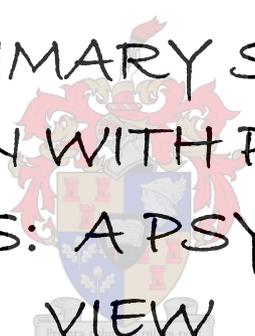


DEPARTMENT OF SOCIAL WORK

UNIVERSITY OF STELLENBOSCH

EQUINE-ASSISTED THERAPY
FOR PRIMARY SCHOOL
CHILDREN WITH PHYSICAL
DISABILITIES: A PSYCHOSOCIAL
VIEW

A faint, semi-transparent watermark of the University of Stellenbosch crest is centered behind the title text. The crest features a shield with various symbols, topped by a crown and flanked by two figures.

AVRIL HELFER

EQUINE-ASSISTED THERAPY FOR
PRIMARY SCHOOL CHILDREN WITH
PHYSICAL DISABILITIES: A
PSYCHOSOCIAL VIEW

by

AVRIL HELFER

Thesis presented in partial fulfilment of the
requirements for the degree of Master of Social
Work at the University of Stellenbosch.

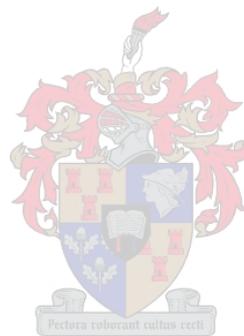


SUPERVISOR: PROFESSOR S. GREEN

December 2006

DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis, is my own original work and that I have not previously in its entirety or in part submitted it at any university for a degree.



Signature

Date

SUMMARY

This study endeavours to understand the psychosocial functioning of primary school children involved in a therapeutic horse-riding program. A qualitative study was done using an exploratory research design.

Much research has been documented regarding the physical benefits of equine-assisted therapy. Little research has however been done regarding the psychosocial functioning of children involved in such projects, and in the field of social work, not much research has been conducted to the knowledge of the researcher. This study was thus motivated by the current lack of research in this area and by the desire to discover whether this form of therapy has a place within the social work field.

The literature study firstly explored the various physical disabilities that are most commonly encountered in the therapeutic riding world, namely cerebral palsy, spina bifida, muscular dystrophy and epilepsy. The developmental milestones of the primary school child were explored with a view to how these physical disabilities may effect the reaching of these developmental milestones.

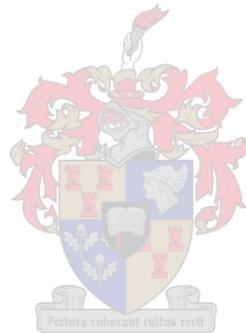
The concept of rehabilitation psychology was then explored, comparing it with various social work methods, popular theories and perspectives and it was found that there were many overlaps in the two fields. Lastly, the literature study looked at equine-assisted therapy and research that has already been done on this topic.

The empirical investigation consisted of case studies on five primary school children from Astra School for the Physically Disabled. A qualitative investigation was done, by means of a focus group held with various key team players in the therapy such as the physiotherapists and riding instructors. Individual interviews were then held with each of the five children. An interview guide was used for both the focus group and the individual interviews.

The findings of the investigation were in line with what was found in the literature study, namely that these physically disabled children struggled in reaching their

psychosocial developmental milestones. The riding however was shown to have made a significant contribution in the areas of social participation, confidence, self-image, emotional control, discipline and cognitive and educational stimulation in each of the five children concerned.

Rehabilitation philosophy and psychology were found to be in line with much of what social work aims to achieve. In light of the fact that equine-assisted therapy was shown to be a viable means of rehabilitation, and therefore a viable means of reaching social work goals with physically disabled clients, recommendations were made in terms of social work practice, social work theory, social work training, social work research and social work policy regarding the physically disabled client.



OPSOMMING

Hierdie studie is onderneem om begrip te ontwikkel vir die psigo-sosiale funksionering van die laerskoolkind wat aan 'n terapeutiese perdry program deelneem. 'n Kwalitatiewe studie is gedoen en 'n verkennende navorsingsontwerp is vir die doel benut.

Daar is aansienlike navorsing gedoen oor die fisiese voordele van terapeutiese perdry. Baie min navorsing is egter gedoen oor die psigo-sosiale funksionering van kinders wat aan hierdie tipe projekte deelneem, en op die gebied van maatskaplike werk is weinig navorsing tot dusver oor terapeutiese perdry gedoen. Dié studie is dus gemotiveer deur die tekort aan navorsing op die gebied, asook deur die navorsers se begeerte om vas te stel of terapeutiese perdry 'n plek binne die gebied van maatskaplike werk kan vind.

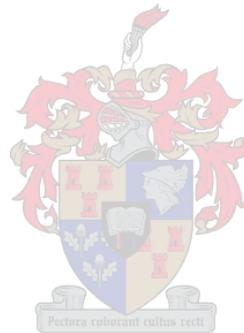
Die literatuurstudie fokus eerstens op die fisiese gestremdhede wat gereeld in die terapeutiese perdry wêreld aangetref word, byvoorbeeld serebrale verlamming, mukulere distrofie, spina bifida en epilepsie. Die literatuurstudie dek ook die ontwikkelingsake wat die laerskoolkind moet bemeester asook hoe die gestremdhede die bemeestering van lewensake beïnvloed.

Onderzoek is ingestel na die konsep rehabilitasie. Dit is vergelyk met maatskaplike werk metodes, gewilde teorieë en perspektiewe en dit is gevind dat daar baie ooreenkomste bestaan. Laastens dek die literatuurstudie die 'kuns' van terapeutiese perdry en navorsing wat reeds daarvoor gedoen is.

Die empiriese studie bestaan uit gevallestudies van vyf laerskool kinders van Astra Skool vir Fisiese Gestremde Kinders. 'n Kwalitatiewe studie is gedoen deur 'n fokus groep met belangrike rolspelers in die terapeutiese perdry program te hou, byvoorbeeld, die fisioterapeut en die perdry afriger. Individuele onderhoude is ook gevoer met elk van die vyf kinders. 'n Onderhoudskedule is gebruik vir die fokus-groep en die individuele onderhoude.

Die resultate van die studie stem ooreen met die bevindinge van die literatuurstudie. Met ander woorde, die fisies gestremde kinders ondervind probleme tydens hulle ontwikkelingstake. Die terapeutiese perdry het gewys dat dit 'n positiewe bydrae maak tot aspekte soos sosiale ontwikkeling, self-vertroue, self-konsep, emosionele – beheer, dissipline en kognitiewe stimulering.

Met die literatuurstudie is bevind dat daar ooreenkomste is tussen rehabilitasie filosofie en dit wat maatskaplike werk wil bereik. Aangesien bewys is dat terapeutiese perdy 'n benutbare vorm van rehabilitasie is, is aanbevelings gemaak vir die maatskaplike werk praktyk, maatskaplike werk teorie, maatskaplike werk opleiding, maatskaplike werk navorsing en maatskaplike werk beleid soos die van teopassing is op die fisiese gestremde kind.



RECOGNITION

A sincere thank you to the following people and organisations:

- **My Lord Jesus** – He helped me put this thesis together.
- **My husband** for keeping me motivated.
- Everyone at **SARDA** Constantia for their patient cooperation.
- **Astra School for Physically Disabled Children** for the participation of the children in the case studies.
- And last, but not least, **Professor Green** for reading through hundreds and hundreds of pages of my work!

<u>TABLE OF CONTENTS</u>	<u>PAGE</u>
 CHAPTER 1: INTRODUCTION	
1.1 MOTIVATION FOR THE STUDY	1
1.2 PROBLEM STATEMENT	3
1.3 AIM AND OBJECTIVES OF THE RESEARCH	3
1.3.1 AIM	3
1.3.2 OBJECTIVES	4
1.4 DEFINITION OF CONCEPTS	4
1.4.1 EQUINE-ASSISTED THERAPY	4
1.4.2 REHABILITATION	5
1.4.3 DISABILITY	5
1.4.4 PSYCHOSOCIAL	6
1.5 DELIMITATION OF THE RESEARCH AREA	6
1.6 RESEARCH METHODOLOGY	6
1.6.1 LITERATURE STUDY	7
1.6.2 EMPIRICAL INVESTIGATION	7
1.6.2.1 Target group	8
1.6.2.2 Ethics	8
1.6.2.3 Interviewing	9
1.7 DATA PROCESSING PROCEDURE	10
1.8 LIMITATIONS OF THE STUDY	11
1.9 PRESENTATION OF THE STUDY	12
 CHAPTER 2: PHYSICAL DISABILITIES AND THEIR PSYCHOSOCIAL DEVELOPMENTAL IMPLICATIONS	
2.1 INTRODUCTION	14
2.2 MIDDLE CHILDHOOD DEVELOPMENT	15
2.2.1 PHYSICAL DEVELOPMENT	16

2.2.2	COGNITIVE DEVELOPMENT	17
2.2.3	PSYCHOSOCIAL DEVELOPMENT	18
2.2.3.1	The extension of social participation	18
	a) Co-operation	19
	b) Helping / Empathy	19
	c) Peer relationships	20
2.2.3.2	The acquisition of greater self-knowledge	22
	a) Self concept	23
	b) Psychological development	25
	c) Emotional development	25
2.2.3.3	Moral judgement and behaviour	26
2.3	COMMON PHYSICAL DISABILITIES AMONG CHILDREN	28
2.3.1	CEREBRAL PALSY	28
	2.3.1.1 Definition	29
	2.3.1.2 Causes	29
	2.3.1.3 Types	30
	2.3.1.4 Associated impairments	32
2.3.2	SPINA BIFIDA	32
	2.3.2.1 Definition	33
	2.3.2.2 Causes	33
	2.3.2.3 Associated impairments	34
2.3.3	EPILEPSY	34
	2.3.3.1 Definition	34
	2.3.3.2 Causes	35
	2.3.3.3 Types	35
	2.3.3.4 Associated impairments	36
2.3.4	MUSCULAR DYSTROPHY	37
	2.3.4.1 Definition	37
	2.3.4.2 Types	37
2.4	PSYCHOSOCIAL CHALLENGES OF PHYSICAL DISABILITIES	39



2.4.1	PSYCHOSOCIAL CHALLENGES REGARDING THE EXTENSION OF SOCIAL PARTICIPATION	39
2.4.2	PSYCHOSOCIAL CHALLENGES REGARDING THE ACQUISITION OF GREATER SELF-KNOWLEDGE	42
2.4.3	PSYCHOSOCIAL CHALLENGES REGARDING MORAL DEVELOPMENT AND BEHAVIOUR	44
2.5	SUMMARY	45

CHAPTER 3: REHABILITATION AND SOCIAL WORK METHODS

3.1	INTRODUCTION	47
3.2	REHABILITATION	47
3.2.1	REHABILITATION PHILOSOPHY	48
3.2.2	COMPONENTS OF REHABILITATION	50
3.2.2.1	Medical rehabilitation	51
3.2.2.2	Educational rehabilitation	51
3.2.2.3	Psychological rehabilitation	52
	a) Rehabilitative application of Freud's psychoanalytic theory	52
	b) Rehabilitative application of person-centred theory	53
	c) Rehabilitative application of gestalt therapy	54
	d) Rehabilitative application of rational emotive therapy	54
3.2.2.4	Social rehabilitation	55
	a) Social skills training	55
	b) Social support	56
3.3	HINDRANCES TO REHABILITATION	56
3.4	REHABILITATION AND SOCIAL CASEWORK, GROUP WORK AND COMMUNITY WORK	57
3.4.1	SOCIAL CASEWORK	57
3.4.1.1	Principles of casework	58
3.4.1.2	Perspectives, theories and models of social casework	59

3.4.2 SOCIAL GROUP WORK	60
3.4.2.1 The value and principles of group work	60
3.4.2.2 Types of groups	61
3.4.2.3 Group work with children	63
3.4.3 SOCIAL COMMUNITY WORK	64
3.4.3.1 Principles of community work	64
3.5 REHABILITATION AND SOCIAL WORK PRACTICE PERSPECTIVES	65
3.5.1 STRENGTHS PERSPECTIVE	66
3.5.1.1 Basic assumptions of the strengths perspective	66
3.5.2 DEVELOPMENTAL PERSPECTIVE	67
3.5.2.1 The developmental perspective made South African	67
3.5.2.2 Values and principles of the developmental approach	68
3.6 REHABILITATION AND SOCIAL WORK	69
3.6.1 SHARED PRINCIPLES	71
3.6.2 SHARED THEORIES	72
3.7 SUMMARY	73



CHAPTER 4: EQUINE-ASSISTED THERAPY: A PSYCHOSOCIAL VIEW

4.1 INTRODUCTION	75
4.2 HISTORY	75
4.2.1 HISTORY OF THE SOUTH AFRICAN RIDING FOR THE DISABLED ASSOCIATION (SARDA)	77
4.3 AIMS OF THERAPEUTIC RIDING	79
4.3.1 PHYSICAL AIMS FOR CHILDREN WITH CEREBRAL PALSY	79
4.3.2 PHYSICAL AIMS FOR CHILDREN WITH SPINA BIFIDA	79

4.3.3 PHYSICAL AIMS FOR CHILDREN WITH EPILEPSY	80
4.3.4 PHYSICAL AIMS FOR CHILDREN WITH MUSCULAR DYSTROPHY	80
4.4 PSYCHOSOCIAL AIMS OF THERAPEUTIC RIDING	81
4.4.1 LANGUAGE AND COMMUNICATION	81
4.4.2 CONCENTRATION	82
4.4.3 INDEPENDENCE	82
4.5 BENEFITS OF RIDING	83
4.5.1 PHYSICAL BENEFITS	83
4.5.2 SOCIAL BENEFITS	85
4.5.3 PSYCHOLOGICAL BENEFITS	85
4.5.4 LANGUAGE BENEFITS	87
4.5.5 EDUCATIONAL BENEFITS	88
4.6 REPORTS FROM THERAPEUTIC RIDING CENTRES	89
4.7 THERAPEUTIC RIDING AND SOCIAL WORK	90
4.8 SUMMARY	91

**CHAPTER FIVE: PSYCHOSOCIAL ASPECTS OF EQUINE-ASSISTED
THERAPY FOR THE PHYSICALLY DISABLED
PRIMARY SCHOOL CHILD.**

5.1 INTRODUCTION	92
5.2 EMPIRICAL STUDY	93
5.2.1 RESEARCH METHOD	93
5.2.2 SAMPLE SELECTION	93
5.2.3 METHODS OF DATA COLLECTION	95
5.2.3.1 Focus Group	95
5.2.3.2 Interviews with the children	96
5.3 RESULTS OF THE STUDY	97
5.3.1 CHILD A	98
5.3.1.1 Profile of participant	98
5.3.1.2 Social behaviour	98

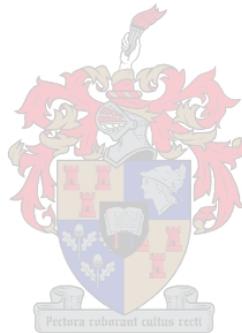
5.3.1.3	Confidence and self-image	99
5.3.1.4	Emotions	100
5.3.1.5	Discipline	100
5.3.1.6	Cognitive or educational stimulation	100
5.3.2	CHILD B	100
5.3.2.1	Profile of participant	100
5.3.2.2	Social behaviour	101
5.3.2.3	Confidence and self-image	101
5.3.2.4	Emotions	102
5.3.2.5	Discipline	102
5.3.2.6	Cognitive or educational stimulation	102
5.3.3	CHILD C	102
5.3.3.1	Profile of participant	102
5.3.3.2	Social behaviour	103
5.3.3.3	Confidence and self-image	103
5.3.3.4	Emotions	104
5.3.3.5	Discipline	104
5.3.3.6	Cognitive or educational stimulation	104
5.3.4	CHILD D	105
5.3.4.1	Profile of participant	105
5.3.4.2	Social behaviour	105
5.3.4.3	Confidence and self-image	105
5.3.4.4	Emotions	106
5.3.4.5	Discipline	106
5.3.4.6	Cognitive or educational stimulation	106
5.3.5	CHILD E	107
5.3.5.1	Profile of participant	107
5.3.5.2	Social behaviour	107
5.3.5.3	Confidence and self-image	107
5.3.5.4	Emotions	108
5.3.5.5	Discipline	108
5.3.5.6	Cognitive or educational stimulation	108
5.3.6	INSIGHT INTO THE LIFE PHASE AND DISABILITIES OF THE CASE STUDIES	108

5.3.6.1	Life phase	108
5.3.6.2	Disabilities	110
5.3.6.3	Psychosocial challenges as a result of a disability	111
5.4	DISCUSSION OF THE FINDINGS	112
5.4.1	PROFILE OF THE PARTICIPANT	112
5.4.2	SOCIAL BEHAVIOUR	113
5.4.2.1	Relationships with peers	113
5.4.2.2	Relationships with helpers	114
5.4.2.3	Relationship with the horse	114
5.4.3	CONFIDENCE AND SELF-IMAGE	115
5.4.3.1	Feelings about themselves	115
5.4.3.2	Response to challenges and games	116
5.4.3.3	Sense of achievement	116
5.4.4	EMOTIONS	117
5.4.4.1	Positive emotions	117
5.4.4.2	Emotional interaction and skills	117
5.4.4.3	Emotional control	118
5.4.5	DISCIPLINE	118
5.4.6	COGNITIVE OR EDUCATIONAL STIMULATION	119
5.4.6.1	Concentration	119
5.4.6.2	Knowledge expansion	119
5.5	SUMMARY	120

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1	INTRODUCTION	121
6.2	CONCLUSIONS	122
6.2.1	THE EXTENSION OF SOCIAL PARTICIPATION	122
6.2.2	THE ACQUISITION OF GREATER SELF-KNOWLEDGE	123
6.2.2.1	Self-image	123
6.2.2.2	Emotions	123

6.2.3 THE DEVELOPMENT OF MORAL JUDGEMENTS AND BEHAVIOUR	124
6.3 RECOMMENDATIONS	125
6.3.1 SOCIAL WORK PRACTICE	126
6.3.2 SOCIAL WORK THEORY	126
6.3.3 SOCIAL WORK TRAINING	127
6.3.4 SOCIAL WORK RESEARCH	127
6.3.5 SOCIAL WORK POLICY	128
6.4 CONCLUDING REMARKS	128
BIBLIOGRAPHY	130
ADDENDUM A – E	



<u>TABLES</u>		<u>PAGE</u>
TABLE 2.1	Cerebral palsy by physiological type.	31
TABLE 2.2	Cerebral palsy by distribution.	31
TABLE 4.1	The benefits of therapeutic riding as they relate to the applicable developmental milestones.	89
TABLE 5.1	A representation of the demographics of the children who met the criteria for inclusion.	95

<u>FIGURES</u>		<u>PAGE</u>
FIGURE 2.1	An outline of the contents of chapter 2.	14
FIGURE 2.2	The development of the self concept in middle childhood.	24
FIGURE 2.3	The pattern of social malintegration for children with physical disabilities.	42
FIGURE 2.4	A graphic representation of the contents of the chapter.	45
FIGURE 3.1	A diagrammatic representation of the components of rehabilitation for those with disabilities.	50
FIGURE 3.2	A diagrammatic representation of the shared principles of rehabilitation and social casework, group work and community work.	71
FIGURE 3.3	A diagrammatic representation of the shared theories used in both rehabilitation and social casework, group work and community work.	72

CHAPTER 1: INTRODUCTION

1.1 MOTIVATION FOR THE STUDY

Individuals with disabilities have always been a *social phenomenon*, yet 'Disabled People South Africa' reflect on how internationally, society has changed from seeing such individuals as weak and helpless, to the current situation where these individuals are taking up their rightful place in society. This has largely been due to the 'rising up' of the disabled community in being active participants in determining their care and by challenging their discrimination (Pocket Guide on Disability Equity, 2001:45–48).

In 1995 South Africa had an estimated disability prevalence of approximately 5 % (Office of the Deputy President, 1997: 1). Attention however, is drawn to the Western Province where the study will be conducted.

In the Western Cape, two percent of children between the ages of 0 and 17 are affected by a physical disability (including intellectual and emotional disabilities). What is of concern is that among these 29 796 children, 32 % neither attend any educational nor support centres (Statistics South Africa, 2001). It is thus reasonable to assume that 32 % of the children with disabilities in the Western Cape are neither receiving any therapeutic nor support services.

Whitney (2003: 1) conducted a study in a United States Massachusetts General Hospital and found that children with disabilities involving learning or communication impairments are significantly more likely to experience poor psychosocial adjustment than their peers. The author adds that family stressors, such as poverty, increase the risk of poor psychosocial adjustment e.g. anxiety, depression, hostility or poor interaction with their peers.

The White Paper on an Integrated National Disability Strategy (Office of the Deputy President, 1997: 2) mentions that in South Africa "...there is a higher proportion of disabled people amongst the very poor...where there is a lack of educational and recreational facilities..." It can be seen therefore, that the children with disabilities in South Africa are disproportionately prone to psychosocial problems.

The White Paper on an Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) states that “(a)ccess to appropriate rehabilitation services can make the difference between leading an isolated and economically dependent life and playing an active role in society.” One of the objectives of the White Paper on an Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) is to enable the disabled to reach and maintain their optimal physical, sensory, intellectual, psychiatric, and/or social functional levels. It mentions that the appropriate training of people involved in rehabilitation services is a core component of reaching this objective and that personnel and other rehabilitation workers include amongst others: therapists, psychologists and **social workers**.

Benda, McGibbon and Grant (2003: 818) explain that children with disabilities at times require life-long therapy. These authors refer specifically to physiotherapy. However, social workers understand that psychosocial support/therapy may also be a life-long necessity. It may be difficult to find means of therapy that will address the specific impairment, improve general functioning and still maintain the interest and enthusiasm of the child. Benda et al. (2003: 824) state that equine-assisted therapy is a “...therapeutic strategy that may fill an existing void in the care of a child with a life-long, chronic disability and offers the parent and the pediatrician, a valuable treatment option.” Social workers too are involved in work with the disabled in every area (Asch & Mudrick, 1995: 756) and equine-assisted therapy can thus be an important therapeutic option for the **social worker** as well.

What is clear is that there is a lack of greatly needed therapeutic and recreational facilities for South African children with disabilities. Heimlich (2001: 48) recognizes that though there is ever increasing support for the use of animals in therapy, there is little empirical research evaluating such programs. Although focusing more on children with cerebral palsy, Benda et al. (2003: 818) claim that there is little objective research to document the widespread clinical impression of the benefit of equine-assisted therapy reported by therapists, parents and pediatricians. They mention that many studies recognize the physical benefits of equine-assisted therapy, but make no reference to the emotional, psychological or social elements of equine-assisted therapy. This indicates a gap in research regarding the holistic experience of equine-assisted therapy. Gatty (2004: 1) supports Benda et al’s (2003: 818) claim by

stating that “(t)here is much literature that supports the use of therapeutic riding and hippotherapy for improving physical well-being, however, mostly anecdotal reports support the positive effects that this form of therapy can have on a child’s emotional well-being.”

The researcher is currently involved with the South African Riding for the Disabled Association, Constantia, Cape Town, as a volunteer helper and candidate instructor. Considering the large numbers of children that need to be reached and the fact that equine-assisted therapy can be administered in groups, it can be advantageous to the disabled children’s community of the Western Cape.

1.2 PROBLEM STATEMENT

As can be seen from above, there is a very large percentage of physically disabled children in South Africa and specifically in the Western Cape, who are not receiving adequate therapeutic services. Research shows that children with physical disabilities are significantly more likely to experience developmental difficulties, making therapeutic services of utmost importance (Whitney, 2003: 1). As The White Paper on an Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) states, “(a)ccess to appropriate rehabilitation services can make the difference between leading an isolated and economically dependent life and playing an active role in society.” Equine-assisted therapy offers a holistic means of rehabilitation for these children and as identified by Benda et al. (2003: 824), it is a valuable treatment option that can be used for the physically disabled child.

1.3 AIM AND OBJECTIVES OF THE RESEARCH

1.3.1 AIM

The aim of the study is to present a description of the psychosocial elements of equine-assisted therapy for physically disabled primary school children.

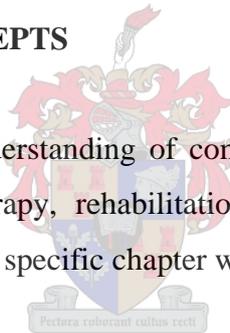
1.3.2 OBJECTIVES

To reach the aim of the study, the following objectives are set out:

- To describe the different types of physical disabilities and the effects thereof on the psychosocial development of the primary school child.
- To explain psychosocial rehabilitation of the physically disabled primary school child from a social work perspective.
- To describe the physical, psychological, emotional, cognitive and social benefits of equine-assisted therapy for children with disabilities.
- To investigate the psychosocial dynamics occurring in primary school children who have participated in an equine-assisted therapy program at the South African Riding for the Disabled Association.

1.4 DEFINITION OF CONCEPTS

To ensure uniformity in the understanding of concepts, the following concepts are defined i.e. equine-assisted therapy, rehabilitation, disability and “psychosocial”. Concepts that are used solely in a specific chapter will be defined in that chapter.



1.4.1 EQUINE-ASSISTED THERAPY

Lechner, Feldhaus, Gudmundsen, Hegermann, Michel, Zäch and Knecht (2003: 502) make a distinction between *therapeutic horseback riding*, which they explain as teaching riding skills to individuals with disabilities, and *hippotherapy*, explained as a neurophysiological treatment using the movement of the horse. Benda et al. (2003: 818) describe hippotherapy as a physical therapy treatment that uses the movement of the horse to improve posture, balance and overall function. For the purpose of the study, **equine-assisted therapy** will encompass both the concept of *hippotherapy* and *therapeutic riding* and any other associated equine activities, e.g. vaulting.

1.4.2 REHABILITATION

According to Reber (1995: 651), **rehabilitation** is to restore to a good form or proper functioning condition. Swanell (1980: 484) mentions a similar definition namely “to restore to previous condition, normal health or capacity.”

For the purpose of this study, **rehabilitation** will follow on from the above definitions and coincide with one of the goals of the White Paper on an Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) namely, to enable the disabled to reach and maintain *their optimal* physical, sensory, intellectual, psychiatric, and/or social functional levels.

1.4.3 DISABILITY

Individuals, organizations and government agencies define disability in different ways. Despite these differences, there is consensus that a person with a disability can have either a permanent physical or mental impairment, or a chronic health or mental health condition, which may be visible or invisible to others, may be present at birth or begin at any age (Asch, s.a: 752). Annicchiarico, Gilbert, Cortés, Campana and Caltagirone (2004: 835) define disability more specifically as “...the difficulty or inability to independently perform basic activities of daily living or other tasks essential for independent living without assistance.”

Disabled People South Africa in their *Pocket Guide on Disability Equity* (2001: 5-6), cover four definitions of disability, namely

- The biomedical definition, where disability is associated with illness and impairment and focus is on the ‘curing’ of the person.
- The philanthropic definition, where disability is looked upon with sympathy and the view is that such people should be ‘cared for’ in institutional settings.
- The sociological definition, where disability is seen as a “...form of human difference or deviation from the social norms of the acceptable levels of activity performance.”

- The economic definition, where disability is seen as a social cost, owing to the extra care that people with disabilities require and to their limited ability to work productively (as compared to able bodied people).

While embracing the above views on disability, for the simplification of the study, the definition of disability will lean more towards that of Annicchiarico. More simply put, “A disability is the lack or loss of a function or a capacity” (Thomas, 1978: 4).

1.4.4 PSYCHOSOCIAL

The term psychosocial is “(g)enerally, a grab-bag term used freely to cover any situation where both psychological and social factors are assumed to play a role” (Reber, 1995: 620).

Thomas (1978: 4) concludes that when one focuses on the social psychology of a person with a disability, one would take into consideration the handicapped persons behaviour, attitudes, impression formation and preferences.

1.5 DELIMITATION OF THE RESEARCH AREA

The study was done at The South African Riding for the Disabled Association (SARDA), Constantia, Cape Town. SARDA, Cape Town, catered for 202 children in 2004 (SARDA National Statistics – Census: 2004) with 11 qualified instructors presenting the lessons. The universe consists of these 202 children participating in equine-assisted therapy at SARDA, Cape Town. The target group consists of five of these children between the ages of seven and twelve. They are of mixed genders, race and disabilities.

1.6 RESEARCH METHODOLOGY

A literature study, supplemented by an empirical investigation, was done for the purpose of this research.

1.6.1 LITERATURE STUDY

The literature study involves an exploration of the developmental phases of the age group pertaining to this study, namely middle childhood (seven to twelve years). The various physical disabilities common to SARDA are discussed. It is then looked at what challenges these children face in their developmental milestones as a result of their disabilities.

The literature study also covers the gist of rehabilitation philosophy and the common methods and practice frameworks used in social work. The attempt is then made to point out how equine-assisted therapy as a means of rehabilitation for the physically disabled fits into the social work field.

South African as well as international literature is used in compiling the literature study. Sources include scientific journals, encyclopaedias, books and government policy documents from social work but also from related fields of psychology, sociology, physiotherapy, occupational therapy and medicine.

The gist of the study is to show that equine-assisted therapy is a valuable means of rehabilitation for the physically disabled primary school child, and that it can be utilized effectively by social workers in their work with their physically disabled clients.

1.6.2 EMPIRICAL INVESTIGATION

The empirical investigation is based on the literature study and is aimed at exploring and describing psychosocial dynamics in disabled primary school children that have participated in equine-assisted therapy.

In the empirical investigation, the researcher wishes to satisfy a curiosity and desire for better understanding of the psychosocial elements of equine-assisted therapy, making the study **exploratory** (Babbie, 1989: 80). As mentioned in the “motivation for the study”, much is known on the physical advantages of equine-assisted therapy, yet very little is known on the psychosocial elements that the researcher wishes to

explore. There is thus support for Babbie's notion of the study being **exploratory** as Ferreira (2001: 21) and Fouché (2002: 109) agree that exploratory studies aim to explore a relatively unknown terrain.

The study endeavours to understand the psychological and social aspects of equine-assisted therapy, leading to a more holistic outlook on this form of therapy. Fouché (2002: 109) recognizes this desire for a "thicker description" as being a **descriptive** study.

1.6.2.1 Target group

Non-probability selection sampling took place as a **convenience sample** is used i.e. the sample is aimed at a part of the population which is readily available (Ferreira, 2001: 42), namely, the children riding at SARDA. The target group consists of approximately five of these 202 children between the ages of seven and twelve. They are of mixed genders, race and disabilities.

The target group was taken from the first group attending on a Thursday morning. They are from Astra School and vary in number each week, between four and seven children – i.e. the children take turns coming each week. This group was chosen for convenience purposes, as this is the group that the researcher is using in training as a candidate instructor. Each of the five children involved in the case studies met the criteria for inclusion, namely that they were between the ages of seven and twelve years old and each had a physical disability. As the school that was used is in a coloured residential area, all of the children included were coloured.

1.6.2.2 Ethics

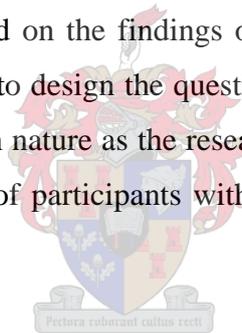
Written permission and support was received from SARDA to undertake the research within their organization (see addendum A). The researcher understands that informed consent ensures the co-operation of the subjects and clears up any existing concerns that they may have (Strydom, 2002: 66). In keeping with the ethical code of the South African Council for Social Service Professions (South Africa Republic, 1986), namely to "...respect the client's right to decide whether or not to cooperate

with the social worker...” the respondents were thoroughly informed as to the aims and most important details of the study. Written permission was received from Astra School to involve five of their pupils in case studies (see addendum B). Written permission was also obtained from the guardians of two of the school pupils who were day-scholars (see addendum C).

1.6.2.3 Interviewing

Semi-structured interviewing by means of interview guides (see addendum E) was utilized on the identified children, the children’s helpers and their schoolteachers/therapists. The same information was sought from the different participants, but obviously questions were structured accordingly, i.e. to the age, vocation and role of the participant.

The interview guides were based on the findings of the literature study; therefore a deductive process was followed to design the questionnaire (Grinell, 1998: 327). The research is **mainly qualitative** in nature as the researcher aims to “describe the social reality from the points of view of participants within the systems studied” (Epstein, 1988: 188).



A focus group was held with the helpers, instructor and therapist of this group of children, utilizing the interview guide (see addendum D). The group involved in the empirical investigation can be regarded as a focus group, as they perfectly fit the description of a ‘focus group’ as explained by Greeff (2002: 306) in that it was a group focused on a topic, namely equine-assisted therapy. The environment was one that encouraged the participants to “...share perceptions, points of view, experiences, wishes and concerns, without pressurizing participants to vote or reach a consensus.” Each child was discussed individually within the group.

The respective children were then interviewed individually at their school. Kvale (as cited by Greeff: 2002) explains the usefulness of the interview in learning about people’s experiences. He says that the qualitative interview “attempts to understand the world from the participant’s point of view, to unfold the meaning of people’s experiences [and] to uncover their lived world prior to scientific explanations”, which

is exactly what the researcher was wanting from the children. From the information gathered from both the focus group and the individual interviews, five case studies were compiled to determine the psychosocial functioning of these children while participating in the therapeutic riding programme.

The child was an obvious choice as a participant in the study, as the child can best explain ¹his experience of horse riding. The helpers were chosen as participants in that they are present during each riding session. They have observed the children, know them well and are in a position to describe the psychosocial dynamics of these children. (A Handbook for Volunteer Helpers, s.a: 7) The therapist and instructor were chosen as participants in that they understand the disabilities of the children, have professional training in the development of children and are thus able to offer a more professional and objective opinion.

1.7 DATA PROCESSING PROCEDURE

Case studies on the five respective children are presented; comparing the data gathered from the children themselves, the lay observers (i.e. the helpers) and professionals (i.e. the therapist and instructor). Case studies were chosen as the researcher wished to have a rich knowledge on each of the participants. As Fouché (2002: 271) explains, the case study seeks to gain as much knowledge on the ‘case’ as possible through various methods such as interviews, documents and observations. This specific study made use of the intrinsic case study method where the aim is to gain a better understanding of the individual case.

Collected data from the empirical investigation (i.e. interviews) is sorted in themes, namely social behaviour, confidence and self-image, emotional control, discipline, and cognitive and educational stimulation. These themes are based on the main developmental milestones that the middle-aged child must reach as identified in the literature study, i.e. the extension of social participation, the acquisition of greater

¹ For the purpose of this study, the term “his” refers to “his or her”, unless indicated otherwise.

For the purpose of this study, the term “him” refers to “him or her”, unless indicated otherwise.

self-knowledge and the development of moral judgement and behaviour. All of the information is presented in a qualitative manner.

1.8 LIMITATIONS OF THE STUDY

There are no equine-assisted therapy projects or therapeutic riding projects to the researcher's knowledge, which are run by or even utilized by social workers in their field. It was therefore not possible to gain insight from social workers as to where equine-assisted therapy fits within the primary methods and common practice frameworks of social work. The empirical investigation was thus done by gaining insight from the children and from those directly involved in the therapy as to the psychosocial functioning of the children who are involved in the riding project. The conclusions and recommendations are based on the findings of the empirical investigation. However, the conclusions and recommendations as they pertain specifically to social work methods and practice frameworks are also largely based on the information gathered in the literature study. It was not possible to gain this information first hand from any social workers involved with equine-assisted therapy, as they do not exist.

Astra School for Physically Disabled Children has two physiotherapists. Only one of these physiotherapists was able to attend the focus group. The other physiotherapist was interviewed individually, however, the same interview guide was used. This may have had an influence on the response of the second physiotherapist, as being in the focus group influences and shapes the topics of conversation and what is said. What the second physiotherapist had to say though, was very similar to what the focus group had said.

Another limitation is that the children were not adequately prepared for the interview and the researcher found the children very quiet. Dworetzky (1995: 298 –301) and Louw, van Ede, Ferns, Schoeman and Wait (1998: 367) mention that between the ages of about seven and nine, children seem to mainly associate with others of the same gender and age. Although they did provide some usable information, all five children were generally quite shy and much probing needed to be done by the interviewer. This may be as a result of the fact that this is the age where they are most

comfortable within their own peer groups and felt a little intimidated and shy towards the older interviewer. The researcher did use relevant information from the individual interviews with the children but found that the focus group provided more substantial information than the children themselves.

As mentioned previously, convenience sampling is used, i.e. the researcher focused on five children from the group that ride on a Thursday morning. The children therefore are not an exact representation of the universe regarding variables such as disability, length of riding, race, age and gender. The generalization of the findings to the universe could therefore possibly be a limitation of the study, as identified by the researcher.

1.9 PRESENTATION OF THE STUDY

In **Chapter one** an orientation is provided as to the motivation of the study. The aims and objectives are outlined and the details of the methodology of the study are laid out. General terms that will be used throughout the study are defined and given meaning.

Chapter two provides a discussion of the various physical disabilities as identified in the SARDA handbook. The psychological and social implications of these respective disabilities on the development of the primary school child enjoys special attention.

A “rehabilitative” perspective is investigated in **chapter three**, in relation to social casework, group work and community work. This will provide the framework and context of the study.

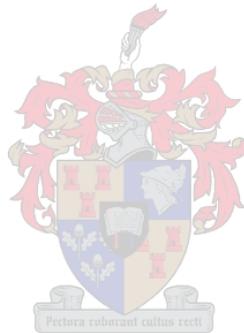
Equine-assisted therapy and related terms such as hippotherapy and therapeutic riding are investigated in the **fourth chapter**. The proven physical, psychological, emotional, cognitive and social advantages of this form of therapy are discussed in depth in this chapter.

Chapter five involves the processing, categorizing and interpreting of the empirical data, as gathered from the interviews. Meaning is assigned to the findings in this

chapter with regards to the psychosocial context of the study and the findings of the literature study.

The conclusions and recommendations based on the literature study and on the empirical investigation are outlined in the **sixth and final chapter**.

The research report can thus be seen to consist of four main parts i.e. an orientation (chapter one), a literature study (chapter two, three and four), an empirical investigation (chapter five) and conclusions and recommendations (chapter six).



CHAPTER 2: PHYSICAL DISABILITIES AND THEIR PSYCHOSOCIAL DEVELOPMENTAL IMPLICATIONS

2.1 INTRODUCTION

In keeping with the psychosocial focus of the study, this chapter presents a discussion on the psychological and social developmental milestones of the middle-aged / primary school child. These milestones form the focus when discussing the identified physical disabilities and their psychosocial implications for the primary school child. The chapter will present a brief overview of the physical and cognitive growth during middle childhood, but will focus primarily on three psychosocial goals of this age, namely: the extension of social participation, the acquisition of greater self-knowledge and the further development of moral judgement and behaviour.

Four common childhood disabilities will be discussed i.e. cerebral palsy, spina bifida, epilepsy and muscular dystrophy. Attention will then be returned to the three psychosocial developmental milestones to investigate how the aforementioned disabilities (and disability generally) affect these milestones.

A graphic representation of this chapter could thus be as follows:

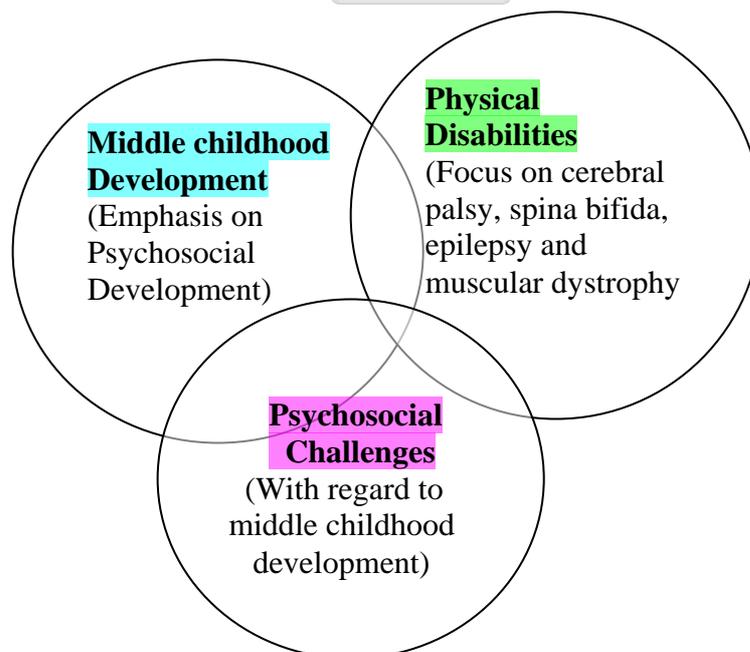


FIGURE 2.1: An outline of the contents of chapter two

As can be seen from the figure, each of these elements will be discussed separately within the chapter, but with a view to understanding how they influence one another and are thus interlinked.

2.2 MIDDLE CHILDHOOD DEVELOPMENT

In order for the social worker to understand the dynamics of equine-assisted therapy for the middle-aged child, there would need to be an understanding of the normal psychosocial development that takes place during this age. This would be necessary to identify important areas that need attention and encouragement. Understanding the norm would also provide a benchmark of what is considered healthy development.

Middle childhood involves the ages of approximately six to twelve years of age (Feldman, 2000: 294; Louw, van Ede, Ferns, Schoeman & Wait, 1998: 322). Although it is a relatively quiet period in terms of physical development, it is an active period as far as cognitive, social, emotional and self-concept development is concerned (Louw et al., 1998: 322).

Feldman (2000: 294) recognises that middle childhood or the “school years” are characterised by physical, cognitive and social advancements. In earlier writings, Louw et al. (1998: 322) identified these advancements or developmental tasks that should be mastered in middle childhood as the following:

- “further refinement of motor skills
- the consolidation of gender-role identity
- the development of various cognitive skills
- the extension of knowledge
- the extension of social participation
- the acquisition of greater self-knowledge
- the further development of moral judgement and behaviour.”

Although, for the purposes of this study, attention will be focused on the latter three tasks, physical and cognitive tasks will also be very briefly discussed.

2.2.1 PHYSICAL DEVELOPMENT

The social worker providing therapy to the middle-aged child would need to understand what physical advancements are made during this age. In practice, it is seen that physical developments have a host of emotional and behavioural implications (e.g. hormones). The social worker would need to have an understanding of what is normal physical development and the accompanying behaviour for this specific age.

Louw et al. (1998: 323) and Feldman (2000: 295) agree that physical growth can be described as *slow and steady* during this phase of life, as compared to the pre-school and adolescent years.

Middle childhood involves a rapid growth of the arms and legs in relation to the body, resulting in the characteristic lanky look of children during middle childhood. Other major changes include the brain reaching adult size, the respiratory system becoming more elastic and functioning more economically, permanent teeth replacing milk teeth and the mastering of a number of psychomotor skills (Louw et al., 1998: 323).

Physically, girls develop more rapidly than boys in the ages ten to eleven. This is the only phase of life where girls are physically taller than boys (Louw et al., 1998: 323; Feldman, 2000: 296).

It can be concluded therefore, that although this phase is observed to be one of more rapid development for girls, there is agreement that for boys and girls, this phase is one of slow but certain physical development and the attainment of greater motor skills. This norm would need to be considered in the context of the physical ability of the child with a physical disability. In certain cases, they may develop greater motor skills in their able areas, whereas with other diseases, such as muscular dystrophy, this is usually the age where physical condition deteriorates (see 2.3.4).

2.2.2 COGNITIVE DEVELOPMENT

As mentioned in the previous section, the social worker needs to have an understanding of the person as a whole and what is normal development for a specific age. It would be important, especially with regards to communication to understand what the cognitions of the middle-aged child should be and to approach him accordingly.

Dworetzky (1995: 39) and Louw et al. (1998: 75) both refer to Jean Piaget, a prominent developmental psychologist, who divided human cognitive development into the following four stages:

- Sensori-motor period (birth to two years).
- Pre-operational period (two to seven years).
- Concrete operational period (seven to twelve years).
- Formal operational period (adolescence).

As can be seen, the middle childhood years fall into the concrete operational period. During the concrete operational period, the following cognitive tasks are mastered (Dworetzky, 1995: 236; Louw et al., 1998: 326–330), namely:

- Classification: the child is able to classify objects on the basis of more than one criterion simultaneously.
- Conservation: the child comes to understand identity, decentring and reversibility.
 - *Identity*: the child understands that the quantitative relationship between things does not change, unless something is added to or taken away from it, even though perceptual changes (transformations) take place.
 - *Decentring*: the child is able to consider various aspects of a matter.
 - *Reversibility*: the child is able to reverse operations in his/her mind.
- Seriation: the child is able to arrange objects in a systematic way from small to large or vice versa.

- Number concept: the child understands the **ordinal** (e.g. that $2 < 3 < 4$) and the **cardinal** (the absolute numerical size) characteristics of numbers as well as number conservation (Louw et al., 1998: 330).

At the completion of the above-mentioned tasks, it can be observed that the middle-aged child is able to (in agreement with Piaget's theory) reason and think logically and is able to see the world realistically and no longer as based on their perceptions alone (Dworetzky, 1995: 236; Feldman, 2000: 307). As the disabilities dealt with in this study are physical disabilities (although some may have associated cognitive impairments), it would be expected that these children's cognitions would follow normal development.

The study is specifically focussing on the psychosocial elements of equine-assisted therapy. The three psychosocial developmental milestones of middle childhood will now be discussed in depth.

2.2.3 PSYCHOSOCIAL DEVELOPMENT

As described in the first chapter, "psychosocial" is a grab-bag term used freely to cover any situation where both psychological and social factors are assumed to play a role (Reber, 1995: 620). Identified earlier were three psychosocial developmental milestones that occur during middle childhood, namely: the extension of social participation, the acquisition of greater self-knowledge and the further development of moral judgement and behaviour. These will be discussed in depth in this section. It is important for the social worker to have knowledge of normal psychosocial development, so as to identify and appropriately deal with any maladjustment that the disabled child may experience.

2.2.3.1 The extension of social participation

The extension of social participation or pro-social behaviour is encouraged throughout a person's life. The development of certain traits such as co-operation, helping/empathy, sharing and the move from egocentrism to sensitivity towards others, equips children for the demands of social participation (Dworetzky, 1995: 246;

Louw et al., 1998: 349). These traits, i.e. co-operation, empathy and the development of peer relationships will be further discussed in this section.

a) Co-operation

According to Dworetzky (1995: 246) co-operation involves two or more people working together for their mutual benefit. He explains how children are often spontaneously cooperative at a young age (i.e. between about four or five years of age), but how by the time they reach high school, individual competition has been reinforced by society to such an extent that co-operation tends to “fade away”. This is especially true for high school boys who tend to correlate competitiveness with self worth, but show little correlation between co-operation and self worth.

Dworetzky (1995: 248) holds the view that by fostering a “we” rather than “I” atmosphere, society can encourage children to work with, rather than against each other. He and Louw et al. (1998: 349) advocate consistently modelling cooperative/altruistic (unselfish) behaviour to children, as well as guiding them in cooperative ventures, that they may learn how others may depend on their actions and increase their sense of social responsibility (i.e. moral development).



b) Helping / Empathy

Helping involves providing services, skills or information needed by another. Middle-aged children are more likely to be of help than preschoolers owing to their greater ability and their greater empathy (Dworetzky, 1995: 249).

Dworetzky (1995: 250) discusses Hoffman’s stages of empathy development, namely:

- Distress reaction (0 – 2 years): the infant is aware that someone in the vicinity is in distress, but not aware of who the person may be.
- Person permanence stage (2 – 7 years): the child is aware of who is in distress, but unable to distinguish that that person has feelings different to his own.

- Role taking (7 – 11 years): the child is able to imagine him-/herself in the distressed person's position and is thus able to respond appropriately.
- Comprehensive empathy (11 years and older): the child is able to understand and empathise with people's general life situations (in a wider context).

The latter two stages are thus applicable to the middle childhood phase. By the time the child reaches adolescence he should be able to have a general understanding and empathy towards the larger population with regard to any particular distress, and should be able to place himself "in their shoes". Louw et al. (1998: 349) supports the notion that children in middle childhood become aware that people have different perceptions from one another and from themselves and that they develop a greater sensitivity towards others.

c) Peer relationships

For the school-aged child, peer relationships are important and create a necessary sense of belonging. In the following section, the necessity and development of peer relationships will be discussed as well as the importance of being accepted within the peer group.

- The necessity of friendships

Dworetzky (1995: 298 –301) and Louw et al. (1998: 367) mention that between the ages of about seven and nine, children seem to mainly associate with others of the same gender and age. At this age, friends become an important source of information (it is with friends that social skills are refined) and the child will use his friends as a standard by which to measure himself (Dworetzky, 1995: 298 – 301; Louw et al., 1998: 367).

Louw et al. (1998: 367) state that peer relationships provide the following:

- comradeship

- opportunities for trying out new behaviours
- transfer of knowledge and information
- opportunities to show obedience to rules
- reinforcement of gender roles
- weakening of the emotional bond between child and parents
- relationships where healthy competition can take place

From the above, it can be deduced that friendships will allow the child to develop an own identity within a safe environment, while reinforcing acceptable and unacceptable behaviour. In a nutshell, friends provide the school going child with a network of social, emotional and moral support (Feldman, 2000: 352).

- The development of peer relationships

Friendships can be seen to move from very informal groups (at about the age of six or seven) to more formal and structured groups, based on the children's different abilities and personalities (Dworetzky, 1995: 298 –301). Louw et al. (1998: 366) agree that greater solidarity and cohesion develops within the peer group during middle childhood and characterise a middle childhood peer group as "... a relatively stable collection of two or more children who interact with one another, share common norms and goals and who have achieved a certain social structure of leaders and followers that ensures ... group goals will be met."

Louw et al. (1998: 368,369) take on the view of Robert Selman (1979) who divided the development of a friendship into the following stages:

- *Stage 0 - Momentary playmateship (3 – 7 years):* During this phase the child forms no real friendships.
- *Stage 1 – On- way support (4 – 9 years):* A friend is described by the child as one who does what he wants him to do.
- *Stage 2 – Two-way fair-weather co-operation (6 – 12 years):* The child realises that friendships require give and take.
- *Stage 3 – Intimate mutually shared relationships (9 – 15 years):* The friendship develops into a meaningful relationship where secrets and feelings are shared.

- *Stage 4 – Autonomous interdependence (12 years and older):* The friends need for dependence and independence is recognised.

It would therefore be expected to observe individuals in middle childhood moving towards more structured and deeper friendships, where intimate support is offered and the child is provided with a place of unconditional acceptance.

- Acceptance and rejection of peers

The kinds of behaviour that make a child an accepted or rejected member of a friendship group differ from group to group. There are however certain common traits that are generally grounds for rejection. Feldman (2000: 355) identifies them as follows; immaturity, acting silly, aggression, hostility to peers, being overbearing, being withdrawn, being obese, thin or “looking funny”. Not being stereotypically attractive might prove to be a vulnerable aspect for the children discussed in this study.

Louw et al. (1998: 369) mention the following characteristics of popular children as identified by Reece (1961), namely that they are friendly, extrovert, cooperative, pleasant, have initiative, are adaptable and conforming, reliable, affectionate, considerate, have a realistic self-image, perform well academically and have higher IQ's than unpopular children.

It can be deduced therefore, that children who possess a greater social competence (i.e. have the skills to perform successfully in a social situation) are generally the popular children (Feldman, 2000: 355).

2.2.3.2 The acquisition of greater self-knowledge

The second psychosocial developmental milestone that occurs during middle childhood is the acquisition of greater self-knowledge. Although not as big an issue as when in adolescence, children in middle childhood attempt to answer the question “who am I?” (Feldman, 2000: 343). When looking at the acquisition of greater self-knowledge during the middle childhood years, the focus will be on how the self-

concept develops and on psychological and emotional development during middle childhood.

a) **Self concept**

Reber (1995: 701) describes the self-concept as “(o)ne’s concept of oneself in as complete and thorough a description as is possible for one to give.” Meyer, Moore and Viljoen (1997: 466) take this further and analyse the self-concept as being how one sees oneself and ones characteristics, how one judges one’s self in terms of appearance, ability, talents, motives, goals, ideals, social interactions and relationships. It can be seen therefore, that the child’s self-concept would be his holistic view of himself.

Hazel Markus and Paula Nurius (as cited in Dworetzky, 1995: 292) discuss four areas in which children in middle childhood refine their self-concept, namely:

- Developing a stable understanding of the self: The child begins to understand the “parts” of himself i.e. that the body, self, mind and brain are separate from one another. Feldman (2000: 343) agrees that the child’s view of himself becomes differentiated and that he comes to understand that he may be good at one task and not so good at another. The child begins to base his self-esteem on his failure or success.
- Understanding how the social world works: The child begins to understand the complexities of social roles and that a person can keep various roles simultaneously, e.g. being both a father and a son. The child understands that other people’s perceptions are different from one another and from his own.
- Developing standards for their own behaviour: The child begins to integrate the standards of society into his own personal system.

- Developing strategies for controlling their behaviour: The child not only adopts the standards of society but also develops strategies to control his behaviour to keep within these standards.

Agreeing with Markus and Nurius (as cited in Dworetzky, 1995: 292) that the child's self-concept becomes more differentiated in middle childhood, Feldman (2000:344) presents the following diagram, explaining how the middle-aged child develops a self-concept.

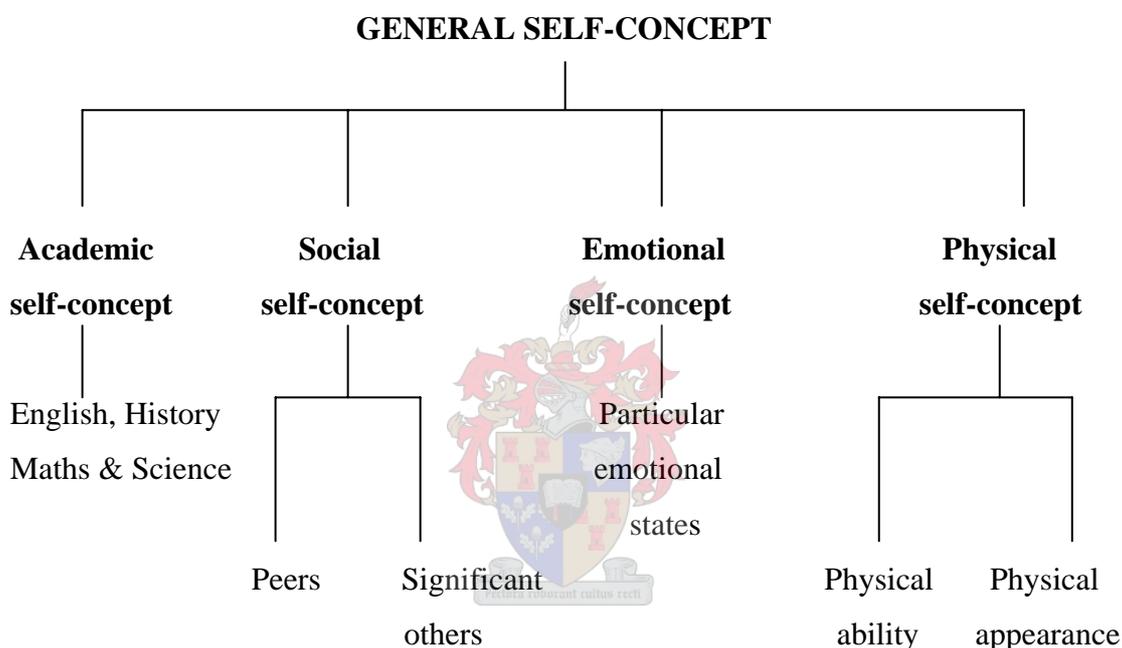


FIGURE 2.2: The development of the self-concept in middle childhood

Source: Feldman (2000:344)

The diagram above shows how the child's overall self-concept is made up of various components. His concept of himself academically is based on how he performs with regards to academic subjects such as English, History, Maths and Science. His social self-concept is based on the way in which he relates to his peers and significant others. His emotional self-concept forms as a result of the emotions that he experiences and the way in which he is able to express them. Lastly, his physical self-concept is based on his opinion of whether he is physically attractive or not and whether he is able to perform certain physical activities with skill, for example sporting activities.

It can be seen from Markus and Nurius (as cited in Dworetzky, 1995: 292) and Feldman (2000: 344) that the individual in middle childhood develops a holistic view of himself. It would follow therefore, that he would now be able to assess himself accurately. Louw et al. (1998: 344) explain that it is in this stage that the child no longer describes himself in terms of mere activities e.g. “I can ride a bike”, but rather in terms of how well the activities can be performed e.g. “I can ride a bike better than my friend”, or as Feldman (2000: 344) puts it – the child begins “...to use social comparison processes to determine levels of accomplishment during middle childhood.” The child also develops a concept of his *real* self, who he really is, and his *ideal* self, who he would like to be (Papalia & Old as cited in Louw et al.:1998: 344).

b) Psychological development

According to Erik Erikson (as cited in Dworetzky, 1995: 292; Louw et al., 1998:53; Feldman, 2000: 345), middle childhood encompasses the phase of *industry versus inferiority*. Between the ages of about six and twelve, the child focuses on successfully performing challenges and tasks that are necessary to survive in the adult world. Performing these tasks with success is very important for the child at this stage and will result in a feeling of confidence and competence. Difficulties in this stage, however, will lead to feelings of failure and inadequacy.

c) Emotional development

Vander Zanden (1993) as mentioned by Louw et al. (1998: 345) states that between the ages of six and eleven, children’s understanding of their emotions / emotional experiences changes. The child begins to recognise internal causes for emotions and is aware of social rules on how to express those emotions. The child becomes more able to control and hide his emotions. He begins to more accurately read facial expressions and realises that one can experience different emotions simultaneously. He shows better understanding of how others are feeling and why.

In summary it can be said that during middle childhood the child becomes emotionally mature, moving away from helplessness towards independence and self-

sufficiency, showing greater emotional flexibility and greater emotional differentiation (Louw et al., 1998: 345).

2.2.3.3 Moral judgement and behaviour

The third developmental milestone is the child's development of moral judgement and behaviour.

Morals are the attitudes and beliefs held by children and by adults that help them to determine what is right and wrong (Dworetzky, 1995: 242). Reber (1995: 469) explains moral development to be the process whereby children acquire these attitudes and beliefs, by internalising the standards of right and wrong of their society.

For the purposes of this chapter, three of the most well known theories, as identified by Louw et al. (1998:372 – 375) regarding moral development will be briefly discussed, namely:

- Freud's psychoanalytic theory

Meyer et al. (1997: 61) explains that Freud held the view that moral development was largely dependent on the child's relationship and identification with his parents. He believed that the child's superego (i.e. his internal censor) took on the moral standards of his parents and that any "breaking" of these would automatically lead to guilt feelings by the child.

Freud divided the personality up into three categories – the id (natural drives which want to be met, e.g. the sexual drive), the ego (finds suitable ways of meeting the drives) and the superego. Moral development, according to Freud can also be seen as the development of the superego. The superego is the part of a person that represents societies morals and forces the person to keep within these morals, by causing guilt feelings for any immoral wishes or behaviour. Freud further saw the superego as having two parts – a punishing part (i.e. the conscience) and a part that encourages moral behaviour (i.e. the ego-ideal). (Meyer et al., 1997: 61).

- Bandura's social learning theory

Although acknowledging that moral values can be taught by instruction, Bandura (as cited in Louw et al., 1998: 372 – 375) focussed on the way in which the child learns behaviour from observing others in his social surroundings, i.e. modelling or observational learning.

As can be seen, both Freud and Bandura place a large emphasis on children learning morals and values through the observation of their family and society and by having these behaviours modelled to them.

- Piaget's developmental theory

Piaget held the view that moral development takes place in a particular sequence, in accordance with the stage of cognitive development that the child is in:

- Children younger than five are premoral, meaning that they do not understand the concept of rules and can therefore not tell if rules have been broken. *(Would fall in sensori-motor and pre-operational periods of cognitive development).*
- Between five and ten, children reach moral realism, meaning that they develop an enormous respect for rules and the fact that they must be obeyed. *(Would fall in pre-operational and concrete operational period of cognitive development).*
- At ten years of age, children show greater moral flexibility and realise that rules can be questioned (autonomous morality). *(Would follow on from concrete operational period into the formal operational period of cognitive development).*

Whether one takes on the view of Freud, Bandura or Piaget, or whether one emphasises that morals are intrinsically kept within people via their superego, or that they are learned through observation; or whether it is agreed that people learn morals in stages as their cognitions develop – one thing is for sure – during middle childhood,

children definitely become aware of certain social rules, develop the means and make the effort to keep them.

Having a sound knowledge of the developmental milestones of middle childhood development, focus will now need to shift to the specific disabilities experienced amongst children. A discussion on the four most common disabilities as identified in practice will receive attention in the following section.

2.3 COMMON PHYSICAL DISABILITIES AMONG CHILDREN

As children at the South African Riding for the Disabled Association are participants in the study, the disabilities that enjoy attention in this chapter are those identified in the SARDA Handbook (SARDA, 1999: Section 10A, p3) as common neurological/physical disabilities among children. These include cerebral palsy, epilepsy, spina bifida and muscular dystrophy.

The researcher has observed that no visually impaired children are presently accommodated at the South African Riding for the Disabled Association (Constantia). Although a group of hearing-impaired children do participate at the South African Riding for the Disabled Association, the researcher is not involved with this group. For these reasons none of the aforementioned disabilities will be discussed in this chapter.

2.3.1 CEREBRAL PALSY

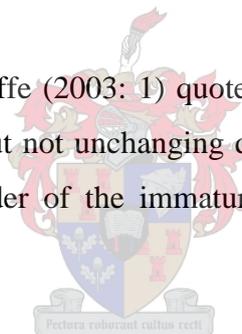
As early as 1862, a man called William Johan Little documented symptoms of cerebral palsy, believing this motor impairment syndrome to be a consequence of adverse events at the time of birth. Cerebral Palsy as a term however, was introduced and popularised by the writings of Sir William Osler (a founding father of modern medicine) in the early nineteen hundreds (Dorman & Pellegrino, 1998: 4).

2.3.1.1 Definition

There is much controversy around the definition of cerebral palsy. “Cerebral” appropriately emphasizes the brain in the condition; however, “palsy” is associated with “paralysis, which suggests a complete lack of movement that is not typical of cerebral palsy (Dormans & Pellegrino, 1998: 5; Hinchcliffe, 2003: 1). Dormans and Pellegrino (1998: 5) do however recognise three important elements that run through all of the definitions offered since the 1980’s, namely that

- Cerebral palsy is associated with significant problems with motor function.
- Motor impairment is a result of something that went wrong in the early development of the brain.
- Cerebral palsy is not progressive.

In line with the above, Hinchcliffe (2003: 1) quotes a modern definition of cerebral palsy as being “(a) persistent, but not unchanging disorder of movement and posture due to a non-progressive disorder of the immature (that is under 2 years of age) brain.”



2.3.1.2 Causes

As mentioned in the definition, cerebral palsy is a result of a disturbance in early brain development. The brain grows most rapidly during the prenatal period and continues rapid growth in the postnatal period. Any insults to the brain prior to the age of three results in neurological impairments such as cerebral palsy. It was previously believed that damage to the brain of the infant occurred as a result of lack of oxygen during birth. There is increasing evidence however, that the damage to the brain occurs even before birth. Babies born prematurely however, are more susceptible to brain damage.

A distinct characteristic of cerebral palsy is that although the motor impairment/functioning as a consequence of cerebral palsy may change or even worsen over time (e.g. due to poor handling or positioning), the actual injury to the

brain (anomaly) that caused the motor impairment remains unchanged (i.e. non-progressive) (Dormans & Pellegrino, 1998: 6; Hinchcliffe, 2003: 1).

The most important aspects to remember therefore are that cerebral palsy is a result of damage to the young brain either before and during birth and that though symptoms may get worse, the actual injury does not.

2.3.1.3 Types

Dormans and Pellegrino (1998: 8) explain that children suffering from cerebral palsy may experience abnormalities of

- Movement: there may be involuntary movements or disturbances of voluntary movements.
- Muscle tone: there may be hypertonia (increased muscle tone) or hypotonia (decreased muscle tone).
- Posture: this refers to the motion of positioning of the parts of the body in relation to one another.

Types of cerebral palsy are classified according to their physiological type and their geographic distribution in the body – the following two tables demonstrate:

TABLE 2.1: Cerebral palsy by physiological type

PHYSIOLOGICAL TYPE	DESCRIPTION
Spasticity	Velocity-dependent resistance to stretch, clasp-knife response, increased deep tendon reflexes (basically very stiff i.e. hypertonic)
Athetoid	Child's tone fluctuates between low and high. Involuntary jerky movements (intermittent tension of trunk or extremities)
Rigidity	Hypertonia, fluctuating tone, prominent primitive reflexes.
Ataxia	Problems with balance and controlling position of body in space. Lack of coordination to perform smooth movements – seen when child tries to carry out fine motor activities – tremor develops in upper limbs (intention tremor).
Hypotonia	Low muscle tone, normal or increased deep tendon reflexes
Mixed	Evidence of two or more physiological types

Sources: Dormans & Pellegrino, 1998: 8; Scherzer, 2001:13; Hinchcliffe, 2003:2

**TABLE 2.2 : Cerebral palsy by distribution**

DISTRIBUTION	DESCRIPTION
Hemiplegia	Arm and leg on same side involved, arm usually more than leg.
Monoplegia	One limb affected (usually arm)
Diplegia	Both sides of the body involves (usually legs more than arms)
Quadriplegia	Both sides of the body affected – both legs and arms
Triplegia	Both sides of body involved – but one limb (usually arm) reasonably spared
Double hemiplegia	Both sides of body involved, but one side is worse than the other (arms usually more affected)

Source: Dormans & Pellegrino, 1998: 8

It can be seen therefore that although all of the above are classified as cerebral palsy, there is a vast difference in the location and extent of disability for children with this condition and individual care plans would be of the utmost importance.

2.3.1.4 Associated impairments

Although cerebral palsy is defined as affecting motor control, there are various other impairments affecting the nervous system associated with cerebral palsy (Dormans & Pellegrino, 1998: 24; Scherzer, 2001: 16; Hinchcliffe, 2003: 5).

These include:

- Vision: Children may experience nearsightedness, loss of vision due to a “lazy eye” or loss of vision in segments of the visual field.
- Hearing: Children may have difficulties processing the sounds they hear (i.e. if the head is constantly moving, it is difficult to attend to one particular sound).
- Sensory impairments: Children may struggle with an awareness of the position of their limbs in space.
- Cognitive impairments: Children may experience difficulties regarding memory, learning, language processing, problem solving and attention.
- Neurological, orthopaedic and other physiological impairments: Children may experience seizure disorders, muscular contractures, hip dislocation, scoliosis, respiratory and gastrointestinal problems and urinary tract dysfunction.
- Epilepsy: About half of children with cerebral palsy also suffer from epilepsy.

The child with cerebral palsy thus may be exceedingly challenged, as the possibility exists for multiple disabilities as a result of the condition. As pointed out when discussing the various classifications of cerebral palsy, an individual care plan is of the utmost importance owing to the varying degrees of the motor impairment, but also owing to the “extra” disabilities that the child may be faced with.

2.3.2 SPINA BIFIDA

The second physical disability common to children is that of spina bifida. According to Mitchell (2004: 1885), spina bifida is one of the most common malformations of

the human structure and tends to be more common in girls than in boys. It is the leading cause of paralysis in infants in the world today (Vaccha & Adams, 2005: e58).

2.3.2.1 Definition

Spina bifida is a failure of fusion of the caudal neural tube. The most severe form of spina bifida, **myelomeningocele**, occurs when there is a bony defect in the spine, causing a “protrusion of the neural tissue from the spinal cord, and a lack of skin covering the defect” (Vaccha & Adams, 2005: e58). In other words, there is a defect in the spine, allowing the lower part of the spine and the nerves associated with this region to bulge through. This deformity affects not only the spine but, owing to exposed nerves, the central nervous system as well (SARDA, 1999: 10A, p11; Vaccha & Adams, 2005: e58).

2.3.2.2 Causes

Mitchell (2004: 1885) identifies a number of established and suspected risk factors that may cause spina bifida in the unborn child.



- History of previous affected pregnancy with the same partner.
- Inadequate maternal intake of folic acid.
- Pregestational maternal diabetes.
- Anticonvulsant drugs.
- Hyperthermia owing to maternal fever.
- Maternal diarrhoea.

The above emphasises the importance of the mother taking the necessary care of herself, especially when suffering from other chronic illnesses such as diabetes or epilepsy where the use of anticonvulsants may be necessary.

2.3.2.3 Associated impairments

Some children with spina bifida may have hydrocephalus, which is a blockage to normal circulation of the fluid surrounding the spinal cord and brain. The pressure that builds up from this unreleased fluid can cause brain damage and even cerebral palsy, which is why some children with spina bifida have signs of cerebral palsy (SARDA, 1999.: 10A, p12). The spinal cord lesion is usually closed within 48 hours of birth. Should there be signs of hydrocephalus, a shunt is usually inserted at the same time as the lesion is closed. The shunt is used to drain the fluid from the brain/spinal cord, usually into the abdominal area (Mitchell, 2004: 1889).

Regardless of the timing of treatment, individuals with spina bifida are at risk of the following: leg weakness and paralysis, sensory loss, bowel and bladder dysfunction, apnea, swallowing difficulties, headaches, balance and coordination difficulties, cognitive disabilities and language difficulties. (Mitchell, 2004: 1890). Children with spina bifida may also suffer from epilepsy (SARDA, 1999: 10A, p12).

As with cerebral palsy, the single deformity may leave the child with a host of related disabilities, some of which if not controlled appropriately, may even be life threatening (e.g. appropriate draining of fluid from the brain).

2.3.3 EPILEPSY

Epilepsy is the third childhood disability that will be focussed on. Although epilepsy is usually used in the singular, it, like cancer is used to describe a diverse set of abnormalities with different expressions and different causes (Schwartzkroin, 2001: 4710).

2.3.3.1 Definition

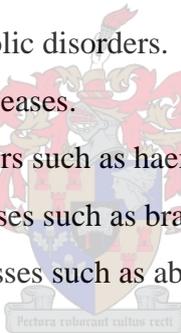
Schneider (1990: 618) defines epilepsy as a convulsive disorder, where there is a sudden, excessive and disorderly discharge of neurons in a normal or diseased cortex. This discharge leads to disturbance in sensation, a loss in consciousness and convulsive movements. Livingston, (1977: 355) and Schwartzkroin (2001: 4710)

identify epilepsy as a condition of the central nervous system where these seizures are spontaneous and recurrent.

2.3.3.2 Causes

Livingston (1977: 355), Schneider (1990: 619) and Schwartzkroin (2001: 4711) identify the following factors that may predispose an individual to epileptic seizures:

- Genetic/Heredity.
- Biochemical imbalances.
- Drug withdrawal.
- Physical stimuli such as flickering lights.
- Structural causes such as birth trauma, developmental abnormalities.
- Inherited metabolic disorders.
- Degenerative diseases.
- Vascular disorders such as haemorrhaging.
- Neoplastic diseases such as brain tumours.
- Infectious processes such as abscesses/early childhood infection.



With such a diverse panel of possible causes for epilepsy, it would be of the utmost importance to correctly diagnose the cause of the epilepsy, so that focused and effective treatment can be administered.

2.3.3.3 Types

Livingston (1977: 356) and The New Encyclopaedia Britannica (Anon, 2002: 525), both discuss the types of seizures experienced by individuals with epilepsy. The seizures may consist of a sudden unconsciousness, falling and shaking of the limbs – these are referred to as **grand mal**. This is the most common type of epilepsy experienced. The **petite mal** seizure is characterised by a momentary lapse of awareness. This usually occurs in childhood, where the child will stare unresponsively for a period of five to thirty seconds. A **focal** seizure is when there is local movement or sensations in specific parts of the body (e.g.. face).

Knowledge of the type of epilepsy that the child experiences is of the utmost importance with regard to therapeutic horse riding, as it could be very dangerous for the child to experience a seizure while on horse back. The seizures must be under control for the child to meaningfully participate in the riding programme.

Epilepsy can be controlled by a number of means:

- Management of life style: Because various factors can cause the onset of a seizure, e.g. lack of sleep and alcohol, the individual can be advised on correct rest or diet (Livingston, 1977: 359).
- Drug treatment: Anticonvulsant and tranquillising drugs can be used by the child to control the seizures (Livingston, 1977: 359; Schneider, 1990: 619).
- Surgery: Damaged brain tissue can be removed through neurosurgery. (Livingston, 1977: 360; Schneider, 1990: 619; The New Encyclopaedia Britannica, 2002: Vol. 4, p525).

It is also of importance within therapeutic riding to know the treatment that the child is undergoing and to make sure that it has been administered appropriately before engaging in the activity of horse riding.

2.3.3.4 Associated impairments

Livingston (1977: 358) mentions additional struggles that may be experienced by an individual with epilepsy. These include mental deterioration in the case of uncontrolled epilepsy, head trauma as a result of the fits, personality disorders as well as social ostracism, anger, hostility and resentment.

As epilepsy is not “physically noticeable” (unless the fit is witnessed), most of the associated impairments appear to be psychological and social. Thomas (1978: 78 – 80) quotes a number of studies investigating whether there is a particular personality type for epilepsy. Pond (1952) believed that children with petit mal were stubborn, serious, passive, well mannered, but given to severe anxiety. Among those with brain injury he found aggression and explosive, unpredictable behaviour. Bagley (1971)

also found than epileptics show a higher incidence of psychiatric disorder – aggression, emotional behaviour and neuroticism, and anxiety.

2.3.4 MUSCULAR DYSTROPHY

The final disability that will enjoy attention is that of muscular dystrophy. Much of the literature available on muscular dystrophy is from the medical field and the researcher found it difficult to find literature that a social worker or layperson without a medical background could understand and relate to. Muscular dystrophy will therefore be very briefly discussed in this chapter, in terms that are easily understandable.

2.3.4.1 Definition

Muscular dystrophy is an inherited disease, occurring more commonly in boys, causing increasing weakness of the muscle tissue, especially that of the skeletal muscles. The muscles of the hips and shoulders usually deteriorate first, and paralysis then spreads into the limbs and eventually to the muscles of breathing and occasionally the heart muscle. Children with this disease usually die of pneumonia or respiratory failure in their late teens (SARDA, 1999: 10A, p13; The New Encyclopaedia Britannica, 2002: Vol. 8: 439).

2.3.4.2 Types

There are a number of types of muscular dystrophy. The most common is **Duchenne's muscular dystrophy**. Duchenne's muscular dystrophy is a gender-linked disorder, affecting males almost exclusively and is caused by a defect on the 23rd chromosome. There are very few symptoms in the first year of the child's life. When he starts to walk however, there is a waddle in his gait and he tends to walk on his toes. Weakness is most prominent in the pelvic area. The child struggles to get up once fallen and difficulties in bending the knees are noticeable. By the time the child is five years of age, there is usually an enlargement of the calf muscles, an inability to run and climbing stairs is nearly impossible. As the child grows older, the condition becomes worse and by adolescence the child is unable to walk and is wheelchair

bound. Degeneration is usually from the legs upwards, eventually affecting the upper limbs and the muscles of the diaphragm. Infections or respiratory failure often bring about death before the age of twenty. **Becker's dystrophy** has much the same symptoms as that of Duchenne's dystrophy, but its onset is later in life and it is generally not so devastating (Bender, 1977: 398; The New Encyclopaedia Britannica, 2002: 439).

Limb girdle dystrophy is the most vague of the muscle diseases and includes all patients that have an inherited progressive weakness in the pelvic and shoulder muscles. Limb girdle dystrophy would obviously then include both sexes. Symptoms are manifest in late childhood and include frequent falling, inability to climb stairs and a waddling gait (The New Encyclopaedia Britannica, 2002: 439).

Facioscapulohumeral dystrophy is characterised by a progressive weakness beginning in the upper arms. Onset is usually during adolescence and the first sign is difficulty in raising the arms. Progression is slow and the person may have a normal life expectancy. In some cases symptoms are so mild that they may go unnoticed and others may be totally disabled. The main effect on the facial muscles is difficulty in closing the eyes and a "transverse smile" (Bender, 1977: 398; The New Encyclopaedia Britannica, 2002: 439).

There is no specific treatment for muscular dystrophy. "Respiratory therapy, physical therapy to prevent painful muscle contractures, orthopaedic appliances used for support and corrective orthopaedic surgery may be needed to improve the quality of life in some cases." (NINDS Muscular Dystrophy Information: 2005)

Most, in fact almost all of the types of Muscular Dystrophy are eventually life threatening or extensively and progressively crippling for the individual suffering from the condition. Perhaps the saddest part is the fact that there is no specific treatment.

2.4 PSYCHOSOCIAL CHALLENGES OF PHYSICAL DISABILITIES

The following section will be taking a closer look at the psychosocial challenges that are experienced by children with physical disabilities. The context of the study remains middle childhood and psychosocial development during this stage (i.e. the extension of social participation, the acquisition of greater self-knowledge and the development of moral judgement and behaviour). The psychosocial challenges faced by children with physical disabilities on the whole will be discussed, with specific reference being made to the disabilities on which a focus was placed, namely: cerebral palsy, spina bifida, epilepsy and muscular dystrophy.

Medical advancements have allowed many children with physical disabilities to live well into adulthood or even enjoy normal life expectancy. Although these disabled young people have the same aspirations as their able-bodied peers, Antle (2004:167) reports that years of experiments have shown that young people with physical disabilities experience significantly greater difficulties with psychosocial adjustment or as Thomas (1978: 102) puts it, a physical handicap is a variable that inhibits the acquiring of developmental skills at the appropriate age.

Thomas (1978: 38) feels that there are many forces that shape the development of handicapped children such as the nature and severity of his disability, the attitudes of those in regular contact with him and the institutions that cater for him (e.g. home and school). In interaction these forces will affect his adjustment to his handicap and the kinds and levels of skills, aptitudes and attainments that he is encouraged to develop.

2.4.1 PSYCHOSOCIAL CHALLENGES REGARDING THE EXTENSION OF SOCIAL PARTICIPATION

Antle (2004) speaks of a social model of disability that was designed by people with physical disabilities. The model describes how challenges experienced by those with physical disabilities are more a consequence of the social world than the actual reality of their disability. Yet, children with disabilities and their families continue to face misconceptions and stigma from society. Thomas (1978: 35) reports that there is evidence that shows "...progressive involvement of the handicapped with others like

themselves and indicates an abandonment of community membership.” It is of vital importance though that the child’s sense of self is not negatively affected by this stigma, as a positive sense of self is vital for success in school performance and the forming of friendships. Garber (2004) emphasises the link between the self-esteem of the child and his social participation. He claims that if the child feels negative about himself, he will be an outsider on the playground, stigmatised in the classroom, awkward in his peer group and will be continually teased until his shame shows through.

Alienation and social malintegration are related to health status and may be further exacerbated by physical incapacity (Romeis, 1990: 48). Cutsforth (1990: 64) makes a significant statement in saying that society views the disability and the person as synonymous and that disabled people arouse anxiety and discomfort in others and are thus socially stigmatised. Thomas (1978: 37), in earlier writings, already recognised how these previous negative social experiences may lead the disabled person (in this case, the child) to anticipate the anxiety or awkwardness of a non-disabled person, increasing the difficulties of interpersonal communication and reinforcing a belief that others hold negative attitudes towards them. Negative social reinforcement may encourage a disabled person to limit social interaction, thus confirming for others that he is ‘difficult to get along with’.



Solot (as cited in Dormans & Pellegrino, 1998: 347) explains that “(t)he use of speech and language for communicating, learning, and regulating behaviour is a critical developmental task and forms the basis for all social interactions.” Owing to neuromotor impairments however, children with cerebral palsy often struggle with the development of speech, language and feeding skills. Impairments in oral-motor function and communication may seriously disrupt the normal process of bonding and attachment e.g. a parent or friend may misinterpret a facial expression due to low muscle tone. Cerebral palsy children may also suffer from cognitive or learning disabilities. When discussing peers and social relationships earlier in this chapter, it was explained that popular children are usually those who perform well academically and have the skills to perform successfully in a social situation. It is obvious then, that the child with cerebral palsy would be at a serious disadvantage regarding peer and social relationships. The spina bifida child along with the cerebral palsy child has

to deal with physical, cognitive, language, memory and temperamental challenges. For them, even the most mundane daily tasks can prove to be a source of stress (Vaccha & Adams, 2005: e61). This would thus limit the opportunities of the child and consequently affect opportunities for peer relations. It would be expected too, that the child suffering from muscular dystrophy (as discussed in 2.3.4.2) would also experience physical limitations in communication and would thus have limited opportunities for social interaction.

For any of the children with the conditions discussed in this chapter, well meaning, yet overprotective parents may even further restrict opportunities for peer relations. Schneider (1990: 623) found that parents' worry, advice and protection often magnifies the "...the significance of epilepsy in children's lives and could become a kind of control that isolate(s), restrict(s), and further disable(s) the children." Ayrault (2001: 56) believes that being overprotective can cause the child to be self centred, demanding of attention, frightened to interact with strangers and encases the child in his own problems. It restricts self-initiative or self-exertion. The child becomes impassive to everything around him and frightened to function in any manner without his parents.

In conclusion, it can be seen that the majority of the struggle experienced by the child with a physical disability is related to the development of peer relationships. This could either be as a result of the child's physical limitations in communicating, his own insecurities or the insecurities and "over-protectiveness" of his parent or caregiver. A pattern that seems to emerge for the researcher regarding cerebral palsy, spina bifida, muscular dystrophy, epilepsy and physical disabilities in general is reflected below.

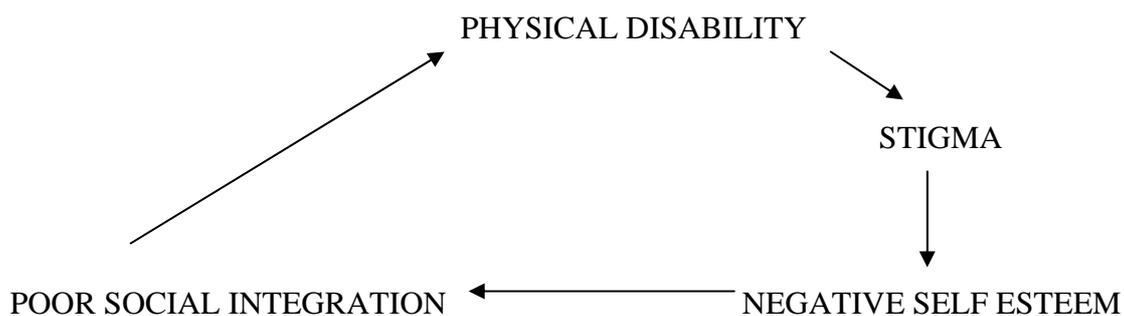
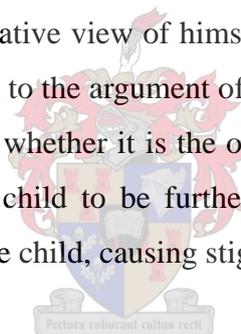


FIGURE 2.3: The pattern of social malintegration for children with physical disabilities

As the above figure reflects, the child's physical disability may cause an uncomfortable feeling in the able bodied person, causing them to stigmatise the child with the physical disability. The child may then develop a negative self-esteem. As has been discussed, a positive view of self is vital in performing successfully in social situations. If the child has a negative view of himself, he will experience poor social integration. This then leads back to the argument of whether it is actually the physical disability that limits the child or whether it is the obstacles created by society (i.e. in reaction to him) that cause the child to be further "disabled". Thus, poor social integration will further disable the child, causing stigma.... and the cycle continues.



2.4.2 PSYCHOSOCIAL CHALLENGES REGARDING THE ACQUISITION OF GREATER SELF-KNOWLEDGE

There is much debate in research when "generalising" about the self-concept of a child with a physical disability. Antle's (2004) research found that individuals with disabilities have self worth scores similar to those of their non-disabled peers. This is in contrast with studies that show that disabled persons face significant psychosocial adjustment difficulties. Antle (2004) feels the discrepancy could be owing to the fact that young people with physical disabilities need higher than average levels of self-esteem to counteract the physical and attitudinal barriers they face throughout their lives. Thomas (1978: 89) however, speaks of a study done by King (1964) on 72 handicapped and non-handicapped children. The study found that handicapped children saw themselves as less physically adequate than the non-handicapped children. They had fewer close relationships and fewer opportunities for social

participation. Although they had similar life-goals to the non-handicapped, they felt less able to achieve them. An own observation from practice leans more towards the view expressed by Thomas (1978: 89). Referring to a previous discussion, it could be seen that this may be particularly relevant for the child with muscular dystrophy who is most often wheelchair bound by the teenage years, and though he may have 'big' ambitions, owing to physical restraints is not able to fulfil these ambitions.

Antle (2004) proposes that the age of the onset of the disability has a profound effect on the self-concept of the disabled person. He argues various studies for and against the idea, but concludes that there is a fairly solid body of literature showing that individuals who acquired their disability later in their life (i.e. not from birth) experience a negative effect on their sense of self and their perceived quality of life

The child's self concept is affected by his physical self-concept and how well he or she can perform an activity in relation to peers. All of the disabilities discussed may have a profound effect on this comparison and thus self-concept. According to Geyer, Kurtz and Byarm (as cited in Dormans & Pellegrino 1998: 323) children with cerebral palsy differ widely in their ability to perform tasks of self-care (i.e. dressing, feeding and managing personal hygiene) owing to the different extent of motor impairment. Being able to participate in meaningful daily activities though is central to the child's adaptation at home, school and within the community. It would be reasonable to conclude then that should the child not be able to perform daily tasks of self-care to the same degree as the rest of the family, school or community that his self-concept would thus be negatively affected. This would be in line with Erikson's theory of *industry versus inferiority* and the child focusing on successfully completing tasks that are necessary to survive in the adult world.

As with social participation, the influence of the parent on self-concept is an important aspect to consider. Schneider (1990: 622) interviewed eighty adult epilepsy sufferers to determine their experiences of growing up. A number of the participants explained how their parents particularly, would constantly caution them on what they may not do – developing within them the feeling that they were people who were *not* able. Others recounted how their families felt that the condition was stigmatising to their family, further exasperating the feeling of being less than able. Antle (2004)

speaks of a study done on cerebral palsied children by Hansen (1994), which described the biggest difficulty experienced by these children as having a sense of being treated differently by others.

Antle (2004) found that the support received by children with disabilities from their families was a big indicator of positive self-image. Social support, which is a key aspect in social work practice, has been recognised for some time as being a protective factor for children with physical disabilities. Antle's (2004) study of 85 individuals with spina bifida between the ages of three and 25, found a positive correlation between perceptions of social support from close friends and self worth.

As can be seen, the self-concept is influenced by a multitude of factors (refer to figure 2.1). The physically disabled child realises his limitations in daily tasks, which has a negative effect on self-image. Parental and societal influences can go 'a long way' in rectifying this situation by being supportive of what the child *can* achieve and by encouraging him to do so.

2.4.3 PSYCHOSOCIAL CHALLENGES REGARDING MORAL DEVELOPMENT AND BEHAVIOUR



Romeis (1990: 48) is one of the few authors that address moral behaviour of the disabled person, and in this case, the child. He describes the "interested persons" in the disabled person's life as being family, friends, rehabilitation specialist, counsellors and other impaired individuals. Romeis (1990: 48) further explains that it is these very "interested persons" that may cause a sense of normlessness for the disabled persons, because there is no clear cut societal norms regulating the behaviour of disabled persons yet he is expected by different persons to behave in different ways.

In section 2.2.3.3 Bandura's social learning theory placed much emphasis on how the child learns behaviour by close observation of and modelling those in his close surroundings. It could thus be confusing for a child if a parent or guardian expects the child to behave differently to the manner that is modelled to them, e.g. perhaps the parent is very assertive and independent, yet for fear that the child may hurt himself, would expect the child to be more dependent and less assertive.

2.5 SUMMARY

At the beginning of the chapter, figure 2.1 (An outline of the contents of chapter two) presented the themes that would be discussed in this chapter. Below, the same figure is elaborated on to provide a summary of what was discussed in this chapter.

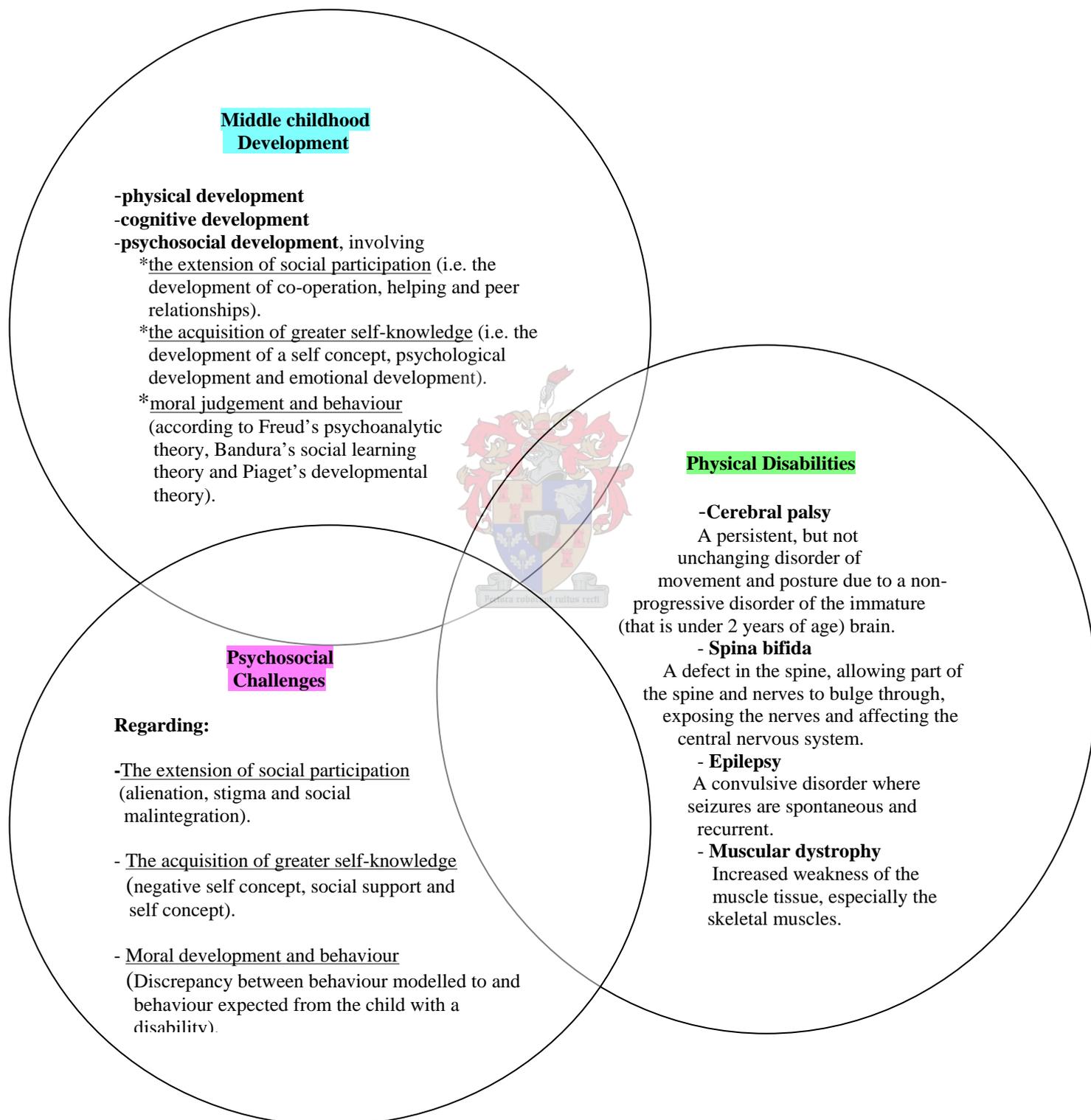


FIGURE 2.4: A graphic representation of the contents of the chapter

As explained, the figure above is an elaboration of figure 2.1 (An outline of the contents of chapter two) presented in the beginning of the chapter. As it shows, the focus of the study is the child in his primary school years or middle childhood development. Middle childhood development is fairly stable regarding physical development, but is rich in cognitive, social and emotional development. The main psychosocial developmental tasks of middle childhood involve the development of greater social participation, the forming of a self-concept and knowledge of the self and the development of morals. Peer relations are of the utmost importance for the school aged child. The forming of a positive self-image will determine the extent to which the child can successfully participate in social situations. The recognition and internalisation of community morals will also determine the success of the child within his social environment.

Four specific disabilities were focused on namely; cerebral palsy, spina bifida, epilepsy and muscular dystrophy. All of these disabilities may have similar effects on the child, i.e. impaired motor, language and cognitive skills.

These disabilities and physical disabilities in general, have a profound influence on the normal psychosocial development of the child, which was the third area of focus of the chapter. Physical disabilities frequently lead to the child being socially stigmatised, causing a poor self-image and consequently even greater social malintegration. The child may also experience moral confusion, as the behaviour modelled to him is not always the behaviour expected from him. The support of family and friends can act as a buffer against these difficulties and should be focused on and encouraged in social work practice.

CHAPTER 3: REHABILITATION AND SOCIAL WORK METHODS

3.1 INTRODUCTION

Psychosocial middle childhood development, the various physical disabilities and how these affect psychosocial development of the child have been extensively covered in the preceding chapter. The next logical step would be to understand how to deal with the affects that a physical disability has on the psychosocial development of the middle-aged child, within the context of social work.

This chapter will therefore reflect in depth on rehabilitation for the physically disabled (keeping in mind that the study is dealing with children between the ages of seven and 12). As the focus of the study is the psychosocial dynamics of equine-assisted therapy, the psychosocial aspects of rehabilitation will receive the most attention.

Each of the social work methods will then be discussed respectively (i.e. social case work, social group work and social community work), with a view to where the concept of rehabilitation for the middle-aged child with a physical disability would fit into social work. Thus, the chapter aims to meet the second objective of the study as set out in 1.3.2, namely to explain psychosocial rehabilitation of the physically disabled primary school child from a social work perspective.

3.2 REHABILITATION

As was mentioned in chapter one, for the purposes of this study, the definition of **rehabilitation** will coincide with one of the goals of the White Paper on an Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) namely,

- To enable the disabled to reach and maintain *their optimal* physical, sensory, intellectual, psychiatric, and/or social functional levels.

The White Paper on An Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) also goes on to mention a further three objectives of rehabilitation for the physically disabled:

- “to provide people with disabilities with the tools to change their lives and to give them a greater degree of independence;
- to prevent secondary disabilities or to reduce the extent of disability;
- to take into account the specific needs of different disability groupings.”

Having an understanding of what rehabilitation is, the objectives of rehabilitation and rehabilitation philosophy/psychology will now be explored.

3.2.1 REHABILITATION PHILOSOPHY

Chwalisz and Vaux (2000: 537) explain that rehabilitation psychology is concerned with the life problems of individuals who have experienced a loss in the quality and value of life as a result of issues such as old age, poverty or disability. According to Geller (2004: 179) rehabilitation is meant to enhance well-being, restore integrity and facilitate the creation of meaning.

Patterson, Bruyère, Szymanski and Jenkins (2005: 28) explain that within the context of rehabilitation counseling/psychology, rehabilitation is summed up as “...services, mutually planned by the consumer and rehabilitation counselor, to maximize employability, independence, integration, and participation of people with disabilities in the workplace and the community.”

Pediatric rehabilitation is similar to the aforementioned, in that it aims to “...improve all levels of the children’s functioning in their homes, schools, and community environments by reducing impairment and increasing activity and participation” (Geller, 2004: 179).

The following is a mention of the most recently listed values and beliefs that underlie rehabilitation counseling and philosophy (Patterson et al., 2005: 29), namely:

- Belief in the dignity and worth of all people.
- Commitment to creating equal opportunities for people with disabilities in all privileges available to all people, and a commitment to supporting such persons in activities to achieve this status.

- Emphasis on a holistic approach to people, that is facilitated by interdisciplinary teamwork, counseling from a holistic perspective and a commitment to handling individuals within the context of their family and community.
- Recognition of the importance of focusing on the abilities and assets of an individual.
- Commitment to models of service delivery that involve mutual planning by the individual with a disability and the rehabilitation counselor.

In light of these values, there are certain practical considerations to be kept in mind during intervention with an individual with a physical disability, as identified by Patterson, DelaGarza and Schaller (2005: 156), namely:

- The individual: Personal traits will determine how the individual gives meaning to his disability. Factors that are essential to consider in order to be an effective helper are the individual's personal characteristics, interests, activities, goals, gender and culture.
- The environment: It is necessary for the rehabilitation counselor to pay attention to the immediate environment such as family, friends and community resources; as well as the broader environment such as laws and social definitions of disability.
- The nature of the disability: Important aspects include the functions that are impaired, the severity of the disability, the time of the onset of the disability and the type of onset.

All of these values and considerations are reflected by Ylvisaker, Adelson, Braga, Burnett, Glang, Feeney, Moore, Rumney and Todis (2005: 107), who discuss six goals of rehabilitation for children with traumatic brain injuries. Firstly, they state that intervention must span across the following fields, namely the child's cognition, communication, behaviour, social competence and education. Secondly, they believe that rehabilitation should take place in an environmental context. Thirdly, the family or caregivers need to be encouraged to keep up hope of and to notice improvements. Fourthly, both parents and professionals need to play a role in assisting the child in integrating his 'new identity' in a positive way. Fifthly, professionals should think

broadly and recognize the overlap of needs and interventions among differently disabled children. Lastly, a multidisciplinary approach should be implemented, while making the utmost use of the family support system. According to Ylvisaker et al. (2005: 107), these goals and integrations are in line with the evolving disability framework of the World Health Organization.

Rehabilitation will now enjoy a more in-depth view, as the various methods and perspectives in rehabilitation are discussed.

3.2.2 COMPONENTS OF REHABILITATION

The diagram below was drawn up from what the White Paper on An Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) recognizes as components of rehabilitation. Vocational rehabilitation is also mentioned in the White Paper on An Integrated National Disability Strategy, but is left out for the purposes of this study, as it is not seen as relevant for the target population, namely children between the ages of seven and 12.

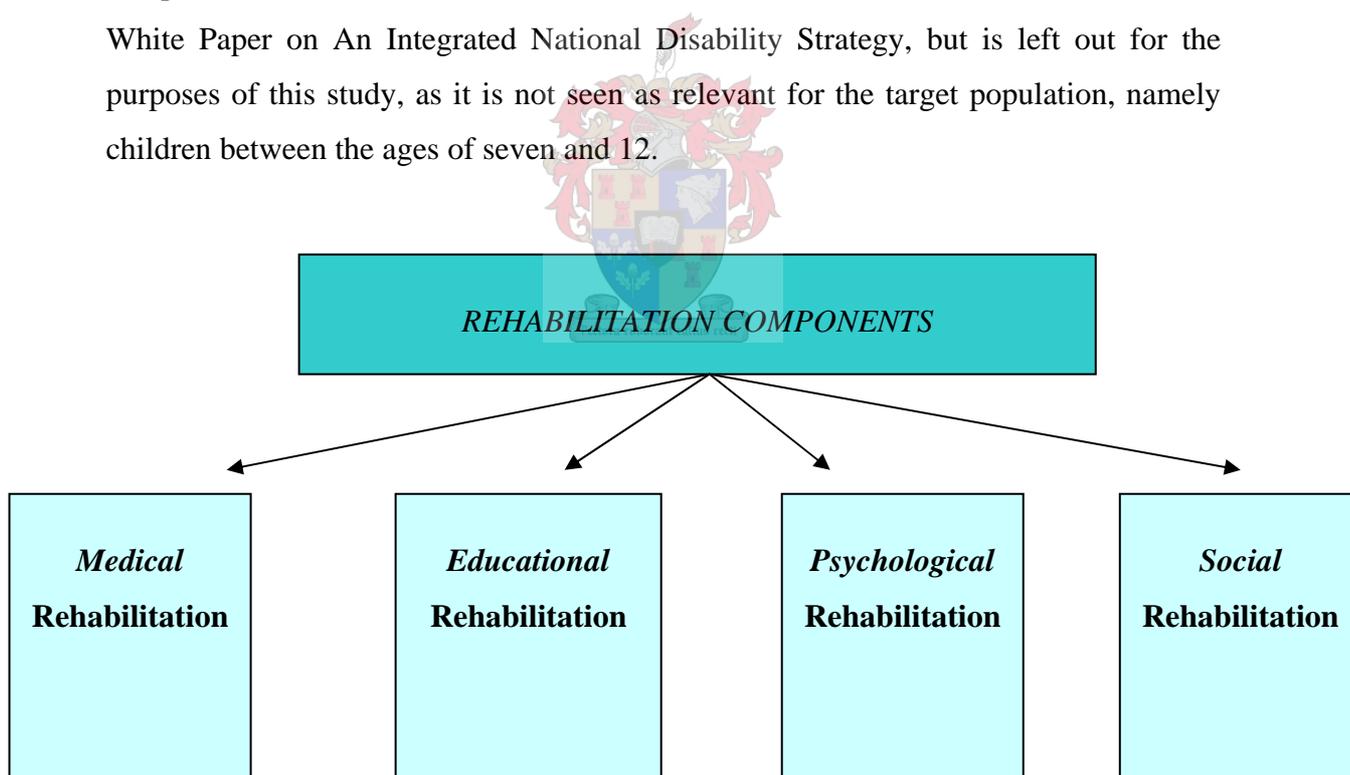


FIGURE 3.1: A diagrammatic representation of the components of rehabilitation for those with disabilities (source: Office of the Deputy President, 1997: 27).

Each of the above mentioned components of rehabilitation are now discussed.

3.2.2.1 Medical rehabilitation

According to the White Paper on An Integrated National Disability Strategy (Office of the Deputy President, 1997: 27), medical rehabilitation includes screening, early identification and intervention, splinting limbs to prevent contracture, swallowing therapy, muscle strengthening and retraining, learning how to use an assistive device, bowel and bladder rehabilitation. Ylvisaker et al. (2005: 97) explain that the focus of physical or medical rehabilitation has shifted from one of general performance improvement to one of a 'meaningful activity context'. This is where patients are helped to achieve activities that are meaningful for them in social reintegration and independence. This approach has proved very effective for improving motivation for most children and adolescents.

In practice, medical rehabilitation could be the most important kind of rehabilitation in allowing the child to practically live an independent life. As mentioned in the first chapter, the physical benefits of equine-assisted therapy for the child with a physical disability have been widely documented in literature and will be widely discussed in chapter four. Physical or medical rehabilitation though, is not primarily the field of the social worker and falls more within the expertise of the medical doctor, physiotherapist and occupational therapist. For this reason and owing to the fact that the focus of the study is on psychosocial issues, medical rehabilitation will not be extensively covered in this chapter.

3.2.2.2 Educational rehabilitation

The White Paper on An Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) sees educational rehabilitation as involving aspects such as identification of learners with special education needs, individual therapy at special schools, career guidance, support programmes and advice for teachers in regular centres of learning and vocational guidance.

As with medical rehabilitation, educational rehabilitation does not fall into the field of expertise of the social worker and is not the focus of the study so will therefore receive no further attention.

3.2.2.3 Psychological rehabilitation

Psychological rehabilitation involves improving concentration and memory, the reconstruction of thought processes, improving coordination (and) improving interpersonal relationship skills (Office of the Deputy President, 1997: 27).

This falls more within the focus of the study and within the expertise of the social worker. As most social workers attend universities and have psychology as a major subject, they are familiar with behaviour and thought modification theories such as Freud's psychoanalytic theory, person-centered approach, gestalt therapy, emotive therapy and behaviour therapy. In light of the fact that most social workers should have received some manner of formal counselling education that would have covered these approaches, theories and therapies, the gist of some of these will now be briefly covered. However, the main focus will be on how each of these approaches, theories or therapies fit into rehabilitation counselling and the rehabilitation perspective.

a) Rehabilitative application of Freud's psychoanalytic theory

Psychoanalysis in its true form is inappropriate for use by rehabilitation counsellors as extensive training in the theory is necessary. However, a basic understanding of the theory can help the counsellor to understand human behaviour and there are certain aspects of the theory that have applications within rehabilitation counselling (Parker, Hansmann, Thomas & Thoreson, 2005: 120).

The theory recognizes that people with disabilities may experience abnormal internal and external sensations that may alter their body image. Freud believed that if a person with a disability has successfully adapted psychologically, there is an integration of physical, sensory, and cognitive changes into a reconstructed body image. Unsuccessful adaptation on the other hand, Freud believed to be marked with psychiatric and physical symptoms such as chronic fatigue, pain, anxiety, depression and social withdrawal (Livneh & Cook, 2005: 188-191). Understanding the various defence mechanisms identified by the psychoanalytic theory, may aid the counsellor when dealing with the patient's adjustment to their disability. The various defence mechanisms include regression, projection, reaction formation, repression,

compensation, displacement, sublimation, restriction of the ego and rationalization (Robertson & Brown, 1992: 41).

Freud's theory also proposes that each developmental phase holds certain conflicts that need to be resolved. He believed that should any of these conflicts not be resolved as a result of the onset of a disability (or other traumatic event), that a fixation with that stage may develop and effect adult personality development (Livneh & Cook, 2005: 188-191).

With regards to the above, it can be concluded that Freud's theory aims to bring the person with a disability to the place where he accepts the disability, knows how to handle it in his daily life and relationships; and develops a holistic, healthy and positive self-concept (Livneh & Cook, 2005: 188-191).

b) Rehabilitative application of the person-centred theory

Livneh and Cook (2005: 191) describe the person-centred theory of Carl Rogers as mainly being concerned with an individual achieving self-actualisation, which is "...the motive to realize all one's potentialities" (Reber, 1995: 7000). The theory suggests that it is not the person's objective disability that has psychological consequences, but the subjective meaning attached to the disability that influences the way the individual adapts.

Similarly to Freud's psychoanalytic theory, Roger's theory focuses on the discrepancy between the ideal and actual selves of the disabled individual and how this can cause a negative self-concept and ultimately affect the desired state of self-actualisation. According to Livneh and Cook (2005: 191), "(t)he ensuing incongruences between the objective reality of the functional limitations imposed by the disability and the subjective experience, or meaning, attached to it could, most likely, impede rehabilitation."

The person-centred theory takes the approach that it is the client who is the active agent of change in the counselling relationship. Potentially positive outcomes of therapy may be greater congruence, openness of experience, reduced defensiveness

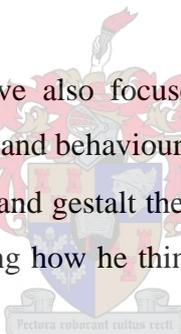
and more realistic perceptions (Robertson & Brown, 1992: 44). The person-centred theory would thus focus on helping the person with a disability see the disability “for what it really is.” In other words, the person would be encouraged to have a realistic view of their disability and their capabilities and to ultimately reach the point of self-actualisation.

c) Rehabilitative application of gestalt therapy

Gestalt therapy was developed by a Frederick Fritz, and emphasizes “...awareness, holism, integration of fragmented components and polarized elements, personal responsibility, and the ‘here and now’ ” (Livneh & Cook, 2005: 192).

According to Livneh and Cook (2005: 192), gestalt therapy is in line with rehabilitative philosophy in that:

- the rehabilitative perspective also focuses on holism, the ‘here and now’, experiences, feelings, skills and behaviours.
- both rehabilitative theories and gestalt therapy emphasize the responsibility of the individual in determining how he thinks and feels and how he chooses to live with his disabilities.



The gestalt theory therefore offers fertile ground for rehabilitative strategies. It can be used on children and adults and is particularly useful for those who have difficulties with interpersonal relationships or have distorted self-images (Robertson & Brown, 1992: 46; Parker et al., 2005: 120).

d) Rehabilitative application of rational emotive therapy

Rational emotive behaviour therapy developed by Albert Ellis (as mentioned in Parker et al., 2005: 132) focuses on recognizing and changing negative and false beliefs, with the idea that changing the negative thought can change the associated negative and undesirable emotion.

Rational emotive behavioural therapy is not really applicable in rehabilitation of mental disabilities, low intelligence or cognitive disorders. It can however be very useful in rehabilitation for those with physical disabilities as it proves very useful for issues such as low self-esteem, poor social skills or when struggling to accept the disability (Robertson & Brown, 1992: 52; Parker, Hansmann, Thomas & Thoreson, 2005: 133).

Rational emotive therapy can therefore fit comfortably into therapeutic riding, as the aim of therapeutic riding is to improve low self-esteem and poor social skills for the physically disabled person. Social rehabilitation will be discussed further in the following section.

3.2.2.4 Social rehabilitation

According to the White Paper on An Integrated National Disability Strategy (Office of the deputy president, 1997: 29) social rehabilitation has to do with training in self-care activities, communication skills, daily living skills, adaptations in the home, sexuality counselling and peer counselling.

As can be seen, social rehabilitation mainly deals with improving social functioning. This falls within the psychosocial “boundaries” of the study and will therefore be further discussed.

a) Social skills training

As discussed in the previous chapter, the challenge of social situations can prove very daunting for children with disabilities as their disabilities at times cause anxiety and awkwardness in others. Rumsey et al. (1986) as referred to by Clarke and Cooper (2001: 2) state that in controlled conditions, it was the behaviour rather than the appearance that produced awkwardness in social situations.

The teaching of social skills can therefore be of the utmost importance in helping the child with a disability to function successfully within social situations and is an important aspect of rehabilitation counselling.

b) Social support

Chwalisz and Vaux (2000: 537) make the statement that “(s)ocial support is an important asset in combating barriers faced by people with disabilities...” They believe that social relationships can be invaluable to the person with a disability as they enhance the capacity to cope with and adapt to the disability and “...can profoundly expand the individual’s functional capacity.” Longo and Peterson (2002: 337) agree that social support does have a positive effect on well-being and offers a buffer against the impact of a specific stressor (e.g. the onset of a disability).

The above was also emphasized in chapter two and may be an important issue in the context of therapeutic horse riding. In each lesson, the child with a disability is surrounded by supportive instructors, helpers, children (and horses).

3.3 HINDRANCES TO REHABILITATION

Gregory (2001: 22) discusses the problems experienced in Australia regarding the rehabilitation of individuals with disabilities. He mentions how they struggle with limited resources, threats to the existing holders of power and a lack of appropriate training of service delivery personnel. These problems are also common to South Africa. In the first chapter, The White Paper on an Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) was quoted saying that “(a)ccess to appropriate rehabilitation services can make the difference between leading an isolated and economically dependent life and playing an active role in society...” and that the appropriate training of people involved in rehabilitation services is a core component of reaching this objective.

Gregory (2001: 23) also mentions the struggle in New Zealand where the social workers’ case loads have increased to up to 300 cases per worker. From own experience, this increase in case load, and thus reduction in the quality of service delivery is definitely a phenomenon common to South Africa, especially within the NGO sector. Along with pointing out all the difficulties experienced by the different countries, Gregory (2001: 24) also makes a few suggestions on possible solutions to the dilemmas facing rehabilitative service delivery. These include offering further

training on rehabilitation at university level, educating stake-holders on the benefits of community based rehabilitation and generating research that proves the benefits of rehabilitation. Galambos (2004) agrees that these measures may assist in service rendering for the disabled community as she recognizes that "...social work does not do enough to advance the knowledge base related to people with disabilities in the areas of practice, education, and research."

Galambos (2004) explains that research suggests that social workers generally focus on the disability of the person when rendering services. They are unable to move beyond the disability, look at the strengths and allow the opportunity for self-determination and autonomy. The education of social work students is therefore the first step in improving social work practice with people with disabilities.

3.4 REHABILITATION AND SOCIAL CASEWORK, GROUP WORK AND COMMUNITY WORK

From the above, it is now understood what rehabilitation for the child with a physical disability entails, with special attention given to psychosocial rehabilitation. In order to make this information applicable to the social worker working with children with disabilities, it is important to understand where and how rehabilitation fits into the various social work methods of social casework, group work and community work.

Lombard (1991: 11) explains that social work is fundamentally aimed at improving the social functioning of people at a personal, group and community level. Each social work method is vital in obtaining the aim of social work and no one method is more important than the other.

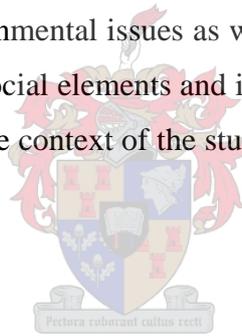
Each of the social work methods will be briefly discussed and attention will then be given to how rehabilitation can take place within the context of the method.

3.4.1 SOCIAL CASEWORK

Skidmore and Thackeray (1982: 58) refer to the definition of social casework as written by the pioneer of social casework herself, Mary Richmond, who stated "social

casework consists of those processes which develop personality through adjustments consciously effected, individual by individual, between men and their social environment.” Breugmann (2006: 6) builds on this ‘pioneer definition’ of social casework and explains that in this area of individual assistance rendering, social workers have developed special skills in medical social work, school social work, psychiatric social work, probation and parole, family and child care and even in the arena of public financial assistance.

In all of the above-mentioned ‘specialty’ areas, social casework is a method of helping individuals to solve their problems by using knowledge, understanding and skills. The Department of Social Development (2004: 6) views casework in a similar manner and states that social casework is a “method whereby a variety of skills, techniques and other aids are used to facilitate improvement in the social functioning of a client.” Although it is based on scientific knowledge, it also involves artistic effort. It focuses on both environmental issues as well as on issues inside the person. It combines psychological and social elements and is therefore psychosocial; a perfect method to be discussed within the context of the study (Skidmore & Thackeray, 1982: 59).



3.4.1.1 Principles of casework

There are a number of key principles that direct the way in which the social worker will conduct himself with each individual client. Potgieter (1998: 42) explains them as follows:

- Individualisation: involves a respect for the individual value of every person.
- Acceptance: involves acceptance of who each person is and how they conduct themselves.
- Controlled emotional involvement: involves having empathy, directed by sound cognition, for the purpose of reaching a therapeutic goal (Hancock 1997: 131).
- Being non-judgemental: involves an understanding that the purpose of social work is not to judge, but to be an instrument in finding a solution to the client’s problems.

- Self determination: involves an understanding that clients are free to make their own choices and decisions.
- Accountability: involves accountability of the social worker towards the client, the profession of social work, the welfare organisation and the supporters of the organisation (Johnson, 1989: 384).

Now that it is understood what principles govern social casework, a few of the social work perspectives, theories and models will now be discussed.

3.4.1.2 Perspectives, theories and models of social casework

Skidmore and Thackeray (1982: 69) and Payne (2005: 73, 97, 119) identify a few perspectives, theories and models often used within social casework, namely:

- The psychosocial theory was one of the first theories to be applied to social casework. It is largely Freudian in its principles and focuses on the way in which the mind stimulates behaviour, as well as how both the mind and behaviour influence and are influenced by social environment.
- The behaviour modification theory is mainly Pavlovian and Skinnerian in principle (i.e. positive and negative reinforcement). The main techniques include operant conditioning, social learning, skills training and cognitive restructuring of the belief systems of individuals.
- The task-centred model where the client's problems are organized around tasks or actions that the client and caseworker develop together. It is a brief, focused and structured theory that deals with immediate, practical problems.
- The systems and ecological perspective focuses on individuals being systems within larger systems, integrating social and psychological elements of practice.

In social casework practice, social workers tend to be guided by the *principles* of a particular theory or model or even of many theories or models. At times however, owing to their own style, social workers *practice* in such a manner that their way of working resembles nothing of existing practices. Developing new ways of working based on personal styles and existing situations leads to new theories and practice

models being developed constantly. Thus theory building continues and practice is enriched by diversity, as social workers gain more specialized skill through research and master's degree programmes (Skidmore & Thackeray, 1982: 68; Brueggeman, 2006: 7). Therapeutic riding could be seen as a new way of working for the social worker. Although it incorporates elements of conventional social work theories, such as the systems theory (i.e. believing that any improvement that the child makes within the riding environment will be carried over to other environments of his life), it is certainly not a conventional method and possibly with further research could take on a 'character' of its own and possibly even be considered as a 'theory' or a 'model'.

3.4.2 SOCIAL GROUP WORK

Social group work, as a method, aims to improve the social functioning of the individual through participation in group experiences, under the guidance of a professional i.e. social worker. (Sheafor, Horejsi & Horejsi, 2000: 109). It is a method of helping groups as well as individuals and enables individuals and groups to influence personal, group and community problems (Brown, 1992 as cited in Becker, 2005: 13).

Brown (1994: 35) recognizes that the essence of group work lies in the being together of people who are experiencing the same situation, which in the context of social work is usually a problematic situation. There are many types of groups with many different formats and goals, but the gist of the group is the fact that it is a group of people who are all 'in the same boat'.

Social group work is, as are all methods, based on certain principles and objectives, which will now receive attention.

3.4.2.1 The value and principles of group work

It has been established that group work uses the power of the group to assist the individual. Becker (2005: 17) documents the value and benefits of this 'system', namely:

- Commonality is experienced and similar goals and interests can be shared in the group.
- Groups have much problem-solving potential, as group members have the freedom to exchange ideas and develop new approaches to solving problems.
- Small-group force is potent and can be effectively utilized to bring about individual and social change.
- Groups are cost-effective, convenient and efficient.

Despite the obvious value of group work, for group work to be successful, i.e. for individuals to assist each other within the group setting, there are a number of principles that need to be understood by each group member and group worker. These include self-determination, respect and consideration, acceptance, individualization, entering the living world of the group member, self-help, acknowledgement, confidentiality, empathy, uniqueness, a non-judgmental attitude and voluntary participation (Cawood, 1999).

Should the group members therefore adhere to these principles and fully invest themselves in the group, the group setting is a highly effective way for the individual to help himself. It is also the place where group members have the opportunity to be of reciprocal help to fellow group members. All of these benefits are applicable to the riding for the disabled in their typical lesson setting, where they all have a physical challenge and are able to encourage one another within the lesson.

3.4.2.2 Types of groups

Social group work theory often refers to three main models for conducting groups. The **reciprocal** model believes that the therapist and group members are on equal footing, a contract is reached by mutual decision and the worker is merely a facilitator, rather than a group leader. The **rehabilitative / remedial** model suggests that the therapist is in a somewhat superior position to the group members. This model sees the group as a place where individuals who are experiencing problems (often related to social behaviour) can come to help them change their deviant behaviour. In this model the worker will act from a point of authority, instructing and modelling behaviour to the group, creating an atmosphere that leads to individual

growth of the members. The **psychosocial** model uses intrapsychic methodologies and relies heavily on insight and reflection. It is mainly used in long-term rather than time limited groups and as in the case of rehabilitative groups, the worker is in a position of authority, stressing the need for self-disclosure and confidentiality (Brandler & Roman, 1999: 8; Payne, 2005: 46).

Brown (1994:37) recognizes that there are many different types of groups and group models, but identifies several features that are common to the majority of groups, namely:

- Every group has a purpose, whether clearly defined or not.
- Group members share something common which has brought them to the group.
- Group members will be communicating, verbally and non-verbally.
- Each member gets to be helped and to be a helper.
- Each member will be influenced and will influence.
- The group is affected by size and composition.
- Groups are dynamic i.e. change occurs.
- Issues of closeness and intimacy will affect the group life and the behaviour of the members.
- All groups take place in a context, whether social or political and will influence the group life.

When focusing specifically on children, groups can be useful for children from divorce situations, children with social competency problems, children with health-related difficulties and those involved in delinquency (Alissi & Casper, 1985: 19). Brown (1994: 38) goes on to further identify a number of types of groups or individuals who can benefit from group work, these include individuals with physical health issues, emotional and mental health issues, 'linked fate' groups (i.e. family members who have special needs e.g. siblings of the disabled), empowerment groups (e.g. for minority groups), behavioural change groups, groups for people in life transitions and educational groups. As the focus of the study is specifically physically disabled children between the ages of seven and 12, group work specifically with children is now focused on.

3.4.2.3 Group work with children

Fatout (1996: 4) and Bruegemann (2006: 7) explain that group work with children began with early programmes and agencies such as boy scouts, girl guides and YMCA. Over time however, group work with children has evolved into treatment groups focussing on a wide range of problems, including mental or physical health problems. In earlier writings, Brown (1994: 38) recognized that individuals with, or treating people with physical health problems, could benefit from group work. The recognition that the group can be of benefit to individuals with physical health problems is particularly relevant for the context of this study.

Alissi and Casper (1985: 18), referring specifically to time-limited groups for children explain that small groups create a safe environment in which the children can simulate the responses and reactions of the real world. This may be important for children with disabilities, as they can learn how to respond appropriately to people's behaviour towards them. They go on to explain that the group can provide the opportunity for children to witness emotional responses, practice patterns of thinking, try out new social behaviours, and receive feedback from their peers. The group also allows for social learning and activities practiced in the safe environment of the group can then be employed in the child's social world. De Jager and Truter (2005: 123) in discussing group work with young adolescents place an emphasis on the emotional exchanges that take place in these groups. They state that the group can be important in dealing with earlier developmental experiences, defences and unconscious drives and motives.

In the light of previous perceptions mentioned i.e. that it is more the reaction of the physically disabled child than the disability itself that causes awkwardness in able-bodied person, having a safe environment such as a group in which to practice social reactions may be of the utmost importance for the disabled child.

3.4.3 SOCIAL COMMUNITY WORK

Social community work is the third method in social work practice. It has been established that social workers deal with individuals and groups, but they also and very often deal with communities as their clients.

There are many subdivisions and sub-definitions in literature regarding community work and community development. These all entail different aims, various types of task goals, process goals, operational goals and objectives, making the concept of social community work seem quite complex. In an attempt to understand where rehabilitation for the physically disabled child fits into social work, a very basic view of community work will be considered. The New Dictionary of Social Work (Terminology committee for social work, 1995: 12) states that community work is the planned action of the community and community worker, working together to improve the social functioning of the community as a whole. This is done by reducing the gap between the community's needs and the community's resources, which is ultimately the aim of social community work (Lombard, 1991: 76).

In order to understand community work properly, it will be necessary to understand the concept of community. Mayo (1994: 67) gives certain definitions that "fit" appropriately into this study. He relates community work largely to those who have been disadvantaged either through poverty or discrimination as a result of race, class, gender, sexuality, age or **disability** and refers to the sociological distinction between the two 'meanings' of community. A community can either be a group of people living in a specific geographic area or a community can be a group of people with a shared interest, e.g. ethnicity or **disability** (the latter definition being more appropriate for the purpose of this study).

3.4.3.1 Principles of community work

As with group work, where the success of the group depended on each of the members adhering to a core set of principles; there are a number of principles relating to community work that will also need to be adhered to in order to be successful within the community.

Lombard (1991: 73) summarizes these principles as follows:

- Respect for human dignity: The uniqueness of each individual is recognized as well as his ability to deal with his own problems according to his beliefs and resources.
- Individualising: The uniqueness of each community is recognized in that they have their own religious, social and economic factors.
- Self-determination: All people have some capacity to improve their own interests.
- Self-help: This implies that the community members accept the responsibility to do something for themselves.
- Respect for community needs: Needs should be identified by the community.
- Promotion of partnerships: The community and community worker are partners in the process of change, while the community worker gradually withdraws from the relationship as the community members begin to accept more responsibility.
- Promotion of change: Community work implies change.
- Development of local leadership: Community work identifies those leaders in the community who will encourage others participation.
- Involvement and participation: Involvement in a community brings about a sense of security for its members.
- Justice: Justice implies creating the same opportunities for all people to become what they have the potential to become.

As with social casework and group work, community work also aims for better social functioning, only on a larger scale. As can be seen from Mayo's (1994) definition as discussed in 3.4.3, this can be applicable to either disabled children within a specific geographic community or the disabled children's community as a whole.

3.5 REHABILITATION AND SOCIAL WORK PRACTICE PERSPECTIVES

The various methods that social workers use to bring about social change have been assessed. These methods however are carried out in different 'manners' according to

a “set of beliefs and assumptions about how and under what conditions people change and what a social worker can do to facilitate desirable change.” (Sheafor et al., 2000: 82). This set of beliefs that affects the practitioners’ way of working is known as a practice framework. Two of the ‘modern’ perspectives that can be used as part of a practice framework are discussed below, namely, the strengths perspective and the developmental perspective.

3.5.1 STRENGTHS PERSPECTIVE

Saleebey (1999: 14) states that the strengths perspective has become increasingly relevant over the last decade, both in social work and various relating fields. This perspective is an important one within the context of therapeutic horse-riding, as there the aim is to focus on what the child can do, rather than what he can not do, and this attentiveness to the clients’ strength is what Sheafor et al. (2000: 93) describe as being ‘the strengths perspective’.

3.5.1.1 Basic assumptions of the strengths perspective

The strengths perspective holds the belief that it is much easier to bring about lasting change in a client, when focusing and building on the strengths of the client, rather than trying to identify and eliminate his ‘problem areas’.

Saleebey (1999: 16) and Sheafor et al. (2000: 93) mention five assumptions of the strengths perspective namely:

- Every client has strengths (whether individual, group or community).
- Trauma and struggles may cause injury, but can also be an opportunity for growth.
- No one can know the upper limits of a client to grow and change
- Clients are best served when THEIR identified desires are taken to heart.
- There are plenty of resources that can be harnessed in the environment in which the client lives.

The strengths perspective therefore addresses issues as identified by the client. It has a very positive ‘outlook’ though, focusing on the resources that the client DOES have, both within himself and within his immediate environment. Once again, this is in line with the whole ethos and gist of therapeutic riding, where it is focused on what the child CAN achieve. As mentioned above, no one can know the upper limits of a client’s capacity.

3.5.2 DEVELOPMENTAL PERSPECTIVE

Very similar to the strengths perspective is another social work perspective that has become increasingly relevant, namely the developmental perspective. So much so, that the White Paper on Social Welfare introduced the developmental approach to the delivery of social welfare services. This emphasizes the multi-dimensional and integrated nature of service delivery, as well as the achievement of social and economic justice. (Department of Social Development: 2004).

The concept of the ‘developmental perspective’ will now be explored, as explained in the service delivery model for developmental social welfare services (Department of Social Development: 2004).



3.5.2.1 The developmental perspective made South African

The values and ethos of the developmental perspective to service delivery are based on the ‘Batho Pele’ principles, meaning ‘people first’, unique to South Africa (South African Government: 2005). The Batho Pele principles include:

- “regularly consult with customers
- set service standards
- increase access to services
- ensure higher levels of courtesy
- provide more and better information about services
- increase openness and transparency about services
- remedy failures and mistakes
- give the best possible value for money.”

Based on the above which appeared on the South African government's website (www.info.gov.za/aboutgovt/publicadmin/bathopele.htm), it would suffice to say that through the Batho Pele principles, the South African government aims to increase the quantity, quality and accessibility of services to South Africans. As mentioned in the first chapter, this is of great importance for the disabled community, as the majority of disabled children do not have access to specialised services such as special schools, occupational- or physiotherapy.

3.5.2.2 Values and principles of the developmental perspective

Taking the Batho Pele principles into consideration when setting up a developmental perspective to service delivery, has resulted in the social worker demonstrating the following values and ethos when using the developmental perspective:

- The people social workers serve come first in the performing of their duties.
- Social workers will ensure equity and freedom from discrimination and harassment.
- Social workers will work in partnership with the people they serve.
- Social workers will use the resources entrusted to them to deliver on the governments' priorities in the most efficient way. This means resources should be dispersed according to need, priority and historical imbalances and response should be according to social and economic conditions.
- Social workers will be transparent and accountable for their decisions, actions and performance.
- Social workers will share their knowledge with other departments.
- Social workers will uphold the Constitution of the Republic of South Africa.
- Social workers will acknowledge and respect peoples' potential to develop and change.
- Social workers will recognize the rights of all to participate in their own development.
- Social workers will commit to facilitate social processes that will bring about effective relationships, healthy organizations and communities.
- Social workers will ensure that people are fully involved in their own learning and change.

- Social workers will ensure that people are connected to others, so that they are more self-reliant.
- Social workers will ensure that all people will have access to all services.
- Social workers will strive to disperse resources according to need, priority and historical imbalances and response will be according to social and economic conditions.

(Department of Social Development: 2004).

From the above values, what particularly relates to the disabled community is the undertaking of social workers to avoid discrimination on any grounds. The sharing of knowledge and resources amongst South African service providers can also be of benefit to the disabled community. The developmental perspective therefore is focused on helping the client improve his situation by using the resources (social and economic) within and around the individual, group or community. It is an integrated perspective, making use of various government departments and 'disciplines' such as health and education to achieve maximum results.

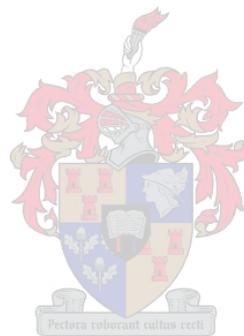
Both the strengths perspective and developmental perspective to service delivery fit perfectly with the aim of therapeutic riding, which as mentioned before is to focus on what the rider can do and build on that. Equine-assisted therapy is in line with the developmental perspective in that it makes use of multi-disciplined staff. The setting up of riding centres encourages the community to make use of the resources around them and creates employment opportunities. Therefore, while the children are being helped therapeutically and socially, the community is being assisted economically through job creation.

3.6 REHABILITATION AND SOCIAL WORK

When dissecting rehabilitation and social work methods and practice frameworks, definite parallels can be drawn between the principles of rehabilitation philosophy and the principles of social casework, group work and community work. Definite parallels can also be drawn between the theories and practice perspectives used in the

practice of rehabilitation psychology and the theories, perspectives and models used in the practice of social casework, group work and community work.

The diagram below marks the main principles of rehabilitation philosophy as well as the main principles of the various social work methods. The arrows are the ‘parallels’ between the principles, with the colour arrows showing the corresponding principles. As can be seen the gist of both rehabilitation and all of the social work methods is to enhance the social functioning of the individual, group or community within the context of their environment, by narrowing the gap between the clients’ needs and resources.



3.6.1 SHARED PRINCIPLES

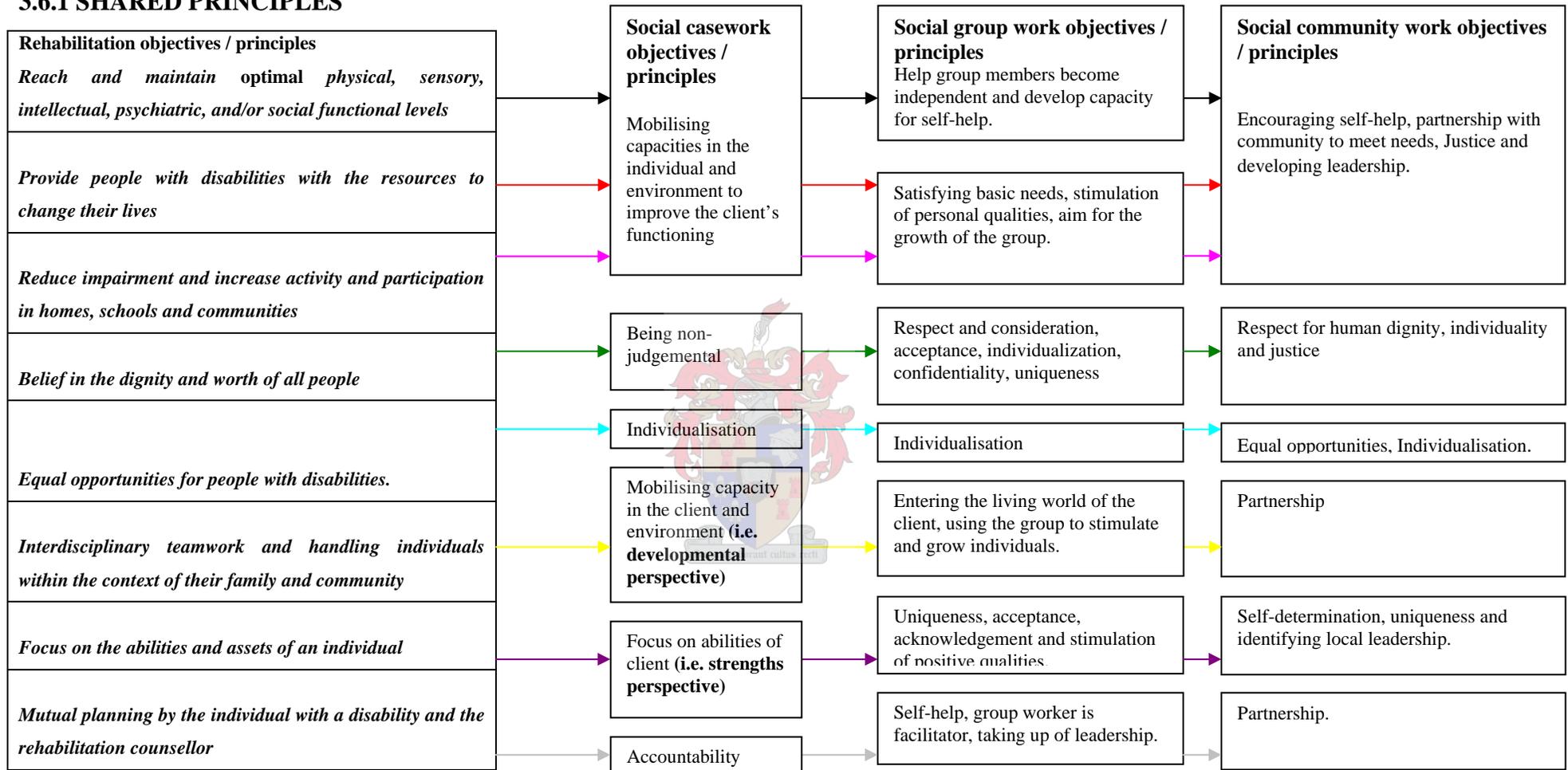
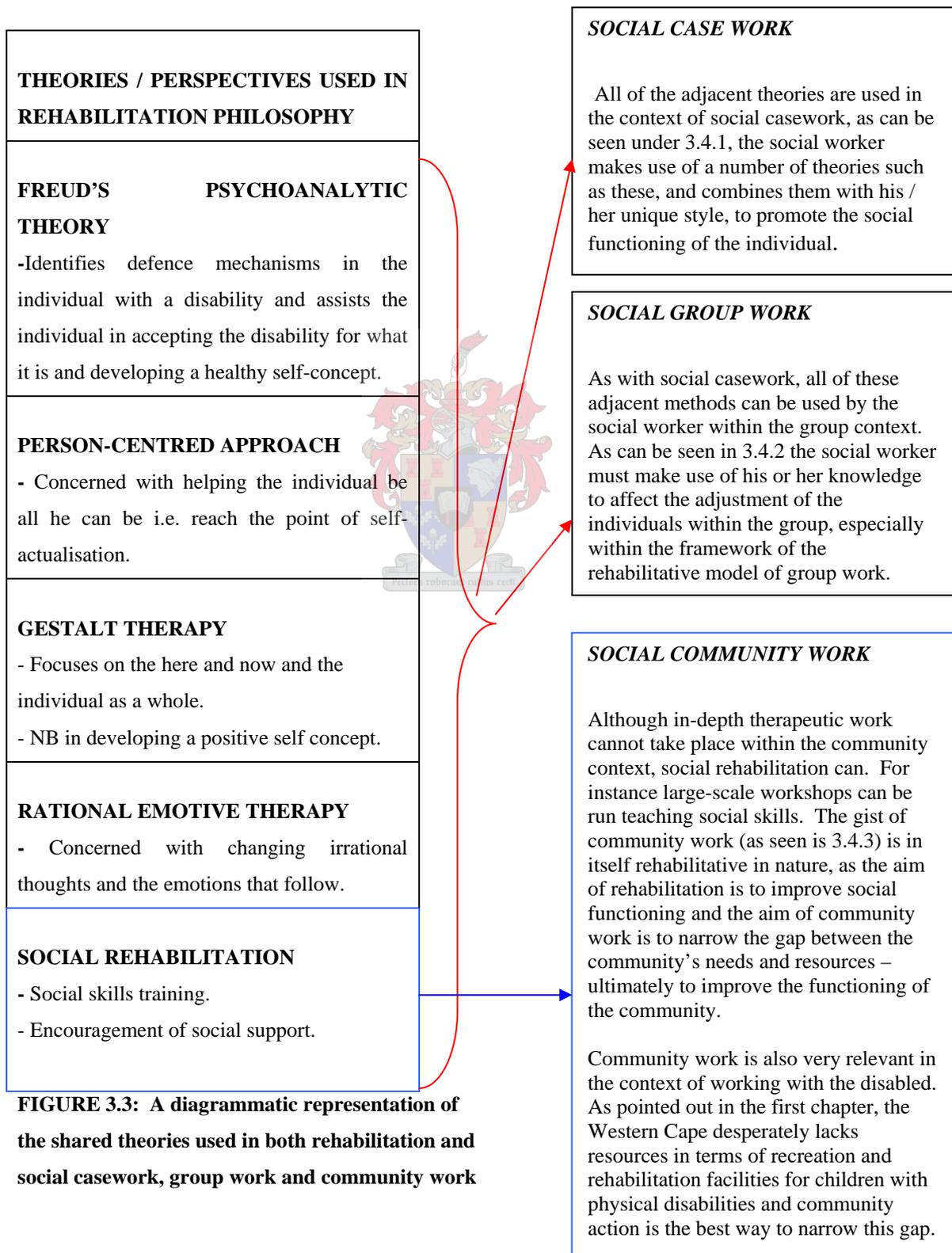


FIGURE 3.2: A diagrammatic representation of the shared principles of rehabilitation and social casework, group work and community work

3.6.2 SHARED THEORIES

In an attempt to understand how rehabilitation fits into social work, a diagram is presented below that explains how theories used in rehabilitative work are exactly the same theories that are utilised within the social work profession.



The diagram above is fairly self-explanatory. It shows that the theories and perspectives used in rehabilitation philosophy and the theories and perspectives used in social work are actually, to a large degree, the same. As we can see from the diagram, all the theories used in rehabilitation philosophy are used in social casework and group work (parallels indicated in red). Even theories used in community work correspond with theories used in rehabilitation philosophy, although in this case, only one theory, namely social rehabilitation (parallels indicated in blue). This would imply that although for the purpose of the study, rehabilitation and social work were looked at separately, rehabilitation is actually embedded in social work. It is an integral part of the social worker's mission, i.e. rehabilitation for all individuals; and in this case, rehabilitation for children with physical disabilities.

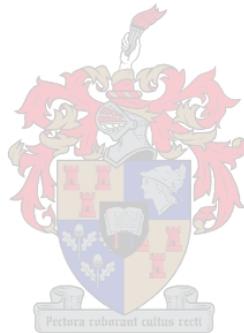
3.7 SUMMARY

This chapter provides an idea of how 'rehabilitation practice' fits into social work practice. The concept, principles, objectives, components and practices of rehabilitation were explored in the chapter. Rehabilitation is concerned with the individual adapting to his environment in a healthy manner and developing his abilities to the maximum. While it was acknowledged that medical and educational rehabilitation is key in becoming a 'whole' person, the focus of the chapter remained psychological and social rehabilitation. The gist of the various psychological schools of thought were explored and how they are used in rehabilitation – all of which are familiar to the social worker that has received formal counselling training (i.e. Freud's psychoanalytic approach, the person-centred theory, gestalt therapy and rational emotive therapy). The importance of social support in rehabilitation was established.

The increase in case loads for social workers and the lack of training social workers receive regarding rehabilitation was explored and how this effects rehabilitation in the South African context. Training in rehabilitation for social workers in South Africa leaves much to be desired.

Each of the social work methods enjoys individual attention, namely social casework, group work and community work, followed on by the most modern social work

perspectives, namely the strengths and developmental perspectives. From exploring these, it became evident that many principles and practices of rehabilitation philosophy/psychology and social work casework, group work and community work are similar. These similarities are presented in two tables (refer to table 3.1 and 3.2). This chapter proves that rehabilitation is a key component of the aim of social work in general. Although looked at separately in this chapter, rehabilitation and social work cannot, for all intents and purposes, be separated.



CHAPTER 4: EQUINE-ASSISTED THERAPY: A PSYCHOSOCIAL VIEW

4.1 INTRODUCTION

In the previous chapter rehabilitation philosophy and methods were explored. Various social work methods and practice perspectives were then discussed and rehabilitation was shown to be an integral part of social work, in that many of the principles and theories used in rehabilitation philosophy and social work were shown to be similar. In this chapter the focus is on one method of rehabilitation for the physically disabled primary school child, namely equine-assisted therapy. It attempts to meet the third objective of the study as mentioned in 1.3.2, i.e. to describe the physical, psychological, emotional, cognitive and social benefits of equine-assisted therapy for children with disabilities.

For the purpose of this chapter it will be necessary to remember that equine-assisted therapy encompasses all forms of hippotherapy and therapeutic riding and related equestrian activities.

The chapter deals with a brief overview of the history of therapeutic riding around the world, as well as in South Africa. Thereafter, the aims and benefits of therapeutic horse riding are explained, with the focus remaining on the psychological and social benefits that riding holds for the physically disabled primary school child.

4.2 HISTORY

This section endeavors to understand where the concept of using horses for rehabilitation came about and how it has developed through the years.

Stuart (1999: 15) in her thesis *An Evaluation of the physical and psychological effects of a riding therapy programme for cerebral palsied children*, reports that the use of the horse for disabled persons has appeared in literature for centuries. It is believed that the ancient Greeks used horses to improve the spirit of individuals who were considered incurable or untreatable. Riede (1998) as cited in Benda, Nancy, McGibbon and Grant (2003: 823) confirms that documentation of the benefits of the

horse to health and well-being have existed since the fifth century when injured Greek and Roman soldiers were placed back on their horses to facilitate recovery. As far back as 1735 Quellmaltz published writing on the therapeutic use of the horse in his publication *Novum Sanitatis Praesidium ex Equitatione, Mchinae Beneficio Instituenda*.

NARHA (1995: 2) in their NARHA Strides Magazine, (NARHA standing for North American Riding for the Handicapped Association) report another early publication regarding the use of the horse in treatment, namely an 1870 thesis by Chassain, a student at the University of Paris. Stuart (1999: 15) also makes mention of a 1875 study by Gassigne (probably the same person), who found that riding was beneficial for hemiplegia, paraplegia and other neurological disorders, hypothesizing that it improved the posture, balance, joint movement and muscle control of these patients.

The Riding for the Disabled Association (1990: 13) explains how, in Britain, the use of horses in rehabilitation was first recognized by Dame Agnes Hunt. She started the first orthopedic hospital in Oswestry in 1901. The Riding for the Disabled Association (1990: 13) also mention Miss Olive Sands who took her horses to Oxford Hospital to assist the wounded soldiers of the 1914-18 war.



It was however Madame Lis Hartel who made the most significant impact on the equestrian world for the disabled, bursting open the realm of opportunities that exist for the disabled person and the horse. Madame Hartel contracted polio in 1943 and despite being confined to a wheelchair; she went on to win a silver medal in the 1952 Olympic Games dressage event in Helsinki (RDA, 1990; Adams & McCubbin, 1991; De Pauw, 1986; Whalley, 1980; Wood, 1990 as cited in Stuart, 1999). Since then, riding for the disabled has spread across Europe, Britain, U.S.A, South Africa and Australia.

The first therapeutic riding centre in the U.S.A was set up in 1969 in Michigan and NARHA was formed that same year. In the late 1970's regular articles were published (in German) regarding the use of therapeutic riding. Today hippotherapy is practiced in more than thirty countries across the world (Wilson & Turner, 1998 as cited in Benda, Nancy, McGibbon & Grant, 2003: 823). In 1985 the Riding for the

Disabled International organization (RDI) was established (A Handbook for volunteer helpers: s.a).

Not only have horses been recognized for the facilitation of physical rehabilitation, but Boris Levinson, a psychologist, pioneered much interest in the psychological benefits using animals in therapy. In his case, he found that he was significantly more successful in reaching a child patient, when the patient's pet dog, Jingles, was present. (Mallon, 1992 as cited in Heimlich, 2001).

It can be seen therefore, that the horse has been used as a means of rehabilitation almost as long as modern society has existed and not only for physical, but also for psychological rehabilitation.

4.2.1 HISTORY OF THE SOUTH AFRICAN RIDING FOR THE DISABLED ASSOCIATION (SARDA)

As seen above, therapeutic riding has a long history. It started slightly later in South Africa though, being brought to the country in 1973 by Belinda Sampson, the mother of a cerebral palsied son. After a visit to the RDA Diamond Centre in England, she returned to Cape Town keen to start a similar programme. Through various donations and the assistance of Joy Finlay, a well-known equestrian in South Africa, lessons were started with five cerebral palsied children. The programme snowballed over time and in 1976 the South African Riding for the Disabled Association was established.

By 1979 there were various groups all over South Africa offering therapeutic riding and the SARDA National Association was founded. SARDA National moved to its current location in Constantia in 1982.

Today SARDA has major centres around the country, is an associated member of the Riding for the Disabled Association in the United Kingdom and is affiliated to the Riding for the Disabled International organization.

A typical SARDA lesson requires a team of people to make the riding therapy possible, these people include:

- The instructor: decides on the lesson plan, equipment, and matches horse to rider and volunteers to rider. The instructors have to do approximately fifty hours of teaching at a SARDA branch before they are allowed to write the various modules of the exam. The modules include sections on physical disabilities, mental disabilities, stable management, an able bodied teaching exam and a disabled teaching exam. The researcher is currently a candidate instructor and is in the process of completing the various modules of the exam.
- Physiotherapist: attends as many of the lessons as possible to ensure that the child is deriving maximum benefit from the lessons.
- Leader: is responsible for the leading of the horse. If there are no side-walkers, he will have to keep an eye on the child as well.
- Side-walker / helper: acts as a 'go-between' between the rider and the instructor, relaying the instructions to the rider and assisting them in performing the instruction (A handbook for volunteer helpers, 1999: 10).

All of the above would take into account the kind of disability of the child and would focus on what the child IS able to do. The leaders and side-walkers are mostly laymen with a passion for the children and the horses. The therapists and instructors on the other hand, would have a more professional knowledge on the condition of each child and will attempt to plan the lessons according to the child's developmental stage as discussed in chapter two, as well as their type of disability, but most importantly, their **ability**. The riding lessons for the disabled take on very much the same form as an able-bodied lesson, encouraging the correct riding position (which is the position where the physically disabled child derives the most benefit), and encouraging the children to ride as independently as possible.

Later in this chapter, it is looked at what influence the therapeutic riding programme may have on the child. To fully understand these benefits though, it is important to understand the aims of therapeutic riding.

4.3 AIMS OF THERAPEUTIC RIDING

It has been established that the main aim of this chapter is to describe the physical, psychological, emotional, cognitive and social benefits of equine-assisted therapy for children with disabilities. Therefore the focus will remain psychosocial aims of riding. Each of the disabilities discussed in chapter two however, have specific 'physical goals' for therapeutic riding that are worth discussing.

4.3.1 PHYSICAL AIMS FOR CHILDREN WITH CEREBRAL PALSY

The fact that cerebral palsy is a persistent, but not unchanging disorder of movement and posture due to a progressive disorder in the developing brain was discussed in chapter two (2.3.1.1).

Physical aims for the cerebral palsied child will include improving balance and posture, improving symmetry, reducing spasticity, reducing involuntary movements or repeated abnormal patterns that may lead to deformities and encouraging use of the affected side of the body (The Riding for the Disabled Association, 1976: 81; SARDA, 1999: Section 10A, p17).

4.3.2 PHYSICAL AIMS FOR CHILDREN WITH SPINA BIFIDA

As discussed in chapter two (2.3.2.1), spina bifida is a defect in the spine, affecting the nerves associated with that region. It may lead to leg weakness or paralysis, sensory loss, bladder dysfunction, apnea, swallowing difficulties, headaches, balance and coordination difficulties, cognitive disabilities and language difficulties.

From the researcher's own observation as a candidate SARDA instructor, the physiotherapist or occupational therapist will need to be consulted regarding the physical aims for each individual child with spina bifida, as the severity of disability can differ significantly from child to child. Some children are only mildly affected and will be able to ride independently, whereas others have absolutely no use of their legs. Children with a shunt as a result of hydrocephalus will also be slightly more restricted than those without.

The standard physical aim, however, for a child with spina bifida would include improving posture and balance and increasing trunk control (SARDA, 1999: Section 10A, p31).

4.3.3 PHYSICAL AIMS FOR CHILDREN WITH EPILEPSY

Epilepsy is described as a convulsive disorder in chapter two (2.3.3.1), where there is a sudden, excessive and disorderly discharge of neurons in a normal or diseased cortex. It is a disease of the central nervous system where seizures are spontaneous and recurrent.

Therefore the majority of children with epilepsy are only physically affected during a seizure. From the researcher's own experience, the physical aims for the child with epilepsy would be to teach them the basic sport of riding, until they are able to ride independently. However, the instructor would have to be sensitive to avoid any stimuli that may trigger a seizure, e.g. bright or flashing lights.

4.3.4 PHYSICAL AIMS FOR CHILDREN WITH MUSCULAR DYSTROPHY



Muscular dystrophy is described in chapter two (2.3.4.1) as an inherited disease occurring more commonly in boys, causing increasing weakness of the muscle tissue, especially that of the skeletal muscles.

SARDA (1999; section 10A, p13) recommends consulting the physiotherapist when planning a riding programme for these children, because although graded exercise can help keep these children fit, it is of the utmost importance to avoid fatigue. Children may also be at different stages within this progressive disease, so professional advice would have to be sought before setting up goals for these children. General goals however would also include improving balance and posture, improving symmetry and body awareness (The Riding for the Disabled Association, 1976: 81; SARDA, 1999: Section 10A, p17).

It can therefore be seen that individual goals for these children are of the utmost importance and the expertise of a physiotherapist or an occupational therapist will need to be consulted regarding the physical goals. Equally important however, are the psychological goals for these children. These goals are discussed further in the following section.

4.4 PSYCHOSOCIAL AIMS OF THERAPEUTIC RIDING

While SARDA places great emphasis on fun and recreation, their main aim is to incorporate physical exercise with the learning of social skills and educational skills **e.g. language, communication, concentration and independence** (A handbook for volunteer helpers: s.a.). In light of the psychosocial challenges faced by physically disabled children, these four social and educational skills are critical.

4.4.1 LANGUAGE AND COMMUNICATION

It was established in chapter two that children with physical disabilities are often found to have impairments in oral-motor functions (particularly children with cerebral palsy), making communication even more difficult. Solot (as cited in Dormans & Pellegrinio, 1998: 347) explains that the use of speech and language for communicating, for learning and for regulating behaviour is a critical developmental task and forms the basis for all social interactions. He goes on to explain that impairments in oral-motor functions and communication can seriously disrupt the normal process of bonding and attachment.

The problem with communication for the physically disabled child is further exacerbated by the fact that the disabled child senses the awkwardness of able-bodied people towards him, discouraging social interaction and thus confirming that he is 'difficult to get along with' (Thomas, 1978: 37). The encouragement of the use of language and communication is therefore of great importance to the middle-aged child with a physical disability, as developing greater social relationships is one of the developmental milestones of their age group.

4.4.2 CONCENTRATION

Stimulating the middle-aged child and encouraging concentration within the riding lesson, can assist the child's cognitive development. As established in chapter two when discussing cognitive development, the middle-aged child is in the concrete operational period, where he is developing classification and conservation skills and developing number concept (see 2.2.2). From the researcher's experience as a candidate SARDA instructor, there are numerous exciting games within the therapeutic riding world that can be successfully used to develop these skills, while keeping it fun and therefore prolonging concentration, e.g. asking the children to collect two flags of a specific colour. Each week the child can be asked to collect more flags, then the game can be made more complicated by asking him to collect a certain number of flags of one colour and another number of flags of another colour. The game can be made more and more fun and more and more complicated as the child progresses.

4.4.3 INDEPENDENCE

Encouraging independence in the child can be of the utmost importance. In chapter two, it was looked at how overprotective parents of physically disabled children can restrict the child's self-initiative and make him afraid to function in any manner without his parents (see chapter two, 2.4.1).

Ultimately the aim is to develop the person with the disability to his full potential in all areas of his life. As can be seen, everything that the child is encouraged to develop in the lessons are 'rehabilitative tools' which he will need to learn in order to function successfully in his ordinary life situation.

In light of the above mentioned aims, the benefits that the children derive from therapeutic riding programmes will be explored.

4.5 BENEFITS OF RIDING

The rapid development and growth of therapeutic riding around the world serves as proof that the riders and all involved not only enjoy equestrian activities, but also derive much benefit from these programmes. The following section will delve into what these benefits are.

Mary Longden (1988: 1), a well known individual in the therapeutic riding circles of Australia, states that “(t)he benefits of riding are physical, psychological, and an intermingling of the two. The psychological benefits are entirely related to the physical or mental nature of the disease, the physical nature of riding and the mental and emotional state of the rider.”

4.5.1 PHYSICAL BENEFITS

Although the focus of this study is the psychosocial aspects of therapeutic riding, it is understood in the social work profession that an individual is not a fragmented entity and should be considered in his whole context. In other words, it is understood that any improvement in the physical condition of a disabled person, will naturally have an impact on his psychological and social well-being.

Bertoti (1988) as cited in Stuart (1999: 46) explains that the whole rationale for riding therapy is that the horse's movement imparts a smooth, rhythmic pattern of movement to the rider. The horse's centre of gravity is displaced three-dimensionally when it walks. This creates a movement in the pelvis of the rider that is very similar to the movement of the pelvis during the human gait (Fleck, 1997 as cited in Benda et al., 2003: 824).

When riding, the rider's lung capacity is increased, aiding circulation and improving muscle tone, brain function, stamina and general health (Longden, 1988:2; Bertoti, 1988 as cited in Stuart, 1999: 46). Longden (1988: 3) believes so strongly in the therapeutic value of riding that she states that the position of sitting on a horse without doing anything else is in itself, an exercise. For example, when a cerebral palsied child with adducted hips and extended knees and feet is mounted, the child is

immediately placed in a position encouraging abduction of the hips and flexion of the knees and ankles. Liz Baker, NARHA Medical Committee Chairperson, when addressing the benefits of therapeutic riding for cerebral palsied children, agrees that the rhythmic movement of the horse, as well as the shape, warmth and inherently motivating quality of the horse is very useful to the cerebral palsied individual, promoting relaxation (NARHA, 1995: 2; Bertoti, 1988 as cited in Stuart, 1999: 46). According to Baker, riding improves sensorimotor and cognitive development. It creates a sense of responsibility and self-confidence, while simultaneously encouraging good posture, balance and flexibility (NARHA, 1995: 2).

Riding and related activities, like grooming, improve eye-hand coordination and aid the development of fine and gross motor skills. This in turn assists the disabled child to participate in daily activities with greater ease, activities such as feeding themselves and personal hygiene (Longden, 1988: 3).

In a study evaluating the effect of hippotherapy on muscle activity in children with spastic cerebral palsy, Benda et al. (2003: 817) concluded that hippotherapy improved symmetry in muscle activity. They state that hippotherapy improves physical, cognitive and emotional capabilities and enhances nurturing capabilities that may be untapped by conventional therapeutic methods.

Similarly, Lechner, Geldhaus, Gudmundsen, Hegemann, Michel, Zäch and Knecht (2003: 502) from the Institute for Clinical Research at the Swiss Paraplegic Centre, conclude that hippotherapy is a valuable supplement to conventional physiotherapy. They conducted a study to evaluate the short-term effect of hippotherapy on spasticity of spinal cord injury patients and found that it significantly alleviated spasticity in the lower extremities of these patients (thirty two patients between the ages of 16 and 72). In their discussion of hippotherapy, they quote Strauss (1995) who assigns the success of hippotherapy to the unique effect it has on neural facilitation and sensorimotor stimulation as well as its psychosomatic influence, i.e. it has both mental and bodily effects (Reber, 1995: 620).

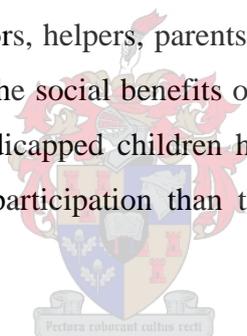
Therapeutic riding and related activities therefore aid the development of the child and uniquely achieve the individual therapy goals for the child i.e. in a child with

‘floppy muscles’ such as athetoid cerebral palsy, the muscle tone and trunk control is increased with riding, whereas in the ‘tight muscled’ spastic child, the muscle tone is decreased and the child achieves greater range of motion in the limbs. Equine-assisted therapy provides a fun and effective alternative to conventional therapy methods.

4.5.2 SOCIAL BENEFITS

Despite having obvious physical benefits, equine-assisted therapy also has many social benefits.

Centres often report on improved social interaction with peers once the child has started riding (Longden, 1988: 2). Children are given many social opportunities when taken for therapeutic riding lessons and given the chance to interact with many new people such as the instructors, helpers, parents and fellow riders, and of course, the horses (Stuart, 1999: 47). The social benefits of therapeutic riding are important in light of the finding that handicapped children had fewer close relationships and fewer opportunities for social participation than their non-handicapped peers (see chapter two, 2.4.2).



4.5.3 PSYCHOLOGICAL BENEFITS

As mentioned earlier in this chapter (4.4.1), therapeutic riding has a psychosomatic effect, in that it not only has a physical effect on the disabled individual, but also affects them mentally and psychologically, which in essence is the focus of this study.

To the disabled person, riding offers the opportunity to participate alongside able-bodied individuals. Dworetzky (1995: 292), Louw et al. (1998: 53) and Feldman (2000: 345) discuss Erik Erikson’s theory in chapter two (see 2.2.3.2 b), that is that children between the ages of seven and twelve are in the psychological phase of *industry versus inferiority*. This involves the child developing his self-concept by comparing what tasks he is able to perform in comparison to his peers. Affording the disabled child the opportunity to participate alongside his able-bodied peers results in

a newfound independence and success that leads to improved self-image and consequently greater confidence (Longden, 1988: 2).

Riding is also good for the spirit in that it allows especially the wheelchair bound child to take part in experiences that he otherwise never would, e.g. a walk along the beach on horse-back (it would be extremely difficult to push a wheelchair along a sandy beach) or to go on an outride through the rugged country side. All this and the experience of being able to look down on others from horseback instead of looking up from the wheelchair allows a great feeling of well-being (Longden, 1988: 2).

Benda et al. (2003: 824) came to the same conclusion in their statement that hippotherapy offers the psychological enhancement of being able to move freely through space on a powerful animal without the aid of assistive devices. There are also positive emotional ties that are formed between the child and the horse. It is therefore as far as possible, attempted to keep the same child on the same horse (with the same helper) during every session.

Glazer, Clark and Stein (2004: 171) of Ohio, U.S.A. focused on the impact of hippotherapy on grieving children. Although not necessarily focused on disabled children, their findings shed much light on the way equine-assisted therapy and the use of the horse can facilitate the grieving process. This may be applied to disabled children too, who may be grieving the loss of a limb or a loss of physical ability and freedom.

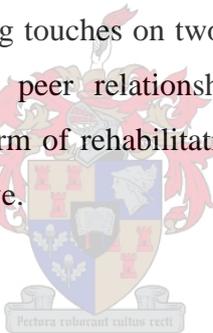
Glazer et al (2004: 171) had six riding sessions with five children aged four to fourteen. Their research showed that the children gained in confidence, trust and communication skills. They communicated more freely with others and with the horses as the research advanced. There was a transfer of behaviour learned during the riding sessions to home and parents reported that the children gained in self-confidence and self-esteem.

The website for the North American Riding for the Handicapped Association (NARHA) makes available a pilot study that was conducted by three students at Catham College, Pittsburgh, under the assistance of Carolyn Gatty, assistant professor

in the Master of Occupational Therapy program at the college. Gatty's (2004: 2) pilot study included five children between eight and thirteen with congenital hypotonia, learning disabilities and cerebral palsy. The students and Gatty wanted to determine whether self-esteem is enhanced by therapeutic riding. Self-esteem was found to be higher after the riding therapy programme, although this was only a pilot study with no control group, therefore no conclusive statements could be made.

From the above, it appears that the greatest psychological achievements of riding are in the area of improved self-esteem and self-confidence leading to greater communication. In chapter two the three psychosocial developmental tasks that the middle-aged child needs to develop were spelled out. These include the acquisition of a greater self-knowledge and self-concept, the extension of social participation, i.e. developing a peer group (for which communication skills are of the utmost importance) and lastly, the development of moral judgement and behaviour. When it is considered that therapeutic riding touches on two of these three tasks directly (i.e. self-concept, communication and peer relationships), therapeutic riding can be justifiably said to be a relevant form of rehabilitation therapy for the disabled child between the age of seven and twelve.

4.5.4 LANGUAGE BENEFITS



The encouragement of the use of language was identified as one of the main aims of therapeutic riding. The importance of language and communication was explained earlier in this chapter (4.4.1) and speaking from many years of experience, Longden (1988: 2) explains that it is in this area of language development that riding has one of its greatest successes.

Being around an animal that is not critical of the person with a disability seems to unlock the rider's inhibitions of talking. Longden (1988:2) reports that children have been known to speak their first words while on horseback. Other children who usually only speak in the home environment learn to communicate with words during the riding lesson. By bringing language and singing into the games played, speech skills are encouraged and lung capacity is increased, causing a relaxed upper body.

In line with Longden's observations, Liz Baker, chairperson of the NARHA medical committee, discusses articles by Ruth Dismuke Blakely, who found that the movement of the horse increases the quantity, quality and volume of vocalization in the rider. Riding tends to improve the coordination of breathing, swallowing and sound production thereby aiding speech and language development (NARHA, 1995:2).

Once again, improved language and communication aids the successful development of the age-appropriate 'milestone' for the middle-aged child, namely that of increased social participation.

4.5.5 EDUCATIONAL BENEFITS

When disabled children are taken riding, they are provided an educational opportunity outside of the classroom. They are exposed to nature and may develop alternative interests e.g. birds and plants.

The development of concentration was identified as a main aim for therapeutic riding. Concentration can be increased gradually within the riding situation, with many interesting and enjoyable games that aid concentration and demand more from the child as he progresses e.g. the ribbon game, where the child is required to untie and name a series of ribbons placed around the arena – with the series becoming longer as the child progresses (Longden, 1988: 4).

Research therefore shows that there are definite benefits of riding for the 'whole' person, in other words for their physical being, social and psychological being and all that that entails. There are however many reports on these benefits that have not necessarily come from scientific research but from the experience and observations of those who work with the disabled children and their horses on a daily basis. These will be explored in the following section.

4.6 REPORTS FROM THERAPEUTIC RIDING CENTRES

There are a number of long standing therapeutic riding programmes around the world that mention the following benefits of therapeutic riding for the rider. These benefits are not based on scientific research, but have come from hands-on experience of those involved; yet they are in agreement with the studies discussed above. In order to see how these benefits are in line with other research results and to gain a feel as to how they relate to this study, they are presented in the following table .

TABLE 4.1: The benefits of therapeutic riding as they relate to the applicable developmental milestones

		Psychosocial	Developmental	Milestones
Physical benefits	Cognitive benefits	Benefits regarding the extension of social participation	Benefits regarding the acquisition of greater self-knowledge	Benefits regarding moral judgement and behaviour
*Language development *Development of eye-hand coordination *Development of muscle strength *Improvement of balance *Increase in range of motion	*Sensory stimulation (from the smells of the farm and the feeling of the horse) *Teaching of sequencing, counting, colours *Increase in attention span, spatial awareness	*Language development *Increase in social interaction (the child gets one on one attention – at times three on one attention, with two helpers and the horse)	*Increase in self-confidence, self-image and self-esteem	*Development of emotional control (e.g. the child learns that emotional outbursts will only upset the animal)

Sources: Special Child Information Avenue Archives; Carousel Ranch Therapeutic Riding Program; Lovelane special needs horseback riding program; Sunrise Park Inc.

As seen above, the observed benefits of these riding programmes have a bearing on the developmental milestones of children between the ages of seven and twelve, and also on the areas they struggle in as a result of their disabilities.

4.7 THERAPEUTIC RIDING AND SOCIAL WORK

The researcher did not find any information on social workers practicing equine-assisted therapy within South Africa (although there are those social workers who incorporate animal assisted therapy as part of play therapy).

The social workers at Thomas University in the United States of America however, have grasped how beneficial equine-assisted therapy can be in their work. In Bridges (2005: 3), their Newsletter for alumni and Friends of the Thomas University division of social work (2000: 3), they enthusiastically speak of a pioneer therapeutic Horseback Riding Course that was offered by Dr Laura Myers to the social work students of the University. Dr Myers stated that the course provided the students with knowledge of the various physical and mental disabilities and gave them the opportunity to work individually with these children within a therapeutic riding environment. Should a social worker not necessarily desire to work with the children and the horses, being involved even if only for a short period, will definitely increase knowledge of the various disabilities and the challenges that these children face. This in turn can only be beneficial in the social worker's service rendering towards the disabled client, whether it be in the case work, group work or community work context.

Much of therapeutic riding and equine-assisted therapy is in line with the strength perspective and developmental perspective as discussed in chapter three (3.5), which was identified as an integral part of South African social work service delivery. The gist of these two perspectives involves focusing on the resources that the client DOES have and helping the client improve his situation by using these resources (social and economic). Much of the success and benefits of therapeutic riding comes from exactly this, i.e. focusing on what the disabled child CAN do and not on what he CAN'T do.

As seen in the previous chapter, rehabilitation is intertwined in social work. From the information in this chapter, it can be seen that therapeutic riding holds benefits for each developmental milestone for the child between seven and twelve years of age. Many of the struggles that the disabled child experiences in relation to these milestones as a result of disability are directly counteracted within the therapeutic riding environment. Based on all of the information above, therapeutic riding may be a valuable tool for social workers in their rehabilitative work.

4.8 SUMMARY

This chapter explores how equine-assisted therapy came about and how it has developed around the world and in South Africa to what it is today. As equine-assisted therapy has developed, many benefits have been found to come from this form of therapy including the physical benefits of improved symmetry, muscle control and sensory stimulation.

Apart from the physical benefits that equine-assisted therapy holds for disabled children, there are many psychological benefits including improved self-esteem, improved confidence and increased socialization and communication. Language abilities are increased and being in a new and interesting environment also offers many educational opportunities outside of the classroom.

Owing to the holistic influence that equine-assisted therapy has on disabled individuals, it may offer the social worker an interesting and exciting way of working with disabled clients in assisting them to reach their full potential.

CHAPTER FIVE:
PSYCHOSOCIAL ASPECTS OF EQUINE-ASSISTED THERAPY FOR THE
PHYSICALLY DISABLED PRIMARY SCHOOL CHILD.

5.1 INTRODUCTION

The White Paper on an Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) holds the view that access to appropriate rehabilitation services for the disabled community can make the difference between leading an isolated and economically dependent life and playing an active role in society.

One of the objectives of the White Paper on an Integrated National Disability Strategy (Office of the Deputy President, 1997: 27) is to enable the disabled to reach and maintain their optimal physical, sensory, intellectual, psychiatric, and/or social functional levels. It mentions that the appropriate training of people involved in rehabilitation services is a core component of reaching this objective and that personnel and other rehabilitation workers include amongst others: therapists, psychologists and social workers.

This study envisages the equipping of social workers in their work with the disabled by gaining insight into a groundbreaking method of rehabilitation i.e. equine-assisted therapy. The study aims to present a description of the psychosocial elements of equine-assisted therapy for physically disabled primary school children. This was to be done by investigating the psychosocial dynamics occurring in primary school children that have participated in an equine-assisted therapy program at the South African Riding for the Disabled Association.

This chapter will take a look at the methods of this investigation. In other words, the chapter will denote how the data was collected, analyzed and interpreted during the empirical investigation. The chapter consists of two parts, namely, an outline of the work procedure, followed by the results obtained from the qualitative interviews and the interpretation thereof.

5.2 EMPIRICAL STUDY

The empirical investigation is based on the literature study and is aimed at exploring and describing psychosocial dynamics in disabled primary school children that have participated in equine-assisted therapy. This section will explain the research design used and the methods used in collection of the data.

5.2.1. RESEARCH METHOD

As described in chapter one, the study is exploratory and descriptive. In the empirical investigation, the researcher wished to satisfy a curiosity and desire for better understanding of the psychosocial elements of equine-assisted therapy, making the study exploratory (Babbie, 1989: 80). As mentioned in the “motivation for the study”, much is known on the physical advantages of equine-assisted therapy, but very little on the psychosocial elements that the researcher wishes to explore. There is thus support for Babbie’s notion of the study being exploratory as Ferreira (2001: 21) and Fouché (2002: 109) agree that exploratory studies aim to explore a relatively unknown terrain.

The study endeavours to understand the psychological and social aspects of equine-assisted therapy, leading to a more holistic outlook on this form of therapy. Fouché (2002: 109) recognizes this desire for a “thicker description” as being a descriptive study.

A qualitative research method was applied to the study, in that case studies were done on five children from SARDA and the researcher aims to “describe the social reality from the points of view of participants within the systems studied.” (Epstein, 1988: 188).

5.2.2. SAMPLE SELECTION

Non-probability selection sampling took place as a **convenience sample** was used, i.e. the sample was aimed at a part of the population that is readily available (Ferreira, 2001: 42).

Case studies were done on five children from Astra School for Physically Disabled Children who have participated in the therapeutic riding programme at SARDA, Cape Town on a Thursday morning. These children were all between the ages of seven and twelve with various physical disabilities. As Fouché (2002: 271) explains, the case study seeks to gain as much knowledge on the 'case' as possible through various methods such as interviews, documents and observations. This specific study made use of the intrinsic case study method where the aim is to gain a better understanding of the individual case.

The children from Astra were selected out of convenience, as they rode on one of the mornings that the researcher volunteered at SARDA. Out of various groups that were available to be 'studied' this group was selected owing to their disabilities being only physical, meaning that they would be able to communicate with the researcher when the interviews needed to be done. Several other available groups manifested both physical and mental disabilities, making communication and thus the research, difficult. The five children chosen out of the Astra School group were children that were the appropriate age for the study, i.e. between the ages of seven and twelve.

Permission was received from SARDA as well as from Astra School for Physically Disabled Children to conduct the study. Two of the children were day scholars at the school and permission was gained from their respective parents to conduct interviews with these children (Addendum A). The other three children were in the school hostel and their guardian was therefore the principal, who had already granted permission for the participation of his pupils in the study. The table below reflects the demographics of the children chosen who met the criteria for inclusion.

TABLE 5.1: A representation of the demographics of the children who met the criteria for inclusion

<i>Case study</i>	<i>Race</i>	<i>Age</i>	<i>Gender</i>	<i>Disability</i>	<i>Approximate time involved in riding</i>
A	Coloured	11	Male	Through knee amputee with spina bifida.	6 months
B	Coloured	12	Female	Spina Bifida	2 years
C	Coloured	11	Male	Cerebral Palsy	1 year
D	Coloured	10	Female	Spina Bifida	2 years
E	Coloured	9	Male	Spina Bifida	6 months

5.2.3 METHODS OF DATA COLLECTION

Data was gathered by two means, namely a focus group, and individual interviews with the five children.

5.2.3.1 Focus Group

The group used in the empirical investigation can be regarded as a focus group, as it perfectly fit the description of a ‘focus group’ as offered by Greeff (2002: 306), i.e. it was a group focused on a specific topic, namely equine-assisted therapy. The environment was one that encouraged the participants to “...share perceptions, points of view, experiences, wishes and concerns, without pressurizing participants to vote or reach a consensus.”

The focus group was held at SARDA on a Saturday morning. It consisted of the SARDA instructor for Astra School for Physically Disabled Children, the school’s physiotherapist who always attended the riding sessions; and five of the helpers who assist in the Astra class on a weekly basis. The helpers are the individuals who lead the horses and walk next to the children to ensure a safe ride.

The second Astra School physiotherapist (referred to from here on as physiotherapist B) was however unable to attend the focus group and was interviewed individually at

a later stage. (The same interview guideline that was used for the group was used in the discussion with this physiotherapist as well). Her response was much the same as those who participated in the focus group.

From the literature review, a deductive interview 'guideline' was drawn up by the researcher (Addendum D). During the focus group meeting, each child on whom a case study was being done was discussed individually. A review was done on the child's disability and then the 'guideline questionnaire' was run through for each child respectively i.e. the researcher asked the question and a discussion was held around the question.

The 'guideline questionnaire' consisted of open-ended questions aimed at addressing various themes as identified from the literature review. These themes included social behaviour, self-esteem and self-image, confidence, emotions, discipline, communication, cognitions and academic performance.

The members of the focus group were informed well in advance of the group. They were informed that the researcher was interested in the psychosocial functioning of each of the respective children. They were also informed of which children would be discussed and, the week before the focus group, each of the respective children were brought for a riding lesson to refresh the memories of the helpers. (There are approximately ten Astra children that take turns riding and therefore the children only ride on alternate weeks.)

The focus group was video-recorded with the consent of the participants to afford the researcher the freedom of listening and probing without the need to take notes. As a result of the group members being well prepared for the group, many of the 'themes' were discussed naturally within the course of conversation and consequently all questions in the interview guideline were covered.

5.2.3.2 Interviews with the children

A qualitative semi-structured individual interview was held by the researcher with each of the five 'subjects' of the case studies. The interview was held at the school

with the permission of the principal and physiotherapist. The researcher wished to understand the children's experience of their riding therapy. Kvale (as cited by Greeff: 2002) explains the usefulness of the interview in learning about people's experiences when he says that the qualitative interview "attempts to understand the world from the participant's point of view, to unfold the meaning of people's experiences [and] to uncover their lived world prior to scientific explanations".

An interview 'guideline' was also used for these interviews (Addendum E), with the aim of discussing the children's social behaviour, self-esteem and self-image, confidence, emotions, discipline, communication, cognitions and academic performance. These were the same themes covered in the focus groups, but the questions were made more age appropriate.

The children were not however, adequately prepared for the interview and the researcher found the children very quiet. Dworetzky (1995: 298 –301) and Louw et al. (1998: 367) mention that between the ages of about seven and nine, children seem to mainly associate with others of the same gender and age. Although they did provide some usable information, all five children were generally quite shy and much probing needed to be done by the interviewer. This may be as a result of the fact that this is the age where they are most comfortable within their own peer groups and felt a little intimidated and shy towards the older interviewer. The researcher did use relevant information from the individual interviews with the children but found that the focus group provided more substantial information than the children themselves.

5.3 RESULTS OF THE STUDY

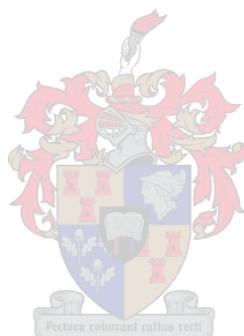
In the case studies, the information that was gathered during the focus group and interviews with the children will be presented according to themes, namely social behaviour, confidence and self-image, emotions, discipline and cognitive or educational stimulation. These themes were chosen as they correspond with the developmental milestones of the primary school child as discussed in chapter two, namely: the extension of social participation, the acquisition of greater self-knowledge and the development of moral judgement and behaviour. These were also the themes that children with disabilities were found to struggle with as discussed in

chapter two and are the themes that equine-assisted therapy appeared to have a positive influence on, as discussed in chapter four.

As can be noted in the ‘interview guide’ (Addendum D, question 6), there was a question on language communication. In chapter four, the improvement of language communication was seen to be one of the main psychosocial aims of therapeutic riding and research also showed that this is one of the areas in which therapeutic riding has its greatest successes. From the interviews done in this study however, none of the children were found to make any significant strides in this area. As explained by the second physiotherapist though, with whom an individual interview was held, most of the children concerned are spina bifida children, who are not generally prone to oral motor or linguistic problems. Therefore, language communication is not discussed in any of the case studies below.

5.3.1 CHILD A

5.3.1.1 Profile of participant



Age: 11

Gender: Male

Race: Coloured

Disability: Through-knee amputee (with spina bifida) – uses a wheelchair

Time involved in riding: Approximately six months

5.3.1.2 Social behaviour

The focus group identified child A as a confident young man who made an effort to respond to conversation. He is introvert though, in that he will not necessarily initiate conversation. In the individual interview however, child A stated that his helpers vary every week and he did not indicate any relationships built with a specific helper. He did however mention three specific friends that he has made as a result of horse riding and identified with the horse that he rides (Flea). Child A mentions that he and his friends often discuss on the bus to the riding “how the horses ride lekker!” thereby showing enjoyment of the activity.

5.3.1.3 Confidence and self-image

One of the helpers in the focus group indicated that she had asked child A about his amputation and he confidently told her about the amputation. According to her he answered confidently and did not seem troubled by the question, or self-conscious in any way.

It came out in the focus group that child A is not involved in many other extra-mural activities, so the horse riding gives him a sense that he is good at something. One of the helpers felt that being on a horse was a whole new world for child A. The 'height thing' was also felt to be very positive for the child, as this is the only time that he gets the opportunity to look down on others; usually others are looking down on him. The instructor described child A as having a 'wheelchair bound mentality'. She explains child A as feeling as if he is out of his safe space when he is out of his wheelchair. The instructor has been consistently challenging child A in his riding. She describes how when he started riding he had two side-walkers, and held the saddle with both hands. He has now progressed to only one side-walker and holds his reins independently.

The instructor went on to describe how child A was petrified of trotting in the beginning, but is now very confident at the trot, which is amazing considering that he is balancing on a 'stump'. Child A also identified trotting as his favourite riding activity during the individual interview. The instructor describes how she feels that the riding has "done something for him, getting him out of his wheelchair mentality that when he's out of his wheelchair, he's lost... He's not! And I think he's starting to discover that."

Child A shows some pride towards being able to ride a horse, in that he indicates that he has told his family about his riding, and they think it is 'lekker' and it's the first time that they had heard of a disabled person horse-riding.

5.3.1.4 Emotions

Not much was said in the focus group regarding the child's emotions, other than that he is fairly stable both at school and when riding.

5.3.1.5 Discipline

According to the physiotherapist, child A is beginning to show gangster tendencies at home, but according to the helpers and instructor he has never shown any disrespect while at the stables or during the riding lesson. The instructor and physiotherapist thought that the relationship with the horse may help in combating these gangster tendencies, but that child A would need to attend riding more often for it to have any great consequential value.

5.3.1.6 Cognitive or educational stimulation

The physiotherapist feels that child A concentrates fairly well when riding for a spina bifida child. The physiotherapist also explains that child A is often out of class at school, showing that academically he is bored and has reached his plateau. She reckons that child A is more physically inclined than academically inclined and that this needs to be channeled. This may explain why he is better able to concentrate when riding without becoming bored.

Although it took much probing, child A did indicate that he had learned various riding exercises in his lessons, such as making the horse walk on and halt, directing the horse with his reins and trotting. He particularly enjoys trotting and having to use his reins to direct the horse in different directions and in circles.

5.3.2 CHILD B

5.3.2.1 Profile of participant

Age: 12

Gender: Female

Race: Coloured

Disability: Spina Bifida – uses a wheelchair

Time involved in riding: Approximately two years

5.3.2.2 Social behaviour

The focus group revealed that child B is generally a very quiet, reserved person, with little outward demonstration of emotion. The group confirms that this is how she is within the riding sessions too. The instructor however commented that one needs to build a relationship with child B, before she opens up to one. The instructor explains how she has been making a concerted effort spend time on child B and chat to her and describes how she has been opening up and the instructor has noticed her smiling more often.

Out of all the children interviewed, child B was the only one who specifically mentioned that she felt she had made friends with the horse that she rides (Trophy). She did indicate that she had made friends with one of the helpers, but couldn't remember her name.



5.3.2.3 Confidence and self-image

Child B was seen by the group as a complacent person who, although she works hard, almost has an attitude of accepting her lot. An attempt is made to overcome this by presenting child B with a challenge in her riding. According to the instructor, child B thrives on a challenge and describes how the child 'grows' when she's presented with a riding challenge and realizes that she can do things on her own, for example, riding off the lead rein (i.e. rein used by helper to lead the horse).

During the individual interviews child B indicated that she especially likes the games on the horses, which is in line with what the instructor felt about the child enjoying the challenges presented in the riding lesson.

5.3.2.4 Emotions

As mentioned under social behaviour, the focus group found that child B was a very expressionless person, but the instructor has found the child opening up, as she has been making a concerted effort to build a relationship with the child.

All the helpers agree though, that child B is very stable when riding and that she is a hard worker.

The researcher also found child B very staid and 'emotionless' during the individual interviews. In fact, the group described her as a 'little grown-up'.

5.3.2.5 Discipline

The focus group describes child B as a very hard worker, who really tries to pay attention and concentrate during the riding lessons. The physiotherapist also reports that child B is a hard worker at school and presents no disciplinary problems.

5.3.2.6 Cognitive or educational stimulation

Child B tries very hard at her riding, and concentrates well, according to the focus group. In the individual interview child B indicated that she had learned the techniques of riding, such as sitting up straight. The physiotherapist confirmed that child B performs averagely at school, but comments that her academic performance is probably more due to her diligence and hard work rather than her intelligence per se.

5.3.3 CHILD C

5.3.3.1 Profile of participant

Age: 11

Gender: Male

Race: Coloured

Disability: Cerebral Palsy – uses crutches

Time involved in riding: Approximately one year

5.3.3.2 Social behaviour

It came out in the focus group that child C is very much a loner at school. He is generally very boisterous and teases his peers a lot. At SARDA however, he is quite shy and introvert. During the individual interview, he did not indicate any special relationships that he has built while at SARDA. He could not remember who he had ridden the previous session, but did name a favourite horse (Trophy).

5.3.3.3 Confidence and self-image

During the focus group, the physiotherapist explained how the horse riding definitely boosts child C's self-esteem. She explained how proud child C is of his riding and how he boasts at school about what he can do on the horse. Although in the interview when asked if he enjoyed riding, he only said 'a little'.

The instructor also found with child C that although he needs constant reminding to maintain a good riding position, that he responds very well to a challenge. All the helpers confirm that when child C is asked to trot and really has to concentrate, that his riding immediately improves, as compared to when he is just walking, which does not require much effort on his part. Child C mentions trotting as his favourite activity, which may indicate that he realizes that this is an activity that he performs well and is proud of it. His riding also improves when he is off the lead rein and has to do all the riding unassisted.

It also came out in the group that child C will often try to get the attention of child E while they are riding, to show his friend what he is able to do on the horse.

5.3.3.4 Emotions

According to the group, child C is always well behaved at SARDA. No emotional outbursts or anything of significance was reported. This is very interesting considering that he is very boisterous and teasing towards his friends at school.

5.3.3.5 Discipline

As mentioned earlier, child C is very naughty towards his peers. The focus group however reports that he is very quiet and well behaved when at the stables and when riding. He does however need constant reminding to carry out riding instructions, but this seems to be more because of his habitually bad posture and perhaps lack of concentration, but not because he is being defiant or undisciplined.

5.3.3.6 Cognitive or educational stimulation

The helpers reported that child C finds it very difficult to concentrate during riding for any length of time. As he has cerebral palsy, he tends to slope to the one side and needs constant reminding to sit up straight. It was unanimous however that it is not so much that child C doesn't listen, just that his habitually bad posture makes maintaining a good riding position difficult. He needs constant reminding to concentrate on his position.

In the individual interview, child C indicated that he had learned certain riding techniques such as telling the horse where to go with the reins, stopping the horse and had learned to name certain parts of the horse.

The physiotherapist in the group reported on how coming to SARDA is a new environment and educational for the children, as they come from poor backgrounds and even just the drive to the horse riding is educational in itself. She reports on an incident on the way back from riding where child C had some money and wanted to stop and buy sweets. The bus driver stopped at a mall for child C to buy the sweets and apparently they had to weigh the sweets a couple of times, each time taking sweets off until the child's money could cover the cost of the sweets. According to

the physiotherapist, the child was most upset, complaining that his 'Miss' must not bring him to these 'white shops' again, as they are too expensive. The group found this most amusing, but it proved that not only the riding in itself, but the whole outing is educational for the children who ride.

5.3.4 CHILD D

5.3.4.1 Profile of participant

Age: 10

Gender: Female

Race: Coloured

Disability: Spina Bifida – uses crutches

Time involved in riding: Approximately two years

5.3.4.2 Social behaviour

The group describes child D as a very chatty, confident person when at the stables. The physiotherapist confirms that she is generally outgoing. According to the physiotherapist child D is involved in various extra-mural activities but loves her riding and is very demanding about attending her riding lessons. During the individual interview, child D named five friends that she feels she has made as a result of riding. She also identifies with one specific horse (Blue). She did not however identify with any specific helper, saying that they varied every session.

5.3.4.3 Confidence and self-image

Child D is well known to the group for 'hard work' – she tries extremely hard to ride well. She is however, famous for her uncontrolled laughing when trotting. The instructor explains how child D thinks that trotting is the best thing "since sliced bread." Although child D has a good riding posture at a walk, the instructor feels that she is not strong enough to sustain herself at a trot – "she wobbles all over the place, but laughs her head off and thinks it's so funny that she is bouncing all over the place". A very interesting statement was made by the instructor when she said, "I

think she thinks she can do more than she can.” Evidently then, child D may be a little over-confident. In the individual interview, child D confirms that her favourite activity when riding is trotting.

Child D did indicate in the individual interviews that she has shared with her friends what she does at horse riding, showing a sense of pride towards what she is able to achieve.

5.3.4.4 Emotions

The physiotherapist explained to the group how child D can become very moody at school when she does not get her way. None of the helpers or the instructor though, had ever experienced any problems with her at the stables.

5.3.4.5 Discipline

As mentioned, child D can be very demanding and moody in general. There have however never been any problems experienced with her at SARDA. In fact the instructor stated that she “wouldn’t have thought she was like that.” The physiotherapist attributes this to her pure happiness when at SARDA and her thorough enjoyment of her riding.

5.3.4.6 Cognitive or educational stimulation

The physiotherapist shared with the group that child D often asks to have her physiotherapy during class time, to get out of class, showing that her academics bore her. The group agrees that she seems like a bright girl and was surprised that she would be bored academically. At SARDA however, she is very cooperative and the instructor describes her as one of the best pupils, as she always pays attention, tries very hard, is always happy when riding and is very responsive. Child D shared in the individual interview a few of the things she had learned at riding e.g. holding the reins correctly and the names of the various pieces of tack.

5.3.5 CHILD E

5.3.5.1 Profile of participant

Age: 9

Gender: Male

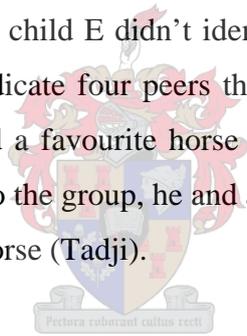
Race: Coloured

Disability: Spina Bifida – walks independently

Time involved in riding: Approximately six months

5.3.5.2 Social behaviour

The group describes child E as responsive to their conversation. This was the child that child C kept trying to call in his lesson to show him how he could ride. As was the case with the other children, child E didn't identify with a specific helper in the individual interview, but did indicate four peers that he found he had made friends with since riding. He identified a favourite horse and said that he found the horse "relaxing and fun." According to the group, he and another child in the lesson used to fight over who would ride this horse (Tadji).



5.3.5.3 Confidence and self-image

In the group, the physiotherapist explains that the horse riding has been a real confidence booster for child E, as he is very much 'in the background' at school. He apparently often speaks of and boasts about his riding to the others in the school.

The instructor explains how well child E responds to competition. In fact, in the individual interview, child E stated the games and competitions, along with the trotting done in the lessons, are his favourite part of riding. The group agrees that child E is a very capable rider and is capable of going much further in his riding, if he could receive more individual attention.

5.3.5.4 Emotions

The group stated that child E was very quiet when he first started riding. He has definitely come ‘out of his shell’ and is in fact very flamboyant on the horses. The instructor describes him as a fairly levelheaded boy.

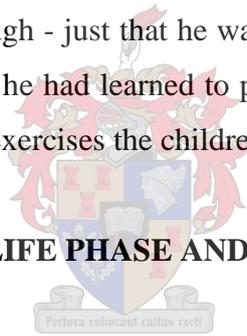
5.3.5.5 Discipline

No discipline problems were reported either at school or at the stables.

5.3.5.6 Cognitive or educational stimulation

The group was informed by the physiotherapist that child E loses interest in the classroom quickly. The horse-riding instructor did not find that he lacked concentration in her lessons though - just that he was lazy at times. In the individual interview, child E indicated that he had learned to perform different exercises on the horse (referring to the warm-up exercises the children do before the lesson starts).

5.3.6 INSIGHT INTO THE LIFE PHASE AND DISABILITIES OF THE PARTICIPANTS



This section will recapitulate the main findings from the literature review regarding the psychosocial development that takes place in the primary school child. This recapitulation is offered to provide a context for the empirical findings. The gist of their disabilities will also be revised, as well as the psychosocial developmental difficulties that they face as a result thereof.

5.3.6.1 Life phase

Dworetzky (1995: 298 –301) and Louw et al. (1998: 367) mention that between the ages of about seven and nine, children seem to mainly associate with others of the same gender and age. At this age, friends become an important source of information (it is with friends that social skills are refined) and the child will use his friends as a standard by which to measure himself (Dworetzky, 1995: 298 – 301; Louw et al.,

1998: 367). Friendships will allow the child to develop an own identity within a safe environment, while reinforcing acceptable and unacceptable behaviour. In a nutshell, friends provide the school going child with a network of social, emotional and moral support (Feldman, 2000: 352). Considering the difficulties those children with disabilities face in making friends, the value of the therapeutic riding can be seen in the way it encourages peer relationships. This will be covered more extensively later in this chapter though.

Markus and Nurius (as cited in Dworetzky 1995: 292) state that between the ages of seven and twelve the child's self-concept becomes more differentiated. Feldman (2000: 344) goes on to name the differentiated self-concepts that the child will develop, namely an academic, social, physical and emotional self-concept. Therapeutic riding was seen to assist in the forming of each of these self-concepts.

Louw et al. (1998: 344) describes that it is in this stage that the child no longer describes himself in terms of mere activities e.g. "I can ride a bike", but rather in terms of how well the activities can be performed e.g. "I can ride a bike better than my friend", or as Feldman (2000: 344) puts it – the child begins "...to use social comparison processes to determine levels of accomplishment during middle childhood." The competitions within the riding lessons proved to be the perfect place to develop this healthy comparison of self to others.

During middle childhood, the child becomes more emotionally mature, moving away from helplessness towards independence and self-sufficiency, showing greater emotional flexibility and greater emotional differentiation (Louw et al., 1998: 345). As will be seen later in this chapter, the riding seemed to encourage the appropriate expression of emotions.

Regarding morals, during middle childhood, children definitely become aware of certain social rules, develop the means and make the effort to keep them. Again, the therapeutic riding environment was found to encourage appropriate behaviour.

5.3.6.2 Disabilities

The children involved in the research were mainly affected by spina bifida and cerebral palsy, with one boy being a through-knee amputee.

Spina bifida is found to be a failure of fusion of the caudal neural tube (spinal column). The most severe form of spina bifida, **myelomeningocele**, occurs when there is a bony defect in the spine, causing a “protrusion of the neural tissue from the spinal cord, and a lack of skin covering the defect.” (Vaccha & Adams, 2005: e58). In other words, there is a defect in the spine, allowing the lower part of the spine and the nerves associated with this region to bulge through. This deformity affects not only the spine but, owing to exposed nerves, the central nervous system as well (Vaccha & Adams, 2005: e58; Carruthers, s.a.: 10A, p11).

Much controversy around the definition of cerebral palsy exists. Dormans and Pellegrino (1998: 5) do however recognise three important elements that run through all of the definitions offered since the 1980’s, namely that

- Cerebral palsy is associated with significant problems with motor function.
- Motor impairment is a result of something that went wrong in the early development of the brain.
- Cerebral palsy is not progressive.

In line with the above, Hinchcliffe (2003: 1) quotes a modern definition of cerebral palsy as being “(a) persistent, but not unchanging disorder of movement and posture due to a non-progressive disorder of the immature (that is under 2 years of age) brain.”

Both disabilities are therefore associated with loss of function or loss of sensation in the extremities, with some cases obviously being worse than others. Regardless of the severity of these disabilities though, children with both these disabilities as well as the other disabilities mentioned in the literature review, namely muscular

dystrophy and epilepsy, are faced with many psychosocial developmental difficulties as a result of their disability.

5.3.6.3 Psychosocial challenges as a result of a disability

Antle (2004: 167) reports that years of experiments have shown that young people with physical disabilities experience significantly greater difficulties with psychosocial adjustment. As Thomas (1978: 102) puts it, a physical handicap is a variable that inhibits the acquiring of developmental skills at the appropriate age.

Thomas (1978: 35) reports that there is evidence that shows the progressive involvement of the handicapped with others like themselves, which indicates an abandonment of community membership. It is of vital importance though that the child's sense of self is not negatively affected by this stigma, as a positive sense of self is vital for success in school performance and the forming of friendships. It is in this area that therapeutic riding can have a noticeable influence, in that the children are exposed to other able-bodied members of the community, such as the helpers and instructors.

Solot (as cited in Dormans & Pellegrino, 1998: 347) explains that "(t)he use of speech and language for communicating, learning, and regulating behaviour is a critical developmental task and forms the basis for all social interactions." Owing to neuromotor impairments however, children with cerebral palsy often struggle with the development of speech, language and feeding skills. Although language was noticeably a problem with the children who were interviewed, it may have played a part in their quietness.

Cerebral palsy children may also suffer from cognitive or learning disabilities. It is obvious then, that the child with cerebral palsy would be at a serious disadvantage regarding peer and social relationships. The spina bifida child, along with the cerebral palsy child, has to deal with physical, cognitive, language, memory and temperamental challenges. For them, even the most mundane daily tasks can prove to be a source of stress (Vaccha & Adams, 2005: e61). This would thus limit the opportunities of the child and consequently affect opportunities for peer relations. It

would be expected too, that the child suffering from muscular dystrophy (as discussed in chapter two, 2.3.4.2) would also experience physical limitations in communication and would thus have limited opportunities for social interaction. Again, riding therapy was found to make huge strides in the area of encouraging social interaction. The cognitive challenges that these children face may again have been a factor in their hesitancy to elaborate in the individual interviews.

The child's self concept is affected by his physical self-concept and how well he or she can perform an activity in relation to peers. All of the disabilities discussed may have a profound effect on this comparison and thus self-concept. This would be in line with Erikson's theory of *industry versus inferiority*. Garber (2004) emphasises the link between the self-esteem of the child and his social participation. He claims that if the child feels negative about himself, he will be as an outsider on the playground, stigmatised in the classroom, awkward in his peer group, being continually teased until his shame shows through. In the therapeutic riding set-up, the child is continually praised, as it focuses on what he is able to achieve rather than what he is not. He is able to interact with other able-bodied people, but is given the opportunity to compete with others with similar disabilities to himself and thus cannot feel like an outsider or stigmatised in any way. It is in light of the above recapitulation that the findings of the research will now be discussed.

5.4 DISCUSSION OF THE FINDINGS

This section looks at the findings of the study done on each child and examines whether there are common trends in social behaviour, confidence and self-image, emotions, discipline and cognitive or educational stimulation. Throughout the section, the findings are correlated with the findings of the literature study to see if what was found is in line with scientific findings, and whether there are any new or thought-provoking findings.

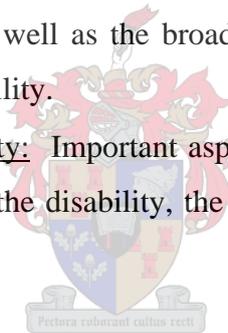
5.4.1 PROFILE OF PARTICIPANT

As the children involved in this study were from a school in the coloured community of Cape Town, all of them were coloured. They all matched the criteria for inclusion,

i.e. they were between the ages of seven and twelve and they all had a physical disability. Three of the five children had spina bifida, one child had a through-knee amputation with spina bifida and the fifth child had cerebral palsy.

As was explained by Patterson, DelaGarza and Schaller (2005: 156) in chapter three, there are certain practical considerations to be kept in mind when working with an individual with a physical disability, namely:

- The individual: Personal traits will determine how the individual gives meaning to his disability. Factors that are essential to consider in order to be an effective helper are the individual's personal characteristics, interests, activities, goals, gender and culture.
- The environment: It is necessary for the rehabilitation counselor to pay attention to the immediate environment such as family, friends and community resources; as well as the broader environment such as laws and social definitions of disability.
- The nature of the disability: Important aspects include the functions that are impaired, the severity of the disability, the time of the onset of the disability and the type of onset.



In light of the above, the findings of the study will now be presented.

5.4.2 SOCIAL BEHAVIOUR

In the context of the study, social behaviour is demonstrated by issues such as relationships with peers, relationships with helpers and relationship with the horse.

5.4.2.1 Relationships with peers

Child A, D and E indicated that they had made friends with various peers as a result of horse riding. The finding that these children had made friends as a result of the riding is in line with Longden (1988: 2), who found that riding centres often report on improved social interaction with peers once the child has started riding.

Physiotherapist B also reported on immediate social results, saying that the children are much more animated on the bus on the way back from riding than on the way to riding, comparing and discussing what each had achieved during their ride.

This is an important contribution made by the therapeutic riding, as in middle childhood, friends become an important source of information for these children and they use their peers as a standard by which to measure themselves (Dworetzky, 1995: 298 – 30; Louw et al, 1998: 367). Peer support also enhances the capacity to cope with and adapt to a disability (Chwalisz & Vaux, 2000: 537). The facilitation of peer interaction that therapeutic riding offers these children, is of special significance when one takes into account the above explanation of the importance of friendship, and the finding that handicapped children generally have fewer close relationships and fewer opportunities for social participation than their non-handicapped peers (King, 1964 as cited in Thomas, 1978: 89).

5.4.2.2 Relationship with helpers

The fact that none of the children identified with a specific helper was surprising to the researcher, as the helpers should be the ones who build relationships with the children (A Handbook for Volunteer Helpers, s.a: 7). It has been the experience of the researcher though, that owing to the shortage of volunteers and helpers at SARDA, it is not always possible to place the same helpers with the same children on a weekly basis. This results in the children not being able to build up the desired trustworthy relationship with a single helper.

5.4.2.3 Relationship with the horse

All of the children identified favourite horses. Child B specifically mentioned the horse as one of the ‘people’ she felt she had made friends with at SARDA. Child E also felt very strongly about his favourite horse. The focus group even reported that he fights to ride that specific horse. These findings are in line with Benda et al (2003: 824) who state that during therapeutic riding, strong positive emotional ties are formed between the child and the horse. Benda is an American doctor who served in Rwanda after the genocide. Upon returning to the USA, he devoted himself to the

study of equine therapy and it is the result of his studies and those of his colleagues' that are widely documented throughout the literature review. In an interview conducted with Bill Benda on the documentary 'Carte Blanche' on 7 May 2006, Benda confirmed that he "...believes that animals are creatures of God... animals have a way of exhibiting unconditional love that we with our egos and mind talks are unable of carrying out. So the child gets to connect at a higher level with the animal and form a real bond – a real connection." The participants in this study confirm this.

5.4.3 CONFIDENCE AND SELF-IMAGE

The children's confidence and self-image will be discussed in terms of the way that they feel about themselves, the way in which they responded to challenges and games and their sense of achievement from riding.

5.4.3.1 Feelings about themselves

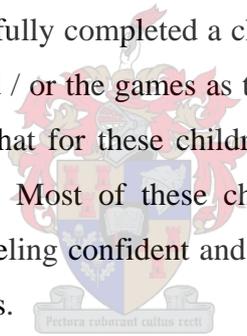
A common trend in the information gathered on each of the children was the way that the riding has made them feel better about themselves and improved their self-esteem. Therapeutic riding seems to be particularly effective for children A and B who are both in wheelchairs. Particularly for child A, the 'height thing' was felt to be a positive attribute. As Longden (1988: 2) puts it, the experience of being able to look down on others from horseback instead of looking up from the wheelchair allows a great feeling of well-being (Longden, 1988: 2). Bill Benda (Carte Blanche, 7 May 2006), although talking of disabled children in general, 'hammers the nail on the head' and articulates what seems to be the experience of child A and B. He claims that on an emotional level, you have got children who have spent their entire lives in wheelchairs or in bed, watching others play. They are now able to ride a horse, giving them a strong sense of empowerment, a sense of engaging in sport and a perception of risk behaviour.

Benda's statements are supported by this study in comments such as those made by the instructor regarding child A, namely that riding has "done something for him, getting him out of his wheelchair mentality that when he's out of his wheelchair, he's lost... He's not! And I think he's starting to discover that." The children in this

study, such as child A and B are not alone. There are other children assisted daily by SARDA who have similar results, e.g. Robin. Robin is a cerebral palsied diplegic preschooler who was documented in the Carte Blanche coverage of SARDA on 7 May 2006. She had been riding at SARDA in Johannesburg once a week for a period of three years. Her mother also gave positive reports on therapeutic riding and says that the riding has created an attitude in her daughter that "...I can ride a horse... I may not be able to walk yet, but I can ride a horse!" "It's remarkable" her mother states "...it's done wonders for her."

5.4.3.2 Response to challenges and games

Another common trend noticed in the children is their positive response to the challenges and games set to them in the lesson, when they realize that they can do things on their own. The instructor mentioned for instance how child B 'grows' on horseback when she has successfully completed a challenge. All of the children also either mentioned the trotting and / or the games as their favourite activities of riding. It must be understood though, that for these children to mention those activities as their favourite is phenomenal. Most of these children are unable to even walk unassisted and for them to be feeling confident and be enjoying an activity that is so difficult for them speaks volumes.



The children in the study therefore confirm Benda et al. (2003: 824) who state that riding therapy offers a definite psychological enhancement of being able to move freely through space on a powerful animal without the aid of assistive devices. When one realizes that it is at this age that the child begins to base his self-esteem on his failure or successes (Feldman, 2000: 343), then one can grasp how valuable the contribution of therapeutic riding is in that it offers the child a feeling of success and not failure.

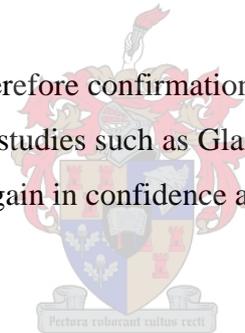
5.4.3.3 Sense of achievement

Through the focus group and individual interviews it also came out that each of the children either are very boastful about their riding, or are keen to discuss their riding with their peers. This shows that the riding has offered each of the children a sense of

achievement. This lines up with Gatty (2004: 2), who found children who participated in a therapeutic riding programme had significantly higher self-esteem than prior to the riding programme.

With all of the children, but specifically with child C, the riding seems to have provided the opportunity for the child "...to use social comparison processes to determine levels of accomplishment during middle childhood." This is said as it came out in the focus group that child C will often try to get the attention of one of his friends (child E) while they are riding to show child E what he can do. Nurius (as cited in Dworetzky: 1995) and Feldman (2000) describe how this *should* be happening in the middle-aged child and how he should now no longer be describing himself in terms of mere activities but in terms of how he can perform those activities in relation to his peers. Should these activities be performed well, self-esteem will obviously be built up.

The children in this study are therefore confirmations of what is found by other riding centres (see table 4.1) and other studies such as Glazer (2004: 171), that children who participate in therapeutic riding gain in confidence and self-esteem.



5.4.4 EMOTIONS

Emotions will be considered in terms of how the children felt about their riding, how they expressed their emotions and how they controlled their emotions.

5.4.4.1 Positive emotions

During the individual interviews the children all indicated positive emotions when riding, with words such as 'nice', but no useful elaboration.

5.4.4.2 Emotional interaction and skills

It was mentioned in the focus group that child B and E were very quiet but were slowly 'coming out of their shell'. For these children then, the riding environment has slowly caused them to interact more with those around them at the stables. As

explained, getting the children to learn social interaction skills is important, as the 'extension of social participation' is one of the developmental milestones for children their age.

5.4.4.3 Emotional control

Child C and D were also found to be more emotionally stable at the riding centre and during their lessons, than at school. Physiotherapist B attributes this to the children needing to remain calm and concentrate when riding. According to her, the children are still a little unsure on the horses. She reckons that when one is very sure of what one is doing, then one can get 'cocky' about it – but these children, even though they enjoy the activity, realize that they need to concentrate and behave in order to ensure their own safety. The riding then seems to produce 'good behaviour', stable emotions and concentration when riding.

This significant finding seems to be in line with Van der Zanden (as cited in Louw et al.: 1993) who states that children between the ages of six and eleven should begin to recognize internal causes for emotions and should become aware of how to express, control or hide these emotions. Riding schools generally report on greater emotional control from the children involved in equine therapy. As a physical handicap is a variable that inhibits the acquiring of developmental skills at the appropriate age (Thomas, 1978: 102), therapeutic riding is priceless in offering the ideal platform for the children in the study to develop the appropriate developmental emotional skills.

5.4.5 DISCIPLINE

What was fascinating with regard to discipline is that child A, C and D were reported to have discipline problems either at school or at home, but were reportedly very well behaved and pleasant at the stables. This may be evidence of what physiotherapist B stated about the children not feeling one hundred percent secure on the horses and so making the effort to concentrate and behave to ensure their safety on the horse.

It shows that these children are developmentally on par with their peers, as Piaget describes that children between five and ten should reach moral realism, where they

develop an enormous respect for rules and the fact that they must be obeyed. They should develop strategies to control their behaviour (Louw et al: 1998: 372 – 375). Once again, the riding therapy appears to create the ideal platform for these middle-aged physically disabled children to mature in this developmental milestone, as it did for their emotional developmental milestones.

5.4.6 COGNITIVE OR EDUCATIONAL STIMULATION

Cognitive or educational stimulation will be looked at in terms of the children's concentration during the riding lessons and whether they were found to have learned anything new in these lessons.

5.4.6.1 Concentration

Children A, D and E are reported to be fairly bored at school, either always being out of class, or asking to have their physiotherapy during class times because they are bored. The physiotherapist stated that this happens when the children have reached their academic plateau and are bored in class. All of these children however, are reported to concentrate well during their riding lessons. This confirms that the middle-aged child in the concrete operational period is developing classification and conservation skills. Therapeutic riding has numerous exciting games that can enhance these skills. The child is learning and being encouraged to concentrate, while having fun, so he doesn't even realize that he is working.

5.4.6.2 Knowledge expansion

Each of the children also indicated specific things they felt they had learned while riding, ranging from the correct seat, to the names of the pieces of tack and parts of the horse, to the exercises done during the lesson. This shows that the riding has broadened the knowledge base of these children. Once again, the riding has educated the children and forced them to think and concentrate without them really realizing it – they just enjoy it!

As explained when discussing child C, even the trip itself from the school to the riding and back again can be educational for these children, who often do not know much more than their school and neighbourhood. Therapeutic riding therefore seems to offer the children an educational stepping-stone.

5.5 SUMMARY

This chapter spelled out the type of study that was done, the type of sample that was used and the methods of data collection namely, a focus group and individual interviews with the five children.

It was then attempted to present the useful information on each of the case studies that had come from the focus group and individual information and trends were identified for each theme. This information was then taken and analyzed against the background of the literature study to see whether there was any information to confirm the psychosocial aspects of riding as discussed in the literature review.

For the children studied in this investigation, the riding was seen to have a positive influence on the social interaction with their peers. Their confidence and self-esteem were seen to have benefited from their involvement in the horse-riding programme. They were provided with the platform to develop their age appropriate skills regarding the control of their emotions as well improving their disciplinary skills. They also appeared to concentrate better when riding as compared to school and the riding on the whole appeared to be an educational experience for these children.

Therapeutic riding therefore holds many positive features, not only for the physical rehabilitation of physically disabled children, but it seems to do wonders for their psychosocial development and rehabilitation, as well as for their spirits.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

This study attempts to explore the psychosocial aspects of equine-assisted therapy for physically disabled primary school children. In order to understand what psychosocial aspects deserved attention in this study, it was necessary to understand what the primary school child's psychosocial developmental milestones are. It was also necessary to explore the physical disabilities that were commonly dealt with at the South African Riding for the Disabled Association (SARDA) where the study was done, in order to gain insight into which developmental milestones these children would find challenging. Both of the aforementioned were discussed in chapter two.

Owing to the fact that social work research into equine-assisted therapy, as a form of rehabilitation for physically disabled children, has not been done in South Africa to date (not to the researchers' knowledge), the researcher found it necessary to clarify what the goals of rehabilitation therapy / psychology for these children are, and to explore if and how it fits into social work. This was explored in chapter three, where it was found that many of the core goals of social work are perfectly aligned with the goals of rehabilitation therapy / psychology. The conclusion was then drawn, that because equine-assisted therapy is a valuable and viable method of rehabilitation for the physically disabled primary school child, and rehabilitation therapy / psychology is in line with and intrinsically part of social work, then equine-assisted therapy can be a valuable tool to social workers in their work with physically disabled children.

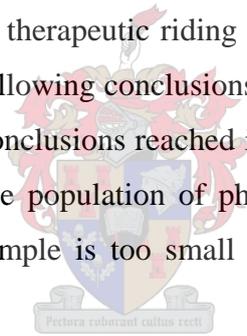
The study was initially done because of an understanding that much research had been done into the physical benefits of equine-assisted therapy and therapeutic riding, but very little research had been done into the psychological and social value of riding for the disabled. Chapter four attempts to explore the research that has been done, touching on the physical benefits, but mostly focusing on the psychosocial aims and benefits of riding for the physically disabled.

The literature study is supplemented by an empirical investigation, which is documented in chapter five. In chapter five, five case studies were done on children

from the Astra School for Physically Disabled Children. Data was gathered by means of a focus group (consisting of helpers, the physiotherapist and riding instructor) and individual interviews held with the children. In this chapter, the findings from the interviews are documented and analyzed in conjunction with information gathered in chapter two, three and four. Conclusions and recommendations of both the literature and the empirical investigation are presented in this chapter.

6.2 CONCLUSIONS

The conclusions will be expressed in terms of the three psychosocial developmental phases that are important for the primary school child, namely the extension of social participation, the acquisition of greater self-knowledge and the further development of moral judgement and behaviour. It is with these developmental phases in mind and the struggles that physically disabled children experience regarding them, as well as with the aims and benefits of therapeutic riding and the psychosocial experiences of these five children, that the following conclusions and recommendations are made. It is important to note that the conclusions reached in this chapter bear witness to the five children studied and not the population of physically disabled primary school children, simply because the sample is too small to generalize the findings to the greater population.



6.2.1 THE EXTENSION OF SOCIAL PARTICIPATION

The literature supports that children with physical disabilities have difficulties with regards to the extension of social participation as they generally have fewer opportunities for social participation than their able-bodied peers.

Equine-assisted therapy clearly counteracted this difficulty for each of the five children. Therapeutic riding had a positive influence on the social interaction of the five children, causing them to form bonds with their fellow riders and their horses. The horse riding allowed for a topic and point of conversation and healthy competition for these riders, providing a platform of overcoming social difficulties and developing the necessary developmental skills in this regard.

This study indicates that equine-assisted therapy for the children participating in this study, coincided with rehabilitation in that it aimed to “enable the disabled to reach and maintain *their optimal* physical, sensory, intellectual, psychiatric, and/or **social functional levels.**” It therefore meets one of the goals of the White Paper on an Integrated National Disability Strategy (Office of the Deputy President, 1997: 27).

6.2.2 THE ACQUISITION OF GREATER SELF-KNOWLEDGE

6.2.2.1 Self-image

In the literature review it was established that the acquisition of a greater self-knowledge had largely to do with developing a self-image. A self-image is not only based on one’s successes, but also based on how well one can perform a task in relation to peers – once again highlighting the importance of healthy social relationships. Various studies were discussed in the literature review that found that children with physical disabilities generally had lower self-esteem scores than their able-bodied peers.

For the five children in this study, it is in the area of boosting self-esteem that equine-assisted therapy held its greatest value. All of the children in the study had their self-esteem boosted by the knowledge that they can ride independently and complete the challenges given them on horseback. For these children therapeutic riding provided an opportunity to compete on equal footing with their peers and gave them a sense of achievement, irrespective of their disability, giving them a good self-image.

One needs to consider the individual circumstances of each child to see the value that therapeutic riding held regarding their self-esteem, but it was in the two wheelchair bound children where the riding appeared to offer them completely new possibilities for themselves and new opinions of themselves.

6.2.2.2 Emotions

Another area that falls within the acquisition of greater self-knowledge is the understanding of one’s emotions.

For the children involved in this study, the therapeutic riding did two things. It caused the children who were quiet 'to come out of their shells' and it caused the children who were boisterous 'to climb back in.' Therapeutic riding provided the platform for these children to learn the appropriate emotional behaviour – behaviour that would not upset the horse and therefore ensure their safety. The horse is a very sensitive animal. It senses and almost 'mimics' the emotions of the rider, so the child is forced to control his emotions.

6.2.3 THE DEVELOPMENT OF MORAL JUDGEMENT AND BEHAVIOUR

In the literature it was determined that children between the ages of seven and twelve should be developing attitudes and beliefs that help them to determine what is right and what is wrong. Moral development is said to be the process whereby children acquire these attitudes and beliefs, by internalizing the standards of right and wrong of their society.

Very little information was available on what struggles the physically disabled child may have with this development phase per se. What was said is that confusion may arise for the child when certain behaviour is mirrored to him by those around him; yet very different behaviour is expected from him as a result of his disability.

When looking at the discipline of the children in the study, they were seen to be well behaved at the stable yard irrespective of bad behaviour at home or school. At the stables, a calm yet authoritative disposition towards the horses is mirrored to the children at all times, and nothing less than the same is expected from them. The children in the study have obviously noted that rules at the stables, and when riding need to be obeyed. Therefore their behaviour and their emotions need to be controlled.

Equine-assisted therapy can therefore be said to not only have a positive effect on the physical rehabilitation of physically handicapped children, but the study also shows its value in assisting the child with psychosocial rehabilitation. Horse riding for disabled children provides the perfect platform to develop their age-appropriate

psychosocial skills and to overcome any hindrances to these skills that their disability might otherwise hold for them.

6.3 RECOMMENDATIONS

The recommendations made will be in light of social work practice, social work theory, social work training, social work research and social work policy.

In chapter one, the shocking statistics around physically disabled children and the services available to them in South Africa were explored. There is a higher proportion of disabled people amongst the very poor in South Africa where there is a lack of educational and recreational facilities.

It was seen that the government has a commitment to improving this sad situation by making necessary services available to the disabled community in several ways, one of which includes the training of those who work with the physically disabled, such as social workers.

The recommendations are made in light of the above situation in South Africa, namely that there is a huge percentage of the disabled children's community that are not receiving appropriate services. The recommendations are also based on the qualitative information that was found during the empirical investigation while speaking with the children and those involved 'hands-on' in the therapeutic riding world. However, as explained in the first chapter, there are no social workers to the researcher's knowledge that are practicing therapeutic riding with their clients. It was therefore not possible to interview any social workers to gain their insight into how therapeutic riding can be used within social work or how main practice methods and practice frameworks can fit into equine-assisted therapy. A lot of the recommendations therefore are also based on the extensive information gathered in the literature review.

6.3.1 SOCIAL WORK PRACTICE

Affording the disabled child the opportunity to ride and work with horses seems to bring about physical, psychological and social benefits without much effort on the part of the child. The horse moves the child physically through his gait, and the child seems to automatically be more sociable, better behaved, have more emotional control and better self esteem all round, without the child even giving much thought to any of the above – it just happens! Where does this method fit into social work exactly? This is a really difficult question to answer. It was established in the research that the goals of rehabilitation, and riding as a form of rehabilitation, are in line with the general goals of social work. Therapeutic riding or equine-assisted therapy takes place in groups or individually as the respective riders demand. *It is therefore recommended that Equine-assisted therapy be considered as ‘group work’ or ‘case work’, although not in the most traditional sense of the word.*

A typical riding session, although fitting within the ethos of social work, should not be boxed into one particular social practice method. *It is recommended that this method of equine-assisted therapy be registered with the South African Council for Social Service Professions as what could be termed, a ‘speciality’ mode of intervention. It should be considered as an important tool of rehabilitation available to the social worker without stifling its value by pressing it into, or having to define it in terms of a specific method.*

6.3.2 SOCIAL WORK THEORY

There are two perspectives in social work that could be expanded to include therapeutic riding and equine-assisted therapy, namely the strengths perspective and the developmental perspective. Social workers who base their practice upon these frameworks, especially with regards to physically disabled children, should draw their attention to the way in which equine-assisted therapy grabs hold of the notion of promoting the strengths and assets of an individual. This means of rehabilitation, namely riding for the disabled, seems to almost have a heavenly source, bringing about results that many other conventional methods of social work can not, such as having the children control their emotions and behaviour. It is particularly valuable

for children of the ages discussed in this study, as it is often difficult to engage these children in therapeutic scenarios, owing to their lack of concentration and limited ability to consciously change their thoughts, feelings and behaviour. As mentioned earlier, the riding seems to miraculously perform the aforementioned for a person. *It is therefore recommended that owing to the fact that the riding seems to naturally enhance the strengths and abilities within the child, that it be considered as a means of rehabilitation under the strengths perspective.*

6.3.3 SOCIAL WORK TRAINING

As mentioned in the first chapter, in South Africa there is a need for greater training regarding disabilities and rehabilitation amongst professionals who work with the disabled communities.

Professionals who may benefit from training in equine-assisted therapy include social workers, physiotherapists, occupational therapists, remedial teachers and even nurses.

It can only be beneficial for the professional encountering disabled clients to have knowledge of the various common disabilities and the challenges they respectively hold for the individuals. *It is recommended that equine-assisted therapy be slotted into training programmes from university level, much the same as play therapy or loss and trauma counseling comprise part of the social work programme at university.*

6.3.4 SOCIAL WORK RESEARCH

As this study is the first of its kind in the social work field within South Africa (to the researcher's knowledge), there is room for endless further research. This research was based on five case studies and although its findings are similar to what therapeutic horse riding centres are reporting, the sample is too small to generalize to the larger population of disabled children. The researcher has no doubt as to the value that therapeutic riding had for these five children and also for all the other riders that the researcher has come into contact with. However, further scientific

proof of this knowledge is required to fully incorporate this method into the social work profession.

It is recommended that considerably more research be done on this topic. Research may expand to include children of other ages, or research may be focused on children or adults with a specific disability. Research may even be expanded to include the dynamics of equine-assisted therapy for mental disabilities, such as autism and Down's syndrome. The possibilities for research in this area are endless.

6.3.5 SOCIAL WORK POLICY

Not enough research has been done on the psychosocial dynamics of equine-assisted therapy to have a significant effect on social work policy. However, equine-assisted therapy is a far-reaching practice because it requires the use of a team of helpers and leaders and obviously grooms for the horses. *It is recommended that equine-assisted therapy be incorporated into the social work profession and that it be considered as a means of therapy and as a means of job creation for the team members needed.* If poorly skilled people could be trained and used in being part of this therapy, whether it be leading or tending the horses, it could be a therapy for these people in itself, which could open up an entire world of possibilities for them.

6.4 CONCLUDING REMARKS

This study set out to explore the developmental phases of the middle-aged child. Various common disabilities among children were discussed, namely cerebral palsy, muscular dystrophy, spina bifida and epilepsy. It was then explored how these disabilities may hamper developmental psychosocial developmental phases. The concept of rehabilitation for the physically disabled was explored and it was found to fit well within the goals and ethos of social work.

Five case studies were then done on children from Astra School for Physically Disabled Children who participated in a riding programme at SARDA (South African Riding for the Disabled Association). It was found that the riding expanded the social sphere of these children, causing them to make friends with their peers and their

mounts. They were assisted in controlling their behaviour and emotions through the riding and were also offered a 'duty-free' way of maintaining concentration... not to mention all the physical benefits.

As the researcher is a candidate instructor for this means of therapy and is very involved at SARDA, she believes immensely in the value of this therapy and in the endless possibilities pertaining thereto, not only for social work, but also for all related fields.



BIBLIOGRAPHY

1. A Handbook for Volunteer Helper
see
Anon. s.a. South African Riding for the Disabled Association.
2. Alissi, A.S. & Casper, A. 1985. Time as a factor in Group work, Time Limited Group Work Experiences. New York: Haworth.
3. Annicchiarico, R., Gilbert, K., Cortés, U., Campana, F. & Caltagirone, C. 2004. Qualitative profiles of disability. Journal of Rehabilitation Research and Development. 41(6): 835-845, Nov/Dec.
4. Anon. 2002. Epilepsy. The New Encyclopaedia Britannica (4: 525). U.S.A: Britannica.
5. Anon. 2002. Muscular Dystrophy. The New Encyclopaedia Britannica (8: 439). U.S.A.: Britannica.
6. Anon. s.a. South African Riding for the Disabled Association, A Handbook for Volunteer Helpers. Cape Town. Digital Bureau, The.
7. Antle, B. 2004. Factors associated with self-worth in young people with physical disabilities. Health and Social Work. 29(3): 167 –176.
8. Asch, A. & Mudrick, N.R. 1995. Disability. In Encyclopaedia of Social Work. (Vol. 1, 752-761). Washington: NASW.
9. Ayrault, E.W. 2001. Beyond a Physical Disability, the person within – a practical guide. New York: Continuum International.
10. Babbie, E. 1989. The Practice of Social Research (5th ed). California: Wadsworth.

11. Becker, L. 2005. Working with Groups. South Africa: Oxford University Press.
12. Benda, W., Nancy, M.D., McGibbon, N.H. & Grant, K.L. 2003. Improvements in Muscle Symmetry in Children with Cerebral Palsy After Equine-Assisted Therapy (Hippotherapy). The Journal of Alternative and Complementary Medicine. 9(6): 817-825, Dec.
13. Bender, A.N. 1977. Muscle, Skeletal, Clinical aspects of disease. International Encyclopedia of Psychiatry, Psychology, Psychoanalysis and Nuerology. (7: 398) New York: Aesculapius.
14. Brandler, S. & Roman, C.P. 1999. Group Work, Skills and Strategies for Effective Interventions. New York: Haworth.
15. Bridges. 2005. Newsletter for alumni and Friends of the Thomas University division of social work.
16. Brown, A. 1994. Groupwork in Britain. In Hanvey, C. and Philpot, T. (eds), Practising Social Work. London: Routledge.
17. Carousel Ranch Therapeutic Riding Program. Retrieved on 27 December 2004 from the World Wide Web: <http://carouselranch.org/benefits.htm>.
18. Carte Blanche documentary, 7 May 2006
19. Cawood, T.A. 1999. University of the Orange Free State: Social group work notes. Bloemfontein: UOFS.
20. Chwalisz, K. & Vaux, A. 2000. Social Support and Adjustment to Disability. In Frank, R.G. & Elliott, T.R. (eds), Handbook of Rehabilitation Psychology. USA: American Psychological Association.

21. Clarke, A. & Cooper, C. 2001. Psychosocial rehabilitation after disfiguring injury or disease: investigating the training needs of specialist nurses. Journal of Advanced Nursing. 34(1): 1-13.
22. Cutsforth, T.D. 1990. Personality Crippling through Physical Disability. In Nagler, M.(ed), Perspectives on Disability. Canada: Health Markets: 64.
23. de Jager, W. & Truter, B. 2005. Group therapy with young adolescents. In L. Becker. (ed). Working with Groups. South Africa: Oxford University Press.
24. Department of Social Development. 2004. Service delivery model for developmental social services. Pretoria: Government Printers.
25. Dormans, J.P. & Pellegrino, M.D. 1998. Caring for Children with Cerebral Palsy. U.S.A: Paul H. Brookes.
26. Dworetzky, J.P. 1995. Human Development, A Life Span Approach (2nd ed). United States of America: West Publishing Company.
27. Epstein, I. 1988. Quantitative and Qualitative Methods. Social Work Research and Evaluation (3rd ed). Grinnell, R.M. (ed), Canada: Peacock.
28. Fatout, M.F. 1996. Children in Group, A Social Work Perspective. London: Auburn House.
29. Feldman, R.S. 2000. Development Across the Life Span. New Jersey: Prentice Hall.
30. Ferreira, SB. 2001. Free State University Department of Social Work Social Work Research. Bloemfontein: UOFS.
31. Galambos, C. 2004. Social work practice with people with disabilities: Are we doing enough? Health and Social Work. 29(3): 163-165.

32. Garber, B.D. Self-Esteem, Shame and the Differently-Abled Child. Retrieved 27 December 2004 from the World Wide Web:
<http://www.specialchild.com/archives/fi-022.html>.
33. Gatty, CM. s.a. Psychosocial Impact of Therapeutic Riding: A Pilot Study. Retrieved December 27, 2004 from the World Wide Web:
http://www.narha.org/PDFfiles/Psychosocial_Im.
34. Glazer, H.R., Clark, M.D. & Stein, D.S. 2004. The impact of hippotherapy on grieving children. Journal of Hospice and Palliative Nursing. 6(3): 171-175, July – Sep.
35. Geller, G. 2004. Toward an Optimal Healing Environment in Pediatric. Journal of Alternative & Complementary Medicine. 10: 179-193.
36. Greeff, M. 2002. Information collection: Interviewing. In de Vos, A.S. (Ed), Research at Grass Roots, For the social sciences and human service professions. Pretoria: Van Schaik
37. Gregory, R.J. 2001 Communitiy based service delivery: power and pathology: or, social rehabilitation is still a ‘Commie plot’. Disability and Rehabilitation. 23(1): 22-25.
38. Grinell, R.M. 1998. Social work Research and Evaluation (3rd Ed). Canada: Peacock.
39. Hancock, M.R. 1997. Principles of social work practice: A generic practice approach. New York: The Haworth Press.
40. Heimlich, K. 2001. Animal-assisted therapy and the severely disabled child: A quantitative study. Journal of Rehabilitation. 67(4): 48-54, Oct – Dec.

41. Hinchliffe, A. 2003. Children with Cerebral Palsy, A Manual for Therapists, Parents and Community Workers. UK: ITDG.
42. Johnson, L. C. 1989. Social work practice: A generalist approach. 3rd ed. Massachusetts: Allyn & Bacon.
43. Lechner, H.E., Feldhaus, S., Gudmundsen, L., Hegermann, D., Michel, D., Zäch, G.A. & Knecht, H. 2003. The short-term effect of hippotherapy on spasticity in patients with spinal cord injury. Spinal Cord. 41(9): 502-505, Sep.
44. Livingston, S. 1977. Epilepsy. International Encyclopedia of Psychiatry, Psychology, Psychoanalysis and Neurology. New York: Aesculapius.
45. Livneh, H. & Cook, D. 2005. Psychosocial Impact of Disability. In Parker, R., Szymanski, E.M. & Patterson, J.B. (eds), Rehabilitation Counseling, Basics and Beyond. USA: Pro-ed.
46. Lombard, D.A. 1991. Community work and community development, perspectives on social development. Pretoria: HAUM Tertiary.
47. Longden, M.L. 1988. Teaching Disabled Riders, A complete and practical approach to teaching horse riding to disabled people. Australia: Acacia.
48. Longo, D.A. & Peterson, S.M. 2002. The Role of Spirituality in Psychosocial Rehabilitation. Psychiatric Rehabilitation Journal. 25(4):333-340.
49. Louw, D.A., van Ede, D.M., Ferns, I., Schoeman, W.J. & Wait, J. 1998. Middle Childhood. In Louw, D.A. van Ede, D.M. Louw, A.E. (eds), Human Development (2nd ed). Pretoria: Kagisho: 322.
50. Lovelane special needs horseback riding program. Retrieved on 27 December 2004 from the World Wide Web: <http://www.lovelane.org/benefits.html>.

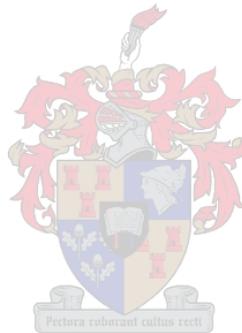
51. Mayo, M. 1994. Community Work. In Hanvey, C. and Philpot, T. (eds), Practising Social Work. London: Routledge.
52. Meyer, W.F., Moore, C., & Viljoen, H.G. 1997. Personology, from Individual to Ecosystem. Sandton: Heinemann Higher and Further Education.
53. Mitchell, L. 2004. Spina bifida. Lancet. 364(9448): 1885-1895.
54. NARHA. NARHA Strides Magazine, October 1995 (Vol1, no 1). Retrieved from the world wide web on 01 November 2005:
<http://.twinenterprises.com/cp/hippotherapy/articles/cp.htm>.
55. NINDS Muscular Dystrophy Page. Retrieved 29 April 2005 from the World Wide Web: <http://www.ninds.nih.gov/disorders/md/md/md.htm>.
56. Office of the Deputy President. 1997. White Paper on An Integrated National Disability Strategy. Ndabeni: Rustica Press.
57. Parker, R., Hansmann, S., Thomas, K.R. & Thoreson, R.W. 2005. Rehabilitation Counseling Theories. In Parker, R., Szymanski, E.M. & Patterson, J.B. (eds), Rehabilitation Counseling, Basics and Beyond. USA: Pro-ed.
58. Patterson, J.B., DelaGarza, D. & Schaller, J. 2005. Rehabilitation Counseling Practice: Considerations and Interventions. In Parker, R., Szymanski, E.M. & Patterson, J.B. (eds), Rehabilitation Counseling, Basics and Beyond. USA: Pro-ed.
59. Patterson, J.B., Brruyére, S., Szymanski, E.M. & Jenkins, W. 2005. Philosophical, Historical and Legislative Aspects of the Rehabilitation Counseling Profession. In Parker, R., Szymanski, E.M. & Patterson, J.B. (eds), Rehabilitation Counseling, Basics and Beyond. USA: Pro-ed.

60. Payne, M. 2005. Modern Social Work Theory, third edition. Great Britain: Palgrave.
61. Pocket Guide on Disability Equity
see
South Africa (Republic). 2001
62. Potgieter, M.C. 1998. The social work process. Development to empower people. South Africa: Prentice Hall.
63. Reber, A.S. 1995. Penguin Dictionary of Psychology (Second Edition). England: Penguin.
64. Robertson, S.E. & Brown, R.I. 1992. Rehabilitation Counselling, Approaches in the field of disability. London: Chapman and Hall.
65. Romeis, J. 1990. Alienation as a Consequence of Disability: Contradictory Evidence and its Interpretations. In Nagler, M. (ed), Perspectives on Disability. Canada: HealthMarkets: 48
66. Saleebey, D. 1999. The strengths perspective: Principles and practices. In Compton, B.R & Galaway, B. Social work processes. Illinois: The Dorsey Press.
67. SARDA. 1999. The SARDA Handbook, a Guide for Branches, Instructors and Candidate Instructors. SARDA: South Africa.
68. SARDA. National Statistics – Census 2004, SARDA National: Cape Town
69. Scherzer, A.L. 2001. Early Diagnosis and Interventional Therapy in Cerebral Palsy, An Interdisciplinary Age-Focused Approach. New York: Basel.

70. Schneider, J.W., 1990. Disability as Moral Experience: Epilepsy and Self in Routine Relationships. In Nagler, M. (ed), Perspectives on Disability. Canada: Health Markets: 618.
71. Schwartzkroin, P.A. 2001. Epilepsy. International Encyclopedia of the Social and Behavioural Sciences. Oxford: Elsevier Science.
72. Sheafor, R.W., Horejsi, C.R. & Horejsi, G.A. 2000. Techniques and guidelines for social work practice. London: Allyn and Bacon.
73. Skidmore, R.A. & Thackeray, M.G. 1982. Introduction to Social Work. USA: Prentice Hall.
74. South African Government. 2005. Batho Pele – Putting People first. Retrieved from the world wide web on 30 October 2005 from www.info.gov.za/aboutgovt/publicadmin/bathopele.htm.
75. South Africa (Republic). Disabled People South Africa Parliamentary Office. 2001. Pocket Guide on Disability Equity. s.n.: Cape Town.
76. South Africa (Republic). 1986. South African Council for Social Service Professions, Code of Ethics. (General Notice 292 of 1986.) Government Gazette, 10205, April. 25.
77. Special Child: Information Avenue Archives. Retrieved on 27 December 2004 from the World Wide Web: <http://www.specialchild.com/archives/ia-008.html>.
78. Statistics South Africa, South Africa (Republic). Census 2001.
79. Strydom, H. 2002. Ethical aspects of research in the social sciences and human service professions. In De Vos, A.S. (ed), Research at Grass Roots - For the Social Sciences and Human Service Professions (2nd ed). Pretoria: Van Schaik: 66.

80. Stuart. 1999. The evaluation of the physical and psychological effects of a riding therapy programme for cerebral palsied children. Unpublished masters thesis. Stellenbosch: University of Stellenbosch.
81. Sunrise Park Inc. Benefits of Therapeutic Riding. Retrieved on 27 December 2004 from the World Wide Web: <http://sunriseparkinc.tripod.com/id8.html>.
82. Swannell, J.(Ed). 1980. The Little Oxford Dictionary (Fifth Edition). Great Britain: Oxford University.
83. Terminology committee for social work. 1995. New Dictionary of social work, revised and comprehensive edition. Parow: CTP Book Printers.
84. The New Encyclopaedia Britannica, 2002: Vol. 4
see
Anon. 2002. Epilepsy
85. The New Encyclopaedia Britannica, 2002: Vol. 8
see
Anon. 2002. Muscular Dystrophy.
86. The Riding for the Disabled Association. 1976. The Handbook of the Riding for the Disabled Association. RDA: Britain.
87. The Riding for the Disabled Association. 1990. The RDA Official Manual. Great Britain: Kenilworth.
88. Thomas, D. 1978. The Social Psychology of Childhood Disability. Cambridge: University Press.
89. Vaccha, B. & Adams, R. 2005. Myelomeningocele, Temperament Patterns, and Parental Perceptions. Pediatrics. 114(1): e58-e63.

90. Whitney, P. 2003. Study identifies factors increasing risk of Psychosocial Problems among Disabled Children. Retrieved December 27, 2004 from the World Wide Web: http://www.eurekalert.org/pub_releases/2003-07/mgh-sif070903.php.
91. Ylvisaker, M., Adelson, P.D., Braga, L.W., Burnett, S.M., Glang, A., Feeney, T., Moore, W., Rumney, P. & Todis, B. 2005. Rehabilitation and Ongoing Support After Pediatric TBI. J Head Trauma Rehabilitation. 20(1): 95-109.



**ON THE ELECTRONIC COPY OF THE THESIS
ADDENDUM A AND B ARE TO BE FOUND ON ATTACHED PDF FILES**

ADDENDUM C

28 February 2006

Attention: _____

RE: PERMISSION TO INTERVIEW _____

Our telephone conversation on 27 February 2006 refers.

I am currently doing my masters degree in social work at the University of Stellenbosch. My focus is the psychological and social aspects of horse riding for children with physical disabilities.

I have been doing my practical work at the South African Riding for the disabled association (SARDA), where _____ was a keen rider in 2005. For the purpose of my study, I will be interviewing the volunteers at SARDA to gain their views on the progress of the children. I would however, like to interview the children themselves, to gain their impressions on what therapeutic horse riding has meant to them.

As _____ is under the age of 18, it is ethically required to gain written permission from his parent / guardian to conduct the interview. The interviews will be conducted at the school and consist of a few questions, which shouldn't take longer than fifteen minutes to answer. As the answers will need to be transcribed for the purpose of the study, the interview will be video-recorded.

For your convenience, I have attached an example of the questions that will be asked. If you require any further information, please feel free to contact me at 082 8344 617.

Should you be in favour of me interviewing _____, please could you sign the form below and fax it back to **ATTENTION: C. HELFER, FAX NO: 021-658 3357.**

Regards.

Avril Helfer

**I, (parent / guardian's name) _____ hereby grant
permission to Avril Helfer to interview (child's
name) _____,**

**for the purposes of obtaining her master's degree in Social Work at the
University of Stellenbosch.**

DATE

SIGNATURE OF PARENT / GUARDIAN

ADDENDUM D

QUESTIONNAIRE FOR HELPERS, INSTRUCTORS AND OR THERAPISTS

1. How has the child performed socially since he or she has been involved in therapeutic riding? (e.g. how did he get on with helpers, instructors, other riders and also how has he been socially outside of the riding school?)
-

2. How does the child feel about himself A) When riding and B) since having been involved in the riding programme?
-

3. How would you describe the child's confidence since having been involved in riding? (on horseback and generally).
-

4. How would you describe the child's emotions A) when riding and B) generally since he has been riding?
-

5. What is the child's discipline like A) when riding and B) generally since he has been riding?
-

6. What is the child's language communication like A) when riding and B) generally since he has been riding?
-

7. (Only for therapists) Has the riding complemented the child's academic performance and if so, in what way?
-

8. Anything further worth mentioning?
-

ADDENDUM E

QUESTIONNAIRES FOR THE RIDERS / CHILDREN

1. How many friends have you made at SARDA?

2. What do you think of the horse you ride?

3. Tell me about your helper?

4. What's your riding teacher like?

5. How do you feel when you are on the horse?

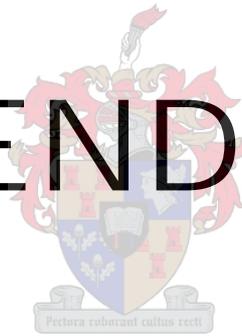
6. What do you tell your friends or family about the horse that you ride?

7. What have you learned since riding horses?

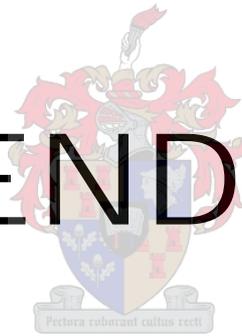
8. What's your favorite thing to do at SARDA?



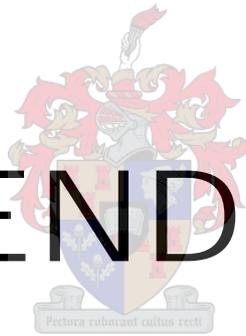
ADDENDUM A



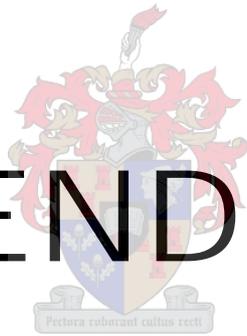
ADDENDUM B



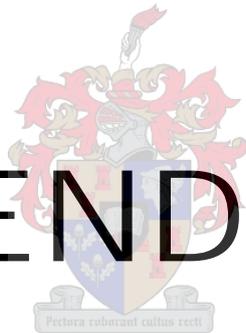
ADDENDUM C



ADDENDUM D



ADDENDUM E



19 Geneva Crescent
UITZICHT
7550

21 April 2005

Attention: Headmaster
Astra School

PERMISSION FOR CASE STUDIES

I am currently doing my masters degree in social work at The University of Stellenbosch, with the focus on the psycho-social dynamics of equine assisted therapy. For the purpose of this course, I have also enrolled as a candidate instructor at the South African Riding for the Disabled Association (SARDA).

For exam purposes of the instructors' course, I will be using the group of children from your school that attend SARDA on a Thursday morning. As I will be focusing most of my attention on this group, I would like to obtain permission from the school to possibly use this group as my focus group for my thesis.

This entails having an interview with the children and physiotherapist towards the end of the year, regarding their experiences at SARDA . (Dawn, the accompanying physiotherapist on a Thursday morning, is aware of the study). The questionnaire will be drawn up from the research done during the year. I do of course understand that permission will also have to be obtained from the parents of the respondents closer to the time.

I would gladly provide a copy of the completed thesis to the school.

For the purpose of the study, I would need to obtain permission from the school in writing. I am available on the following telephone number should any more information be required - Cell: 082 8344 617. Your cooperation will be much appreciated.

Thank you.

Regards.

Mrs Avril Helfer



S.A. Riding for the Disabled Association : Cape Town Branch

Hon. Life Presidents : Mrs B. Sampson, Mrs J. Finlay,
Hon. Life Members: Mrs O Hurst, Mrs S Carter

SARDA Centre
Brommersvlei Road
CONSTANTIA 7806

Non Profit Organisation Reg: 002-822
Public Benefit Organisation No : 18/11/13/2516

Tel: 794-4393
Fax 794-2497
Email: sarda-cf@iafrica.com

Box 235
CONSTANTIA
7848

7 February 2005

To whom it may concern

This is to certify that Avril Helfer became involved at S A Riding for the Disabled in January 2005.

She is undertaking this as part of her M.A. Social work study on the psychosocial dynamics of equine assisted therapy. Avril is working as a volunteer / helper for the year 2005 / 6 and is involved in all aspects of the therapeutic riding lessons. This involves close contact with the disabled rider, the instructor and other helpers. She will also have the input of physiotherapists.

SARDA willingly supports Avril in her study.

Yours sincerely


PP
Brenda Wright
Chairman

