff, 2002; Shechtman & Katz, 2007; Shechtman & Pastor, 2005). Shechtman and Pastor (2005) conducted a controlled study on interventions with learning-disabled children that included individual remedial assistance and group therapy, specifically comparing the process and outcomes of cognitive-behavioural and humanistic (emotional-supportive) modalities. They found that the remedial intervention was inadequate in addressing the inter-related difficulties of the child with learning problems (academic, social and emotional) and that gains, on the whole, were increased with group therapies. In terms of psychosocial adjustment, outcomes in the humanistic therapy groups were superior to those in CBT groups. The researchers extrapolate from the findings the hypothesis that group therapies attend to the socio-emotional difficulties of the learning-disabled child, which may in turn, increase motivation to cope with academic difficulties. With appropriate modifications from adult approaches, group psychotherapies are also reported to provide children and adolescents with opportunities to experience support and acceptance among peers and to develop social skills (Mishna & Muskat, 2004). This was demonstrated to be beneficial to children with learning disabilities in a study investigating the role of group bonding processes as a variable for positive outcomes in social competence (Shechtman & Katz, 2007). Interestingly, findings in the latter study suggest that bonding with the therapist (as a caring and responsive adult) is even more instrumental than bonding with peers.

***Parent psycho-education and support***

Parents of children with LDs experience emotional stress, including worries about their child's scholastic performance, peer relationships, problem behaviour and future adjustment (Dyson, 1996 in Williams, 2001; Fuller & Rankin, 1994 in Williams, 2001; Shechtman & Gilat, 2005). Social support can be a positive alleviating factor that offsets parents' sense of isolation, despondency, helplessness and, at times, self-blame (Shechtman & Gilat, 2005). South African parents of children with LDs face the additional challenge of accessing and optimally utilizing scarce remedial and mental health services, of which they often have little

or no knowledge (C. Taylor[5], January 2008, personal communication). Furthermore, Yssel et al (2007) found that these parents show a great need to voice their experiences in a supportive environment. The abovementioned stressors are understood to subsequently have a negative impact on parent-child interaction as well as the general well-being and functioning of the family system (Dyson, 1996 in Williams, 2001; Rourke & Fuerst, 1991). Parental intervention is therefore included as an important component of most interventions in LDs (Carr, 1999; Rutter et al, 2002). Carr (1999) suggests a number of parent-centered interventions including psycho-education (regarding diagnosis and associated emotional and behavioural features) and involvement of parents in remedial support (active participation in structured tasks and homework activities), and behaviour management training (teaching parents basic behaviour techniques to manage problem behaviours).

A South African study of the effectiveness of a psycho-educational programme for children with LDs and their parents supported the value of educational interventions for parents (Skuy & Solomon, 1980). Shechtman and Gilat (2005) demonstrated the effectiveness of group counselling for parents of children with LDs in Israel by evaluating the outcomes of two different intervention groups: *educational-didactic*, involving psycho-education regarding different aspects of LDs, training in parenting strategies, coping skills and behavioural management and *process-oriented counselling*, which focused on sharing experiences and information and expressing feelings. Findings showed that the counselling group produced greater gains in parent-child relationships as perceived by both parents and children.

Psychodynamic approaches to parent intervention centre on the principle that primary relationships are key instruments in learning. Attending to the internal world (underlying beliefs, feelings and motivations) of the parent, which is theorized to unconsciously affect the parent's capacity to be emotionally responsive to a child with a LD, will in turn, have benefits for the child. As mentioned in Chapter One, psychodynamic authors note the function of the parent or primary caregiver in containing the difficult emotions of children with learning problems (Bion, 1988; Salzberger-Wittenberg et al, 1983). The process of

[5] Western Cape Resource Centre for Inclusive Education, www.included.org.za

learning initially involves a sense of uncertainty and 'not knowing', which may result in feelings of anxiety, frustration and disappointment in an infant or child. These feelings, if excessive, threaten to overwhelm the child, compelling him or her to 'shut down' all thinking, so inhibiting the ability to learn (ibid.). Caregivers who are able to manage (or bear) difficult feelings within themselves, are open and responsive to their child's emotional needs and can thus provide containment for their child (ibid).

***Systemic interventions***

While remedial and psychotherapeutic interventions with children with LDs and parallel services for their parents are significant in treating LDs, it is argued that systemic interventions, such as community-consultation projects based at schools or school clinics, can complement these direct services (Carr, 1999; Mishna & Muskat, 2004). Schools are increasingly considered as accessible sites for interventions for LDs because of the substantial amount of time children spend in a classroom and the subsequent potential for higher impact on individuals, as well as the opportunity for extensive service delivery (increasing the number of children who may eventually benefit), particularly to those who may otherwise not have access to the service (Gardynik & McDonald, 2005; Mishna & Muskat, 2004). Given the need for sustainable child services in South Africa, Ebersohn and Eloff (2006) explored the common factors that underpin successful child development programmes in this country. They suggest that schools serve as an intersection between community members and professionals because they have both the capacity and resources to facilitate a supportive process in the life of a vulnerable child. For instance, family support and education regarding good practices could be conducted in school-based sessions, where educators, caregivers and professionals collaborate.

A school-based project involving group interventions for children, parents, teachers and school social workers was conducted in the US and findings revealed gains in the children's psychosocial functioning and greater understanding of LDs amongst the adult role-players (Mishna & Muskat, 2004). Packman and Bratton (2003) reported on the efficacy of a school-based play/activity therapy group in addressing the problem behaviour of pre-adolescent learners with learning difficulties. Other studies have found that teaching social skills in classroom-based interventions produces moderate shifts in the social-emotional domains of

learning difficulties, although these were unlikely to generalize to other settings (Bryan et al, 2004). In response to the shortcomings of inclusive education for children with LDs in America, Elias (2005) developed a socio-emotional learning theory (SEL) for classroom-based instruction, recognizing the role of both social and emotional factors in successful academic learning. He puts forward basic skills to assist learners in working through academic and social challenges and prepare them for post-school life, which include, amongst others, recognizing emotion in self and others, regulating and managing strong feelings, recognizing personal strengths and areas of need, listening and communicating accurately and clearly, setting positive and realistic goals, resisting negative peer pressure and working effectively in groups. He reports positive outcomes drawn from a number of programmes utilizing SEL theory as its foundation.

## 2.2 Programme Evaluation

### 2.2.1 Conceptual framework

Programme evaluation research, from the perspective of those involved in human services, is about monitoring the process and assessing the impact of social programmes, with the key aim of improving social functioning. It evaluates the effectiveness of interventions by systematically gathering and interpreting information, and using this to inform future short- and long-term implementation decisions (Kaufman et al, 2006; Nixon, 1997; Potter, 1999; Schalock & Thornton, 1988).

There are essentially two types of programme evaluations, namely, process and outcome evaluations (Louw, 2000; Potter, 1999; Schalock & Thornton, 1988). Process, or implementation, evaluation focuses on monitoring the process of a programme's actions by collecting and analyzing data regarding key aspects of the programme, such as theoretical rationale, participant information, services offered, the roles and responsibilities of project staff and the financial costs involved (Schalock & Thornton, 1988). It aims to answer the question of whether an intervention has been appropriately implemented and whether it was implemented as designed (Potter, 1999). Process evaluation provides a detailed description of the programme and the context within which it operates, which can offer useful feedback to project staff, and it also disseminates sufficient information to replicate the programme,

should others deem it viable (Nixon, 1997; Rossi, Freeman & Lipsey, 1999). Outcome, or impact, evaluation focuses on the programme's effects on its participants (Schalock & Thornton, 1988). It aims to answer the question of whether the intervention has been effective and which, if any, intended and unintended outcomes have materialized (Potter, 1999). On a practical level, interventions cost money, and programme evaluation may, alongside the above activities, enquire whether an evaluation is worth its cost, that is, assessing whether a programme had outcomes that were in proportion to, or significant enough to justify, its cost (Schalock & Thornton, 1988). Social programmes commonly seek to provide services that are cost-effective, and cost-benefit evaluations are instrumental in making decisions regarding the rational investment of resources (ibid.).

There is increasing recognition in South Africa that evaluation procedures are central to the development of effective and sustainable interventions, and that all programmes are amenable to some form of assessment (Potter, 1999). No single, 'correct' way to conduct evaluation has been delineated, and it is suggested that the methods of obtaining answers to evaluation questions be aligned, as far as possible, with the rationale and context of the particular programme being assessed (ibid.). There is, however, consensus regarding a set of features that govern successful practice in evaluation (Kaufman et al, 2006; Potter, 1999; Schalock & Thornton, 1988). These include: clarifying the underlying assumptions in the programme model; adherence to scientific principles; the use of multiple methods; the participation of stakeholders in the evaluation process; building the evaluation capacity of the programme; and the optimal utilization of findings. Each of the above is discussed in further detail below.

***Clarification of the underlying assumptions in the programme model***

'Programme logic' is described by a number of researchers as the 'logical' links between the selection of participants in a programme, the resources invested and the intervention strategies used, and the desired outcomes of a project (Louw, 2000; Schalock & Thornton, 1988). It is often the underlying premise upon which a programme is built, and is generally drawn from available research literature on similar case studies and interventions, psychosocial and developmental theories, previous programme history, as well as from the insights, perceptions and assumptions of project staff and the clinical experience of those involved in the programme or similar programmes (ibid.). It is argued that in order to reflect

on the effectiveness of the intervention in a meaningful way, programme evaluation relies, to a certain extent, on the explication of the programme logic (Kaufman et al, 2006; Rossi et al, 1999). By specifying how the programme is supposed to work, the researcher may, amongst several other advantages, identify variables likely to be important in the intervention; factors which can potentially be isolated or controlled in the evaluation process (Kaufman et al, 2006; Louw, 2000).

***Application of scientific principles in evaluation***

Programme evaluation is regarded as a systematic, science-based activity (Kaufman et al, 2006; Nixon, 1997; Schalock & Thornton, 1988). In a review of evaluation research in mental health programmes for children in the US, Nixon (1997) found that the capacity of results to influence policy and decision-making are limited, and often subjected to criticisms of conjecture, when researchers do not work in a methodical framework. General social research methods, such as research design, sampling and standard analytic procedures, should be applied when assessing the efficacy of interventions.

***Use of multi-method approaches***

Human activity occurs within complex, multi-systemic contexts and therefore evaluations of psychosocial programmes necessitate the use of a range of methods and perspectives to adequately record human experience (Friedman, 1997; Kaufman et al, 2006). 'Triangulation' refers to the collection of data in as many ways and from as many sources as possible (Kelly, 1999). This allows the researcher to approach the programme analysis from a range of different angles. Four basic types of triangulation have been proposed by Denzin (1970, cited in Kelly, 1999): the use of all available sources of data (data triangulation); the employment of different researchers to mediate the impact of the researcher on the evaluation (investigator triangulation); drawing on multiple theories and perspectives to interpret human experience (theory triangulation); and the application of different techniques to analyze data (method triangulation). All research methods have strengths and limitations and by using triangulated approaches in programme evaluation, the researcher can benefit from the advantages of each method used and assess outcomes against multiple perspectives (Louw, 2000; Potter; 1999).

***Stakeholder participation in evaluation***

Due to the common divide between researchers and programme staff and the frequent exclusion of programme staff from programme assessment, evaluation has been criticized as neither viable nor relevant to those involved in the programme being assessed and therefore unlikely to be utilized in future programme planning (Kaufman et al, 2006; Nixon, 1997). The active collaboration with and/or participation of stakeholders in the evaluation process is considered an essential factor in designing and executing a functional evaluation (ibid.). The constructive input from key role-players increases the evaluator's understanding of the programme logic, and the context within which the programme operates, thereby creating a useful framework for evaluation (Nixon, 1997). Partnership with stakeholders also builds trust in the evaluator, which may make results derived from the research more credible to the project staff, and thus more influential in programme development (Kaufman et al, 2006; Louw, Donald & Dawes, 2000).

***Building the capacity for evaluation***

Whether a programme has integrated measures of programme efficacy (such as psychometric assessments for participants) into its model has significant bearing on the quality and productivity of the evaluation (Friedman, 1997; Nixon, 1997). Before embarking on a programme evaluation, an assessment of the programme's evaluability (ability to track and analyze its functioning) must be conducted and, if required, evaluation indicators need to be built into the implementation of the programme (Kaufman et al, 2006). By building the evaluation capacity of a programme, evaluative research can move from the hands of external researchers, to ongoing, internal assessments of programme implementation and efficacy by stakeholders (Kaufman et al, 2006). Researchers argue that numerous evaluations, over time, however small they may be, help to build a sound knowledge base for the programme, and also create a culture of rigorous assessment, which ultimately results in the development of improved interventions (Friedman, 1997; Louw, 2000; Nixon, 1997).

***Optimal utilization of findings***

There is the mistaken assumption that results only become useful at the end of an evaluation, however a cycle of feedback is important and meaningful throughout the course of the intervention and its assessment (Rossi et al, 1999; Louw, 2000). Findings in a programme

evaluation should be shared with stakeholders on an ongoing basis and in so doing, information obtained from one phase of the intervention can inform subsequent activities (Kaufman et al, 2006; Louw, 2000). Furthermore, findings should be communicated in a simple, straightforward manner, framing information (particularly failings) in such a way that project staff can use it to advance the programme, taking into account the context and needs of those who deliver the intervention (Louw et al, 2000; Schalock & Thornton, 1988).

### 2.2.2 Collecting and analyzing data

Programme evaluation operates on the principle that programmes are essentially *choices*; decisions taken by project staff on how to intervene in a social problem (Schalock & Thornton, 1988). Choices imply that there are alternatives to the programme; something with which to *compare* it. As such, research designs in programme evaluation largely involve the measurement of outcomes on either side of structured comparisons (Nixon, 1997; Schalock & Thornton, 1988). There are various ways in which to set up the conditions for evaluation, including: experimental design; comparison or control groups; hypothetical comparison groups; and pre-post measures on a single group (Schalock & Thornton, 1988).

In experimental designs, candidates for a programme are randomly assigned to two groups, of which one is offered the intervention being evaluated, and the other only the services pertaining to the comparison conditions (Schalock & Thornton, 1988). Randomization necessitates that in order for findings to be generalizable, the two groups are identical (in age, gender, schooling, socio-economic status, etc.), excepting for the services being evaluated (Nixon, 1997). Due to the reasonably convincing comparability of the two groups, a relatively high degree of confidence can be placed in results from this design (Schalock & Thornton, 1988). While it is widely used in physical science and medicine, randomized control trials (RCTs) are rare in evaluations of human service programmes (such as socio-economic and psychotherapeutic interventions) (Kazdin, 1991; Nixon, 1997; Potter, 1999; Schalock & Thornton, 1988; Willner, 2005). RCTs are often perceived as ideal, but not practical for social programmes, that is, random assignment may not be possible. It may involve refusing services and treatment to some who need it, it may construct treatment situations that are too distinct from those implemented rationally in developing countries with scarce resources (such as South Africa), the funds needed to conduct RCTs may be excessive, and study samples may be too small to effect statistical power, despite high

Schalock & Thornton, 1988). However, as with the hypothetical comparison group, it fails to produce the certainty and precision associated with experimental, and to a lesser degree, control group designs (Schalock & Thornton, 1988). It rather contributes to a programme evaluation by generating hypotheses about the potential impact of a programme (ibid.).

Programme evaluation uses several methods of data collection (Potter, 1999). The following techniques are typically used: standardized tests, scales and questionnaires; semi-structured interviews (focus group and individual); analysis of existing programme documents (participant records, field notes, case material, etc.); and participation observation (Friedman, 1997; Schalock & Thornton, 1988). More often than not, evaluation research sources all available and usable data (Potter, 1999; Schalock & Thornton, 1988).

As proposed earlier in this section, programme evaluation is most likely to be serviceable if it utilizes both quantitative and qualitative methods of organizing the data collected. While qualitative study designs are criticized as labour-intensive and limited in their capacity to generalize findings, it is argued that there are significant advantages in their use (Friedman, 1997; Potter, 1999; Schalock & Thornton, 1988). In monitoring the implementation of an extensive project focused on improving the quality of schools in South Africa, researchers relied exclusively on qualitative methods such as individual interviews with key role-players, analysis of programme documents, and classroom observations. De Jong (2000) reports that a qualitative case study approach, using interviews, questionnaires, focus groups, observations and analysis of available documentation, was instrumental in providing valuable information regarding the context in which a teacher in-service project was implemented in a poorly resourced South African high school. This information could be shared with other schools in similar circumstances. Researchers argue that it is impossible to develop a valid understanding of human experience without the subjectivity and reflexivity that qualitative methods provide, for instance, qualitative data regarding the experiences of participants in a programme are useful feedback for programme developers, particularly in terms of improving the efficacy of future interventions (Friedman, 1997; Louw et al, 2000; Potter, 1999). At the same time, quantitative data undoubtedly give credence to qualitative findings (ibid.). South African evaluators have demonstrated how triangulation between qualitative and quantitative measures in their assessments of psychosocial projects for children has been constructive (Louw, Donald & Dawes 2000). For instance, in their evaluation of the impact

of a school-feeding project, Richter and colleagues (2000) used both qualitative (teacher observations of classroom behaviour) and quantitative (psychometric tests) methods to measure improvements in the children's attention.

## 2.3 The LSG: Previous research conducted

Since the inception of the LSG programme, research has been conducted on various aspects of the programme to improve its implementation as well as the services delivered. A number of honour's and master's psychology students have used qualitative approaches to study different components of the project. These studies have helped to build a knowledge base for the intervention and have informed the planning and running of subsequent LSG programmes. An overview of the previous research conducted is presented here.

Following the pilot project in 2000, Elkon (2001) researched the perceptions of key role-players in the programme by conducting semi-structured interviews with the project manager, the project co-ordinator, the two clinical psychology trainees and two remedial educator trainees facilitating the groups. He reported that the project staff, on the whole, perceived the programme to be valuable, that is, they felt that the intervention was beneficial to the participants, as well as useful for the trainee group facilitators. The project staff observed several problems in the implementation of the intervention, including: inadequate communication between role-players in the programme, particularly the emotional and remedial therapists; the absence of regular meetings for project staff; the absence of collaborative or feedback meetings between parents and facilitators; the need for psychometric assessment, conducted by a clinician other than a group facilitator, to screen the participants before admittance to the group; and general administrative and logistical difficulties, such as planning for school holidays and absenteeism. Findings were utilized to inform decisions in the implementation of the subsequent LSG intervention.

Also in 2001, a qualitative study on the parent support group was undertaken by Williams. The parent group at this time aimed to offer empathic reflections to parents, highlighting issues in the relationship between the parents and their children, and their impact on their experiences of parenting and parenting style. The main aim of the group was to support parents in expressing and managing their feelings and worries about parenting a child with

learning problems. There were also opportunities to learn and practice parenting skills, such as listening and communicating effectively and setting and maintaining limits in discipline, through discussion and role-play exercises. With the objective of enquiring into the perceptions and experiences of the participants in the group, Williams conducted semi-structured interviews with a sample of seven parents, who, together with their children (aged 7-11 years), had participated in the LSG programme. Parents reported that they felt supported and more competent in their ability to cope with parenting stressors, and that that they had acquired helpful parenting strategies. Some parents observed progress in their children's school performance. In general, parents experienced improvements in the quality of parent-child relationships.

An evaluation plan for the LSG project was submitted by Carver (2002) in a course assignment for an honour's module in Programme Evaluation at UCT. She outlined a non-randomized, pre- and post-measures research design, which aimed to monitor the process of implementation of the programme, and measure the outcomes related to a sample of 16 child participants and their parents, as well as the training outcomes for the psychology interns and remedial teachers. A comparison group was suggested, ideally consisting of 16 children and their parents who would have been assessed at the CGC but declined the offer to participate in the LSG. Pre- and post-tests were suggested, which included both qualitative measures (such as semi-structured interviews with stakeholders and analysis of programme documents) and quantitative measures (such as psychometric tests and questionnaires). The evaluation was to take place in 2003 but could not be conducted due to lack of funding and resources, as well as ethical concerns regarding the exclusion of suitable candidates from the programme to ensure a control group.

Also in 2002, Schiff used the clinical case material obtained during her co-facilitation of an adolescent psychotherapy group in the LSG project to illustrate a proposed method of group work with adolescent boys and girls, who are understood to communicate their feelings in symbolic, non-verbal ways. Schiff explored the use of drama and movement therapy as the primary mode of providing emotional containment to adolescents with learning difficulties, through the process of enacting, naming and then reflecting on the difficult feelings associated with learning problems.

Truter (2003) also used a case study approach, drawn from clinical material, to illustrate the negative impact of traditional, interpretation-based, analytic practices on the therapeutic process in a group for adolescent boys with learning difficulties and behavioural problems. Truter proposed the application of an 'active analytic approach', developed by Evans (1998, cited in Truter, 2003), to the LSG programme. This approach argues that adolescents may experience traditional, interpretive models as attacking and rejecting, and therapists may find it increasingly challenging to respond to and contain the group members' chaotic activity, which is understood as a defence against the 'rejecting' group space and therapist (ibid.). Truter recommended that structured group activities could be used to direct the energies of the group members, and in so doing, set limits and boundaries on their behaviour.

Drawing on the feedback from previous researchers and project staff, the 2003 programme conducted an adolescent psychotherapy group grounded in a psychoanalytic framework, but operating within a more structured and interactive model (Ismail, 2005). The approach comprised of both interpretative elements and structured activities such as drawing and using punching bags, although these activities were not always consistently implemented. A sample of 10 adolescent boys (aged 12-15 years) who participated in the 2003 project was used in a qualitative case study exploration of the use of interpreting psychoanalytic phenomena, particularly oedipal struggles, in working with adolescents with learning difficulties in a group facilitated by a male and female co-therapist dyad (Ismail, 2005). Findings again highlighted the limitations of psychodynamic interpretation with adolescents, as it is understood to be too anxiety-provoking for group members and contrary in assisting them with their primary difficulties in expressing feelings and controlling acting out behaviour. The cumulative findings of Truter's and Ismail's research resulted in the development of a less interpretive, and more structured, therapeutic programme for the 2006 child psychotherapy group in the LSG (discussed further in the next chapter).

In summary, studies on different aspects of the LSG programme included: an enquiry into the perceptions of project staff in an early project, which subsequently provided useful information on key factors in the implementation process; an enquiry into the perceptions and experiences of parents regarding their involvement in the parent support group component of the LSG, which demonstrated the potential benefits of the group; the proposal of a design for formal evaluation of the LSG; and three case study explorations of

psychotherapy for the adolescent therapy group, which essentially proposed that traditional, psychodynamic-interpretive models were inappropriate and a more active, task-based approach is needed. Prior to 2006, no formal evaluation regarding the academic, emotional and behavioural outcomes for the participating children and support outcomes for their parents had been conducted. Also, previous research largely involved case studies by participant-researchers, which have some limitations regarding the objectivity and validity of findings (Holloway & Jefferson, 2000, in Ismail, 2005). Furthermore, while the study on the parent support group found that parents reported that their children's academic performance had improved, no supplementary data was collected in this regard. The need for a more objective and systematic evaluation led to the development of the present outcomes study and the use of an 'external' researcher who was not involved in the programme.

## 2.4 Conclusion

A few key points from the literature review are worth highlighting. Although there is controversy in terms of definition, terminology and aetiology, what should be made clear from this chapter, is the significant impact of LDs on the child's academic performance (which is associated with socio-economic functioning in adulthood), mental health and psychosocial functioning. In addition, parents of children with LDs experience significant stress in relation to these difficulties. Due to a number of expectable constraints in the implementation of the inclusive education policy in South Africa, as well as the lack of collaboration with parents and exclusion of the socio-emotional aspects of learning in the curriculum, the needs of these children are unlikely to be adequately addressed in the formal education system at this time. Literature in the field of learning disorders recognizes the advantages of interventions that address both the cognitive and affective components of LDs. While both individual and group interventions have proven to be effective, it may be that the significance of peer relationships in childhood, the particular need of the learning-disordered child for social connection, and the opportunity to reach a larger number of target participants, makes group interventions a natural and possibly more feasible intervention. Interventions with parents have also been discussed in this section, with controlled studies reporting on the efficacy of group therapies that incorporate both educational-didactic and emotional-supportive elements. The merits of supplementing direct interventions, for example with children and parents, with indirect services in other components of the child's system, such as classroom programmes or interventions with teachers, have been noted.

South African researchers have suggested the growing recognition and importance of evaluating programmes for children, particularly in a context where resources are scarce and incisive intervention is required. Given limited resources, it is suggested that evaluations be tailored to the intervention, within a flexible but responsible framework. Finally, a number of studies by participant-researchers have contributed significantly to the development of the 2006 LSG intervention described in the next chapter.

# CHAPTER 3 METHODOLOGY

This chapter details the methodological framework for the LSG evaluation. Firstly, the aims of the research are enumerated, followed by an outline of the research design. Descriptions of the participants in the study and the selection procedure of the LSG are next provided. Thereafter, the structure and content of the intervention implemented with the participants in 2006 is outlined. Procedures in the collection and analysis of data in the evaluation are then explicated. Finally, the chapter addresses the key ethical considerations in this study.

## 3.1 Research Aims

This research aims to evaluate the outcomes of the LSG programme for children with learning difficulties and their parents. The primary objectives are to:

(i) Evaluate whether there have been any changes in the children's academic, emotional and behavioural functioning.

(ii) Assess for possible shifts in the parents' experiences of parenting a child with learning difficulties.

(iii) Explore the children's and parents' experiences of participating in the LSG programme.

## 3.2 Research Design

The study utilized a single-group pre- and post-test design to evaluate the outcomes for the children and their parents participating in the LSG Programme in 2006. As noted in Chapter Two, quasi-experimental, single-group pre- and post-test designs have been usefully employed in programme evaluations in this country (Donald et al, 2000; Potter, 1999).

It was not feasible to recruit and structure a comparison group for the purposes of this evaluation, primarily due to lack of resources and funds, as well as time-constraints. For instance, one type of comparison group may have been a control group comprised of children and families who were assessed at the CGC and found to be suitable for the intervention, but did not participate (as described by Williams in 2002). While such a comparison would have been beneficial in this study, there were challenging time-constraints involved, that is, the LSG programme was to start in April in order for the intervention to run for most of the year, and at that point, there were too few psychometric assessments conducted at the CGC to develop a control group which could be evaluated on pre- and post-measures alongside the LSG participants. Another type of comparison group could have been a group receiving only

remedial intervention and no psychotherapy. Such an intervention would have required increased staffing resources and funds to accommodate a second remedial group, exceeding those which were available at the time of the intervention. A single-group pre- and post-test design was therefore the most feasible option.

The 2006 LSG programme aimed to address a number of aspects of the functioning of children with LDs (as seen in the Introduction chapter and as will be further discussed in section 3.4 in this chapter). In order to assess whether the children showed any improvement, the evaluation of outcomes had to occur on a number of fronts. Triangulated methods (which, as discussed in Chapter Two, are well supported in the programme evaluation literature) were used to collect and analyze data on the children's functioning from four different sources: (i) a direct assessment of the children's pre- and post-intervention capacity for naming and expressing feelings, as well as their social problem-solving skills; (ii) an assessment of shifts in the parents' perceptions of the children's academic, emotional, behavioural and relationship difficulties; (iii) assessments of the children's remedial progress; and (iv) assessments of the children's academic performance, behaviour and relationships at school pre- and post-intervention. The research design included both quantitative and qualitative data and analytic procedures obtained from the child participants, their parents and their teachers, which are discussed in more depth in sections 3.5 and 3.6 in this chapter.

## 3.3 Research Sample

### 3.3.1 Participants

Randomization was not suitable for the evaluation as there was no large population from which to draw a random sample. Participants in the study thus included all the group members who had volunteered to participate in the 2006 LSG programme[6], which was comprised of six pre-adolescent boys (aged 10-12 years) and their nine participating parents (aged 26-47 years). One of the six boys joined the programme two months after it had begun

[6] No pre- and post-records were available for the previous years' LSG participants and this data could therefore not be included in the study.

and another pulled out prematurely in June, although his mother chose to stay on for the duration of the programme[1].

A summarized profile of each boy is presented in Table 1. This was compiled by the researcher from psychometric and emotional assessment reports, background information obtained by the LSG project staff as part of the intake process, reports from the LSG remedial teacher as well as collateral from school teachers. On tests of general intelligence, two of the candidates obtained scores within the borderline range, whilst another two were found to be in the low average range of functioning[2]. The remaining two children obtained average and high average scores respectively. All were reported to have reading difficulties, although degrees of severity varied, while four had marked problems with numeracy. Five of the participants presented with problems with concentration and attention, of which two were clinically diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD) by private psychologists and another was diagnosed on assessment at the CGC. According to the parent collateral, all the children had difficulty expressing and managing feelings as well as poor social relationships. All the children had experiences of failure or repeated failure and 'slow' progress at school, despite prior remedial support in four cases.

[1] The reasoning behind this appears to be complex. According to his mother, both external (time clashes with his soccer training) and internal (a history of emotionally traumatic separations and loss, which made it difficult for him to emotionally commit to the group) factors played a role in his decision to leave the group. He insisted that no 'problem' had made him want to leave.

[2] Categories of functioning for IQ scores:

| **IQ score** | **Category** |
|---|---|
| < 70 | Intellectual Disability |
| 70 – 79 | Borderline / Below average |
| 80 – 89 | Low Average |
| 90 – 109 | Average |
| 110 – 119 | High Average |
| 120 < | Above average to Superior |

Table 1: **Profiles of participants in the 2006 LSG programme**

| Participant | Psychometric profile | Presenting problem: (Cognitive) | Presenting problem: (Affective and relational) |
|---|---|---|---|
| | **The data in this table has been removed to protect the participants' confidential information.** | | |
| | | | |
| | | | |

| Participant | Psychometric profile | Presenting problem: (Cognitive) | Presenting problem: (Affective and relational) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Of the six families participating in the programme, three consisted of single mothers (sole breadwinners) and absent or uninvolved fathers. Four of the families live in the 'Cape Flats' area of Cape Town, which is characterised by disadvantaged socio-economic circumstances, such as unemployment, community-based violence, inadequate housing, and little access to recreational facilities for children. The remaining two families also live in socio-

economically disadvantaged areas outside the city centre[10]. All the children came from family and social backgrounds with socio-economic difficulties, such as low household income and financial stressors in four cases, overcrowded households in three cases, parental substance abuse in one case, exposure to gang-related violence in five cases, as well as domestic conflict in the case of three of the participants, including witnessing violence and witnessing marital discord. According to the parental reports, most of the boys had conflictual, often physically aggressive relationships with their sibling(s).

In three of the families, Afrikaans was the first language of the parents, and the remaining three parents were English-speaking. However, all the parents reported that they were fluent in both languages and generally spoke English when conversing with their children, although those who spoke Afrikaans as a first language often switched between languages with their children. All the children were reported to speak English as a first language.

Only one of the boys attended a special school, while the remaining five boys attended mainstream schools which were, according to their parents and teachers, characterised by overcrowded classrooms, lack of resources, as well as high levels of bullying and peer-related violence (the latter have recently been highlighted in the media as significant problems in South African schools). All the boys were schooled in English.

### 3.3.2 Assessment and selection procedure

Learners are referred as candidates for the LSG programme via a number of referral routes, including clinical assessment by trainee psychologists at the CGC, referrals from private psychologists, and word of mouth among former clients of the CGC. For the 2006 programme, it was decided to run one group for learner aged 9-12 years, since limited resources precluded the inclusion of an adolescent group also. Younger children were excluded in order to maintain a group that was, to some extent, developmentally similar. In 2006, two of the boys were assessed and referred to the LSG by student psychologists at the

[10] These geographical areas cannot be specifically named due to confidentiality agreements with participants.

CGC in 2005, and another in early 2006. The other three boys were assessed by psychologists in private practice and then referred to the LSG.

Amidst current issues of concern regarding psychometric testing in general (such as the potential for language and cultural biases, and the absence of norms representing all children in South Africa), it has been proposed that, when identifying LDs, possible sensory deficits (such as hearing or vision impairments) first need to be excluded and scholastic assessments and a review of education history should supplement general intelligence testing (Flack, 2005; Gresham et al, 2004; Mather & Gregg, 2006; van den Berg, 2004). The assessment of eligibility for the LSG encompassed all these aspects. Selection for the LSG was based firstly on comprehensive intellectual and scholastic assessments, which included the Senior South African Individual Scale – Revised (SSAIS-R) and a number of scholastic tests for reading, spelling and mathematics, such as the UCT graded reading and dictation tests (these varied across the different participants, although three particular tests were used pre- and post-intervention on all the children participating in the LSG and will be discussed in detail later). The SSAIS-R is a test designed to measure the general intellectual functioning of English-speaking and Afrikaans-speaking South Africans aged 7 years to 16 years, 11 months and it is commonly used in South Africa (van Eerden, 1991; van Eerden & de Beer, 2001). The test consists of verbal and performance scales which are used to obtain a comprehensive picture of cognitive abilities and strengths and weaknesses in an individual's intelligence profile, as well as prognoses for scholastic achievement (van Eerden, 1991). The SSAIS-R has a standardized method of administration and scoring, although the testing clinician's qualitative observations of the testee can provide valuable information regarding non-cognitive aspects, such as anxiety and distractibility, which may affect the child's performance (van Eerden & de Beer, 2001). To be included in the LSG programme, the child's psychometric profile had to include one of the following markers for learning difficulties: (i) at least average intellectual functioning with specific areas of difficulty or (ii) below average or borderline intellectual functioning. Learners who are unable to make scholastic progress due to intellectual disability (mental retardation) are not admitted to the LSG programme, as this range of functioning is distinct from LDs (as discussed in Chapter Two) and requires alternate intervention.

In addition to the intellectual and scholastic assessments, clinical assessment interviews (including a developmental and educational history-taking and in-depth exploration of cognitive, emotional and behavioural problems reported by referring agents, parents, teachers and children) were conducted with each boy and then separately with his parents by the clinical psychologist who co-ordinated the LSG programme.

All of the six families referred to the LSG in 2006 were found to be suitable for inclusion. Gender was not a selection criterion but all the children referred in 2006 were boys. This is in keeping with previous findings from the CGC that in the period from 1990 to 1999, 67.2% of children presenting at the CGC with learning problems were boys (Melvill, 2000). Families selected for the 2006 programme had to be able to commit to weekly meetings during the school term (except public holidays), and the participation of at least one parent of each child in the program was compulsory. Participants were assured (in writing) that all clinical information and material from group sessions would be kept confidential, although these could be utilized for research purposes.

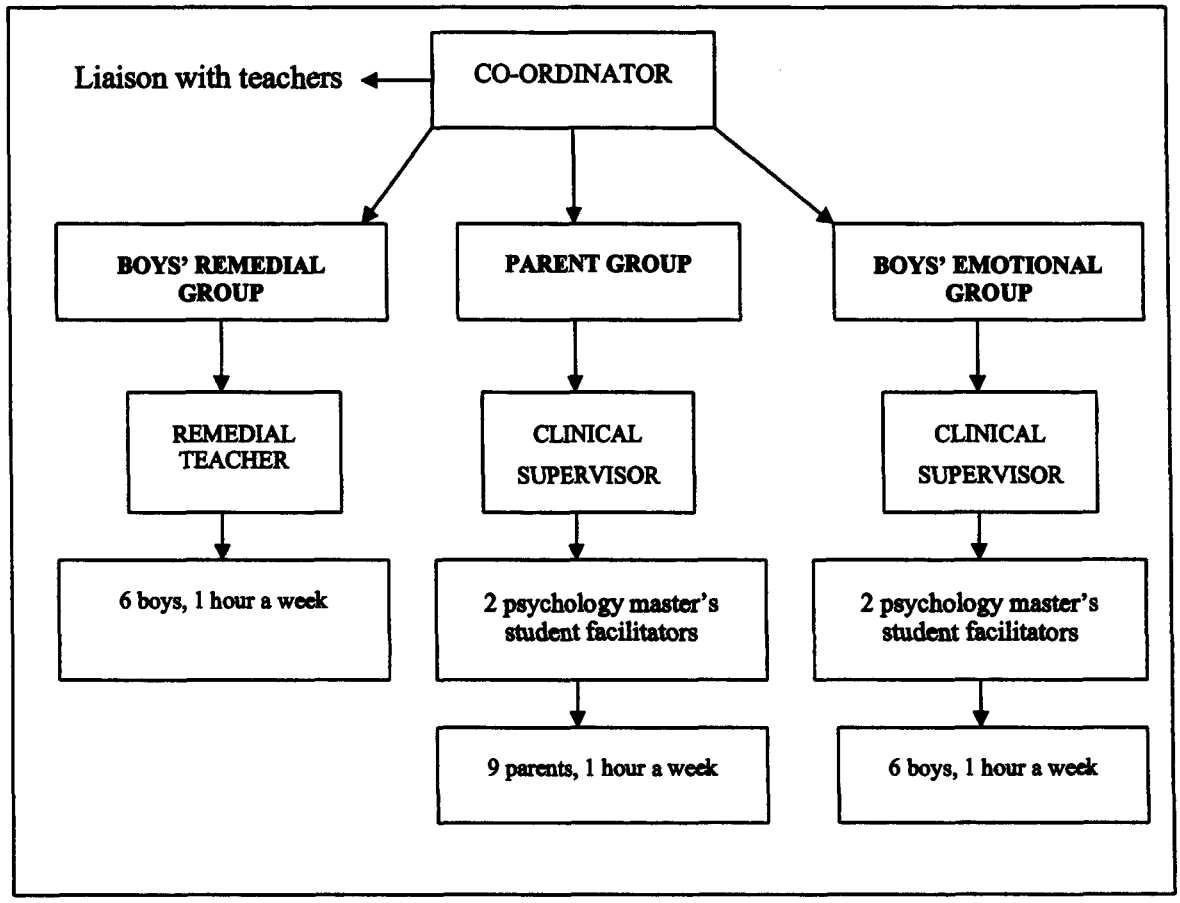
## 3.4 The intervention

The intervention was conducted from April through October 2006 (24 sessions in total). It took place once per week at the CGC. For the children, it comprised of one hour of small group-based remedial tuition followed by a short break and then an hour of emotional group therapy. The parent support group ran parallel to the boys' emotional support group. The children were given a healthy snack between groups and the parents were provided with refreshments prior to commencement of their group. All the groups were conducted in English.

The key role players involved in the LSG (the project coordinator, the psychology trainees facilitating the groups, the remedial teacher and the clinical psychologists who supervise the psychology trainees) met on a weekly basis for feedback and liaison. This also served as a forum for informal monitoring of the implementation process. In addition to the initial assessment interviews, the project co-ordinator held mid-year and end-of-year meetings with each family, to give parents information regarding the work done in the children's remedial and emotional therapy groups and to provide an opportunity for parents to discuss any issues

pertaining to their own, and/or their children's, involvement in the programme. At the end of the year, a 'graduation' ceremony was held for the participating parents and children, as well as the LSG project staff (including the co-ordinator, the psychology student facilitators, supervisors and remedial teacher). The structure of the programme is diagrammatically shown in Figure 2.

Figure 2: **Structure of the 2006 LSG programme**




### 3.4.1 The boys' remedial group

Remedial support was provided by a qualified remedial teacher. This group aimed to equip the boys with user-friendly strategies to assist them with basic schoolwork (spelling, writing, reading, times tables and general mathematics ability). If practiced, these strategies aimed to enable the child to work more independently, gain confidence in his academic ability and develop a better sense of self-worth.

During sessions, the children were given tasks to practice these strategies and by the end of the year a cue card was made for each strategy, which was then collated in a creative and practical way for each child to keep and use (see Appendix A for a list of strategies and lessons used in the remedial group). These activities were also communicated to the parents by the remedial teacher, who encouraged parents to ask their children about each lesson, ask their children to explain the strategies learnt, and help their children with homework, reinforcing the use of cue cards.

### 3.4.2 The boys' emotional group

This group was facilitated by two clinical psychology master's students who were supervised by a clinical psychologist. Drawing on Yalom's (1995) interpersonal group theory, the primary therapeutic function of the group was understood to occur through the interaction between group members. However, based on the experiences of project staff and feedback from previous LSG research regarding practical aspects of group therapy with adolescents, the need for contained and semi-structured activities in the emotional group was taken into account. The 2006 boys' emotional support group thus became a task-based intervention, that is, the group implemented tasks or activities for each session in order to provide structure and boundaries for the boys. These tasks centred on specific themes such as self-concept and social relationships and included, among others, the making of boxes as a way of representing one's self (decorating the outside in such a way as each boy wanted others to know or see him) and housing meaningful items to be shared later; creating plastecine family portraits; drawings of self in relation to family; and constructing life-lines that map the 'good' and 'bad' times in their lives. The content of the tasks were designed to support the specific aims of the group, which included: (i) building self-esteem (through the experience of mastery of tasks, and of being heard and understood by facilitators and group members); (ii) encouraging emotional expression and regulation (through naming, rather than acting out feelings as they arise spontaneously out of the group situation); and (iii) building relational and problem-solving skills (through group interaction). Each of these aims can be seen to relate directly to the boys' presenting emotional problems (as summarised in Table 1). In addition, group rituals for beginnings and endings of sessions, breaks in therapy, birthdays, and so on, were used to mark changes within the group and to track the group process, also facilitating the development and strengthening of group cohesion. The boys' painful experience of their learning problem arose as a central topic, which together with their

difficult social experiences were woven into discussions and activities. Central themes which emerged in the therapeutic process included issues with self-esteem (feelings of incompetence or stupidity, negative views of self and future, and a sense of wanting to 'fix' a 'damaged' self); emotional difficulties (sadness and anger, talking about feelings, and showing strength and weakness); and relationship difficulties (inclusion and exclusion, bullying and being bullied, and finding one's 'voice'/assertiveness) (N. Khumalo & A. Subotzky [group facilitators], December 2006, personal communication).

### 3.4.3 The parent support group

This group was also run by two clinical psychology master's students, under the supervision of a clinical psychologist. It was comprised of psychotherapeutic (emotional) and psycho-educational (information) components. Emphasis was placed on the verbalization of emotions and relief of stress through interpersonal support. Parents were encouraged to express their feelings about, and experiences of, parenting a child with learning, emotional, and often behavioural difficulties, in a supportive context with other parents experiencing similar problems. The intervention aimed to: (i) equip parents with practical information regarding learning problems and associated difficulties, that is, psycho-education; (ii) to help them better understand and respond to the experiences of their children (develop increased empathy); and (iii) to develop parenting skills, such as limit-setting, communication, and helping their children to master appropriate independence. Alongside these functions, the therapists, and the group itself, aimed to act as a holding space responsive to the emotions of the parents, thus modelling a process of emotional containment that parents could use with their children (M. Mangerah & C. Stanley [group facilitators], December 2006, personal communication).

Towards the end of the group process, parents were offered a bound volume of resources that were compiled by the group facilitators. Resource materials were designed to supplement the content discussed in the group sessions and ranged from skills-orientated input to assist the children and their families on a daily basis (such as communication, discipline, homework and other strategies), to information on key issues regarding, for instance, bullying in schools. A reference or reading list for each topic covered in the resource book was also provided. *See* Appendix B for a list of the resources provided.

## 3.5 Instruments

### 3.5.1 Primary data

The primary instruments used in this evaluation study were pre- and post-intervention semi-structured interviews with four of the six boys participating in the LSG in 2006 and with all of the nine participating parents (the parenting couples were interviewed together, so there were six sets of interviews). While every attempt was made to obtain data for all participants, there are data missing in some cases (all data available are summarized in Table 2). One of the boys dropped out of the programme mid-year and another boy was, due to a number of logistical difficulties, unable to meet with the researcher for the pre-intervention interview. As a result, pre- and post-intervention interviews with these two boys were not included as a source of data in this study. A total of eight interview transcripts for the boys (four pre-intervention and four post-intervention) and 12 interview transcripts with the parents (six pre-intervention and six post-intervention) were therefore available for analysis. Interview schedules for the parents and children were developed in consultation with members of the LSG project staff, who were involved in the clinical work of the programme over several years and had valuable insight and knowledge regarding the underlying assumptions of the intervention and aspects of the participants' functioning that could be used as outcome variables in the programme evaluation.

***Child interviews***

The interviews with the children consisted of two sections. The first (consistent for pre- and post-interviews) included a series of vignettes or scenarios likely to be experienced by the boys. For instance, they were asked to recall or imagine a situation where they were being bullied at school, were in conflict with a sibling, and were in a conflictual classroom situation. For each of the five scenarios, the boys were asked how they felt about the situation and how they would respond to it. This aimed to assess two key areas of their socio-emotional functioning, that is, their capacity for emotional expression and their social problem-solving skills. The second section of the pre-intervention interview enquired about the boys' feelings about their difficulties in learning and their expectations of the LSG (general findings from this section were reported to the boys' group facilitators for utilization during implementation of the intervention but the names of specific respondents were kept

anonymous), while the second section of the post-intervention interview elicited the boys' experiences of the LSG, that is, the boys were asked about the activities in the different groups and how they felt about them. *See* Appendix C for a copy of the interview schedule.

***Parent interviews***

The interviews with the parents (see Appendix D) enquired into three outcome areas, namely: (i) the parent's concerns about their children (scholastic, emotional and behavioural) that prompted them to seek help, including their referral route to the CGC or the LSG programme (pre-intervention interview) and their current concerns about their children (post-intervention interview); (ii) their relationships with their children and their parenting experiences, for example, parents were asked to describe how their children communicate their feelings, which difficulties they experienced in parenting, how they experience disciplining their children and homework issues; and (iii) the parents' expectations for the LSG (pre-intervention interview) and experiences of having participated in the programme (post-intervention interview). In the post-intervention interview, parents were asked the same questions in sections one and two of the pre-intervention interview, to record spontaneous responses. The researcher then followed up each area of enquiry with a summary of what was reported in the pre-intervention interview, and initiated discussion about whether these had remained stable or whether they had shifted.

### 3.5.2 Supplementary data

This data is considered supplementary because it utilizes quantitative analysis of data for a very small sample ($n=6$) and therefore is likely to have limited statistical power. It does, however, offer an additional source of data against which to evaluate the findings of the qualitative data. The following supplementary data were included in the evaluation:

***Conners' Rating Scales for child and adolescent problem behaviour***

(i) Pre- and post-intervention Parent Conners' Rating Scale. The Conners' Rating Scale - Revised (CRS-R) is a Likert scale assessing the child's (aged 3 to 17 years) behaviour at home. It is directly related to the DSM-1V clinical and diagnostic features of Attention Deficit/Hyperactivity Disorder (ADHD) and co-morbid disorders. The short format used

in this study generates T-scores and percentiles for ADHD, Oppositional Defiant Disorder, Cognitive Problems and Hyperactivity. The higher the scores in a category, the more severe the problem in that area of functioning. Excellent statistical support has been demonstrated for the reliability and validity of this instrument (Conners, 1997), although no South African validation studies have been conducted. The questionnaires were administered in English.

(ii) Pre- and post-intervention Teacher Conners' Rating Scale (a second version of the above Likert scale assessing the child's behaviour in the classroom, bearing the same proven psychometric properties as the former version). The questionnaires were administered in English. *See* Appendix E for a copy of the questionnaires administered to parents and teachers.

***Teachers' qualitative observations***

Teachers' pre- and post-intervention observations were available as indicators of the children's academic functioning and classroom behaviour. At the beginning and end of the LSG programme, teachers were asked by the LSG project co-ordinator to write a few paragraphs describing their experience of the LSG child participant as a learner in their class, commenting particularly on his learning abilities, his relationships with peers, his relationship with the teacher, and the teacher's feelings toward him.

***School reports***

The boys' school reports were available as an indicator of pre- and post-intervention academic performance. Academic evaluation varies from school to school, with some schools producing four reports for the year, others two or three. As a result, it was decided that the Literacy and Numeracy grades (two key learning areas) for the first and final reports (two in total for each boy) would be utilized in this evaluation.

***Remedial assessments***

The LSG remedial teacher conducted standardized scholastic tests for Mathematics and English spelling and reading, which yielded test-age equivalents for each of the boys on pre- and post-intervention. These tests included the following:

(i) Test of word reading efficiency (TOWRE)

The *Phonemic Decoding Efficiency* and *Sight Word Efficiency* tests, which measure word reading fluency and accuracy, was normed on 1500 individuals in the US, aged 6-24

years (Torgensen, Wagner & Rashotte, 1999). The phonemic decoding test assesses the number of pronounceable words that can be decoded in 45 seconds and the sight word test assesses the number of words that can accurately be identified in 45 seconds. There are two forms of equivalent difficulty for each subtest. The LSG remedial teacher used Form A for both tests. Standardized procedures in administration, scoring and interpretation are provided in the examiners manual (Harcourt, 1999). Extensive evidence has been found for the validity of the measure and reliability studies suggest that examiners can have confidence in the results (ibid.). However, no South African validation studies or norms are available for these tests. *See* Appendix F for copies of the tests.

(ii) Schonell Standardized Spelling and Arithmetic Problems tests (Schonell, 1955; Schonell & Schonell, 1952)

The Schonell Spelling Test A for children aged 6-13 years, is comprised of 80 graded words. Example sentences are provided to illustrate the use of each word for the testee. The Arithmetic Problems Test 5 for children aged 7-14 years is a 'miscellaneous' test, made up of 100 mixed addition, subtraction, multiplication and division sums that must be completed by the testee within five minutes. Standardized procedures in administration and scoring for these tests are outlined by the authors Schonell and Schonell (1952). No South African norms could be found for these two tests although they are frequently used by remedial teachers and other educational professionals (L. Arnaud, January 2008, personal communication[11]), as well as by the clinical staff at the UCT CGC (N. Shabalala & G. Douglas, May 2008, personal communication). The Schonell tests are generally regarded by testing clinicians as useful instruments for scholastic assessment, particularly in obtaining qualitative information about testees, for instance, strategies that they use for spelling, etc. (F. Hemp[12], June 2008, personal communication). *See* Appendix G for copies of the tests.

(iii) Ballard One-Minute Addition and Subtraction tests (Ballard, 1923; 1927)

The Ballard arithmetic test for children aged 6-13 years has two subtests, addition and subtraction, consisting of 30 items each. Procedures in administration and scoring are outlined by the author. As with the above tests, no South African validations studies are available, nor could any South African norms be found. Despite this drawback, the

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[11] Remedial teacher at Forres Nursery and Primary School. LSG remedial teacher in 2006.

[12] Neuropsychological Services, Groote Schuur Hospital, Dept. of Psychiatry and Mental Health, UCT.

Ballard is also commonly used at the UCT CGC (N. Shabalala & G. Douglas, May 2008, personal communication) and by clinicians in the Western Cape, although interpretations regarding age-equivalents are to be made with caution (F. Hemp, June 2008, personal communication). See appendix H for copies of the tests.

Table 2: **Data available for participants**: boys, *n*=6 and parents, *n*=9

| Participant | Pre- & post-interviews with the children | Pre- & post-interviews with the parent(s) | Parent & teacher CRS-R (including teachers' qualitative observations) | School reports with grades for Literacy and Numeracy | Remedial Assessments |
|---|---|---|---|---|---|
| **1** | ✓ | Mo & Fa interviewed | ✓ | ✓ | ✓ |
| **2** | No pre- or post-interviews | Mo | ✓ | ✓ | No pre-test and post-test |
| **3** | ✓ | Mo | ✓ | ✓ | ✓ |
| **4** | No pre- or post-interviews | Pre-interview: Mo & Fa. Post-interview: Mo. | ✓ | ✓ | ✓ |
| **5** | ✓ | Mo & Fa | ✓ | ✓ | ✓ |
| **6** | ✓ | Mo & Fa | ✓ | ✓ | ✓ |

### 3.5.3 Procedure

Prior to the pre-intervention interviews, informed consent was obtained from both the parents and assent was obtained from the children (see section 3.7.1 and Appendices J and K) and interview appointments were scheduled telephonically. Pre-intervention interviews with four of the families were conducted one week before the programme started and for the remaining two families, two weeks into their commencement of the programme due to difficulties with finding a meeting time. Post-intervention interviews were conducted with all participants two to three months after the programme had ended. The interviews were conducted by the

researcher with the parents and children in their homes or in the researcher's office at the CGC, depending on what was most convenient for the participants. The parents for whom Afrikaans is a first language declined the researcher's offer to speak in Afrikaans and all the interviews were therefore conducted in English. In the interviews with parenting couples, the parents were asked whether they agreed or disagreed on the various issues, to accurately record the experiences of all participants. Interviews ranged in duration from 15 to 30 minutes with the boys and 35 to 95 minutes with the parents (despite an initial expectation, stated on the consent form, that parent interviews would take about 45 minutes). Digital recording equipment was used to capture the data, which was then transcribed verbatim by the researcher. The CRS-R was administered to parents and teachers by the LSG project coordinator, who gave the completed questionnaires to the researcher for standardized scoring and interpretation, using the manual (Conners, 1997). The project coordinator also asked teachers to report qualitative observations on the children's academic functioning and behaviour on a sheet attached to the Teachers' CRS-R. School reports were handed by the parents to the CGC administrative secretary who then gave these to the researcher to be photocopied and returned to the parents. The remedial teacher made available to the researcher tabled summaries of her assessments with each of the boys to indicate their pre- and post-intervention scores on the scholastic tests.

## 3.6 Data Analysis

### 3.6.1 Primary data

***Child interviews***

The transcripts of the interviews with the children were analyzed using content analysis (Miles & Huberman, 1994) to document the frequency of occurrence of emotional or 'feeling' words (such as 'sad', 'scared, 'angry', etc) and different types of problem-solving strategies (such as aggression, assertiveness, withdrawal, eliciting support, etc.) in the eight transcripts. The frequency of occurrence of the use of 'feeling words' was then compared statistically between pre- and post-interviews, using a dependent sample t-test to test for significant differences between pre- and post-intervention interviews. Types of problem-solving strategies were compared qualitatively between pre- and post-intervention.

***Parent interviews***

Transcripts were analyzed using an open or inductive coding process (Thomas, 2003, 2006) to identify commonly occurring themes across the parent interviews, within each of the areas covered in the interview schedule. In this approach, data analysis encompasses both deductive (determined by the research objectives), as well as inductive (findings emerging directly from the raw data) processes. Thomas' procedure arose from the need to provide qualitative researchers with a straightforward and efficient means of analysis, without the overly technical and 'jargonized' strategies of more traditional approaches. He suggests that the outcomes of the analysis may be identical to those founded on a grounded theory approach. In addition, Thomas reviewed a number of analytic methods used by qualitative researchers, and frequently by health and social science researchers, which described strategies characteristic of a 'general inductive approach' (ibid.).

The aim of using an open coding process in this evaluation, was to develop a model of outcomes from the comments and responses of the respondents, and in so doing, the data represents, as closely as possible, the actual perceptions and experiences of participants interviewed. The process was undertaken initially by a dissection of the transcripts using a simple coding schedule based on the three broad outcome areas covered in the interview guide, to search for data in the text corresponding with each of the codes, taking into account the contradictions or disagreements between parenting couples in the text. Thereafter, data was studied repeatedly to identify key topics that arose within each code, which were then organised under themes. Given the small sample size, it was decided that only findings (outcome themes) that reflect the experiences and perceptions of at least five of the nine participating parents would be included. As such, a coherent model of parent outcomes was formed, which represents individuals' experiences; was experienced by most of the participating parents (unless otherwise specified); and was grounded in examples from participants' interview transcripts.

Credibility or accuracy checks were undertaken with participants by: (i) obtaining immediate feedback from research respondents during both the pre-intervention and post-intervention interviews by regularly summarizing the data and allowing respondents to confirm or rectify the researcher's understanding of what was reported; and (ii) reminding respondents in the

post-intervention interviews of their earlier responses and frequently asking them to verify the possible shifts in pre- and post-intervention responses, as noted by the researcher.

### 3.6.2 Supplementary data

A dependent sample t-test was used to analyze the differences between the pre- and post-test means for the parents' and teachers' Conners' data, the boys' school Literacy and Numeracy grades reflected on their school reports, and the boys' performance on the LSG remedial tests, although the small number of participants is likely to limit the statistical power of these t-tests. The teachers' qualitative classroom observations were reviewed for possible shifts for each boy regarding the areas of functioning that teachers were asked to comment on.

## 3.7 Ethical Considerations

In the process of evaluating the outcomes for the LSG programme, a number of ethical considerations were addressed. The key issues, including research respondents' informed consent, voluntary participation, confidentiality agreements and ethical issues arising from the assessment activities in the evaluation, are discussed here.

### 3.7.1 Informed consent

Informed consent is considered an integral component of ethical practice in social research (Balen et al, 2006; Fisher, 2004; Miller & Bell, 2002; Neuman, 1994; HPCSA, 2002) and was duly considered in this study. Parents were asked to read and sign (if willing to participate in the study) a brief form clarifying the nature of the research and key aspects of the parents' and their children's participation (see Appendix I). Parents were given the opportunity to discuss any questions or concerns with the researcher. Two psychologists on the Ethics Committee in the UCT Psychology Department were consulted regarding the appropriate procedure for obtaining assent from children aged 10-12 years. Based on South African and international ethical guidelines (Fisher, 2004; HPCSA, 2002) and on standards in common practice, it was decided that while permission for the children to participate was to be obtained from the parents, it was not 'on behalf' of the children, who were invited to give their own verbal assent. A developmentally appropriate explanation of the reason for the interview, the interview duration and procedure, as well as the possible consequences of

participation, were verbally presented to each of the boys by the researcher. Thereafter, a question was formulated about whether or not they agree to participate in the interview (see Appendix J). Verbal responses were documented. Dialogue with participants regarding their participation and queries or concerns about the study was ongoing throughout the research process, where relevant.

### 3.7.2 Voluntary participation

Participation was voluntary; that is, participants were informed that they were in no way obligated to participate; could retract consent for participation at any point during the interview, or the entire research process; that the research was separate from the LSG activities and would not affect their participation in the programme; and that no other penalty or consequence was involved. They were assured that no reason or explanation was required upon withdrawal from the research.

### 3.7.3 Confidentiality

As the sample was very small, absolute confidentiality was limited. Participants were, however, assured that private information would be kept confidential, that is, the researcher would disguise all names and identifying details. In keeping with this agreement, details of the participants' identifying data have not been included in the writing up of this research and were not attached to the research findings. Care was taken to prevent disclosure of private information. All data were secured in a locked cabinet in the researcher's office.

### 3.7.4 Anonymity

Since this research evaluates a service offered to participants, concerns may have arisen regarding their involvement in the intervention, for example, acquiescence or a desire to hide activities or responses that may be considered unacceptable in some way. Respondents were therefore guaranteed that their contributions in the interviews would remain anonymous within the context of the six participating families (for instance, specific respondents were not linked to specific findings) and therefore have no bearing on their participation in the programme or their relationships with the LSG project staff.

### 3.7.5 Assessment activities

For the purposes of this evaluation, standardized procedures in administration, scoring and interpretation were undertaken with all remedial assessments and rating scales. Prior to the assessments, participant assent was obtained and parents (legal guardians of the participants) were offered the opportunity to discuss findings. The assessments were deemed appropriate and useful for the study by the project staff and the researcher, that is, no tests were administered unnecessarily.

## 3.8 Conclusion

A non-randomized, single-group, pre- and post-test design was utilized in the evaluation. Sources of data included primary data, consisting of qualitative semi-structured interviews with the child and parent participants, and supplementary data, including parent and teacher rating scales of the child's behaviour, school grades, scholastic tests and qualitative teacher observations. In keeping with the literature on programme evaluation, both qualitative and quantitative research methods were used, sourcing all forms of supplementary data available at the time. The findings are presented and discussed in the following two chapters.

# CHAPTER 4 RESULTS

The findings from the evaluation of the LSG programme are presented in this chapter, which is comprised of three sections: the first section presents the results of the interviews with the child participants; the second details the themes arising from the interviews with the participating parents; and the final section summarizes the analysis of the supplementary data in the study.

## 4.1 Interviews with the Children

The primary aim of the research interviews with the child participants was to evaluate possible shifts in their socio-emotional functioning from two perspectives, that is, their capacity for expressing their feelings and their social problem-solving skills. Another objective of these interviews was to obtain information regarding their expectations and experiences of the LSG programme. These findings are discussed below.

### 4.1.1 Capacity for emotional expression

As discussed in the methodology section, the boys' ability to express their feelings was assessed by recording the total number of occurrences of the boys' use of 'feeling words' in their responses to the vignettes presented in the interviews, and analyzing whether there was a statistically significant difference between their mean scores pre- and post-intervention. While the number of occurrences of 'feeling words' used by each boy had increased, a dependent sample t-test found no statistically significant difference between the pre- ($\bar{x}$ = 5.75) and post-test ($\bar{x}$ = 7.50) mean number of emotional words ($t = -2.05$; $df = 3$; $p = 0.132$). However, the range of 'feeling words' used by three of the four boys interviewed had expanded. The pre-intervention list of feeling words used by the boys included only the following: *sad*, *happy*, *bad*, *mad* and *angry*. The list from the post-intervention interviews included the original *sad*, *happy* and *angry* adjectives in addition to *cross*, *scared*, *embarrassed*, *excited* and *confident*. The boys therefore appeared to have expanded their repertoire of emotional words somewhat, but in general did not use emotional word significantly more often in response to the vignettes after participating in the LSG programme.

In general, there appear to have been some shifts in either the basic strategies employed (for example, the shift from an aggressive response to an assertive one) or in the range of competent solutions offered by the boys (for example, in the fourth vignette involving conflict with a sibling, three boys chose to first assert themselves, then attempt to negotiate with their sibling and finally opted to elicit support from a parent if the former solutions had failed, as opposed to their pre-test responses of either aggression or passive withdrawal). Furthermore, there were no regressions from a more appropriate (for example, negotiation) to less appropriate (for example, aggression) solution. Appendix K provides a table summarizing the boys' preferred problem-solving strategies for each of the vignettes on pre- and post-testing, as well as descriptions and sample quotes for each response category.

### 4.1.3 Expectations and experiences of the LSG

In the pre-intervention interviews, the boys were asked what they understood about coming to the LSG. Two of the boys reported that they had 'forgotten' or 'did not know' why they were coming to the LSG, while the other two believed that they were going to be helped with 'weaknesses' in mathematics or writing and spelling skills. When asked in the pre-intervention interviews how they felt about their problems at school, two boys replied that they felt 'nothing', while the other two reported that they felt 'sad' about their learning difficulties. In response to the same question on the post-intervention interviews, two boys reported feeling 'more happy', another reported feeling 'excited' about his progress at school, and the remaining boy again said that he felt 'nothing'. Three of the four boys therefore reported a shift in their subjective feelings about their performance at school, in a more positive direction.

In the post-intervention interviews, all four of the boys reported that the activities in the boys' groups were enjoyable and that, if they could, they would have liked to return to the LSG the following year.

- *It was fun, everything was fun ... can we come back?*(C5)
- *It was fun ... I liked the stuff we did ... I will come back next time* (C6)

One boy indicated that he best liked the games in the remedial and emotional groups, while the other three boys liked the activities but felt that making friends and sharing *'stories'* with each other were the highlights of their time spent at the CGC:

'learning support'. In addition, the parents acknowledged that they had very little understanding of the learning problems that their child was experiencing: *"All I know is that he is a 'slow learner' ... what does that mean?"* Of the nine participating parents, two reported that they rejected the diagnosis of a basic learning difficulty and felt strongly that the 'phase' would pass but that in the meantime their child was functioning poorly 'for some reason':

- *In the back of my mind, my child doesn't have a learning disability ... but he is doing badly at school* (P1)
- *He's going to outgrow it ... so I'm not going to put a permanent label on my child* (P5)

Three other parents expressed feelings of ambivalence about the diagnosis but were willing to explore as many options as possible for their child:

- *But nobody's saying why ... there was never a reason why ... maybe it is actually this learning problem that he can't help ... but he needs help you know* (P4)

The remaining four parents reported that they had accepted the diagnosis but lacked adequate understanding of its meaning and ways in which they could assist their child:

- *I just know that next year he's going to struggle again ... This learning difficulty makes it hard for him to progress ... and I don't know how to help* (P3)
- *We don't know if we can help him with it, with this learning problem of his* (P8)

Six of the parents reported that, in addition to the scholastic problems, teachers were concerned about the referred child's disruptive or defiant behaviour in class as well as his difficulty in building relationships with peers, and that they as parents concurred with the teachers, having encountered similar problems at home. The remaining three parents reported that they had noticed and were worried about their child's socio-emotional problems, such as poor self-esteem and difficulty making friends, but that neither they, nor their child's teacher, had observed externalized problematic behaviours with adults, such as aggression or defiance. Behaviour problems were reported to be escalating for the former six parents:

- *He's defiant and disruptive ... out of control ... He's got this moodiness, this aggressive side of him.* (P3)
- *He's got a short temper ... and gets angry very easily* (P8)
- *He acts out in class ... What's going to happen to him if he goes on like this?* (P9)

Socio-emotional problems reported by the parents at the pre-interviews included:

(i) an inability to express and manage feelings (reported by eight parents):

- *He can't express his emotions ... and it's like he can't handle his, any feelings, ... he'll rather kick something or irritate and provoke the rest of us ... until we explode* (P3)
- *He cries for everything ... there's no balance ...* (P2)
- *This child won't tell you what's wrong ... like he doesn't have feelings but we know something is bothering him ... he bottles up ...* (P7)

(ii) a poor sense of self (reported by all nine parents):

- *He's got very low self-esteem* (P5 & P8)
- *He doesn't have confidence in himself* (P6)
- *He's so easily influenced [by peers]... no sense of who he is ... other children take advantage of him* (P8)
- *He's got very low self-esteem and he can't stand up for himself ... he can't be assertive* (P6)

(iii) withdrawal and loneliness (reported by all nine parents):

- *He will come out of class sad and on his own ... He doesn't get involved with other children, he doesn't mix well with others* (P4)
- *He's withdrawn ... lonely* (P7)
- *He's an outsider ... goes into himself very quickly* (P5)

(iv) excessive dependence (reported by six parents):

- *He's so [clingy] with me all the time* (P4)
- *I just wish he could do some things on his own ... without needing me to be there all the time* (P8)
- *He can't make decisions for himself ... he can't act on his own ... We want to support him but not do everything for him* (P9)

Finally, all the parents described their child's sibling relationship(s) as conflictual, although four parents regarded this as 'normal' and unrelated to the primary difficulties experienced by the referred child:

- *They're charged up ... you can run Eskom with it* (P2)
- *They go for each other all the time ... like: I hate you but I think it's normal, like boys* (P4)

***Emotional distress associated with their child's difficulties***

- *It was all so heart wrenching to me, because I was thinking that my brain can work in two ticks and even half an hour is not enough time for him to do a full sentence and be able to memorize it* (P3)
- *It makes me so sad to drop my child off [at school] and see that he's not happy* (P5)
- *To watch him struggle like that, I can't handle it* (P2)

Parents conveyed varying degrees of emotional distress that was often rooted in a sense of empathy for their son's difficulties, and most parents perceived themselves as having difficulty coping with these feelings. All the parents reported some form of personal distress, expressing either one or a combination of the following:

(i) guilt and self-blame (reported by five parents):

- *I want to do this for him [LSG programme]... I had difficulties at school, G's and H's, and that's why I feel so bad about all this* (P6)
- *He lived with my sister... I didn't know it would affect him in any way ... because the thing is, I need to work ... And not knowing that was going to be detrimental to him because of bonding and those kinds of things* (P3)
- *[I'm afraid] I'm going to damage him more* (P5)

(ii) inadequacy and helplessness (reported by six parents):

- *I don't know what to do... What can I do?* (P3)
- *My hands are tied and there's like nothing I can do* (P5)

(iii) isolation (reported by five parents):

- *I had to do everything myself ... my friends didn't get it ... everybody's got something negative to say but no one understands what you're going through ... you who is in it [the situation]* (P3)
- *Nobody cares ... you're on your own* (P4)
- *I thought it was just me* (P5)

(iv) sense of loss of a 'normal' child (reported by five parents):

- *I knew I'd have to make a lot of sacrifices to get him in there [special school] ... I couldn't help thinking: why my child, why must he be so different?* (P3)
- *The whole thing, it was very, very emotional ... that he sukkels [struggles] so much and can't just go on like other children* (P5)
- *Just act like a normal boy ... Maybe he can still be a normal boy after all this* (P4)

***Experiences of the help-seeking process***

Prior to their referral to the CGC, parents had attempted to research and navigate the resources available in the education system as well as gain access to limited resources available for remedial tuition. Problems regarding the above were discussed at length by all the respondents. In addition to the emotional strain resulting from their child's problems, the process of seeking help for their child was experienced as both stressful and discouraging by the parents, who generally perceived existing services as fragmented. Seven parents were sent back and forth between teachers, occupational therapists, and other professionals and given contradictory opinions and advice regarding the child's diagnosis and suitable intervention:

- *This one says this, that one says that ... I can't do it anymore* (P5)
- *We are now so totally confused with this whole issue* (P1)
- *They told me to get him into a more appropriate school, a special school. Then my nightmares started ... and it was up and down from there on ... and I just thought: oh where to now?* (P3)

Six parents conveyed feelings of anger and frustration regarding their experience of professionals and the education system:

- *What kind of system [education] is this ...? Where they're not even prepared to go that extra mile for us? ... It's really pathetic ...* (P3)
- *It's all such a waste of time, you never get answers* (P5)
- *They will all tell you something different ... I'm of the opinion that these people don't know what they're talking about* (P2)

However, five parents expressed gratitude to 'committed' teachers despite difficulties in the school referral process:

- *She really did her best ... actually helped us get to the clinic [CGC] ... she's fully on board with sorting out his problems ... but the school system isn't very helpful* (P5)
- *This new teacher really took an interest in him ... tried ways to help him in class 'cause it can take two-three years to get a support school [special school] for him* (P9)

Six parents appeared to be suffering from feelings of emotional burnout:

- *I'm just so tired, it's been four years [of struggling] ... I can't anymore* (P5)
- *We are just exhausted ... I don't know anymore* (P8)

### 4.2.2 Parents' expectations of the LSG

Prior to its commencement, parents held several expectations regarding their participation in the LSG. They reported that they hoped for improvements in their child's functioning in the areas outlined before, that is, academic performance (for all nine parents), behaviour (for six parents) and socio-emotional functioning, particularly self-esteem and relationship skills (for all the parents):

- *Firstly, the remedial teacher assisting ... like just to help with learning techniques and those kinds of things ... to help him cope with his schoolwork. And the other thing is now with his emotions. I'd really like them to work on his emotions where he can tell me when he's feeling angry or sad 'cause he's not one that talks ... I want them to help with the behaviour, teach him that disruptive behaviour is not good* (P3)
- *Help him with his reading ... confidence ... self-esteem ... his emotional state ... and organizational skills 'cause he's so disorganized and I don't know what to do ... If he could just be a little independent ... confident enough to try and solve a problem ...* (P2)

Two parents acknowledged that they were hoping that the LSG would provide them with a quick solution or panacea regarding their son's diagnosis and intervention:

- *This is what is wrong and this is how we'll fix it – simple* (P2)
- *Just to give us the way out* (P9)

The other seven parents reported that they hoped that the major problems would lessen or desist and that they as parents could learn how to cope with difficulties:

- *If [child's name] is sorted out with the learning problems ... if it gets better ... then it will take a load off me as well ... I also want to learn about his disability. ... And if I understand things in the sense of the learning and so on, then I can deal with it and help him to cope better* (P5)
- *I think things will follow, like if his problems at school get better and we can know how to manage him, what to look out for, then it will be ok* (P4)

Regardless of how parents felt about the clinical diagnosis of a learning disorder or disability, or whether they expected a magical cure, all the parents hoped that the LSG parent support group would assist them in:

(i) understanding their child's learning difficulties:

*... to understand this learning problem that our child is sitting with ... to learn about it* (P8)

*... to learn about his learning disability ... if I can understand it, I can cope with it* (P5)

(ii) strategies to help with his learning difficulties at home:

- *... to help him to plan his tasks and organize his work ...* (P1)
- *How to help him to get the things into his brain at home* (P9)

Seven parents expected to acquire parenting strategies such as discipline and behaviour management:

- *How to cope with a child like him ... how to deal with his behaviour* (P8)
- *How to manage it when he acts up ...* (P3)

The other two parents felt that the LSG could assist their child in learning strategies but that they as parents were able to deal with discipline and other parenting issues without assistance:

- *I have a very aggravated way of speaking to my kids ... children don't listen otherwise ... They [LSG clinical staff] are not in my home ...* (P2)
- *I have my own way of dealing with them [children]* (P4)

Six parents conveyed that they hoped for help with understanding and responding to their child's emotional needs:

- *... what he goes through inside himself, what his feelings are ... and then what we must do, to show him that, to help him* (P8)
- *... to know how to help him, what I can do to help him be open with his emotions* (P3)

Six parents desired changes within themselves that they hoped would alleviate the situation:

- *Sometimes you as a father, you take your frustration out on the child, now if I can just get some help with that* (P9)
- *I get angry at him, then I want to explode ... I want uhm, how can I say, anger management?* (P6)
- *Maybe if I could deal with things in a calmer way ... I get hyper and I shout* (P3)

With regard to any concerns about participating in the LSG, one mother voiced concerns about the parents' and children's groups being separate and felt that she would have liked more details about the content of the boys' groups. All the parents participating in the LSG had not previously been involved in a support group and six parents spoke about initial

anxieties centering on uncertainty about their roles and the facilitators' roles in the group, as well as the content of the group:

- *We have never been in a support group before so ... I don't know what to share ... I'm apprehensive. I don't know if you just talk about your child or can you talk about your family life. I don't know what it [the support group] is for* (P1)
- *What are they going to do in the group? I mean, will they give us the information or how ... what should we do? What must we bring?* (P8)
- *I'm someone that prefers to keep things inside ... [what if] it gets too, uhm ... emotional?... I can't grasp things if you tell me to read a book or something ... I suppose that they're [group facilitators] going to have to keep my attention [laugh], because of my own learning difficulties* (P6)

### 4.2.3 Shifts in parenting experiences

In the post-intervention interviews, all the parents conveyed that they had observed positive shifts in their child's academic, behavioural and socio-emotional functioning, that aspects of their own parenting style had altered to the benefit of both parent and child, and that there had been an improvement in their relationship with the participating child and, to a lesser extent, in their child's relationship(s) with his sibling(s). A discussion of each of these follows.

#### *Changes observed in the child participants*

All the parents reported that their child's scholastic performance had improved. One parent noticed improvements in school results but felt that her child still had significant academic problems, however, all the other parents felt that their child had been given a learning foundation upon which to build:

- *There is a definite improvement in his schoolwork, we are so happy with it, it just now has to be maintained ... we need to work to maintain it* (P7)
- *You can see it in his final report, there you have it, the proof ... We're more than satisfied* (P9)
- *He did really well [academically] ... He was so confident about that report, he knew that he'd passed so well* (P5)

Parents also reported that they had observed a developmental change in their child which they generally described as a sense that their child had '*grown*' or '*matured*'. All the parents

observed changes in their child's behaviour (including the three parents who had not highlighted behaviour as a presenting complaint):

- *We used to have all these problems with him at school ... He's behaviour has improved tremendously* (P9)
- *There's none of that other behaviour, the tantrums* (P3)

One mother indicated that while there were positive shifts in her son's behaviour at school, it continued to be a problem. She felt, however, that she now understood the misbehaviour to a greater extent:

- *The behaviour is better ... he's not so disruptive ... He's still acting out at school sometimes, moody ... His Sir [teacher] also sees it's only on a Friday and Monday, 'cause of the weekend break. He has this fear of losing people, so he rather cuts off ... Too many losses in his life and it [leaving the LSG prematurely] was also a loss for him ... the same scenario is being played out at school ... Now we're back with a psychologist for him, to deal with those issues, a lot of it [the behaviour] is emotionally-based* (P3)

All the parents felt that their child had developed increased confidence and self-esteem:

- *He's so much more confident* (P1, P5 & P7)
- *He believes in himself, you can actually see it in how he tackles a problem ... I can see how my child has grown to like himself* (P2)
- *He's more assertive, outspoken* (P4)

Eight parents perceived their children to be more independent (including two who had not identified dependence as an initial problem):

- *[His clinginess] has shifted a great amount. He's changed, it's great* (P4)
- *... took a load off me ... He'll only call us when he's really struggling ... and I see he's thinking for himself more, can make up his own mind* (P9)

All the parents perceived their child to have made progress in his ability to express and manage his feelings and that he was more willing to 'open up' to parents:

- *Since being at the sessions [LSG], he's opened up ... he'll tell me what's upset him. Before, he used to switch off, now he will talk about it* (P3)
- *Since coming to the group, he's expressing himself so freely ... He says things like 'it doesn't feel nice when you do that, it makes me cross'. That has never happened before* (P6)
- *I noticed that he doesn't get so angry anymore, you know, that short temper. I think he can control himself more* (P9)

- *He used to sulk for hours ... but he's changed a lot ... he's more in check with his emotions* (P2)

Finally, all nine participating parents reported an improvement in their child's social relationships, that is, the children were described as generally being more interactive with peers and able to demonstrate an awareness of others' feelings:

- *He's more interactive with other children since he's been in the programme* (P9)
- *He's playing with children his own age, not running around with children three, four years younger than him* (P2)
- *He's not lonely anymore ... He's even had a friend that slept over for a weekend. First time ... He speaks a lot about feelings now, even thinking about others' [feelings]: 'imagine how he feels when ...'* (P4)
- *... [the boys' emotional group] was the best thing that could have ever happened to him ... he was able to take what he learnt and apply it outside* (P1)

### *Changes in parenting style*

All the parents believed that they had adapted aspects of their parenting style in such a way that it was more effective with their children. Specifically, they employed more child-focused strategies, for example, using a reward system that was particularly meaningful for their child:

- *We [parents] learnt a lot, that's helped us to cope, when usually the ... [issues with TV time, pocket money, chores etc.] turn into a shouting competition ... We've now got steps that we can take, ways to deal with it* (P2)
- *We applied it [parenting strategies discussed in the parents support group] and it worked, but we changed some of the strategies to suit our household. We got the concept but applied it to us, and I must say it worked* (P7)

While the three parenting couples did not specifically report conflict over discipline strategies at the pre-intervention interviews, discord was evident in their responses:

- *He [son] can get anything right with her [wife] – murder. I'm just the father* (P2)
- *He [husband] goes on that I'm too soft with him [son]* (P6)

However, in the post-intervention interviews, the three couples indicated that decisions about discipline strategies were made as a parenting unit:

- *Everyone's on board ... we decide together how we are gonna do this* (P7)
- *We used to be at loggerheads about it ... We talk about that stuff [parenting style] now* (P1)

When asked about homework sessions, eight parents had initially described it as 'frustrating' or 'unbearable'. Six parents felt that the difficulties with homework had impacted negatively on their feelings about spending time with their child and, more broadly, on their relationships with their child because homework sessions often ended in shouting or tears:

- *He said: I hate you 'cause you're making me do this. That's how bad it's become* (P3)
- *If we can only have one normal day without [child's name] and the homework stress ... it's really getting to us* (P8)

In the post-interviews, seven parents conveyed that while homework times continued to be challenging, they were less stressful because of the perceived changes in their children (for example, demonstrating more independence) and the parents' use of learning and communication strategies that they were exposed to in the LSG:

- *We implemented the 'triple L' system. Look, Listen and Learn ... He still uses the Skim and Scan that he got from the remedial teacher ... He will first try things out on his own, then call me if he gets stuck* (P7)
- *We know how to address his way of learning now, what helps him to take things in, and he's one who will now try it on his own also* (P1)

The other two parents decided to withdraw from involvement in homework sessions and preferred to leave it to their spouses because they felt that they were unable to cope with the challenge and that it would be best for their relationship with their son:

- *That's why I rather just stay out of it ... it's better for him and for me and it would have affected our relationship too much* (P5)
- *It's best to leave that to her, she has all the patience in the world ... I just can't handle it ... that probably aggravates him ... it's more suitable for everyone this way* (P2)

### *Changes in the parent-child relationship*

All the parents indicated that the quality of their relationships with their children had improved:

- *This one year that we spent here is like all his years of life together ... like I have a chance to start over, be a better parent ... be someone that my son can talk to* (P7)
- *We are getting to know him, the real him* (P2)

The parents attributed these shifts to what they considered to be the changes in their child's personality and behaviour and its subsequent impact on parent-child interaction:

- *In this year, I've discovered that there is a loving side to him, he can be loving* (P3)
- *We can see that he's trying ...* (P9)

They also noted that the perceived changes within themselves had impacted on the parent-child relationship:

- *We also grew ... it was his way of growing and our way of growing also* (P2)
- *I'm now trying to be more open for him ... let him know that I'm here, it's helping us* (P7)

In the pre- and post-interviews, parents were asked to describe their child and discuss their expectations for his future. Comparisons between the pre- and post-intervention accounts suggest a transition in the way that parents perceived their child as well as their expectations of him:

(i) at post-interview, eight of the nine participating parents offered different descriptions of their children, that is, some offered psychologically-minded and relational descriptions whereas initially, their descriptions were more often concrete, and others were able to, at post-interviews, describe their child in less singular or problem-focused ways:

- Pre-interview: *He plays video games a lot*

  Post-interview: *He's generally a friendly child ... wants to try his best* (P9)
- Pre-interview: *He can draw*

  Post-interview: *He's a child that gives his all to something ... he can also be kind* (P7)
- Pre-interview: *He's irritating ... I don't know other kids like that*

  Post-interview: *He can try your patience but he's also so loving and affectionate* (P3)
- Pre-interview: *He's a child who gets distracted quickly ... It's hard to get him on track*

  Post-interview: *He's funny, likes to laugh ... He can be very soft-hearted and generous* (P4)

(ii) six parents conveyed the sense that they had shifted in their expectations that their child be '*normal*':

- *I'm now not concerned about what others [think]... this is part of who he is ... He needs to go and reach his own potential* (P1)
- *He must just reach his goals ... whatever those are ... I want him to be happy* (P3)

***Sibling relationship(s)***

One mother did not observe any changes in her son's sibling relationship but the other eight parents believed that the referred child's relationship with his sibling(s) had improved, although their accounts varied:

(i) two parents felt that slight shifts had occurred but that these were unlikely to be sustained:

- *It's not as bad, they don't hurt each other like before ... but I can see things still get to that [boiling] point, you know, it's only a matter of time* (P1)
- *They are getting better, a little ... but only time will tell if this keeps up* (P5)

(ii) one mother attributed the decrease in sibling conflict to changes in the non-referred sibling:

- *They don't fight as much, things don't get out of hand ... [child's name] is less, no I think it's that [sibling's name] is getting older so he doesn't feel like this fighting anymore* (P4)

(iii) the other five parents felt that improvements were clearly visible in the referred child's behaviour toward his sibling but that this was not reciprocated by the other child:

- *... their relationship is much better because he [referred child] won't cry as quickly and he doesn't terg [tease] her anymore ... but she is still a nightmare with him* (P2)
- *He won't let [sibling's name] get to him, and he says 'no' ... but [sibling's name]is still a rascal* (P7)

### 4.2.4 Experiences of the parent support group

***Support***

The most significant theme was that all parents felt that the parent group provided them with a sense of being supported. Sharing their feelings with other parents in similar circumstances and learning from each other was reported to have been most valuable.

- *To actually hear that you are not alone ... there are other parents with the same problems ... It was so helpful, and it sort of became like a family ... we miss them* (P5)
- *It was a great help, being able to share your views and opinions ... you always think that yours is the only way, the other parents support you to change the ways that don't work* (P3)
- *We feel comfortable ... much more relaxed here at the clinic ... They clearly understand how we feel* (P2)

***Knowledge about LDs and associated difficulties***

All the parents reported that the LSG parent group had resulted in an increase in their knowledge about their child's difficulties and that they had developed an understanding of the behavioural and socio-emotional problems associated with these difficulties:

- *Every week I learnt something ... tools that I could implement with him* (P4)
- *Coming here meant being enriched with more knowledge ... learning from others [group members] and the facilitators* (P3)
- *We learnt so much, and we didn't like know that this is often coupled with that ... and how most of his problems were related* (P1)

Two of the parents had initially rejected the idea of a learning problem (see *the presenting problem*) but later appeared to have acknowledged that basic difficulties exist:

- *I understand so much more about this learning disability ... and we're feeling better about it, how to help these kids* (P1)
- *I understand this learning disability now ... with a child like this, I have to make sure that...* (P5)

The remaining parents, who had accepted the learning difficulty, or were ambivalent in some way, also made shifts in terms of their roles (how they can help) as parents:

- *This isn't just going to go away, so we have to learn to adapt to it, learn ... strategies to make things easier* (P7)
- *It's not like something you can help him with and it goes away, [rather] try to make it better for them ... improve it a bit* (P2)

***Parenting strategies***

All the parents reported that they had acquired parenting strategies in the LSG parent support group:

- *We've learnt that eye-contact is important in communication, and we can see how it helps* (P1)
- *We use the cards [remedial tools] with the looking and listening techniques* (P7)
- *I saw the difference when he started getting the time-outs* (P2)

### *Coping skills*

Eight parents reported that they were better able to cope with existing problems and felt more confident about dealing with subsequent or future difficulties:

- *We've now got our tools and we see the changes, now it's up to us to maintain it ... we feel armed for the future, like we can just cope better* (P7)
- *We got some stuff here that could help us ... it [the LSG] gave us the foundation, now we must keep it up* (P9)

### *Increased empathy*

Eight parents felt that their understanding of their child's internal experiences had grown or developed:

- *It's so difficult in his world, can't grasp things ... I ask him how that is for him, inside himself* (P4)
- *We used to concentrate on the things around him. Now it's all about him, about us knowing him ... we never saw it like that previously* (P2)

They reported that they felt more equipped to respond to their child's emotional needs:

- *We've also learnt over the last couple of months to concentrate on his emotional side. Previously it wasn't about 'how are you feeling' and stuff like that* (P2)
- *I've learnt to ask him how he feels about things ... and then we can talk, he opens up* (P3)

### *Extended outcomes*

Seven parents reported that participating in the LSG had produced changes within themselves that were, together with benefits for their children, personally rewarding for them:

- *I've also learnt to express my emotions ... which I never did before ... It's been a real benefit for me* (P7)
- *In retrospect now I can see how we changed through the [parent] group, how I look at my son, how I choose to deal with things ... I feel good, like I'm also growing* (P1)

Five parents conveyed that their participation in the LSG support group had produced effects in various other aspects of their lives, including:

(i) changes in marital and family dynamics:

- *We [couple] talk to each other about our feelings now ... the group even had an impact on our marriage, on our family, we're closer than ever* (P7)
- *We know a bit more now ... so we're actually using those things [parenting strategies] with the other one as well* (P9)

(ii) changes in the parent-teacher relationship:

- *[His teacher] then also wanted tips on how to help these kids, to deal with this kind of stuff in the classroom ... We now want to set up a meeting with his new teacher ... build a relationship with her ...* (P1 & P2)

### 4.2.5 Overall experience of the LSG

All the parents reported that they found the LSG programme to be beneficial both for the children and for themselves:

- *Such a valuable service ... to think where we were before and how we are now* (P9)
- *The programme really gave us a fresh start ...* (P2)
- *... it will be such a pity if the LSG is not operational, lots of kids will lose out* (P1)
- *It's made a huge difference ... there are people who don't know their kids have these difficulties, will never be able to explain why they struggle ... I've learnt a lot ... and I can see how it's paid off for my son ... I would recommend that anyone with this problem try this programme* (P7)

### 4.2.6 Recommendations for the LSG programme

***Communication between the LSG subgroups***

All the parents reported that they would have liked to witness, participate in or have regular feedback about their children's groups. Some asked how facilitators in the boys' emotional group had helped their children with their feelings and relationships skills, that is, which methods or strategies were employed. Parents generally felt that more interaction with the boys' groups would further empower them as parents.

- *... more interaction in the different groups. You can feel a bit cut off from the child groups. One of the best things for us was the end of year party, where we could see the children together and how they [facilitators]interact with them, I mean that's how they grew in their feelings and their way of acting with others ... It was nice man ... I think maybe even 10 minutes once every few months, just like an altogether feedback or something* (P1 & P2)

- *In our group they gave us strategies to help with homework and ... I would have liked to know more about the learning techniques in the remedial classes, what helped them [boys] to identify the words and so on. 'Cause a child with a learning problem, he can't really tell me at home, then I'm not really sure if I'm doing the cue cards right. And the emotional group ... I don't know like what they did there, or I know what they did – work with his emotions, just not HOW. What he told me was like the stuff with the clay and so on. I would have liked to know how THEY [facilitators] actually did it. Did they also practice the 'feeling' communication' or what?* (P5)
- *Just to see how those teachers [remedial and emotional group facilitators], how they work with the kids, that would be nice. I think it will help me grow as a parent, make me feel even more confident. They gave us a lot in the parents' group but this could build on that* (P7)

### *Resource materials in the parent support group*

Seven parents indicated that they had found the volume of resources given to them by the facilitators at the end of the parent group very helpful and that they would have preferred such a 'workbook' in the initial sessions of the group, to systematically work through it and use it for discussion. They also reported that a guest speaker for one session, who was a child psychiatrist, was helpful in answering their questions regarding medical aspects of learning and attention problems. Several parents found the session where a video was used to illustrate how a parent might implement a discipline strategy particularly useful. In general, these parents requested that such resource materials be used more often in the group sessions.

- *That book with resources was very useful. But maybe if we got it at the beginning we could work through those different topics for the year ... I just found that it was easier to get the information in the group, and with the other parents. And it's also nice to have something in your hand when the group's not there anymore* (P4)
- *We felt really grateful when they got the child psychiatrist in to answer questions about Ritalin and stuff. They gave us the benefit of all the sides of the professionals, to help us make decisions ... So we think that that sort of approach was useful. They could actually include more guest speakers and videos* (P1 & P2)
- *I think they could include more visual stuff, like that video sessions. It's different and better when you can SEE things happen, you think, 'but sometimes I do that'* (P8)

### *The introduction phase of the parent support group*

Seven parents described the initial stages of the parent support group as a struggle because they were unsure of themselves and what the group entailed. In the post-interviews, these

seven parents felt that their anxieties had been eased when dialogue with facilitators regarding desired session topics had been entered into and when group members became more familiar with each other. The parents suggested that more input be given from the outset to address their initial apprehension, including information on how the group would be run and what was expected of the participants and the facilitators.

- *It was a bit rocky in the beginning with us not knowing where or how to start, or what we were supposed to do ... And when it comes to personal feelings ... I usually don't spill a word, now suddenly I must start talking ... there needs to be like more information and preparation for that at the start of the group* (P7)
- *It will be better if they get an early structure, like starting point: 'This is what this whole thing is about and why we do this'. They [facilitators] wanted a lot of parent participation and interaction and we didn't really get that. They should tell us what they want from us and how that's going to help ... We can see it now, it was beneficial, but if they let us know earlier, it would have saved us the misunderstanding ... and the nerves* (P1)

Table 3: **Summary of the themes emerging from the parents' interviews**

| **Thematic area** | **No. of respondents who mentioned each theme** ($n$=9) |
|---|---|
| *1. Initial problems and concerns:* | |
| Academic and psychosocial presenting problems | 9 |
| Parental emotional distress | 9 |
| Frustrating experiences of help-seeking | 9 |
| *2. Expectations of the LSG* | |
| Improvement in the boys' scholastic performance | 9 |
| Improvement in the boys' psychosocial functioning | 9 |
| Increase understanding of LDs | 9 |
| Homework strategies | 9 |
| Parenting strategies | 7 |
| Improvement in ability to respond to child's emotional needs | 9 |
| Positive changes in themselves e.g. less anger | 6 |
| *3. Perceived shifts in parenting experiences:* | |
| Having observed positive changes in their children | 9 |
| Positive changes in parenting style | 9 |
| Positive changes in the parent-child relationship | 9 |
| Positive changes in sibling relationship(s) | 8 |

4. ***Experiences of the parent support group:***

| | |
|---|---|
| Supportive | 9 |
| Increase in knowledge about LDs and associated difficulties | 9 |
| Acquisition of parenting strategies | 9 |
| Improved coping skills | 8 |
| Increased empathy | 8 |
| Extended outcomes | 7 |

5. ***Overall experience of the LSG as beneficial*** 9

6. ***Recommendations for the LSG programme:***

| | |
|---|---|
| More communication between LSG subgroups | 9 |
| More use of resource materials | 7 |
| Better orientation to the group process | 7 |

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## 4.3 Analysis of Supplementary Data

Table 4 presents a summary of the results for the quantitative supplementary data, that is, the difference between the pre- and post-test means for the parents' and teachers' CRS-R, the boys' Literacy and Numeracy grades from school reports, and the LSG remedial tests - using the t-test for dependent samples. The results should be interpreted with some caution as statistical power is likely to be low due to the small sample.

Table 4: **Summary of analysis of differences between pre- and post-intervention means for supplementary data**

| Outcome measure | Pre-test mean | Post -test mean | t -value (df) |
|---|---|---|---|
| ***Parents' CRS-R*** | **(means for T-scores)** | | |
| Oppositional behaviour | 70.83 | 52.00 | 4.16 (df=5) ** |
| Hyperactivity | 74.17 | 61.67 | 4.33 (df=5) ** |
| ADHD Index | 73.00 | 59.17 | 5.57 (df=5) ** |
| Cognitive problems | 73.33 | 60.33 | 6.39 (df=5) ** |

| *Teachers' CRS-R* | (means for T-scores) | | |
|---|---|---|---|
| Oppositional behaviour | 60.50 | 49.67 | 2.01 (df=5) |
| Hyperactivity | 55.83 | 51.50 | 2.19 (df=5) |
| ADHD Index | 58.83 | 53.67 | 2.44 (df=5) |
| Cognitive problems | 65.50 | 57.67 | 4.87 (df=5) ** |
| | | | |
| *School results* | | | |
| Literacy grades | 2.33 | 3.17 | -5.00 (df=5) ** |
| Numeracy grades | 2.83 | 3.50 | -3.16 (df=5) * |
| | | | |
| *Remedial tests* | (means for age equivalents) | | |
| Schonell spelling test | 7.30 | 8.08 | -1.82 (df=4) |
| Schonell arithmetic problems test | 8.64 | 8.98 | -1.34 (df=4) |
| Towre sight word efficiency | 7.72 | 8.20 | -1.52 (df=4) |
| Towre phonemic decoding efficiency | 8.04 | 8.48 | -1.35 (df=4) |
| Ballard one minute addition test | 8.58 | 8.42 | 0.59 (df=4) |
| Ballard one minute subtraction test | 8.76 | 8.94 | -0.65 (df=4) |

**$p < 0.05$ = * $p < 0.01$ = ** $p < 0.001$ = ***

### 4.3.1 Parents' and teachers' CRS-R data

As shown in Table 4, there was a statistically significant difference at the $p<0.01$ level between parents' pre- and post-test ratings on all four components of the CRS-R, that is, parents rated their child's oppositional and hyperactive behaviour, his ADHD symptoms, and his learning problems as having significantly decreased. Teachers rated the boys as having statistically significant (at the $p<0.01$ level) decreases in their learning problems but while there were reductions in the mean ratings for behaviour problems and ADHD symptoms, these were not statistically significant.

### 4.3.2 School performance data

Results show a significant difference at the $p<0.01$ level between the pre- ($\bar{x}$ =2.33) and the post-test ($\bar{x}$ =3.17) means for the boys' Literacy grades on their school reports (t= -5.00; df=5). A significant difference at the $p<0.05$ level was found between the means (pre-test: $\bar{x}$ =2.83; post-test: $\bar{x}$ =3.50) for their Numeracy grades (t= -3.16; df=5). As such, the boys' scholastic performance in two key areas showed statistically significant improvement between pre- and post-intervention assessment.

### 4.3.3 Remedial assessments

Although the mean age-equivalents increased for all but one of the scholastic tests, there were no significant differences between the means for pre- and post-intervention on any of the scholastic tests used by the LSG remedial teacher. The age equivalents yielded for the boys generally remained stable, and below the chronological age of even the youngest of the child participants.

### 4.3.4 Teachers' qualitative observations

The teachers' classroom observations of the participating boys were used to supplement the CRS-R quantitative data. Findings show improvements in various aspects of learning ability for each of the boys, for example, in post-intervention reports teachers described the boys as:

- *having greatly improved in reading and mathematics* (T1)
- *more able to focus on instructions and work actively* (T2)
- *having strengthened in Literacy and Numeracy skills ... satisfied requirements which were not expected of him* (T5)

Teachers also described improvements in relationships with peers for three boys, while the other three were not initially observed to have problems with peers at all:

- *less aggressive than before* (T2)
- *less disruptive and more able to get on with peers* (T3)
- *no longer short-tempered with seating partner* (T4)

Finally, two boys were reported to have improved in their interaction with their teacher, while teachers had not initially observed the other four boys to exhibit any behavioural problems throughout their interaction with him.

- *less defiant and more respectful* (T2)
- *less disobedient and more willing to please* (T4)

A problem of comparability between pre- and post-testing surfaced from this data. While teachers were asked to comment on their observations in a number of specific areas of functioning, there were at times no post-test comments to correspond with pre-test concerns, for instance, one boy was described on pre-testing as having significant difficulty working on his own in class but no follow up comment was made regarding this problem on post-testing.

## 4.4 Conclusion

The findings in the study were presented in this chapter, that is, the child participants' capacity for expressing their feelings and their problem-solving competency, which were assessed in the interviews with them, and the parents' presenting difficulties, their expectations of the LSG intervention, their perceptions of shifts in their parenting experiences from pre- to post-intervention, their experiences of the LSG parent support group, their overall experiences of the LSG programme, and their recommendations for the LSG programme, all of which were obtained from the interviews with them. Results from the supplementary data were also presented. A discussion of these findings is provided in the next chapter.

# CHAPTER 5 DISCUSSION

The outcomes of the study are integrated and evaluated in this chapter. At this point, a significant limitation of the study must be borne in mind - the absence of a control group against which to compare participant outcomes means that any shifts noted in the children or their parents cannot be attributed conclusively to the LSG intervention, nor can the efficacy of specific components of the programme be measured (limitations of the study are discussed further in section 5.4). These drawbacks are echoed in the evaluation literature (Nixon, 1997), which suggests that methodological limitations prevent psychotherapeutic interventions from stating why that particular intervention is most appropriate. The discussion is therefore cautious when interpreting the results and, in line with the recommendations about single- group designs in the literature (Friedman, 1997; Schalock & Thornton, 1988), it should be regarded as a description of the potential benefits of the programme, rather than a clear determination of its effectiveness.

## 5.1 Outcomes for the child participants

Five sources of data, that is, the boys' school results, the Conners' parent and teacher ratings for cognitive problems, and the subjective reports from parents and teachers, converged on the finding that all the children who participated in the programme significantly improved in their scholastic or cognitive functioning. In addition, at post-intervention interview, the children themselves reported feeling better about their progress at school. Together, these findings indicate an improvement in the boys' scholastic performance at the end of the LSG programme, compared with the beginning. This suggests that the programme may have achieved its aim of enhancing participants' school performance. However, in the absence of a control group, it is also possible that the boys would have improved over time without intervention. Factors outside the intervention, for instance, the natural developmental thrust of childhood, or consolidation of learning over the course of the school year, may be responsible for the improvement. However, given the long-standing nature of all the child participants' difficulties, it is perhaps unlikely that all six would have improved without assistance over the course of only eight months.

What seems less clear is the meaning of the insignificant differences between the boys' pre- and post-intervention performance on the LSG remedial tests. Since all the boys demonstrated significantly improved grades in Literacy and Numeracy, one would have expected a significant improvement in their performance on scholastic tests of literacy and numeracy skills. It is generally acknowledged in the literature regarding test scoring and interpretation, and more importantly by the developers of the scholastic tests used in the LSG intervention, that measures should be used in conjunction with other sources of information, given that no single test can measure a variable in its entirety and that a number of confounding factors such as anxiety or distractibility can have a negative impact on a learner's performance (Ballard, 1927; Foxcroft & Roodt, 2001; Schonell, 1955; Torgensen, Wagner & Rashotte, 1999). It is possible that such variables may have played a role in a 'once-off' testing session pre- and post-intervention. Also, despite their common usage amongst professionals in the Western Cape, the lack of South African norms for these tests is likely to have limited their effectiveness as an outcome measure for these boys. Improvements may have been more adequately represented in longitudinal assessments, such as scholastic evaluation throughout the course of the year, as in the case of school continuous assessment procedures. It is also possible that parents and teachers assessed the boys' academic skills more favourably because of the boys' involvement in the LSG programme, when in fact there may not have been any significant improvement in the boys' skills. However, it is likely that the boys' school grades for Literacy and Numeracy were based on objective assessments in addition to their teachers' subjective evaluations.

The boys' psychosocial functioning, as assessed in the interviews with them, did not demonstrate the obvious progress of its cognitive counterpart. Advancements in the boys' ability to verbalize their feelings were not statistically significant and while there were general signs of improvement in the range of problem-solving strategies they were able to generate, it would be too assumptive to draw firm conclusions from this. It is unclear whether the modest shifts in this area are due to a genuine lack of gains or due to methodological limitations. The instrument or method may have failed to accurately assess that particular outcome. As seen in Chapter Two, research in this area suggests that while children with LDs are able to generate competent solutions, they tend to *prefer* less competent ones (Bryan et al, 2004; Elias, 2004; Kaplan & Sadock, 2003). The hypothetical scenarios in the interviews may not have been effective in assessing the 'actual' responses of the boys as they may play

out in reality. The parents' reports in the interviews that their children had 'matured' and were demonstrating less problem behaviours, such as fighting with siblings and peers at school, may reflect an impact in the boys' ability to problem-solve. Since the boys were able to generate competent solutions more often than not on pre- and post-testing, it may also be that problem-solving was generally not a significant problem for this group of children, despite parents' reports suggesting otherwise. Given that it was inherently complex to assess the boys' capacity for emotional expression and their problem-solving ability, it may have been useful to employ secondary sources of data for these outcomes as well, for example, asking them to label the emotions on a series of pictures with facial expressions, and using clinical material from group therapies and reports from group facilitators concerning the boys' problem-solving abilities and capacity for expressing feelings in the group situation.

Substantial support for gains came from another perspective of the children's psychosocial functioning, that is, the parents' and teachers' reports of the boys' behavioural, emotional and social (relational) functioning. It is notable that parents reported statistically significant improvements in their children's behaviour, as rated on the CRS-R, and in the qualitative interviews reported less problem behaviours in their children, and advances in their child's emotional maturity and social relationships. Although teachers also noted positive shifts regarding these aspects, their reports were less substantive than the parents'. This difference between the experiences of the parents and the teachers could be due to a number of reasons, such as differences between the two testing environments, that is, the home and the classroom. Regarding emotional and relational functioning, it may be easier to observe shifts in, for instance, one of two or three children in the home, as opposed to one of 35-40 children in the classroom. With regard to the behaviour ratings on the Conners', it could be that the children's behaviour at home had improved more than at school, or that circumstances in the classroom, such as the impact of group settings and less individualized attention, may have impacted on the children's behaviour. An interesting question for future research is whether participation in the parent group may have had a role to play in this regard. Are the parents' assessments of their child's behaviour linked to their direct observations of change in their child, or is it possible that increased knowledge and understanding of learning disorders and its psychosocial correlates may have impacted on the parents' views of their children and, in so doing, on their evaluations of their children's psychosocial functioning?

With regard to the children's experiences of the LSG, they reported in the post-intervention interviews that they had enjoyed the activities in both the emotional group and the remedial group. It is noteworthy that they found sharing experiences with other children who had similar difficulties to be particularly helpful and enjoyable. This finding is in keeping with the literature on group therapies for children with learning disorders (Mishna & Muskat, 2004; Shechtman & Katz, 2007; Shechtman & Pastor, 2005) and holds promise for the efficacy of the intervention, particularly since these boys initially struggled with poor social relationships.

## 5.2 Outcomes for the participating parents

In general, the parent participants reported a reduction in the problems that initially prompted them to seek help. They observed positive changes in their children, namely, that their scholastic performance had improved; their behavioural problems had substantially decreased; their self-esteem and confidence had increased; and their social relationships had improved. Each parent also perceived his or her child to have improved in his ability to express and manage his feelings and to be more willing to engage in conversations or 'open up' about feelings with his parents. Alongside changes in their children, parents experienced shifts in their own parenting style, such as using different strategies for discipline and communication, which according to parents' reports, were more effective. An improvement in the quality of the parent-child relationship was reported by all the parents, including 'getting to know', or becoming closer to their child, as well as shifts in the way parents viewed their child, for instance, from a problem-focused to a more balanced and nuanced perspective. The co-occurrence of reported changes in both the parents and the children poses the question of a possible relationship between perceptions of change in the children and change in their parents' parenting experiences and parenting style. The underlying theory of the LSG programme (as described in section 1.1. of the introduction chapter) suggests that a reciprocal process exists, where gains for parents and improvements in the children's functioning influence and impact on each other to produce desired outcomes. This hypothesis has also arisen from other research (Mishna & Muskat, 2004).

The parents attributed particular gains to their participation in the LSG parent group, that is, they described the group as having provided needed support, having facilitated an increase in

their knowledge and understanding of LDs and its associated difficulties, helping them to acquire useful parenting strategies and coping skills, helping them to develop their ability to understand and respond to their child's internal experiences, and finally having a positive effect on other significant relationships in their lives, such as their relationship with their spouse or with their non-referred children. Although it may have been useful to supplement the interviews with other outcome measures for the parents, such as administering self-report scales, for example, the Parenting Stress Index, to the parents, the above findings appear to support the potential efficacy of the LSG parent intervention.

## 5.3 Issues arising from the research

In accordance with the principles of programme evaluation, general issues that arise from the research process are regarded as information that can be used in future programmes or future evaluations (Louw et al, 2000; Rossi et al, 1999). Two key issues are worthy of note here. Firstly, meaningful information was gleaned from the interviews with the parents. As discussed in the literature review, insight into the experiences of programme participants may be helpful for programme developers as it is likely to enhance the relevance and effectiveness of future interventions (Louw et al, 2000). In the pre-intervention interviews, parents spoke of their experiences of the help-seeking process as stressful. They also gave accounts in the pre-interviews of their own emotional distress about their child's difficulties and their ability to cope with these. They described feelings of guilt, helplessness, isolation and a sense of loss of a 'normal' child. Given the drawbacks in relations between parents and education professionals reported in the South African literature (Biersteker & Robinson, 2000; Swart et al, 2004; Yssel et al, 2007), this is an area for further research. If the body of knowledge concerning the experiences of parents with children with LDs in South Africa is expanded, interventions aiming to ameliorate parents' difficulties can be designed in accordance with their needs and, in so doing, enhance the efficacy of the intervention and organize resources available to best serve the target participants. Unfortunately, no follow up questions regarding these aspects were asked on post-interview, although several parents spontaneously reported feeling that their worries about their child had been alleviated to a great extent and that they felt better able to access and utilize resources at the end of the LSG programme.

Parents also offered three basic recommendations for the LSG programme in the post-intervention interviews. They felt that increased communication or interaction between the subgroups of the LSG programme, such as feedback meetings for parents and children every few months, or providing parents with an opportunity to observe practices in the children's groups, would benefit all the participants. Regarding the parent support group, parents found the resource book, the inclusion of a guest speaker for one session, and the use of an illustrative video in another, to be particularly useful. They suggested that such materials be included more often in the content of the group. They also suggested that more information regarding the roles of facilitators and parents in the group, as well as how the group will be run, be included in the initial stage of the intervention, to ease parents' anxieties about their participation in a group therapy situation, which was a novel experience for all the parents.

In addition to the above issues, all the parents conveyed at post-interview, without prompting from the researcher, that they felt that the interviews had given them an opportunity to think about and discuss aspects of their child's problems outside of the parent support group situation, as well as to reflect on their own parenting experience and their participation in the LSG in a meaningful way. The eagerness of parents of children with LDs to talk about their experiences has been noted elsewhere in South African literature (Yssel et al, 2007). It may be that the interviews served a supportive function for the programme, in terms of helping parents gain perspective regarding their experiences and the processes that they, and their children, may have undergone.

A second key issue which emerged from the research process concerns the use of triangulated methodologies in the study. Findings in the evaluation confirmed the merits of triangulation, and the advantages of using both quantitative and qualitative data, referred to in the relevant literature reviewed in Chapter Two. The fact that five sources of data supported improvements in the boys' scholastic functioning enhanced the credibility of that outcome, which is important with such a small sample size. Furthermore, parents reported improvements in their children's behaviour in the qualitative interviews, and the CRS-R quantitative data supported the clinical significance of these shifts. On the other hand, the CRS-R measures a number of specific, externalized behaviour, while the parents discussed shifts not only in their children's aggression and defiance, but also in their tendency to

withdraw. Thus, qualitative data arguably captured the experiences of participants more fully, providing more nuanced information. Without the qualitative reports, no indication of the shifts in withdrawal behaviour would have been recorded. Lastly, it was useful to balance the findings from the interviews with the child participants, which did not indicate substantial shifts in emotional expressiveness and problem-solving competency, against the qualitative reports from the parents, which described the children as more emotionally expressive and 'mature', as well as engaging less in 'tantrum' and other difficult behaviours, at the end of the programme. As such, the lack of significant outcomes in the boys' ability to express their feelings during the interviews was not erroneously taken to mean that there had been no shifts at all in their psychosocial functioning.

## 5.4 Limitations of the study

This evaluation study has considerable limitations. In addition to the lack of a control group mentioned earlier, the research sample was limited to the participants from the 2006 programme. As such, no outcomes data are available for previous LSG interventions. In addition, the small number of participants (six families) in 2006 detracts from the statistical power as well as the generalizability of the findings - further confounded by the missing data (pre- and post-intervention interviews) for two of the child participants. The use of scholastic assessments that lack South African norms as an indicator of boys' academic functioning is also a limitation in this evaluation.

Due to limited resources, no six-month or twelve-month follow-up assessments were conducted with the participants and it was therefore not possible to assess whether gains were maintained over the longer term. This seems particularly relevant given the literature pertaining to interventions for children, which refers to the questionable sustainability of gains in societies where poverty and other socio-economic problems subvert the gains achieved by specialized programmes, as well as to the benefits of supportive or 'top-up' interventions at later stages of the child's development (Dawes & Donald, 2000; Rutter et al, 2002).

At least three of the six child participants had a co-morbid diagnosis of ADHD. No investigation was made regarding the role that a diagnosis of ADHD may have played on the outcomes for participants, nor has there been research into the inclusion of learners with dual diagnoses in the LSG programme. However, given the high incidence of LDs' co-morbidity with ADHD (as discussed in the literature review), it seems inevitable that such learners be included. Even so, this is a limitation of the study and a critical area for future research.

The researcher did not participate directly in the LSG, however she was a member of the CGC in 2006, and so may have had some degree of subjectivity or bias that might have influenced the interview process and interpretation of data in subtle ways. As such, the neutrality and objectivity that might have been provided by a true 'outsider' researcher was not possible.

Finally, the study included only one of the three components of programme evaluation. A formal implementation evaluation may have provided more detailed information on the processes involved in the intervention, whether the programme was implemented as designed and whether there were issues that could be addressed by the programme staff. An assessment of the financial costs of a programme such as this is likely to have also been beneficial.

## 5.5 Recommendations

A number of suggestions regarding methodological considerations for future evaluations of similar programmes for children with LDs are worth mentioning. The benefits of triangulation in the study suggest that it may be useful to augment quantitative methods with qualitative data, using multiple data and methods for all the outcome indicators. It was challenging to design measures for some of the outcomes of interest in this study, an issue which, according to the relevant literature, commonly occurs in evaluations of psychotherapeutic impacts (Kazdin, 1991; Nixon, 1997). With hindsight, the advantages of including relevant scales and questionnaires to supplement the instruments used can be seen. For instance, the VIP Scale (Kokkonen, 1998) to test the children's ability to identify their feelings, the Self Perception Profile (Harter, 1988) to measure the children's self-esteem and

self-confidence, the Parenting Stress Index (Abidin, 1983) to assess whether parents' distress had decreased, and the Parent-Child Relationship Inventory (Gerard, 1994) could be triangulated against the interview data. Each of these impacts was reported by the parents in the interviews, and comparisons with other sources would have been beneficial. Furthermore, the Conners' Rating Scale used in the study is the shorter of two versions, testing aspects of behaviour and cognitive functioning, while the longer version includes items related to emotional functioning, that is, temperament and mood difficulties. This latter version would be preferable in future such evaluations.

Given the reported value of the interviews for parents, it is suggested that these be integrated into the programme at pre- and post-intervention stages, although a few variations in technique are possible if programme staff are not able to conduct lengthy interviews. An open-ended questionnaire enquiring into outcomes and efficacy could supplement or replace the interviews with the parents. On the questionnaire, parents could also rate items on a scale from one to ten, for example, rate their confidence in their ability to respond to their child's emotional needs, or rate their satisfaction with aspects of the intervention, such as the quality of the resources used in the parent support group, or the level of communication between subgroups or between programme staff and participants. Alternatively, an interviewer could work through the questionnaire with each parent (or parent couple).

With regard to the teachers' qualitative observations of the children's functioning, it may be more useful to structure their comments in the form of a few open-ended questions, with a space upon which to respond beneath each question, instead of offering a paragraph requesting the areas which they are required to comment on, as this resulted in a problem comparing pre- and post-intervention reports in this study.

In summary, pre- and post-assessments could be used as routine procedure in the implementation of the intervention. While this may be considered costly or time-consuming, it is worthy of consideration since the capacity of the programme for ongoing internal evaluation may be significantly developed, which in turn will be less costly than dependence on larger-scale, external evaluations at intermittent intervals. A process study is suggested, which would best be conducted using mainly qualitative data, such as interviews with

programme staff, participant observation, analysis of programme records and clinical data (transcripts or videotaped material from the groups). An understanding of the processes involved in the implementation of the programme, particularly therapeutic strategies, together with a controlled study, with participants in the comparison group possibly drawn from a waiting list, or from candidates who opted not to participate, may be useful in determining issues of causality, that is, which components of the intervention are effective and can be usefully replicated by other programmes. Finally, given that cost-benefit studies are complex and dependent on the cost and impact statements of a programme, a small study or a component of more extensive research can include an evaluation of the costs of a programme such as the LSG, compared with the costs involved in private remedial tuition as well as individual supportive psychotherapy, as the only available alternatives for children with LDs and their parents at this time. However, in such an assessment weighing the benefits and costs of either intervention, outcomes data for the comparison intervention(s) are required.

The parents' recommendations for the LSG should be considered both by the LSG programme and by similar intervention programmes that may be conducted in the future. The recommendation for more interaction between the subgroups of the LSG is particularly interesting. The suggestion of allowing parents to 'observe' the children's group sessions is complicated as the children are, according to the clinical staff of the programme, often worried about the possibility of parents watching or overhearing them, particularly in the emotional therapy group, and such an intrusion may damage their sense of safety and autonomy in the group. Perhaps one or two conjoint sessions for the year, discussed with both the children and the parents beforehand, could include an emotional therapy session focusing on parent-child interaction, such as modeling play therapy for the parents, or a joint activity involving, for instance, making family portraits or drawing a relationship map. Conjoint sessions for parents and children are encouraged in the literature (Carr, 1999). For the remedial group, parents can benefit from observing how strategies are implemented by the remedial teacher, and an opportunity to practice these under the guidance of the teacher can be offered to parents.

Finally, one of the primary objectives of the CGC was to disseminate information on a model intervention addressing the needs of children with learning difficulties in this context, which could be transported to settings in the broader community. It may be useful for the staff involved in the LSG programme over a number of years to draw up and publish a manual for the intervention, or components of the intervention, outlining the assumptions, techniques, structure and content of sessions, as well as a summary of the projected costs for the programme. Given that parent psycho-education and support and other systemic interventions are also advocated in the literature on interventions for LDs (see Chapter Two, section 2.1.5.), it may be possible to implement variations of a programme such as the LSG in schools, or at district-based levels.

## 5.6 Conclusion

This study evaluated the participant outcomes for a multi-level remedial and psychotherapeutic intervention programme for children with learning difficulties and their parents. Qualitative and quantitative data were triangulated for a number of outcome indicators in the single-group pre- and post-measures design. What can be stated from the findings of this short-term outcome study is that some significant shifts did occur for the child and parent participants of the LSG programme, from pre- to post-intervention. These were consistent across three perspectives, namely the child participants, their participating parents and the children's school teachers. Furthermore, the children enjoyed both the remedial and the emotional groups and the parents reported that they believed the programme to be valuable for their children as well as for themselves. While the extent to which the reported gains can be attributed to the programme itself remains unclear, findings are very promising and support the potential value of the intervention. Louw et al (2000) propose that those involved in psychosocial interventions should at the very least reflect on and share their research on programmes and, in so doing, service providers may benefit from learning through, or building on, the experiences of others. Despite its limitations, an evaluation of the outcomes for the CGC's LSG programme was an opportunity to disseminate information on practices that aim to address the problems faced by children with learning disorders in South Africa.

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## APPENDIX A: LESSONS AND STRATEGIES USED IN THE BOYS' REMEDIAL GROUP

ENGLISH

Reading strategies:

- Six simple suggestions to find meaning
- Close reading
- Skimming and scanning
- Finding key words
- 3 levels of questions (literal, inferential, deductive)

Writing:

- Structure (beginning, middle, end)
- Setting the scene
- Colourful characters
- Powerful verbs
- The writing process (pre-writing, draft, proofread, second draft, publish)

Spelling:

- High frequency words
- Selective spelling rules

Speaking:

- 'Goodspeakers' tips

MATHEMATICS

Bonds

Times tables

Addition, subtraction, multiplication, division

Fractions

Rounding off

Number lines

120 chart

Measurement (conversions)

*The following are examples of lessons used in the group:*

My strengths at school are...

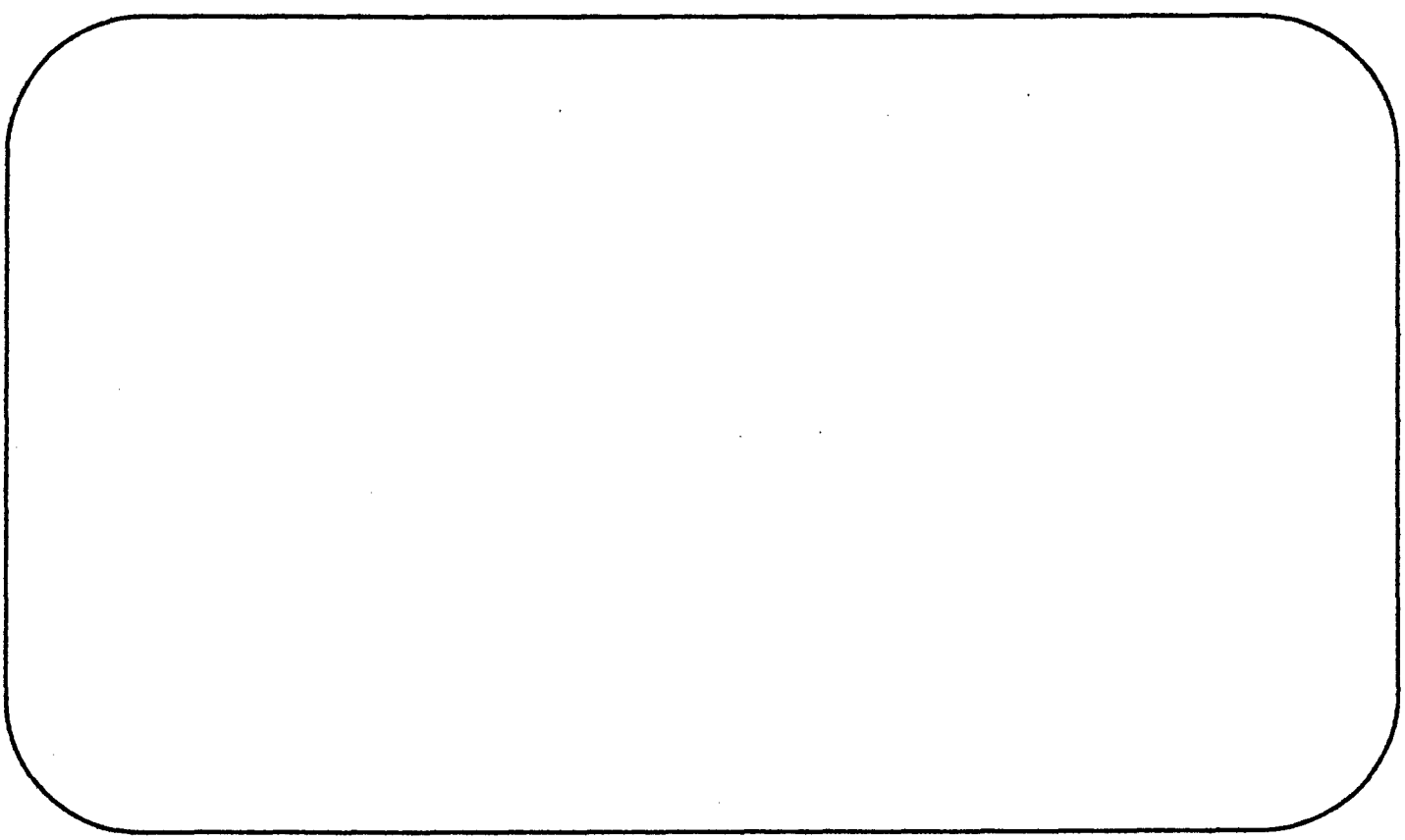
# C.G.C
# Learning hour

Name_____

My weaknesses at school are...

This is a story about me

This is a picture of my family and I.



# Reading for key words

Here is a little story...

**Read the story and answer the questions in full sentences.**

One apon a time there lived a very old and lonely troll called Widgety. He lived in a crumbly tree trunk at the edge of the woods. Widgety was extremely sad because he had no friends, he thought it was because he was terribly ugly and that he smelt like mouldy socks!

1. **What is the troll** called?

The trolls name is Widgety.

2. Where **does the troll** live?

The troll lived at the edge of the woods.

3. Why **was the troll** sad?

The troll was sad because he had no friends.

# Follow these steps to be a winner!

1. Always close read the story. Remember to:

- Read the text carefully
- Read every word
- Read the text twice

2. Always close read the questions. Remember to:

- Read the question carefully
- Read every word
- Read the question twice

## Then skim and scan for key words.

Q1: What is the troll called?
To find the answer look for the key word 'called'

Q1: Where does the troll live?
If the question starts with where? The answer will be a place.
To find the answer look for the key word 'lived'

Q1: Why was the troll sad?
If the question starts with why? The answer will be a reason.
To find the answer look for the key word 'sad'

To the parents.

CGC 30 June 2006

# Paired Reading

## What?

Paired Reading is one of the most effective methods used to improve:

- Reading fluency (smooth, continuous, flowing reading)
- Reading speed
- Word recognition

## How?

- Sit next to your child at a table
- Put the book flat on the table
- Use your finger to keep track of where you are and set the pace
- Read with your child out aloud **(you both read at the same time)**
- You set the pace (speed) and rhythm
- Read with expression
- Exaggerate taking a breath for commas and full stops

When you find that he is improving, just start each sentence with him and trail off for the rest of the sentence. This way he begins to feel more independent but you are keeping the pace and the rhythm. Always come in for harder words so that he doesn't break the flow.

## Paired reading needs to be done everyday for 20min.

## APPENDIX B: RESOURCE BOOK FOR PARTICIPANTS OF THE PARENT SUPPORT GROUP

This resource book* can be found in the Library of the Child Guidance Clinic and includes articles and handouts covering the following areas:

Attention Deficit/Hyperactivity Disorder

- Diagnosis
- Causes
- Associated Disorders
- Treatment & Prognosis
- Attention Deficit and Hyperactive Disorder of Southern Africa (ADHASA)

Bullying: What parents can do about it

Communication: 10 tips for talking with kids about tough issues

Discipline

- 7 reasons children misbehave
- Setting reasonable limits for your child
- Star charts
- Time out: Is this right for me?
- A word on spanking

Homework

- Help your child get organized to study
- Encourage children to tackle homework
- Paired reading and paired oral spelling
- General tips & homework routines

Becoming organized as a family

- Sharing spaces and managing possessions, untidiness
- Helping around the house
- Sibling rivalry

Teaching responsibility

Talking with kids about sex and relationships

TV, games and internet safety

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* *Learning Support Group, Child Guidance Clinic: Resource pack for parents*. Compiled by M. Mangerah & C.J. Stanley.

## APPENDIX C: SCHEDULE FOR THE INTERVIEWS WITH THE CHILD PARTICIPANTS

**SECTION 1 (pre-test and post-test):** *Playing the 'what-if' game*

I'm going to describe different situations to you and then ask you what you would do if these things happened to you.

*Interviewer should probe for a **range** of feelings and strategies in response to each scenario - what would you say next? And then what? Any other ways you might handle it? Which do you think would the BEST thing to do, out of all the things you've thought about?*

1. What if another boy at school, in an older Grade, wanted to steal your tuck-shop money, and he told you that he would beat you up if you didn't give it to him? What would you feel inside when that happened? What would you do? (if child does not respond that they would tell someone about it, ask if there is anyone that they would tell and, if so, who, why that person, and what would that person do about the situation?)

2. What if another boy in your neighbourhood, who was a few years younger than you, got a new Gameboy and you REALLY wanted to try it out, but he wouldn't let you? What would you feel inside when that happened? What would you do?

3. What if the boy who sits next to you in class is talking a lot, and the teacher turns around and shouts at YOU and tells you to go sit outside in the passage, even though you weren't saying anything? What would you feel inside when that happened? What would you do?

4. What if you are busy watching a TV programme, and your brother (or sister) walks in and just changes the channel without asking you. What would you feel inside if that happened? What would you do? (if child says "tell my mommy/daddy", ask what they would do if their parents were not home)

5. What if it's a Sunday evening and you want to go meet some other boys in the road to play soccer, but your mother won't let you because she says you have to learn for a test at school the next day. What would you feel inside if that happened? What would you do? (also probe for what the child would do if the parent/s went out for a while on that Sunday evening - would they go out to play soccer or would they stay at home?)

**SECTION 2:** *Eliciting feelings about their learning difficulties and their expectations and experiences of the LSG*

**Pre-test:**

1. Do you know why you are coming to the Learning Support Group?

2. Do YOU think that there's a problem that you need help with, or is it just mom (and dad, where relevant) that's worried? What is the problem that you and/or your mom/parents are worried about?
3. How do you FEEL inside about the problem you're having? What feelings do you have inside when you think about this problem?

**Post-test:**

1. What do you think about the things you did with Liesl (*remedial teacher*) this year? What did you like? What didn't you like?
2. What do you think about the things you did in the (*therapy*) group with Anya and Nokwanda this year? What did you like? What didn't you like?
3. If you could come back here again next year, would you want to come back?

   If yes: Why would it be nice to come back?

   If no: Why wouldn't you like to come back?
4. When you think about how things are for you at school, with work and learning, how do you feel inside? What feelings do you have inside when you think about it?

## APPENDIX D: SCHEDULE FOR THE INTERVIEWS WITH THE PARTICIPATING PARENTS

### PRE-TEST INTERVIEW

**Concerns**

1. What has been happening with (*child's name*) that brought you to the LSG?
2. What is it that the teacher/school is worried about?
3. Have you noticed similar things?
4. Are there any aspects of (*child's name*) behaviour, at home or elsewhere, that you feel worried about?

**Relationship with child**

5. Tell me about (*child's name*) what is he like, how would you describe him?
6. What are the things you like most about him?
7. What are the things about him that sometimes might make you feel frustrated or upset? What are the hardest things about parenting him?
8. How do you know when (*child's name*) is feeling cross about something? Does he tell you, or does he show you in other ways? What do you usually do when he gets cross about something? Can you describe a recent example?
9. How do you know when he is feeling sad or upset about something? Does he tell you, or does he show you in other ways? What do you usually do when he is sad or upset about something? Can you describe a recent example?
10. What are your hopes for (*child's name*) in the future? What are the things you would like to see happen for him when he gets older?
11. Are you involved in (*child's name*) homework? What is it like for you?
12. How would you describe (*child's name*) relationship with his brother / sister? (Ask for examples to illustrate) (If a parent describes sibling conflict, ask how the parent tries to manage this.)

**Expectations of the LSG**

13. What exactly would you like the LSG to help your child with?
14. What exactly would you like the LSG to help YOU with, as a parent?
15. What changes would you like to see by the end of the year, in your child and in yourself?
16. Do you have any concerns or worries about your child being involved in the LSG or about being involved yourself?

**POST-TEST INTERVIEW**

**Concerns**

1. When we spoke earlier this year, you mentioned the following concerns that brought you to attend the LSG.....
2. Since we last spoke, have there been any changes in these concerns?
3. Do you think your child has any difficulties / struggles at the moment, either at school, or at home, or in other ways?

**Relationship with child**

4. Tell me about (*child's name*) what is he like, how would you describe him?

   *Last time we spoke, you described (child's name) as.....Would you describe him the same way now, or different?*

5. What are the things about him that sometimes might make you feel frustrated or upset? What are the hardest things about parenting him?

   *Last time we spoke, you said the following things about (child's name) made you feel frustrated or upset. You also said the following things are hard about parenting him.....Do you find that you still feel frustrated or upset about these same things or is it different?*

6. How do you know when (*child's name*) is feeling cross about something? Does he tell you, or does he show you in other ways? What do you usually do when he gets cross about something? Can you describe a recent example?

   *Last time we spoke, you told me that (child's name) lets you know when he's cross by..... Is he still the same, or different? (Example?)*

   *You also said that when he gets cross about something, you usually.....Is that still the same or different? (Example?)*

7. How do you know when he is feeling sad or upset about something? Does he tell you, or does he show you in other ways? What do you usually do when he is sad or upset about something? Can you describe a recent example?

   *Last time we spoke, you told me that (child's name) lets you know he's sad or upset by..... Is he still the same, or different? (Example?)*

   *You also said that when you see he's sad or upset, you usually.....Is that still the same or different? (Example?)*

8. What are your hopes for (*child's name*) in the future? What are the things you would like to see happen for him when he gets older?

   *Last time I asked you about your hopes for him in the future, and you said.....would you say that you still have the same hopes for him now, or different?*

9. Can you tell me what homework times are like for you at the moment?

   *Last time you said that ... Is this different?*

10. How would you describe (*child's name*) relationship with his brother / sister? (Examples to illustrate) (If a parent describes sibling conflict, ask how the parent tries to manage this.)

    *Last time you said ... are their any differences?*

**Experience of LSG**

11. What it was like for you to be involved in the LSG?
12. Was there anything that you think was helpful for your child? What things have you noticed that was helpful for him?
13. Was there anything that you think was helpful for you? What things have you noticed about yourself which suggests that this was helpful?
14. If you could recommend any changes to the LSG Programme, what changes would you recommend?

**APPENDIX E: PARENTS' AND TEACHERS' CRS – R**

# Conners' Parent Rating Scale - Revised (S)

**by C. Keith Conners, Ph.D.**

**Child's Name:**_____ **Gender: M F**

**Birthdate:**____/____/____ (Month / Day / Year) **Age:**_____ **School Grade:**_____

**Parent's Name:**_____ **Today's Date:**____/____/____ (Month / Day / Year)

**Instructions:** Below are a number of common problems that children have. Please rate each item according to your child's behavior in the last month. For each item, ask yourself, "How much of a problem has this been in the last month?", and circle the best answer for each one. If none, not at all, seldom, or very infrequently, you would circle 0. If very much true, or it occurs very often or frequently, you would circle 3. You would circle 1 or 2 for ratings in between. Please respond to each item.

| | NOT TRUE AT ALL (Never, Seldom) | JUST A LITTLE TRUE (Occasionally) | PRETTY MUCH TRUE (Often, Quite a Bit) | VERY MUCH TRUE (Very Often, Very Frequent) |
|---|---|---|---|---|
| 1. Inattentive, easily distracted | 0 | 1 | 2 | 3 |
| 2. Angry and resentful | 0 | 1 | 2 | 3 |
| 3. Difficulty doing or completing homework | 0 | 1 | 2 | 3 |
| 4. Is always "on the go" or acts as if driven by a motor | 0 | 1 | 2 | 3 |
| 5. Short attention span | 0 | 1 | 2 | 3 |
| 6. Argues with adults | 0 | 1 | 2 | 3 |
| 7. Fidgets with hands or feet or squirms in seat | 0 | 1 | 2 | 3 |
| 8. Fails to complete assignments | 0 | 1 | 2 | 3 |
| 9. Hard to control in malls or while grocery shopping | 0 | 1 | 2 | 3 |
| 10. Messy or disorganized at home or school | 0 | 1 | 2 | 3 |
| 11. Loses temper | 0 | 1 | 2 | 3 |
| 12. Needs close supervision to get through assignments | 0 | 1 | 2 | 3 |
| 13. Only attends if it is something he/she is very interested in | 0 | 1 | 2 | 3 |
| 14. Runs about or climbs excessively in situations where it is inappropriate | 0 | 1 | 2 | 3 |
| 15. Distractibility or attention span a problem | 0 | 1 | 2 | 3 |
| 16. Irritable | 0 | 1 | 2 | 3 |
| 17. Avoids, expresses reluctance about, or has difficulties engaging in tasks that require sustained mental effort (such as schoolwork or homework) | 0 | 1 | 2 | 3 |
| 18. Restless in the "squirmy" sense | 0 | 1 | 2 | 3 |
| 19. Gets distracted when given instructions to do something | 0 | 1 | 2 | 3 |
| 20. Actively defies or refuses to comply with adults' requests | 0 | 1 | 2 | 3 |
| 21. Has trouble concentrating in class | 0 | 1 | 2 | 3 |
| 22. Has difficulty waiting in lines or awaiting turn in games or group situations | 0 | 1 | 2 | 3 |
| 23. Leaves seat in classroom or in other situations in which remaining seated is expected | 0 | 1 | 2 | 3 |
| 24. Deliberately does things that annoy other people | 0 | 1 | 2 | 3 |
| 25. Does not follow through on instructions and fails to finish schoolwork, chores or duties in the workplace (not due to oppositional behavior or failure to understand instructions) | 0 | 1 | 2 | 3 |
| 26. Has difficulty playing or engaging in leisure activities quietly | 0 | 1 | 2 | 3 |
| 27. Easily frustrated in efforts | 0 | 1 | 2 | 3 |

# Conners' Teacher Rating Scale - Revised (S)

**by C. Keith Conners, Ph.D.**

**Child's Name:**_____ **Gender: M F**

**Birthdate:**____/____/____ (Month / Day / Year) **Age:**_____ **School Grade:**_____

**Teacher's Name:**_____ **Today's Date:**____/____/____ (Month / Day / Year)

**Instructions:** Below are a number of common problems that children have in school. Please rate each item according to how much of a problem it has been in the last month. For each item, ask yourself, "How much of a problem has this been in the last month?", and circle the best answer for each one. If none, not at all, seldom, or very infrequently, you would circle 0. If very much true, or it occurs very often or frequently, you would circle 3. You would circle 1 or 2 for ratings in between. Please respond to each item.

| | NOT TRUE AT ALL (Never, Seldom) | JUST A LITTLE TRUE (Occasionally) | PRETTY MUCH TRUE (Often, Quite a Bit) | VERY MUCH TRUE (Very Often, Very Frequent) |
|---|---|---|---|---|
| 1. Inattentive, easily distracted | 0 | 1 | 2 | 3 |
| 2. Defiant | 0 | 1 | 2 | 3 |
| 3. Restless in the "squirmy" sense | 0 | 1 | 2 | 3 |
| 4. Forgets things he/she has already learned | 0 | 1 | 2 | 3 |
| 5. Disturbs other children | 0 | 1 | 2 | 3 |
| 6. Actively defies or refuses to comply with adults' requests | 0 | 1 | 2 | 3 |
| 7. Is always "on the go" or acts as if driven by a motor | 0 | 1 | 2 | 3 |
| 8. Poor in spelling | 0 | 1 | 2 | 3 |
| 9. Cannot remain still | 0 | 1 | 2 | 3 |
| 10. Spiteful or vindictive | 0 | 1 | 2 | 3 |
| 11. Leaves seat in classroom or in other situations in which remaining seated is expected | 0 | 1 | 2 | 3 |
| 12. Fidgets with hands or feet or squirms in seat | 0 | 1 | 2 | 3 |
| 13. Not reading up to par | 0 | 1 | 2 | 3 |
| 14. Short attention span | 0 | 1 | 2 | 3 |
| 15. Argues with adults | 0 | 1 | 2 | 3 |
| 16. Only pays attention to things he/she is really interested in | 0 | 1 | 2 | 3 |
| 17. Has difficulty waiting his/her turn | 0 | 1 | 2 | 3 |
| 18. Lacks interest in schoolwork | 0 | 1 | 2 | 3 |
| 19. Distractibility or attention span a problem | 0 | 1 | 2 | 3 |
| 20. Temper outbursts; explosive, unpredictable behavior | 0 | 1 | 2 | 3 |
| 21. Runs about or climbs excessively in situations where it is inappropriate | 0 | 1 | 2 | 3 |
| 22. Poor in arithmetic | 0 | 1 | 2 | 3 |
| 23. Interrupts or intrudes on others (e.g., butts into others' conversations or games) | 0 | 1 | 2 | 3 |
| 24. Has difficulty playing or engaging in leisure activities quietly | 0 | 1 | 2 | 3 |
| 25. Fails to finish things he/she starts | 0 | 1 | 2 | 3 |
| 26. Does not follow through on instructions and fails to finish schoolwork (not due to oppositional behavior or failure to understand instructions) | 0 | 1 | 2 | 3 |
| 27. Excitable, impulsive | 0 | 1 | 2 | 3 |
| 28. Restless, always up and on the go | 0 | 1 | 2 | 3 |

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## APPENDIX F: TOWRE PHONEMIC DECODING AND SIGHT WORD EFFICIENCY TESTS

### Sight Word Efficiency Form A

#### Practice Words

on
my
bee
old

---

warm
bone
most
spell

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| | | | |
|---|---|---|---|
| is | work | crowd | uniform |
| up | jump | better | necessary |
| cat | part | inside | problems |
| red | fast | plane | absentee |
| me | fine | pretty | advertise |
| to | milk | famous | pleasant |
| no | back | children | property |
| we | lost | without | distress |
| he | find | finally | information |
| the | paper | strange | recession |
| and | open | budget | understand |
| yes | kind | repress | emphasis |
| of | able | contain | confident |
| him | shoes | justice | intuition |
| as | money | morning | boisterous |
| book | great | resolve | plausible |
| was | father | describe | courageous |
| help | river | garment | alienate |
| then | space | business | extinguish |
| time | short | qualify | prairie |
| wood | left | potent | limousine |
| let | people | collapse | valentine |
| men | almost | elements | detective |
| baby | waves | pioneer | recently |
| new | child | remember | instruction |
| stop | strong | dangerous | transient |

# TOWRE

## Phonemic Decoding Efficiency Form A

## Practice Items

ba
um
fos
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3 4 5 03 02 01

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| (41) | (42) | |
|---|---|---|
| ip | barp | cratty |
| ga | stip | trober |
| ko | plin | depate |
| ta | frip | glant |
| om | poth | sploosh |
| ig | vasp | dreker |
| ni | meest | ritlun |
| pim | shlee | hedfert |
| wum | guddy | bremick |
| lat | skree | nifpate |
| baf | felly | brinbert |
| din | clirt | clabom |
| nup | sline | drepnort |
| fet | dreef | shratted |
| bave | prain | plofent |
| pate | zint | smuncrit |
| herm | bloot | pelnador |
| dess | trisk | fornalask |
| chur | kelm | fermabalt |
| knap | strone | crenidmoke |
| tive | lunaf | emulbatate |

## APPENDIX G: SCHONELL STANDARDIZED SPELLING AND ARITHMETIC PROBLEMS TESTS

S1 GRADED WORD STANDARDISED SPELLING TEST (A) - 30 mins

1. NET. The fish was caught in a net. Write NET.
2. CAN. Can you do this? Write CAN.
3. FUN. It is fun to play games. Write FUN.
4. TOP. He climbed to the top of the hill. Write HILL.
5. RAG. He used a rag to polish the table. Write RAG.
6. SAT. The woman sat on a chair. Write CHAIR.
7. HIT. The man hit the donkey to make it go faster. Write HIT.
8. LID. Put the lid on the tin. Write LID.
9. CAP. The boy put on his cap. Write CAP.
10. HAD. Have you had your lunch? Write HAD.
11. LET. Will you let me do this? Write LET.
12. DOLL. The girl played with her doll. Write DOLL.
13. BELL. The school bell rang. Write BELL.
14. YES. I think your mother will say yes. Write YES.
15. THEN. Do your work and then you can play. Write THEN.
16. MAY. I may go to the swimming bath this afternoon. Write MAY.
17. TREE. The cat climbed a tree. Write TREE.
18. BY. This letter was written by my mother. Write BY.
19. ILL. She is away from school because she is ill. Write ILL.
20. EGG. I like a boiled egg for breakfast. Write EGG.
21. LAND. They sailed their ship to a faraway land. Write LAND.
22. HOW. Show me how you do that. Write HOW.
23. YOUR. Is that your book? Write YOUR.
24. COLD. It is not very cold today. Write COLD.
25. TALK. She likes to talk all day. Write TALK.
26. FLOWER. She picked a flower in the garden, Write FLOWER.
27. SON. The man was very proud of his son. Write SON.
28. SEEM. They seem to be tired after working all day. Write SEEM.
29. FOUR. I gave him four apples. Write FOUR.
30. LOUD. It was a very loud noise. Write LOUD.

31. GROUND. After the rain, the ground was very wet. Write GROUND.
32. LOWEST. Put your books on the lowest shelf in the cupboard. Write LOWEST.
33. BRAIN. Your brain is in your head. Write BRAIN.
34. WRITE. Write a letter to your mother and father. Write WRITE.
35. AMOUNT. Did he give you the right amount of change? Write AMOUNT.
36. NOISE. The children made a lot of noise in the playground. Write NOISE.
37. REMAIN. While you are away, I shall remain at home. Write REMAIN.
38. HOPED. She hoped she would be allowed to go and play with her friend. Write HOPED.
39. WORRY. Don't worry about the dog; it won't bite you. Write WORRY.
40. DANCING. The girl wants to learn dancing. Write DANCING.
41. DAMAGE. The fire caused much damage to the house. Write DAMAGE.
42. ELSE. What else would you like to have? Write ELSE.
43. THROUGH. The train went through the tunnel. Write THROUGH.
44. ENTERED. I knocked at the door and then entered the room. Write ENTERED.
45. COUGH. She stayed at home with a very bad cough. Write COUGH.
46. FITTED. The man fitted a new globe in the electric light. Write FITTED.
47. SPARE. When they had a puncture, they put on the spare wheel. Write SPARE.
48. DAUGHTER. Mrs. Smith's daughter looks very like her. Write DAUGHTER.
49. EDGE. He played too near the edge of the cliff and fell over. Write EDGE.
50. SEARCH. She had to search for the book she had lost. Write SEARCH.
51. CONCERT. The orchestra played at the concert. Write CONCERT.
52. DOMESTIC. Dogs and cats are domestic animals. Write DOMESTIC.
53. TOPIC. The man gave a talk on an interesting topic. Write TOPIC.
54. METHOD. This is the best method of doing that sum. Write METHOD.
55. FREEZE. If it's very cold the water will freeze. Write FREEZE.
56. AVOID. Try to avoid an accident. Write AVOID.
57. DUTIES. A policeman has many different duties. Write DUTIES.
58. RECENT. He bought it during a recent visit to Durban. Write RECENT.
59. TYPE. This is a new type of sum. Write TYPE.
60. INSTANCE. Some animals, cats for instance, are very fond of milk. Write INSTANCE.
61. LIQUID. Water is a liquid and so is milk. Write LIQUID.
62. ASSIST. Please assist me with this work. Write ASSIST.

63. READILY. When asked to help, he readily agreed. Write READILY.

64. GUESS. Can you guess what this is? Write GUESS.

65. ATTENDANCE. Because of the weather, the attendance at the meeting was very low. Write ATTENDANCE.

66. DESCRIPTION. We recognized the man by the description we had heard. Write DESCRIPTION.

67. WELFARE. This man is interested in the welfare of his servants. Write WELFARE.

68. VARIOUS. There are various types of chocolates in this box. Write VARIOUS.

69. GENUINE. Is this leather genuine? Write GENUINE.

70. INTERFERE. Do not interfere in his affairs. Write INTERFERE.

71. ACCORDANCE. You must work out the sum in accordance with the methods you have been taught. Write ACCORDANCE.

72. MECHANICAL. A mechanical engineer works with machines. Write mechanical.

73. ANXIOUS. The boy is anxious because his dog has not come home. Write ANXIOUS.

74. SIGNATURE. Because he wrote so badly we could not read his signature. Write SIGNATURE.

75. ALLOTMENT. In the children's garden each child has a small allotment of land to care for. Write ALLOTMENT.

76. APPROVAL. Before you go you must have your father's approval. Write APPROVAL.

77. ACCOMPLISHED. He plays the piano well; in fact he is really an accomplished musician. Write ACCOMPLISHED.

78. REMITTANCE. If you order that book by post, you must arrange for a remittance of sixty cents. Write REMITTANCE.

79. FINANCIAL. The man's financial troubles were lessened when a friend gave him a present of twenty pounds. Write FINANCIAL.

80. CAPACITY. The capacity of that tin is six litres. Write CAPACITY.

Name: ..... Date: .....

# SCHONELL - TEST 5

There are FOUR kinds of sums here: addition, subtraction, multiplication and division.

Work across the page.

There is a five minute time limit.

| | a | b | c | d | e |
|---|---|---|---|---|---|
| 1 | 3 + 8 = | 12 - 5 = | 7 x 6 = | 3 + 9 = | 42 ÷ 7 = |
| 2 | 27 ÷ 3 = | 5 x 0 = | 12 - 7 = | 11 - 4 = | 15 - 7 = |
| 3 | 9 + 3 = | 36 ÷ 9 = | 7 x 9 = | 7 + 6 = | 8 + 9 = |
| 4 | 9 + 4 = | 12 - 3 = | 1 x 0 = | 4 x 6 = | 13 - 6 = |
| 5 | 0 ÷ 5 = | 48 ÷ 8 = | 64 ÷ 8 = | 9 x 6 = | 8 x 7 = |
| 6 | 14 - 8 = | 4 + 7 = | 5 + 6 = | 5 ÷ 5 = | 3 x 0 = |
| 7 | 6 + 7 = | 8 x 0 = | 63 ÷ 9 = | 18 - 9 = | 7 x 7 = |
| 8 | 4 + 9 = | 0 ÷ 8 = | 63 ÷ 7 = | 6 x 9 = | 11 - 6 = |
| 9 | 15 - 8 = | 0 x 2 = | 9 x 3 = | 8 x 5 = | 4 ÷ 4 = |
| 10 | 54 ÷ 9 = | 5 + 7 = | 8 + 6 = | 9 + 5 = | 7 + 8 = |
| 11 | 11 - 3 = | 13 - 8 = | 6 x 0 = | 14 - 6 = | 7 ÷ 7 = |
| 12 | 36 ÷ 4 = | 15 - 9 = | 13 - 5 = | 6 x 7 = | 7 x 8 = |
| 13 | 0 x 1 = | 6 + 9 = | 17 - 8 = | 15 - 6 = | 0 ÷ 7 = |
| 14 | 54 ÷ 6 = | 4 x 9 = | 0 x 5 = | 13 - 4 = | 16 - 9 = |
| 15 | 11 x 7 = | 84 ÷ 12 = | 88 ÷ 11 = | 12 x 6 = | 10 x 12 = |
| 16 | 12 x 4 = | 11 x 11 = | 96 ÷ 12 = | 11 x 12 = | 121 ÷ 11 = |
| 17 | 60 ÷ 12 = | 12 x 7 = | 108 ÷ 12 = | 12 x 8 = | 120 ÷ 12 = |
| 18 | 72 ÷ 12 = | 11 x 10 = | 11 x 8 = | 32 ÷ 12 = | 12 x 11 = |
| 19 | 11 x 9 = | 77 ÷ 11 = | 144 ÷ 12 = | 12 x 12 = | 110 ÷ 11 = |
| 20 | 48 ÷ 12 = | 12 x 5 = | 99 ÷ 11 = | 132 ÷ 11 = | 12 x 9 = |
| S/T | | | | | |

**APPENDIX H: BALLARD ONE-MINUTE ADDITION AND SUBTRACTION TESTS**

## BALLARD ARITHMETIC TEST

NAME:.....
DATE:.....

---

### 1 MINUTE ADDITION

| | |
|---|---|
| 1 | 1 + 2 =..... |
| 2 | 4 + 1 =..... |
| 3 | 2 + 2 =..... |
| 4 | 2 + 4 =..... |
| 5 | 3 + 2 =..... |
| 6 | 4 + 3 =..... |
| 7 | 2 + 5 =..... |
| 8 | 5 + 4 =..... |
| 9 | 3 + 5 =..... |
| 10 | 8 + 2 =..... |
| 11 | 4 + 4 =..... |
| 12 | 5 + 2 =..... |
| 13 | 6 + 4 =..... |
| 14 | 1 + 8 =..... |
| 15 | 3 + 7 =..... |
| 16 | 6 + 3 =..... |
| 17 | 2 + 6 =..... |
| 18 | 5 + 5 =..... |
| 19 | 7 + 2 =..... |
| 20 | 4 + 6 =..... |
| 21 | 7 + 5 =..... |
| 22 | 8 + 3 =..... |
| 23 | 4 + 9 =..... |
| 24 | 6 + 8 =..... |
| 25 | 7 + 6 =..... |
| 26 | 9 + 8 =..... |
| 27 | 9 + 6 =..... |
| 28 | 8 + 7 =..... |
| 29 | 5 + 9 =..... |
| 30 | 7 + 9 =..... |

### 1 MINUTE SUBTRACTION

| | |
|---|---|
| 1 | 2 - 1 =..... |
| 2 | 3 - 2 =..... |
| 3 | 5 - 1 =..... |
| 4 | 6 - 2 =..... |
| 5 | 5 - 3 =..... |
| 6 | 2 - 2 =..... |
| 7 | 7 - 2 =..... |
| 8 | 6 - 4 =..... |
| 9 | 7 - 3 =..... |
| 10 | 6 - 3 =..... |
| 11 | 8 - 2 =..... |
| 12 | 7 - 5 =..... |
| 13 | 8 - 3 =..... |
| 14 | 7 - 4 =..... |
| 15 | 9 - 3 =..... |
| 16 | 8 - 5 =..... |
| 17 | 10 - 4 = ..... |
| 18 | 9 - 5 =..... |
| 19 | 10 - 3 =..... |
| 20 | 9 - 4 =..... |
| 21 | 11 - 2 = ..... |
| 22 | 10 - 6 = ..... |
| 23 | 12 - 3 =..... |
| 24 | 11 - 6 =..... |
| 25 | 12 - 5 =..... |
| 26 | 13 - 4 =..... |
| 27 | 15 - 9 =..... |
| 28 | 14 - 6 =..... |
| 29 | 17 - 8 =..... |
| 30 | 16 - 7 =..... |

## APPENDIX I: CONSENT FORM FOR THE PARTICIPATING PARENTS

**Project title: Evaluation of Learning Support Group 2006**

You are invited to participate in a study that evaluates the effectiveness of the Learning Support Group at the Child Guidance Clinic in 2006. This research will help us to improve the Learning Support Group (LSG) as much as possible in the future.

If you decide to participate, you will be asked to complete an interview with a researcher which will last approximately 45 minutes, and then another interview with the same researcher at the end of the year. In addition, your child will also complete an interview with the same researcher that will last approximately 30 minutes, and another interview at the end of the year. In the first interview, you will be asked questions about what has brought you to the LSG, and which areas you would like help with. At the end of the year, you will be asked about your experiences of the LSG. Your child will be asked about how they would deal with a variety of different situations at school and home in the interviews at the beginning and at the end of the year.

You and your child are free to stop the interview at any time, or refuse to answer any question, and you do not have to give a reason. Any information obtained during this study will remain absolutely confidential and anonymous. This study is separate from the LSG group activities, and the facilitators of the groups will not be informed of the content of the interviews during the course of the year. At the end of 2006, after the LSG has ended, the group facilitators may be informed of the general content of all the interviews, but will not be told which group members said what - this will remain anonymous. This information will help the LSG organizers to plan for 2007 and to think about which aspects of the LSG could be improved.

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Signature of participant Date

---------- ----------

Signature of investigator Date

## APPENDIX J: VERBAL ASSENT FROM THE CHILD PARTICIPANTS

**Project title: Evaluation of Learning Support Group 2006**

**Child's name and surname:** _____

*Read by researcher:*

I am going to be doing a task that will help us here at the Clinic to get to know you better and to learn more about the groups that you attend here. It would be really useful if you could help me with this. If you agree to do this, we'll play a 'what if' game where I ask you to tell me what you would do if different things happen to you. This conversation will take about half an hour and if you don't want to answer some of the questions you can tell me to stop. Whatever you tell me stays between us and nobody except me will know that you (*...name...*) have said this. I have told your mommy (*and daddy, where applicable*) that I'm going to ask you to help me with this task and she (*they*) said that it's okay. I have also told (*group facilitators*), and they also said it's okay. Do you have any questions for me?

Do you agree to help me with this task?

**Child's Response:** _____

## APPENDIX K: THE BOYS' PROBLEM-SOLVING RESPONSES ON THE INTERVIEW VIGNETTES

| SCENARIO 1 | | Aggression | Assertiveness | Eliciting support |
|---|---|---|---|---|
| *Bullied by an older boy* | *Description & sample quote* | Engage in fighting with the bully<br>*"I'll kick him and I'll hit him"* | Standing up to a transgression of personal rights<br>*"I'll say that I won't give it 'cause this is wrong, can't just take someone's money"* | Seeking help from teachers or other adults; demonstrates a sense of trust in higher authorities to protect<br>*"I'd go to a teacher to help me"* |
| | *Pre-test* | One boy chose to fight the bully | | The three other boys indicated that they would elicit help from teachers or the principal. |
| | *Post-test* | | Two boys indicated that they would first attempt to assert themselves verbally and if unsuccessful, they would then seek help from an adult. | All four boys ultimately chose to elicit help from an adult |

| **SCENARIO 2** | | **Coercion** | **Negotiation** | **Mature acceptance** | **No response** |
|---|---|---|---|---|---|
| *Conflict with a peer:* not allowed to play with another boy's Gameboy | *Description & sample quote* | Using a form of force<br>*"I will irritate him whole time ... I won't leave him alone"* | Attempts to reach a mutual settlement<br>*"I'll be his friend and he can play with my toys"* | Indicating an ability to tolerate frustration as well as disappointment<br>*"I'll feel sad but I'll accept that he said no"* | *"I don't know"* |
| | *Pre-test* | One boy chose to coerce his peer in the vignette | One boy chose to attempt to negotiate with his peer (exchange of toys) *before accepting his peer's refusal* to let him play with the Gameboy. | Two boys chose to accept the outcome, going on to describe a sense of tolerating frustration and disappointment | One boy responded by saying that he did not know what he would do, despite prompting and cues from the researcher |
| | *Post-test* | | | All four of the boys chose to accept their peer's decision | |

| **SCENARIO 3** | | **Withdrawal** | **Assertiveness** |
|---|---|---|---|
| *Conflict with teacher:* wrongfully accused of disrupting the lesson | *Description & sample quote* | Passive or defeatist withdrawal<br>*"I will just go ... My teacher won't believe me"* | Attempts to clear the misunderstanding<br>*"I will tell the teacher that it wasn't me ...* |
| | *Pre-test* | One boy chose to withdraw | The other three boys chose to tell the teacher that they hadn't been talking and if this did not work, |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | they would obey the teacher's command, choosing not to exacerbate conflict with authority figure | | |
| | *Post-test* | The same boy chose to withdraw on post-test as well | | The other three responded in a similar way as before, only they described more options on the post-test, such as privately asking the boy to stop talking to them in class; requesting that the teacher ask the other children (witnesses) which boy had been talking, etc. before obeying the teacher. | | |
| **SCENARIO 4** | | **Aggression** | **Withdrawal** | **Assertiveness** | **Negotiation** | **Eliciting support** |
| *Conflict with sibling* over TV | *Sample quote* | *"I'll hit her"* | *"I'll leave him and just go away"* | *"I'll tell him that I was watching first"* | *"Maybe he can watch the other thing for another half hour"* | *"I'll go tell my mommy 'cause she said he mustn't do it anymore and he mustn't bite me"* |
| | *Pre-test* | Two boys indicated that they would use force | The other two boys chose to withdraw to avoid the conflict | | | |
| | *Post-test* | One boy chose to use force on post-test as well | One boy chose to withdraw on post-test as well | The other two boys chose to assert that it was their turn for TV time; they would attempt to negotiate with their sibling; and ultimately elicit support from a parent if the above strategies failed | | |

| SCENARIO 5 | | Defiance | Obedience and responsibility | No response |
|---|---|---|---|---|
| *Conflict with parents:* told by parents that he has to study for a test instead of play outside | *Description & sample quote* | *"I will go play ... I won't study"* | Obedience to parents but also indicates sense of responsibility for self, as well as delayed gratification<br>*"I will first go study, the maybe play later if I can ... The next day I will feel confident for the test"* | *"I can't talk about that now... look, a squirrel ... "* |
| | *Pre-test* | Three boys chose to defy their parents | | One boy did not answer the question despite prompting from the researcher |
| | *Post-test* | Two boys chose to disobey their parents | The other two boys chose to obey their parents and indicated that to study before a test would be the responsible thing to do | |