

CHAPTER 3

THE RESEARCH PROCESS: DESIGN AND METHODOLOGY

3.1 INTRODUCTION

In the previous chapter, I presented existing research contributions that are relevant to this study, in order to create a platform upon which I could conceptualize and develop this research. In this chapter, I describe the procedures used in the research, the advantages of the chosen research paradigm, the manner of participant selection, the background of the participants and a description of the two sites where research took place. I also delineate the ethical considerations that I took into account during this study.

3.2 METHODOLOGICAL RESEARCH PARADIGM: SINGLE-SYSTEM RESEARCH DESIGN WITH INTERVENTION

This study followed a single-system research design, which applied qualitative and quantitative approaches to examine a single system (a participant) at various stages of therapy. “Single-subject designs are experimental designs using only one participant” (Graziano & Raulin, 2000, in, Strydom, 2005d:145). Multiple measures using the Roberts-2 test were taken from a single participant over time. “Repeated measurements were conducted in order to monitor at regular time intervals whether changes in the problem” or in the participant’s mental or emotional functioning “had occurred prior to, during, or after the treatment was administered” (Strydom, 2005d:146). “A significant aspect of the single-system design is the different phases: the baseline phase, the intervention phase and a return to baseline phase” (Strydom, 2005d:147).

In this study, the baseline phase consisted of standard of care therapy involving talking, drawing and clay, and the intervention phase involved the traditional Sotho stone and narrative therapy, Masekitlana. The single-system design compared each of the four participants with himself during the course of therapy, as it was a pre- and post design that allowed for pre- and post-test measurement of constructs. The independent variables, in this case, types of therapy, were manipulated to observe their effects on dependent variables, that is, the emotional state and coping abilities of the participants in this study. In single-system designs, a control group is not necessary, as each participant becomes his own control.

The single-system design allowed for quantitative indications, which were reflected in graphic form without using formal statistical analysis. Because no control group or statistical analysis was done in this design, this methodology has sometimes been termed ‘quasi-experimental’. The intervention (independent variable) in this study was the traditional Sotho form of narrative therapy, Masekitlana. The single-system design methodology fitted into normal standard of practice which, in the environment where I work, consists of psychological therapy (involving measurement of mental constructs), narrative and play therapy. The essence of the single-system design was to discover trends and analyze change in the problem or challenging areas.

The single-system design used in this study is more rigorous, routinized and methodologically bound than the case-study approach (Strydom, 2005d). It is, however, considered to be an extension of case-study research, with the added introduction of an intervention and repetitive measures of the target problem. What single-system research shares with case-study research is that the cases, subjects or systems under investigation are “holistic, discrete items where description can be deep, rich and concerned with real-life meanings and events” (Pole, 2000, in Denzin & Lincoln, 2000).

Table 2 delineates the advantages of the single-system design that resonated with this study (Strydom, 2005d:154-155):

Table 2: Advantages of a single-system design

Single-system design	Advantages for this research
Control group evaluation	
<ul style="list-style-type: none"> • Whenever research involves testing the success of an intervention, an ethical question arises over placing some of the participants into a control group and therefore sometimes receiving inferior treatment. This does not happen in the single-system approach as all participants can be treated and evaluated. • In a control group experimental situation, confounding factors might be introduced that compromise the validity of the data. In the ex post facto situation the researcher has no control over the independent or causal variables. However, in the single-subject pre- and post-test situation, valid and reliable information about the single individual is obtained. 	<ul style="list-style-type: none"> • In this study, each participant was his own control in that he was measured in the pre- and post-test phases and comparisons were made between these phases. The pre-test phase and measurement, therefore, served as a form of control. • As the participant was his own control, confounding factors were avoided, such as inevitable differences (not caused by the research situation) between control and experimental participants entering the situation.



Convenience and Usefulness of Design in Everyday Practice and Evaluation

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| <ul style="list-style-type: none">• It is a cost effective approach as practitioners can continue with their normal work whilst incorporating the single-system design into their practicing schedule.• Evaluation of therapy can be an ongoing process during normal practicing. Results can be immediately available. This encourages a form of meta-thinking around methods of therapy for therapists. It also enables training psychologists and their supervisors to evaluate their own and their clients experiencing of therapy.• Hypothesis testing and modifications in therapy can be immediately made, particularly in settings where a large variety of patients from different backgrounds are encountered. | <ul style="list-style-type: none">• The research fitted into the normal schedule of therapy that the researcher would have performed on the participant. Child clients in the clinic under normal circumstances participate in different forms of play therapy as well as emotional assessment using various standardized measures.• The application of the Roberts-2 test along the course of therapy in this research presented an immediate and ongoing evaluation of therapy. The value of different forms of therapy in the African setting was facilitated by this ongoing evaluation.• The hypothesis that the African form of therapy, Masekitlana, would be more readily received than more Western based forms of therapy, was able to be immediately tested in this research. |
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3.3 METATHEORETICAL PARADIGM: INTERPRETIVE

The interpretivist research paradigm was felt to be suitable for this study as it is concerned with understanding the ‘subjective’ meaning of the participants rather than offering a simple description of behaviours ‘observed’ by the researcher (Johnson-Hill, 1998). As there is no God’s-eye point of view in interpretive research (Smith & Deemer, 2000, in Denzin & Lincoln, 2000), all that it is possible for researchers to have are “the various points of view of actual persons reflecting various interests and purposes that their descriptions and theories sub-serve” (Putnam, 1981, in Denzin & Lincoln, 2000:880). The interpretivist approach in case studies answers the ‘how’ and ‘why’ of situations or phenomena, and does not try to create a boundary between phenomena and context (Yin, 1989). Therefore, any claim to knowledge in the interpretive paradigm must take into account the perspective of the person making the claim. Hence, the researcher does not only attempt to present faithful recordings of the participants’ worlds, but also attempts to understand the meaning that the participants place on phenomena in their worlds (Denzin & Lincoln, 2000). The emphasis is on understanding the participants’ lives through the mindsets, ideologies and value systems of the participants, and on being taught by the participants and on reconstructing as accurately as possible how they construct their own understandings rather than judging the adequacy of those understandings (Isasi-Diaz, 1993, in Johnson-Hill, 1998). Therefore, research using the

interpretive paradigm is about the intentions of the participants and the emotional, linguistic, cultural and historical discourses that create their ‘realities’ (Green, 2000).

However, in the tradition or method of philosophical hermeneutics, human action is not ‘an object out there’ but is constructed and negotiated almost as a dialogue between the researcher and participants (Swandt, 2000, in Denzin & Lincoln, 2000). Researchers come with their own ‘biography’ and their observations are always socially situated between their worlds and the participants’ worlds (Denzin & Lincoln, 2000). This might then be construed as a limitation of the interpretative paradigm, particularly if the researcher is from a different cultural group to that of the participants. In the latter situation, a researcher, due to his or her own entrenched mindset, might not be able to be adequately objective, interpretive and sensitive to the participants’ essential meanings and intentions. Prejudices, prejudgments and biases cannot just be put aside. Therefore, attempting to be non-judgmental necessitated a reflexive assessment on my part, as the researcher, of where I stood in comparison to the participants, regarding my own values and cultural perceptions concerning the social, political and economic context in which I live and relate to others in South Africa. In this study, my assumption was that this would involve an awareness of similarities and differences between my world and the worlds of the participants. This required an atmosphere of transparency and a certain amount of dutifulness to reveal my own feelings and how these were affecting the course of therapy and the data analysis of the study. Hence, an interpretive approach dictated self-awareness and self-reflection on my part, and understanding what is involved in the process of understanding was as important as the other processes of data gathering and analysis.

The end product in the interpretive paradigm is a colourful interchange between the world of the participants and that of the researcher, a form of modern democracy in the social sciences (Denzin & Lincoln, 2000). Furthermore, research using an interpretive paradigm involves an unfolding process in time. I needed to go back and forth between what I observed and what the meaning was as experienced by the participants. Meaning was not given obviously but emerged through metaphor and through my creativity as the researcher. There were certain explicit facets of the research that were immediately clear, but underneath there were tacit understandings that emerged with time and familiarity as the sessions proceeded (Maykut & Morehouse, 1994).

My aim in choosing the therapeutic modalities of this study was to allow for an unstructured baseline and intervention process whereby story-telling could be spontaneous rather than controlled, scientific and clinical. I felt that the interpretive approach was flexible enough and participant-focused enough to allow for a holistic form of therapy, assessment and interpretation.

3.4 RESEARCH APPROACH: MIXED-METHODS DESIGN

The single-system design allows for a mixed methodology that includes both qualitative and quantitative approaches. Mixed-methods research is formally defined as “the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or languages into a single study” (Burke Johnson & Onwuegbuzie, 2004). In deciding on mixed methods I deviated from the purist method of using either qualitative or quantitative approaches, in favour of a pragmatic view (as determined by experience or practical consequences) that research approaches should be mixed in ways that offer the best opportunities to obtain useful answers to important research questions (Burke Johnson & Onwuegbuzie, 2004). In this study I required a qualitative analysis of the data, as the study involved a rich, deep and detailed investigation into participant narratives with an interpretive focus, taking strongly into account the subjective viewpoints of participants. I also required an objective, quantifiably based method of examining the data in order to give me a concrete way of measuring the effectiveness of the intervention. Hence, using mixed methods allowed me to expand my understanding of the situation better than if I had adopted a mono-method approach.

Furthermore, mixed-methods research was productive because it not only offered an “immediate and useful middle position philosophically and methodologically” (Burke Johnson & Onwuegbuzie, 2004:17) but also “offered a form of interaction between both quantitative and qualitative approaches”. Hence, it has aptly been described as a “practical and outcome-oriented method of inquiry that is based on action and leads, iteratively, to further action and the elimination of doubt” (Burke Johnson & Onwuegbuzie, 2004:17). Using data from one approach to confirm data from the other approach and vice versa can be attributed to the cyclical, recursive process of mixed methods (Onwuegbuzie & Leech, 2004b, in Burke Johnson & Onwuegbuzie, 2004).

Mixed methods suited this study in that its logic of inquiry (using guidelines from de Waal, 2001, in Burke Johnson & Onwuegbuzie, 2004) includes the following characteristics of both paradigmatic approaches:

- The qualitative focus enabled the use of *induction*. I was able to search for patterns or trends arising out of participant narratives.
- The quantitative focus enabled *deduction and hypothesis testing*. From the quantitative results I was able to deduce intervention consequences on participants, and I was able to test the theory or hypothesis that an indigenous Sotho form of narrative play therapy would be equally useful for children of Zulu origin and culture and would be a useful form of therapy for traumatized children affected by HIV/AIDS. The quantitative focus also enabled *prediction and standardized data collection*. Using a normed test enabled me to state the effect of similar intervention opportunities for other children in similar circumstances; it was presumed that the quantified results offered predictive validity.
- As a result of the *combination* of methods, I made use of *abduction*. I was able to uncover and rely on the best set of explanations for understanding my results because I was using different approaches and methods.

Furthermore, a mixed-methods design, according to Bryman (2006) as adapted to this study:

- Improved *validity*, as qualitative and quantitative data corroborated – as I analysed the graphic quantitative results, I turned to the narrative in the themes to help explain the graphs;
- *Offset weaknesses and drew on the strengths* of both approaches – the theme analysis told me a lot about the participants but did not indicate to what extent the intervention helped them, whereas the quantitative results indicated the effect of the intervention but did not tell me why;
- Gave *completeness* to the study – explanations were more comprehensive as a result of both approaches; words, and narratives added meaning to the numbers (Burke Johnson & Onwuegbuzie, 2004);
- *Added* to the process – quantitative results produced outcomes, while qualitative results provided content and process;
- *Answered different questions* – qualitative results answered what the children were saying and feeling, while quantitative results indicated how their answers fitted into normative data and indicated adaptive changes as a result of the intervention;

- Helped to *explain* each other – qualitative data explained changes in the graphic results, and graphic results demonstrated the effect of the qualitative data on the adaptive capacity of participants to their lives;
- Provided *unexpected results* – qualitative data indicated anxiety and depression but quantitative data demonstrated how these feeling states increased right until the end of therapy;
- Ensured *credibility* – both approaches enhanced integrity and confirmed the integrity of each other; both approaches provided more complete knowledge necessary to inform theory and practice;
- Were *illustrative* – the qualitative data developed depth and helped to illustrate the quantitative data;
- Conferred *confirmation* – quantitative data tested the qualitatively generated hypotheses; both approaches provided stronger evidence for the conclusion;
- Provided *enhancement* – each form of data was built on by the other form of data;
- Offered *complementarity* – qualitative analysis is more subject to the biases of the researcher, whereas quantification is more concrete; combining both approaches resulted in complementary strengths and non-overlapping weaknesses (Johnson & Turner, 2003, in Teddlie & Tashakkori, 2009).

The different paradigms provided the foundation for the different phases of the research (Creswell & Plano Clark, 2003). I used a concurrent, embedded, mixed-methods design in that quantitative data testing occurred at different stages of the qualitative data measurement, as Figure 4 illustrates (Creswell & Plano Clark, 2003).

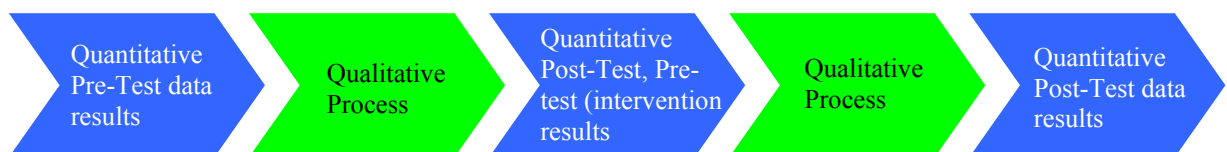


Figure 4: The mixed-methods research process

3.4.1 PUTTING MIXED METHODS INTO PRACTICE IN THE PRESENT STUDY

I favoured the symbolic description of ‘crystallization’ to describe the multi-faceted approach I used in the present study. The topic under review was examined from all angles and hues according to the needs of the study, as one examines a crystal held up to the light (Janesick, 1998, in Denzin & Lincoln, 2000). As such, I exposed my participants to various forms of

therapy and recorded them using various media forms, and analyzed and measured the results using mixed methods.

I presented therapy from various conceptual angles, that is, observing the combined and separate effects of Western forms and African forms of therapy. The participants were exposed to therapy involving drawing and clay in the baseline phase, and an African form of narrative stone play in the intervention phase. Their narratives, movements, facial expressions and general demeanour were continually recorded, videoed and noted. At the different phases, the participants were assessed using the Roberts-2 test, which involves telling stories around picture cards. Semi-structured interviews with caregivers and discussions of the therapeutic process with the therapist also informed the study.

The qualitative and quantitative aspects of this study had definite, expected and anticipated steps and rules, and yet allowed for “improvisation, which involved spontaneity as well as preparation, exploration and formulation” (Janesick, 1998, in Denzin & Lincoln, 2000). I continuously assessed and re-examined my methods of therapy and measurement to ascertain whether they were appropriate for the participants’ therapeutic process. Individual participants used the picture cards in different ways, so I had to adapt the administrative guidelines of the quantitative measurement tool. Methods of using Masekitlana evolved as therapy progressed. For one participant, simply moving the stones up and down his leg and hitting the stones together whilst talking constituted Masekitlana therapy. For another participant, naming the stones and personalizing them into family members characterized therapy with Masekitlana.

The rationale for the variety of techniques and methods to be used was to “fully and rigorously capture the nuance and complexity” (Flick, 1998; Janesick, 1998 in Denzin & Lincoln, 2000:381) of the particular social situation under examination, that is, Zulu-speaking children affected by HIV/AIDS. As an interpretive approach was followed, it was very important that all aspects of the context of the participants’ lives, through their own eyes, were revealed and for this the flexibility and open-endedness of the qualitative approach was useful.

Crystallization also incorporates the use of other disciplines to inform the research process. In addition to consulting the theoretical principles and research findings of educationalists, psychologists, sociologists, and social anthropologists, I was particularly interested in the

writings of theologians of European and African origin, who presented their work on integration of African forms of thinking and knowing into their theological worlds.

A quasi-experimental *quantitative* approach was also felt to be necessary for this study as it was important that ways and means were found to measure *change* in problem areas that were specific, measurable and provided client-desired outcomes (de Vos et al., 2005). The scoring of the Roberts-2 test entailed a graphic presentation of changes (improvement, deterioration or no change) in the problem or challenges, from baseline to termination of treatment, and to the follow-up two months later. This visual presentation of analysis offered more rigour and concrete analysis than thematic analysis alone. Quantifiable results were dictated by an integration of the Roberts-2 and the Dynamic Assessment (Matthews & Bouwer, 2009) models of applying and scoring the measure applied to the participants. The visual presentations entailed simple plotting on graphs, rather than complex statistics. I presented separate data analyses for qualitative and quantitative results, and then an integration of analyses at the discussion phase.

Informing this study were the assumptions that children of African origin can be helped more by using their own forms of traditional narrative and problem solving than the more Western models that are presently being employed in South African settings. Hence, the purpose of this study was to establish an African form of therapy that might inform the field of indigenous psychology. This study did not strive to exclude existing forms of therapy but required the use of both Western and indigenous forms of therapy for the participants. My goal was to make observations on the combined and separate effects of both Western and indigenous forms of therapy. Data was collected in as naturalistic a setting as possible, that is, at the sites where participants lived.

The process illustrated in Figure 5 was repeated four times for the four participants.

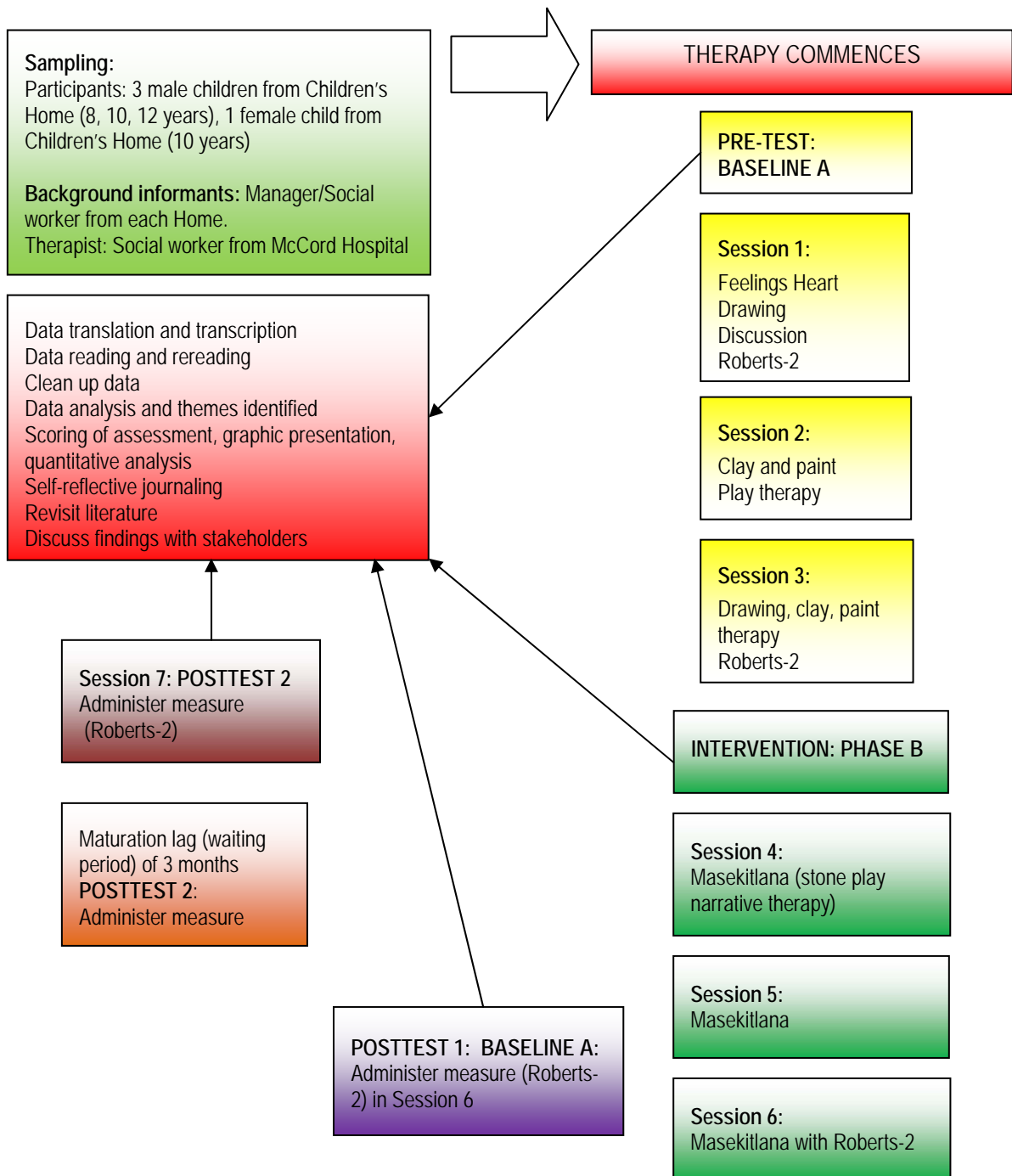


Figure 5: Research and therapy process

3.5 RESEARCH SITES

This study was conducted in two settings in Durban, KwaZulu-Natal: St. Theresa's Children's Home and St. Martin's Children's Home. The three male participants resided at the former and the female participant resided at the latter. In an interpretive study the environmental context of the participants is considered important. Studying the participants of the current study in the setting of the Children's Homes was considered the most naturalistic choice to

represent as closely as possible the inner and outer world of the participants (Johnson-Hill, 1998).

3.5.1 ST. THERESA'S CHILDREN'S HOME

St. Theresa's Home is located in the residential area of Sydenham. This is an urban area situated within six kilometres of Durban's central business district. It has a predominantly Coloured¹³ and Indian population, and caters for the middle to lower income group. It is considered to be a relatively safe area, although according to local residents it houses gangs of youths who commit crimes, and drug dealing appears to be prevalent.

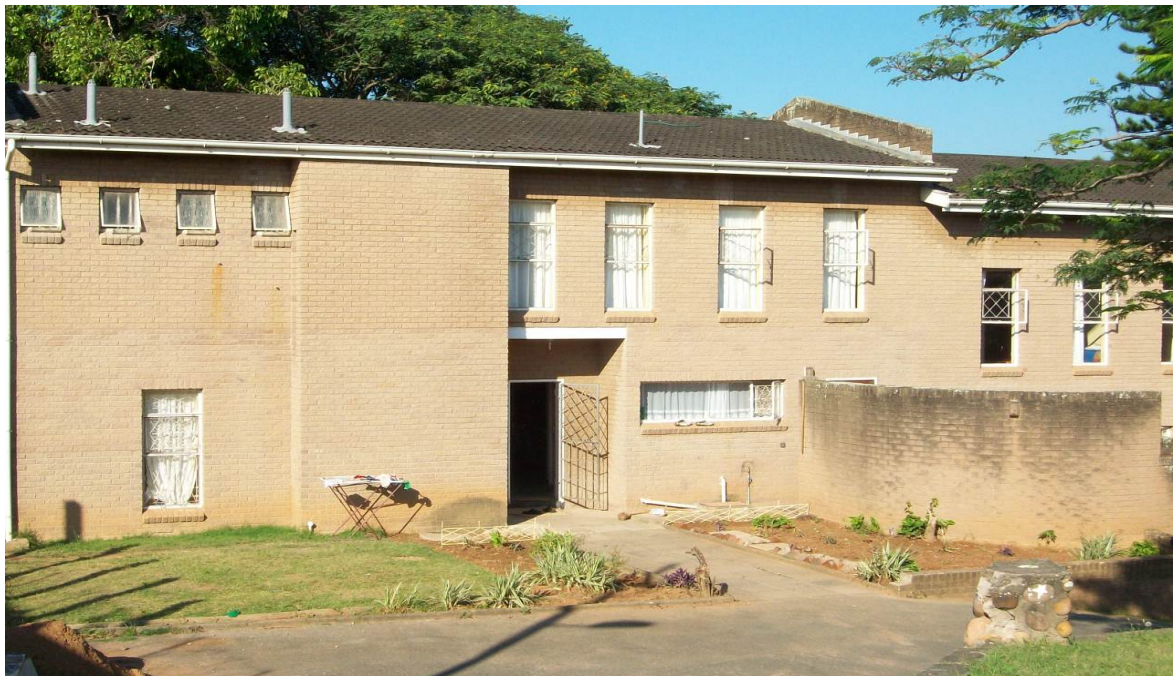


Figure 6: Apartment in St. Theresa's Children's Home where Hlonipho lives

St. Theresa's Home is part of a non-governmental organization which was established in 1925 by the Augustinian Sisters. There are approximately 70 boys in the Home attended to by a staff of 20 to 24, consisting of a director, manager, two nuns (a childcare supervisor and a nurse), a social worker, childcare workers, a stores manager, a receptionist, a cook, a driver and student volunteers from local and overseas countries who work there from time to time.

¹³ In the South African, Namibian, Zambian, Botswana and Zimbabwean context, the term Coloured (also known as *bruinmense*, *kleurlinge* or *bruin Afrikaners* in Afrikaans) refers or referred to an ethnic group of mixed-race people who possess some sub-Saharan African ancestry but not enough to have been considered Black under the former laws of South Africa.

The Home uses the hospitals and doctors in the area and in surrounding areas. One of the hospitals it uses, especially for HIV needs, is McCord Hospital.



Figure 7: Administration block of St. Theresa's Children's Home



Figure 8: St. Theresa's Catholic Church

3.5.2 ST. MARTIN'S CHILDREN'S HOME

St. Martin's Children's Home is situated in Clark Road, Glenwood, which is an old residential area of Durban. Glenwood houses a mixture of people from various economic classes and races, although it was traditionally and still remains, to a large extent, a middle-class 'White' area.

St. Martin's Children's Home was opened in 1896 as a wood-and-iron home and church for the Sisters of St. John the Divine. It is now registered with the Department of Social Welfare to care for 72 male and female children. The Home is run according to the stipulations of the New Children's Act and is partially funded by the Department of Social Welfare and Population Development. Children who are admitted have been abandoned, neglected by parents or have inadequate parents, receive little family support, are from child-headed households or have behavioural problems. St. Martin's Home aims to offer young destitute people an opportunity for a better life.



Figure 9: Front entrance to St. Martin's Children's Home

The medium of therapy in the current study was narrative play, which required a specific environment. The more comfortable children are in the play therapy environment, the more they play (Lemke, 2008). Therefore, in both Children's Homes, the participants were engaged with in informal rooms. In St. Theresa's Home, the designated 'therapy room' contained beds

and a rug on the floor and cots of toys, and had a kitchen nearby where the researcher was able to prepare tea snacks for the participants. In St. Martin's Home, the room where therapy took place was not as comfortable but nevertheless had a large table for the clay and paint therapy, and had enough room on the floor to lay out a rug for the therapist and participant to sit on and enough space for the stones to be scattered and played with.

3.6 STUDY POPULATION AND SELECTION OF PARTICIPANTS

The process of selecting participants in a study is an “important feature of research, as it may affect the outcome of the research” (van Vuuren & Maree, 2004:274). The sampling procedure of the current study consisted of the following features:

- It was *purposive* in that the participants were chosen by the social workers of the Homes based on the purposes of the research questions (Tashakkori & Teddlie, 1998). Furthermore, they purposely chose participants who were most characteristic and representative of the greater population of children of Zulu origin and culture who were traumatized, orphaned and affected by HIV/AIDS.
- It was a *convenient* sample in that participants were chosen because the geographical proximity of the Children's Homes to the hospital provided easy access to them, and they were therefore an “accessible population” (Tashakkori & Teddlie, 1998:63; Yin, 1989). As the participants were routinely transported to the hospital only once a month, I decided that it would be more convenient for me and the therapist to conduct research at the Homes. The psychologists of the Psychology Department of McCord Hospital have been travelling to St. Martin's Children's Home for a number of years to conduct individual and group therapy and staff support, and have also been counselling children regularly from St. Theresa's Home. Therefore, both Homes were familiar to the therapist and me, and staff members from both Homes are seen frequently in Sinikithemba HIV Paediatric Clinic. There is the caution that convenient sampling “saves time, money and effort at the expense of information and credibility” (Miles & Huberman, 1994, in Marshall & Rossman, 1999:78). However, the length of time spent with each participant, the depth of investigation into each participant's life, the accuracy of information, the quality of the measuring instrument and the competency of the therapist meant that it was a feasible study

(Reid & Smith, 1981, Srantakos, 2000, in Strydom, 2005c), which mitigated the aforementioned caution.

- The sample was “considered *representative*” (Strydom, 2005c:193) in that it was “assumed that what was observed in the sample of participants would also be observed in the larger or universal target population” (Tashakkori & Teddlie, 1998:62) of children of Zulu origin and culture who are affected by HIV/AIDS. The sample studied in this research was not “primarily an end in itself, but a means of helping to explain some facet of the population” (Powers et al., 1985, in Strydom, 2005c:194). In this way I felt that the findings could be *generalized* to other groups of subjects from the population, demonstrating “population external validity” (Tashakkori & Teddlie, 1998:65). I felt that two broader forms of external validity (Tashakkori & Teddlie, 1998) could be applied to this study: 1) Masekitlana could be generalized to other situations besides the context of children affected by HIV/AIDS, and 2) other ways of measuring the constructs of interest in this research could be followed.
- The sample demonstrated *translation fidelity*, meaning it was appropriate to the current study’s conceptual framework of indigenous psychology, in that an African indigenous game was used on a sample of African indigenous children.
- The sample was a *non-probability* sample in that the “odds of selecting a particular individual are not known (as they would be in probability sampling)” because I did not know the “population size or all members of the universal population” (Braveller & Forzano, 2003, in Strydom, 2005c:201). Non-probability sampling is specifically used in small-scale, in-depth research projects such as the current study (Tashakkori & Teddlie, 1998).
- Sampling was therefore done twice, once for the selection of the Children’s Homes and once for the selection of the particular children within the Homes. Three boys between the ages of eight and 12 years were chosen from St. Theresa’s Children’s Home, a home solely for boys, and one girl aged ten years was selected from St. Martin’s Children’s Home.

3.6.1 PARTICIPANTS' DETAILS

3.6.1.1 Participant 1: Hlonipho¹⁴

Hlonipho (12 years old, Grade 4) was admitted to St. Theresa's on 3 March 2009. He was reported to be emotionally traumatized and in very poor physical condition. The first history on record of Hlonipho was that his parents had separated so he had lived with his father initially. He was taken away from there by his mother as she suspected that he had been sexually abused. No suspects were known. He went to live with his mother and her boyfriend but fell ill. He then spent a protracted stay in a rural state hospital twenty kilometres out of Durban, to which he had been referred by the Child and Family Welfare Agency of that area. His stay there was long as the hospital initially lost his background information. This delayed placement into a suitable home. His mother died while he was still in the hospital. Her boyfriend initially wanted to adopt him but when he was informed of the adoption protocols and the fact that Hlonipho was HIV-positive, he did not return to complete the procedure. Apparently Hlonipho was asymptomatic for seven years after he had been found to have been "terribly traumatized" and in a "terrible (physical) condition". A district state hospital wanted to perform a colostomy on him but could not find any paperwork on him. In the end, he was treated at McCord Hospital, where his physical condition improved. His social worker feels that there has been much stigma around his status and therefore he has not been placed in a foster home. She also does not feel that he is emotionally stable enough to leave the home. His foster care, where he was before he came to the home, would take him back but it is felt that conditions, such as a lack of running water, are not hygienic enough there to maintain his health and there might not be enough monitoring of his medication. Siphon was not born with HIV. Transmission was from the sexual abuse.

3.6.1.2 Participant 2: Senzo

Senzo (eight years old, Grade 3) was admitted in February 2005 to St. Theresa's Home. He has been there for five years. He was abandoned by his mother in October 2004. She was abusing drugs and alcohol. He was then cared for by a 'step-grandmother'. The latter was also looking after her son's daughter who is two years older than Senzo. Senzo was initially, at the beginning of this study, not considered a blood relative to this 'grandmother'. But both the granddaughter and Senzo share the same mother. The step-grandmother indicated that none of

¹⁴ Pseudonyms were given to participants to ensure anonymity

Senzo's relatives would look after him and he has no contact with them. There are no details of his father. The step-grandmother was not in a position to look after him because of his ill health and because she was sceptical about his HIV status. Senzo was unwell when his step-grandmother brought him to the attention of Child Welfare. He was on tuberculosis treatment at the time, and was taken to a Place of Safety where he was diagnosed with HIV. He has a bond with his half-sister who is still with her grandmother. His sister apparently loves him too. She was born in 2000 and is 10 years old. Senzo has visited this family and spent a week there in the June/July holidays during the course of this study. The family is not proactive in organizing to have him visit but the St. Theresa's care worker takes him there regardless. Two other placements in the form of foster homes have offered to take on Senzo but he will not accept them as he fears he will then lose contact with his sister. He was born with HIV. During the time he was visiting his family in June/July, the step-grandmother's son and former partner of Senzo's deceased mother came to stay and apparently a 'break through' took place in the form of this man recognizing Senzo as being his son (due to likeness in facial features). By the end of this study, it was thought that Senzo could be his biological son.

3.6.1.3 Participant 3: Mandla

Mandla (10 years old, Grade 1) was admitted on July 2009 to St. Theresa's Home from his family home in Pietermaritzburg. He was first placed in a Place of Safety until placement at St. Theresa's was secured. Mandla had problems settling in and adjusting to St. Theresa's Home. He was cared for by his grandmother's sister with her grandchildren. His grandmother had died. Mother and father are unknown. St. Theresa's were told that, before he was in the care of this 'grandmother', he was being physically abused, locked out of his house and forced to sleep on the streets, so this 'grandmother' took over his care. When he was taken into the care of Child Welfare, he was dirty, unkempt and his clothes did not fit. He had not been enrolled in school, as his 'grandmother' did not have the resources to organize this. He used to mess in his bed, which she could not manage. At St. Theresa's he gave endless problems according to the Social Worker. She described how he wanted to pack up and leave to go back to Pietermaritzburg. He was disruptive in the Home and hit the other boys. He refused to attend school so was forcefully taken there, kicking and struggling. He apparently can be arrogant and pushy. He even tore a hole in his shirt and stuffed it into the fence in front of the social worker of the Home. However, he then reportedly "did a 360-degree turn" and had "really settled nicely" at the time of the study. He has friends but still does fight with the

boys at times. He is described as being “streetwise”. He was put in Grade 1, and then Grade R, and then St. Theresa’s Roman Catholic School refused to keep him so he was eventually placed in St. Martin’s School. He has contact with his grandmother’s sister who took him in for the 2009 December holidays. She did not take him for the March holidays but he went to her for the July holidays, during the course of this study. He has bonded with the social worker and visits her every day. He was suspected of being a sexual abuse victim and of taking part in experimental sex in the Home.

3.6.1.4 Participant 4: Nana

Nana was admitted into St. Martin’s Children’s Home in 2009. She came from the Mariannhill area where she was attending a Community Outreach Centre. Nana’s mother had been found to be neglectful of her, abandoning her regularly to the care of her grandmother. Her mother is unemployed and not on good terms with the grandmother. The grandmother was found not to be in a position to look after Nana either as she was scared that the males in her house would sexually abuse Nana. It was also reported that Nana had been coming to school wrongly dressed and with no food for lunch. Her father is also unemployed, reportedly “not interested” in Nana and had physically abused her for stealing R100. Nana’s grandmother also reported stealing behaviour. She was reported to have been sexually abused by three perpetrators in three different places. A Child Welfare Agency had opened a legal case in this connection. At the time of this study, Nana was attending court preparation and hearings. Since being in the Home, her school attendance has been good, her work has been reportedly average, peer relations were average but there were reportedly comments that she was aggressive at times. She also reportedly loves to help. In the Home she is apparently an “instigator at times” “and still steals occasionally. She has visited the home of the priest attached to St. Martin’s, who took her on holiday with other children to a coastal resort south of Durban. However, she reportedly again stole some money there.

3.7 PRE-PROCEDURAL MEETINGS

A researcher should never start the main part of the research until he or she is “confident that the chosen procedures are suitable, and that he or she has taken all possible precautions to avoid any problems that might arise during the study” (Sarantakos, 2000, in Strydom, 2005e:205). Furthermore “as much as possible should be learnt from the experiences of others and from the experts in the field” (Monette et al., 1998, in Strydom, 2005e:207) in order to

“delineate the problem more sharply and gain valuable information about the more technical and practical aspects of the prospective research endeavour” (Cilliers, 1973, in Strydom, 2005e:208).

Therefore before research commenced, I consulted the following people or committees:

- Dr. Kekae-Moletsane and Mrs. Odendaal-Hinze, who had both researched the therapeutic method of Masekitlana in assessment and therapy with children of African origin and culture, to ascertain their opinions on the appropriateness of Masekitlana for the purpose of the current study.
- Professor Herman Strydom, the author of a chapter on single-system research in de Vos et al. (2005), for his advice on the appropriateness of single-system design for the current study.
- Professor Lasich¹⁵, a psychiatrist with a special interest in children and to whom I was referred by McCord Research Ethics Committee to ensure that he approved of the purpose and all research procedures of the current study.
- The HIV Coordinator of McCord Hospital and Head of Sinikithemba Clinic, who confirmed her willingness for me to conduct research on patients from Sinikithemba Paediatric Clinic and who agreed to release the social worker, Head of Sinikithemba Paediatric Clinic, for the hours required to help conduct the research.
- The McCord Research Ethics Committee who proposed certain modifications and then gave me permission to conduct the research on patients attached to Sinikithemba Paediatric Clinic (see Appendix B).
- The Faculty of Education Ethics Committee of the University of Pretoria who gave their approval for the current study (see Appendix A).
- The managers and social workers of the two Children’s Homes to explain the research procedures and obtain their consent to proceed with therapy sessions in the environments of the Homes (see Appendices). The social workers informed me that they had judicial authority to sign consent forms on behalf of the children in the Homes in the absence of parents or family members residing with the children.
- An attorney, legal ethics advisor to McCord Research Ethics Committee, to confirm that it was indeed the case that social workers of the Homes could sign consent forms on behalf of participants’ caregivers or parents.

¹⁵ Professor Lasich is a Durban-based Specialist Psychiatrist. He is considered to be an authority in the field of Child Psychiatry and Psychology.

- Social worker of Sinikithemba Paediatric Clinic, to be the therapist in the study, who I trained on the various play and narrative therapy techniques, including Masekitlana that were used in therapy sessions with the participants. I discussed the picture cards of the Roberts-2 test and the Dynamic Assessment model (Matthews & Boucher, 2009) to be used during administration of the Roberts-2 test. As Strydom (2005e:213) emphasizes, “thorough training of and clear instructions” to field workers (the social worker in this study) “maximize the success of the intervention”. The social worker was particularly interested to learn different and new methods of therapy so that she could apply them in therapy to her child patients thereafter in the clinic.
- Participants in the Homes, to explain the research procedure and obtain their consent (see Appendix I).

Thereafter it was my “final individual responsibility to eventually present a study that (fulfilled) all ethical requirements” (Dane, 1990, in Strydom, 2005a:68).

3.8 DATA COLLECTION METHODS

Data were gathered from therapy sessions as well as participant observation. According to Yin (2003, in Nwanna, 2006:87), the “use of multiple sources of evidence makes the findings of case study research more credible and authentic”. Interviews of the social workers in the Homes were conducted in their offices while the therapy sessions were conducted in the sick bay of St. Theresa’s Home and in the boardroom of St. Martin’s Home. Both environments were made as comfortable as possible with a rug on the floor, on which the therapist sat with the participants. The researcher videoed and recorded from a short distance away, although still in the same room.

3.8.1 INTERVIEWS

After the consent forms were signed by the manager of St. Martin’s and the social worker of St. Theresa’s, I interviewed the social workers of both Homes to obtain background information about the participants. The interviews were structured as follows:

- They were semi-structured interviews, which are considered to be especially suitable where the researcher is particularly interested in “complexity or process, or where an issue is controversial or personal” (Greef, 2005:296).

- They were “a conversation with a *purpose*” (Kahn & Cannell, 1957, in Marshall & Rossman, 1999:108) in that I was particularly interested in how the social workers described the lives of the participants prior to coming into the Homes.
- I prepared an interview guide (see Appendix) rather than a totally open-ended “conversational interview to ensure that the same basic lines of inquiry (were) pursued with each person interviewed” (Patton, 2002:342).
- The schedule of questions “*guided* rather than *dictated* the interviews so I was able to establish a ‘conversational style’ with impromptu questions, depending on the flow of the conversation and the material that emerged” (Patton, 2002:343; Greef, 2005).
- The resultant flexibility allowed maximum opportunity for the social workers to describe many background details, while enabling them to express their own perceptions and concerns around the participants’ lives.

3.8.2 OBSERVATION

Although observational research is normally ascribed to ethnographic research, I took more of an observational position rather than facilitator of therapy sessions in the current study for the following reasons:

- I wanted to observe how Masekitlana encouraged interaction between the therapist and the participants.
- I did not want my biases to influence the content and course of the therapy and I did not want to distract my attention away from what I hoped to observe.
- I conducted “focused observation” in that I was particularly concentrating on actions around Masekitlana and the body language and gestural cues that lent meaning to the participants’ words (Angrosino & Mays de Perez, 2000, in Denis, 2000) and helped them to resolve their experience of trauma in their lives.

Concerning the degree to which a researcher can actually be a “neutral party”, I concurred that the “mere presence of the researcher will in itself alter the situation, meaning that the situation is no longer the original and natural setting” (Dane, 1990, in Strydom, 2005b:275) and that there is “no such thing as neutral observation because there is always rhetoric involved in scientific facts” (Coffey et al., in Pole & Burgess, 2000). Regarding my degree of involvement in the lives of the participants or “participantness” (Patton, 1990, in Marshall & Rossman, 1999:79) and where I fitted on Patton’s (2005) continuum from “complete observer to complete involvement”, I was not able to “shadow the participants in their everyday lives,

making notes of their activities and events of their lives” as encouraged by Muller and Sheppard (1995, in Strydom, 2005b:275). However, I met the “demands of reciprocity” (Marshall & Rossman, 1999:79), such as going into the dormitory or playground to find the participants, making tea, serving snacks and chatting informally to participants, washing cups with participants, showing them their videoed footage, and walking with them back to my car.

In the therapeutic process, I attempted, often without success, to remain neutral. At times the therapist or participant would ask me to clarify a point in their narrative, which I attempted to do. This meant I was “being informative while remaining informal” (Marshall & Rossman, 1999:79). The therapist’s style of therapy was at times different from my own, so I had to resist prompting her to ask questions or develop the therapy in directions I thought would be relevant to the aims of the study. This would have constituted manipulation of therapy so as to produce more positive results than there might not otherwise have been, which constitutes taking on ‘advocacy roles contrary to the interests of good scientific practices’ (Yin, 1989:93).

Being an observer whilst at the same time managing the video and audio recording allowed me to take notes and raise questions in my mind from different perspectives. It also enabled me to “play the dual role of data-collector and interpreter of the data” (Coertze, 1993, in Strydom, 2005b:277). Overall I ensured that my involvement and reciprocity fitted within the “constraints” (and aims) of the research, within the “restraints of maintaining my role as the researcher” and was appropriate to my personal and research ethics (Marshall & Rossman, 1999:90).

3.8.3 FIELD NOTES

Field notes formed part of the data collection strategy and took the form of an electronic journal, which I compiled the evening after each session. In my field notes I recorded:

- Activities in the Homes in the vicinity of the therapy room that might have affected the process in any way.
- My observations of the therapy process and therapeutic progress such as better rapport and increased communicativeness.
- Keen, clear and detailed notes, as the researcher do not always know the relevance of what he or she is observing until later (Strydom, 2005b).
- Participants’ facial expressions as well as the nuances of the participants’ gestures and verbal comments.

- Timbre of voice, tone and inflection, which offered clues as to meaning. I checked their relevance with the therapist when I found them ambiguous. Participants send out many subtle non-verbal cues to give messages and to express themselves, which might not always be readily understood by a person of another culture (Sikkema & Niyekawa-Howard, 1997).
- My experience of liminalism, which was feelings of familiarity with participants' attributions of meaning *and* feelings of strangeness or lack of understanding their meanings.

I included self-reflection or reflexivity in field notes for the following reasons:

- To create transparency of my feelings as researchers tend to “ask for revelations from others, but reveal little or nothing of (them)selves; (they) make others vulnerable but (they themselves) remain invulnerable” (Beharl, 1993, in Denzin & Lincoln, 2000:109).
- To reveal my multiple selves and ‘fluid’ identities that I brought to the research setting (Lincoln & Guba, 1985, in Denzin & Lincoln, 2000).
- To not only “bring the self to the field but also to create the self in the field” (Reinharz, 1997, in Denzin & Lincoln, 2000:3).
- To encourage “openness to being moved by the plight of others” and a “willingness to be touched by another’s life” (Nussbaum, 1990, in Denzin & Lincoln, 2000:204), hence to explore the effect on myself of the participants’ narratives. This involved an ethic of closeness, care, proximity, and relatedness (Swandt, Gadamer & Taylor, 2000, in Denzin & Lincoln, 2000). Expressing feelings and impressions in field notes helped me to develop, understand and tolerate this form of relationship with the participants.
- To encourage a form of flexibility and perceptiveness called *phronesis* or practical wisdom, which arises from discernment and reflection in research (Gadamer & Taylor, 2000, in Denzin & Lincoln, 2000).

3.8.4 TECHNOLOGY

In order to gather data in the current study, I used a video camera as well as an audio recorder. The reasons for the use of these forms of technology as opposed to simply note-taking were:

- Without technical recording of details, I would not be able to rely on my recollection of the conversations or narratives of the sessions (Sacks, 1992, in Denzin & Lincoln, 2000). Written notes would have lost some details.
- Recorded information allowed for new analyses at a future date and a stored record for presentation to other researchers.
- Competency over technology in research is as much a skill to be acquired as psychosocial aspects of research (Angrosini & Mays de Perez, 2000).

However, there were aspects of the technical recording that needed to be guarded against:

- The *ecological ramification*, which is that it might have had an affect on the participants' responses and the environment of research (Angrosini & Mays de Perez, 2000). Besides looking up briefly at the camera occasionally, participants of the current study did not seem to mind the recording, except on one occasion when Nana adopted the persona of an actor and performed a short drama for the camera, which she said she wanted to see afterwards.
- That I might become more neutral to the situation of therapy, as I knew I would be able to peruse the content at a later stage. I was not against remaining neutral but was partially prevented from being so, as the therapist and participants drew me into the sessions at times.
- That it might distract me from the particularities of the sessions in favour of the totality, as it prevented me from making detailed notes during the sessions. I did, however, make notes soon after the sessions and reviewed the recordings for any significant particularities I might have missed during the recordings.

Data were stored as follows:

- The videoed discs from the therapy sessions were transferred onto a computer to act as a duplicate copy and a backup for the recorded tapes, as well as to allow for presentation of photographed images at a future stage.
- After receiving the translated copies of the narratives, each participant's narratives were organized into separate participant computer files with a clear indication of the different sessions. These included the standard of care therapy, the different administrations of the measure and the intervention therapy sessions of Masekitlana.
- Therefore, three copies of the data were created (on laptop, desktop computers and on a flash drive) in case of mistaken deletion of information.

- A fourth paper copy was made for making notes on and for reviewing in situations where I could not work on my computers.

3.8.5 SYMBOLIC PLAY AND MASEKITLANA

The challenge in this study was how to engage meaningfully with children and adolescents who might otherwise be reluctant to co-operate with the therapeutic process. The participants in this study were offered art and play therapy in the form of drawing and clay before being introduced to Masekitlana, the narrative game with stones.

My reasoning for using symbolic play therapy, mostly with natural products, in the current study was based on the following:

- Both Piaget (1962, in McCune, 1998) and Vygotsky (1978, in McCune, 1998) recognize the special role of symbolic play in the child's development and use of representational functions. Similarly in this research, art, clay and stone play were offered as a means to symbolize projections of the participants' lives and to access the internal and relational worlds of the participants (Crenshaw & Hardy, 2007; McCune, 1998; Buhrmann, 1984).
- It has been found that traditional sand story games in a remote Western Desert community in Central Australia, and European sand play therapy that was introduced as part of an intervention program in a Tiwi Island community off the northern coast of Australia, represented the bodies and the lives of the children in symbolic ways (Schilder, 1950, 1951, Merleau-Ponty, 1961, Scheler, 1973 in Eickelkamp, 2008).
- I purposely omitted to use traditional standardized assessment instruments, such as the Goodenough Draw a Person Test or Goodenough Harris Drawing Test (Goodenough, 1926 in Bartle, 2001) and the Kinetic Family Drawing Test (Burns & Kaufman, 1972), as the purpose of the research was to prove that indigenous forms of play reveal more and are felt to be more familiar to the indigenous child.
- Playing with clay and stones fulfilled a "pretend aspect" for participants in that it had "no specific goal, it was spontaneous and voluntary, it involved active engagement, it was all engrossing, it was a child's private reality and was nonliteral" (Segal, 2004, in Pearson, Russ & Cain-Spannagel, 2008:111). In pretend play, "one thing is spontaneously treated as something else" (Pearson, Russ & Cain-Spannagel, 2008:111), and therefore serves a symbolic behavioral purpose.

- It allows children to feel powerful and it is thought that experiencing a sense of agency during play may generalize to a sense of agency outside of play (Pearson et al., 2008).
- Participants felt more comfortable and less threatened by answering questions in a game format, which allowed them to distance themselves from reality (Kaduson & Schaafer, 2001, in Kekae-Moletsane, 2008). For this reason, what the participants drew, what they created out of clay and how they played with the stones was of their own choosing. During Masekitlana, participants evolved their own rules or demonstrated rules of stone play they had learnt previously amongst their peers.
- Universal forms of play such as television games are thought to interfere with the natural development of children (Byers, 1998); hence, cultural aspects of play ought to receive more research attention (Ault, 2007). Masekitlana is part of Sotho children's repertoire of narrative games and hence is considered an indigenous cultural game.

3.8.6 STORY-TELLING AND MASEKITLANA

As the current study came from an interpretivist epistemology, how participants saw their lives as revealed by their stories and the context or background to their stories was the focus of my attention. Story-telling has been described as a portal of entry to reach disconnected children (Crenshaw & Hardy, 2007). I chose to use the healing aspects of story-telling to the benefit of the participants.

In working with post-war Ugandan children, Lamwaka (2004) found that through listening and story-telling, victims of horrifying violence were able to recover from flashbacks, panic attacks and isolation. Lamwaka (2004) found that expression in different ways allows a child to become more aware, and to gain meaning and control of the emotional dynamics that are linked to traumatic events. Story-telling "contains seeds of healing" and ways to express traumatic experiences may vary from child to child, depending on local culture and tradition (Lamwaka, 2004). Kekae-Moletsane (2008) demonstrated that the story-telling arising out of the narrative game, Masekitlana, helped a Sotho child to heal himself from a traumatic incident. Hence, in this study, I hoped that it would be equally effective on Zulu-speaking children and would offer a survival tool for an increasingly complex life that the participants found themselves in (Cox, 2000, in Lamwaka, 2004). I hoped that the participants would take the narrative game of Masekitlana and play it with their peers as, outside of the environment

of therapy, mere listening to others' stories and sharing with others are activities through which children make sense of their inner world and the world around them (Ryokai & Cassell, 1999).

Story-telling also retrieves memory in a constructive way (Whitfield, 1995, in Denis, 2004). Denis (2004) describes the remembering and telling of an event as the *rehearsal* of the experience, which, when validated by a third person, preferably an adult, helps the child to take control of the memory. This is precisely the opposite of what sexual abusers tell their victims: "If you ever speak to anyone about what has happened, I will kill you" (Denis, 2004:4). Hence, validating the child's choice to speak dispels doubt and confusion. "Constructing a life story helps individuals to adjust to their existence by placing it within a context and by inserting it into their environment" (Lani-Bayle, 1999, in Denis, 2004:5). The life story helps children to "avoid being a passive victim of their family history and instead to become the authors of their own history" (Lani-Bayle, 1999, in Denis, 2004:5). Children 'talking about themselves' is much more than information, it is also 'formation', and it is a process of 'realizing identity' (Andersen, 1992).

Masekitlana was used traditionally by a group of children surrounding the narrator, who banged two or more stones together in the middle of the circle while he told a story about his life. The children were able to comment on the narrator's story and were able to show emotions, even to the point of crying (Kekae-Moletsane, 2008). In this study, the therapist's role was to question and interrogate the participants as they played Masekitlana so that they would be better able to analyze their lives. "In that moment when an individual life becomes a story, where it has a structure, where it is shaped not only by chronological order but by a logical structure, then we can say that it has passed from life to history" (Abels-Eber, 2000, in Denis, 2004:6). I hoped that Masekitlana would help the participants to create a historical perspective to their stories, thereby putting the traumatic parts of their lives behind them.

The participants in this study were placed in Children's Homes due to the circumstances of their lives, over which they had no control. Hence, through the power of story-telling in Masekitlana I aimed to encourage the participants empathetically to remember and reconstruct their lives, to validate their fears and concerns, to help them to dispel their confusion and guilt, to empower them and so dispel passivity and hopelessness in their lives, to help them create unique and new identities, and to enhance resilience (Denis, 2004).

3.8.7 TRANSLATION AND TRANSCRIPTION

Care needed to be taken during the transcription and translation process as “to neglect the processes involved in translating research data is to miss fruitful parallels between the problematics of reading and interpreting social situations, and those of reading and translating actual texts” (Magyar, 2003, in Robinson-Pant, 2005:140).

Therapy sessions were conducted in Zulu, which was the mother tongue of the participants and the therapist. The participants would normally, in sessions with me in the clinic in McCord Hospital, have conversed in a mixture of English and Zulu. However, in the context of this study, mixing languages might not have yielded rich enough data and would not have reflected adequately enough the authentic African setting of Masekitlana. Furthermore, participants feeling self-conscious over their language would have been counter-productive to research purposes. In discussing discourses of transparency, Turner (2004, in Robinson-Pant, 2005:140) concurs that “when language is working well, it is invisible. Conversely, however, when language becomes visible, it is an object of censure, marking a deficiency in the individual using it.” I have found in my own experience that incongruence of language between therapist and client can make a session more formal.

The recordings of the sessions were transcribed and translated directly from Zulu into English by two Zulu-speaking post-graduate students who had past experience of transcription and translation from other research projects.

I encountered the challenges of potential loss of meaning, especially cultural nuances, metaphors and symbolism, and differences in language expression between Zulu and English due to direct word-for-word translation by a person who was not an observer during therapy sessions. However, as I had a running understanding of the Zulu spoken in the therapy sessions, I was able to obviate inaccurate points or words in the translation. I also performed translation checking by listening to the video footage concurrent with the translated text.

3.9 DATA ANALYSIS

I used a mixed methodology of quantitative and qualitative analysis which will be described in detail in the following two chapters.

3.9.1 QUALITATIVE ANALYSIS

All data was sorted into numerated ‘turn units’, with each turn of narrative (each time a person spoke) representing a turn. Trends or patterns of thought that emerged in the narratives were then identified. Collating this data into generative themes involved open coding (identifying clusters of meaning), axial coding (looking for links, connections and commonalities or differences between themes in order to merge themes) and selective coding (reducing the number of themes to a manageable amount). Eventually four main themes were identified, with sub-themes and categories. Quotations representative of each category were tabulated and themes were described. In Chapter 6, the themes are interpreted in relation to the existing literature.

3.9.2 QUANTITATIVE ANALYSIS

To demonstrate the effect of Masekitlana in a more concrete, evidence-based way, there needed to be a quantifiable form of comparison between standard of care therapy (pre-test/baseline phase) and the intervention of Masekitlana (phase B). Hence, the Roberts-2 test (Roberts, 2005) measure was chosen to present graphically the measured scores at the different stages of therapy.

3.9.2.1 Assessment measure: Roberts-2 test

The Roberts-2 test devised by G. E. Roberts (2005) is an updated and improved version of the Roberts Apperception Test for Children (1982, in Roberts 2005). The Roberts-2 personality test has been used to measure functioning in children with many different psychological conditions and has been used in research to measure differences in personality functioning between children diagnosed with Attention Deficit Hyperactivity Disorder and Bipolar Disorder (Row, 2008). It uses story-telling to evaluate children’s social perception and focuses on the child’s social understanding as expressed in free narrative. The measured construct in Roberts-2 is Personality in that children are shown pictures that “present situations of interpersonal interactions and problems showing emotions that (have been proven to be) productive in the assessment of children’s personalities” (Roberts, 2005:x). Roberts preferred not to call his test a projective test, as he believed it is difficult to prove that the child is indicating features of his life in the description of the picture cards. However, he did feel that the descriptions were an indication of how the participant would manage similar

problems in his life. I was able to compare participants' description of their lives during play therapy with their descriptions of picture cards and found that their picture card descriptions reflected their stories told during narrative play therapy.

The Roberts-2 test is used with children in the age range of six to 15 years, the administration is individual and the time is untimed. Test pictures or picture cards feature current hair and clothing styles. Children and adolescents are considered to be realistically depicted in everyday situations, with their families, with peers, or alone. In the current study, the version featuring Black children was used (see Appendix M).

At the time of this study, the Thematic Apperception Test (TAT) (Murray, 1949, in Murray, 1971) was the classical personality assessment test that was being taught to South African psychology students. I felt that the Roberts-2 test would be more suitable than the TAT as the figures in the pictures are more typical of the African form than the European form. The content of the pictures and the activities of the characters are also more typical of everyday life in Africa.

Responses to the picture cards were scored according to the Roberts-2 Manuel, Part I: Administration and Scoring Guide (Roberts & Gruber, 2005). Not all of the 16 pictures were chosen in each assessment occasion by the participants, so the t-scores could not be calculated.

Participants' descriptions of the picture cards were also qualitatively analyzed and thematically coded, and so additionally form part of the qualitative data analysis.

The Roberts-2 test was used:

- at session 1, to measure and report on participant social adaptation and perception before standard of care therapy (baseline phase);
- at session 3, to report on the pre-test assessment results (after standard of care therapy and before Masekitlana intervention therapy);
- at session 6 to report on the post-test results (after Masekitlana was used as intervention); and
- to report on the longer term affects of Masekitlana (after a maturation lag of two months after termination of Masekitlana).

An analysis of the results indicated progress or no progress. The results between the two forms of therapy informed findings as to whether Masekitlana was useful and could be recommended in therapy or not.

3.10 DATA INTERPRETATION

Data interpretation involved examining the themes and their connection to the aims of the research. This involved testing the “emergent understandings” against the conceptual framework of indigenous psychology and therapy (Marshall & Rossman, 1999:157). I examined the data to assess its usefulness in answering the research questions. Interpretation became a “temporal process” (Denzin, 1989:108) in that, as I was analyzing themes and calculating quantitative results, I found myself interpreting data according to my background knowledge of literature, testing my assumptions and drawing conclusions. Interpretations and discussion of themes and graphic results are found in Chapters 6 and 7, where the discussion will also be linked to the literature reviewed.

3.11 ETHICAL CONSIDERATIONS

Researchers have an “ethical responsibility to their participants and to the discipline of science to report accurately and honestly” (Cravetter & Forzano, 2003, in Strydom, 2005a:56), to know what is ethically right and wrong as opposed to the values of goodness and desirability (Babbie, 2001, in Strydom, 2005a), and should regard their participants as “co-researchers who need to be fully informed about the goals and purpose of the research” (Tutty, 1996, in Strydom, 2005a:57). Furthermore ethical principles should be “internalized in the personality of the researcher to such an extent that ethically guided decision-making becomes part of his total lifestyle” (Botha, 1993, Bulmer & Warwick, 1983, Corey et al., 1993, Grasso & Epstein, 1992, Levy, 1993, Loewenberg & Dolgoff, 1988, Rhodes, 1986, in Strydom, 2005a:57).

In accordance with these points of caution, the following ethical issues were identified and considered in this study:

3.11.1 AVOIDANCE OF HARM

Social workers in the Homes were reassured that all research procedures would be conducted in a manner that would be as beneficial to the participants as possible. The therapist and I spent time before commencing the research talking to the participants about the process of the research so that they knew what to expect from the therapeutic sessions. An ethical consideration was not to deceive them as to the purpose and reason for the research, and to protect them, as far as possible within my powers and those of the therapist, from experiencing any harm or distress during and after the research (Maree, 2007; Cohen, Manion & Morrison, 2007). The therapist and I attempted at all times to ensure that the participants' dignity and self-respect was not undermined in any way by the research process. In a study of this nature, "emotional harm was more likely to be a consideration than physical harm", and was "more difficult to determine" (Strydom, 2005a:58). Therefore, we were careful to notice the effect that the therapist's questioning and the participants' talking about their lives was having on the participants. We checked regularly with social workers in the Homes as to whether research was affecting participants adversely. However, researchers are perhaps sometimes overly sensitive to harm done to participants, whereas in fact "research benefits, long-term or short-term, usually outweigh any emotional discomfort that might arise during research" (Babbie, 1990, in Strydom, 2005a:58). "What is re-experienced in research through the telling of it is often minimal in comparison to the actual situation that occurred in real life" (Huysamen, 1993, in Strydom, 2005a:58). In fact, participants often feel that it is a chance for the researchers to advocate on their behalf where they do not possess the power and resources to do so (Fine, Weis, Weseen & Wong, 2000).

Participants of the current study were informed that:

- Should the therapeutic process make them feel overawed or emotional in a negatively harmful way, they could withdraw from the research.
- Withdrawal would not jeopardize their medical or psychosocial treatment at Sinikithemba Clinic.
- Should they experience adverse effects from the study, counselling in the Psychology Department of McCord hospital would be organized.

My contact number and that of the Psychology Department of McCord Hospital were given to participants.

3.11.2 INFORMED CONSENT

Although researchers are encouraged to have an egalitarian relationship with their participants (Tutty, 1996, in Strydom, 2005a), there is the opinion that the consent and assent form entrenches the power differential between the participant and the researcher (Fine, Weis, Weseen & Wong, 2000). In the current study, the consent and assent forms did not appear to compromise a warm and open relationship between participants and myself, but they did ensure accountability. One of the facets of a trusting relationship between participants and the research team was to discuss continually with participants the conditions of their participation in this study (Human-Vogel, 2007).

Social workers signed consent forms for this study before the commencement of the study. The choice of social workers as opposed to parents was made according to the Children's Act No. 38 of 2005, where a caregiver is defined as “any person other than a parent or guardian, who factually cares for a child and includes a person who cares for a child whilst the child is in temporary safe care, a person at the head of a child and youth care centre where the child was placed, the person at the head of a shelter or a child and youth care worker who cares for a child who is without proper family care” (Human-Vogel, 2007).

In choosing participants, care was taken not to single out children and adolescents from the Homes for special attention that would mark them as different (Schenk & Williamson, 2005). In particular, other Home children were not to think that participants were singled out due to HIV/AIDS, which has a stigma to it, nor were other children to think that participants would be given gifts or special privileges as a result of the research. Participants were also to be selected fairly in relation to the aims of the activity, rather than simply because of their availability, their compromised position, or their vulnerability. According to this principle of “justice” (Human-Vogel, 2007), particular participants were selected not only due to vulnerability but because the effects of their vulnerability would assumedly be helped by the psychological intervention of Masekitlana therapy. According to the University of Pretoria, Research Ethics Committee, therapeutic psychological interventions are classified as those psychological acts that are designed to bring about a direct improvement in psychological and social functioning, and are likely to provide an immediate or direct benefit to the child, and include trauma counselling and other forms of personal counselling. The Ethics Committee views therapeutic interventions as similar to medical treatment, to which a child over the age

of 12 can consent without being assisted by a parent/guardian/caregiver, according to the Children's Act No. 38 of 2005 (Human-Vogel, 2007).

After participant selection, participants were approached by social workers, who explained the research process and why participants had been selected for this particular therapeutic programme. Thereafter, the therapist presented letters of explanation and assent forms to participants. The two forms of therapy were described to them and the Roberts-2 test was shown to them. The purposes of the research were explained and possible consequences, positive and negative were clarified. Participants were given the opportunity to express their views in age-appropriate ways about the information-gathering approach and the forms of therapy (Schenk & Williamson, 2005; Human-Vogel, 2007). They were encouraged to make an independent decision without any pressure, as every individual should be treated as an autonomous agent with the right to self-determination (Schenk & Williamson, 2005).

Potential risks were pointed out to participants, such as feeling traumatized about revealing their past difficulties. In conducting research of this nature and according to the rules of beneficence, it is a challenge to determine the right balance between benefits and harm, as although the goal is to benefit society, the individual should not be adversely affected in the process. He or she should accrue as much benefit as the larger picture of the research (Schenk & Williamson, 2005; Human-Vogel, 2007). Even if participants are not at risk of any harm and even if they do not listen to the explanations of the researcher or are not interested in knowing, they still should sign informed assent or consent (Strydom, 2005a:60). All participants appeared more than willing to participate in the study.

On the day of the first session, before the session began, participants were again given an explanation of the procedure. There was time given for questions about the process (Strydom, 2005a) and participants were encouraged to discuss any queries they might have as therapy progressed.

3.11.3 VIOLATION OF PRIVACY/ANONYMITY/CONFIDENTIALITY

The differences between privacy, confidentiality and anonymity need to be clarified. Privacy implies the element of personal privacy, while confidentiality indicates the handling of information in a confidential manner. There is a further distinction between confidentiality and anonymity. Confidentiality implies that certain people know who is partaking in research

and what is revealed, and this should be regarded as privileged information. Anonymity means that no one, not even the researcher, should be able to identify the participants afterwards (Dane, 1990, Babbie, 2001, in Strydom, 2005a).

The participants' rights to anonymity were ensured in this study by changing their names in the transcription of data. However, in the recorded therapy sessions, participants were addressed by their original names as they felt it strange to be called by pseudonyms. Confidentiality in data was maintained by securely locking it away. It was explained to participants that confidentiality would be breached if a participant was found to require immediate protection (Schenk & Williamson, 2005). Anonymity in data dissemination was ensured as participants were filmed from their shoulders down.

Participant privacy was assured by offering a quiet, undisturbed setting for research where information was only heard by the therapist and me, the researcher. However, Professor Strydom pointed out in telephonic discussion that the current study would not have been possible without a certain amount of encroachment on the privacy of participants. This is due to the fact that psychological therapy by definition involves a person revealing his or her personal life, which is a compromise of his or her privacy.

3.11.4 COMPETENCY OF RESEARCHER AND THERAPIST

At all times the researcher and therapist must be informed as to the practice requirements of her profession, as well as being competent and adequately skilled to undertake the proposed investigation (Strydom, 2005a; Schenk & Williamson, 2005). Orphaned or vulnerable children in particular need to be managed competently and with special attention in research projects, as they do not have parents who can advocate on their behalf (Human-Vogel, 2007). In the current study, it was important not just to produce valid results but also to act ethically in the therapeutic situation. Hence, the therapist had to be well trained in the therapeutic forms of the current study and the potential effect of therapy on participants had to be well considered. The therapist, social workers and I discussed difficulties that occurred during therapy.

Cultural barriers between the participants and me were ethical considerations. To provide maximum protection to young participants, investigators must be familiar with and respect their cultural norms, including age and gender roles within the family and community,

limitations on social roles imposed by ethnicity or social group, and expectations for child development and behaviour (Schenk & Williamson, 2005). “Objectivity is part of the equipment of competent researchers” (Strydom, 2005a:63) who, if they are to “base their practice on scientific principles, must refrain from value judgments”(Loewenberg & Dolgoff, 1988, in Strydom, 2005a:63). As it was important that I learnt about the cultural perceptions of participants from a different culture from my own, I attempted to suspend my own value judgments during this study. As notes in my journal reflected, this turned out to be a difficult process to follow as, in identifying trends in narratives, my own perceptions of what I was hearing and observing, and how participants were feeling, came to the fore.

3.11.5 TERMINATION OF THERAPY AND RESEARCH

Termination of therapy was difficult in the current study as participants found it hard to say goodbye to the therapist and me. This had to be handled with sensitivity and the participants were assured that contact could be renewed at a later stage, once the follow-up session was completed. Hence, after the follow-up session, I continued to visit one of the Homes to see the participants and after the research process was over, one of the participants, who has no family members, came back on certain weekends to stay in my home with my family. I was aware of ethical issues involved in crossing boundaries with patients and gratification of clinician’s needs as a form of exploitation of the child (Barnett, 2010). I was also aware that my presence in this participant’s life was not to create expectations that I would not be able to meet (Human-Vogel, 2007). My motives for continuing a relationship with the participant were determined by the participant’s needs and the fact that I felt it would be unfair to leave the participant in his solitary life after the research process had revealed it to me, and my family and I were able to help him with an occasional period of family life. Researchers need to give back to their participants as much as they take from them. Notes from my reflexive journal indicated these sentiments:

I felt during the holidays that here I was enjoying myself and relaxing knowing that the practical side of my research was going well while the (subject) participant of my research was languishing away in the Children’s Home. I could just come in and out of my research life at will while the subject (participant) of my research remained always firmly almost as a prisoner in the harsh reality of his life. I began pondering how I could do more for my participant after research was finished (23/6/2010:9).

The Home where the female participant resided was visited once a week by psychologists from McCord Psychology Department and they were asked to consult with the participant should she so require.

3.11.6 DISSEMINATION OF FINDINGS

Results of research need to be written up in an accessible report form and in journal articles as clearly as possible so that other professionals, who might want to emulate the research in their own settings, will not be misled (Human-Vogel, 2007). A report can “manipulate results to confirm hypotheses or points of view; data can be interpreted correctly, but utilized to stress certain focal points; or data can be evaluated differently by different persons” (Judd et al., 1991, in Strydom, 2005a:65). I believe there is a certain amount of inevitability about the aforementioned points, as researchers enter into research with a particular focus in mind and it is upon this that they concentrate. In this research, my aim was to explore how an African form of therapy could potentially enable participants to express their authentic African selves and cultural beliefs, and, although the research revealed a lot of other things about the participants, it was on this area that I concentrated the most.

Acknowledging the contributions of others in the current study and incorporating and acknowledging others’ ideas in the writing up of the research was important as plagiarism is considered to be serious ethical misconduct. Participants should be informed, in “language they understand and without breaching confidentiality”, about the findings of the research “as a form of gratitude for their co-operation” (Strydom, 2005a:66). Authorities should also be informed whether the intervention, if demonstrated to be effective, would be made available to a larger population within the participants’ environment (Schenk & Williamson, 2005). If possible, funding should be obtained to make the results accessible to other organizations as well (Human-Vogel, 2007).

I was aware of the potential challenge of the social workers and participants not agreeing with the conclusions when they reviewed the findings. What is considered innocent by researchers might be perceived to be misleading or even betrayal by the participants (Christians, 2000, in Denzin & Lincoln, 2000). To a researcher, an outcome or point made in the findings of research might appear neutral but to a participant it might be offensive to his or her personal sensibilities. Furthermore, there is the danger that issues reported by researchers might be aggressively or nonsensically taken up by the media. I was aware of these challenges and tried

to be as accurate, sensitive and transparent as possible in the interpretive analysis and presentation of the results of the current study.

3.12 CONCLUSION

“An embarrassment of choices characterizes the field of qualitative research. There have never been so many paradigms, strategies of inquiry, or methods of analysis for researchers to draw upon and utilize” (Denzin & Lincoln, 2000:18). Accordingly I hope to have demonstrated the complexity involved in deciding on the paradigms and models of research required to competently investigate an aspect of the field in question.

In this chapter, the single-system research design of Strydom (2005d) was described. The advantages of the single-system design were tabled. Involved in the single-system design are the mixed methods of qualitative and quantitative approaches to observing, recording, analyzing and recording the data. I discussed the advantages of mixed methods for the purposes of this study. The multi-faceted process of crystallization as it applied to this research was discussed. I described why I used purposive, non-probability sampling methods to select four participants in two Children’s Homes. Details of the research environment and the background to the participants were given. Therapeutic methods, in particular the narrative play therapy with stones called Masekitlana, were described and the rationale for using them was explained. Finally data collection strategies, and methods of analysis and interpretation were discussed, as well as ethical considerations around the research process.

In the next two chapters, I present separately the qualitative and quantitative data analyses.

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